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**THE CREATION AND DEVELOPMENT OF
AN INTEGRATED NURSING SERVICE WITHIN A
RURAL COMMUNITY HEALTH TEAM**

AN ACTION RESEARCH STUDY

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

Margaret Elizabeth Cornish

December, 1995

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FRONTISPIECE

**The citadel of an established practice will not
fall to the polite knock of a good idea.**

B. MacDonald cited in Kemmis & McTaggart (1988, p. 87).

ABSTRACT

This Action Research study, guided by the philosophy of Critical Social Science, was undertaken to facilitate District and Public Health Nurses working in a multidisciplinary team in a rural area to reflect on and change their practice. The goal was to explore the possibility of combining their two separate roles into one integrated role. The idea was initiated by management who anticipated that an integrated role would ensure survival of their nursing service in the competitive environment created by the New Zealand Health Reforms. The study resulted in planned participative change brought about by this nursing group.

Analysis of the process increased knowledge about rural community nursing and showed that the research group created a local theory. Through their reflection the nurses isolated and related factors about their work. From this, they created a model that represented a combined nursing practice while retaining their specialist roles. Using this model the nurses planned strategies that they predicted would bring specific results. During action and evaluation, these strategies were tested and culminated in putting the emergent model into practice. The model has potential to be generalised to other community nursing groups.

Analysis of data showed that many factors enhanced the change process. Observation revealed that some group dynamics also had potential to inhibit change. When analysed with the group, the nurses recognised that there was a relationship between these dynamics and their job structure, their socialisation as women and their indoctrination as nurses. It also highlighted differences between how these District and Public Health Nurses think about their work and their roles. This critical reflection increased their self understanding and ensured that any planned change was more likely to endure.

For the participants, this study has resulted in a positive sense of the value of their work, a strong sense of group cohesion, a better co-ordinated communication network, and confidence in their ability to make decisions for themselves. This has, in turn, given them a stronger nursing representation within their team and organisation.

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This thesis is the result of five years of part-time study doing required papers and this research project. This way of studying has allowed me to balance my life with partner, friends, work and play. As such, I am grateful to Massey University both for organising a part-time Masters' degree and for establishing the Albany Campus. This has meant that for the last two years I have not needed to take the long trips, monthly, to Palmerston North.

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INTRODUCTION

This introduction is designed to inform the reader about editorial, technical and structural features of this thesis.

Editorial Features

The first two points are related to the philosophy of empowerment that guides this work, and to one of the goals of Action Research to bring research, theory and practice together.

Use of the First Person

Throughout this thesis I have chosen to describe my role in the first person. Though there is continued academic debate about the appropriateness of such a stance, I concur with the argument presented by Webb (1992). She states that the researcher's use of the third person in academic writing is meant to convey an objectivity and scientific neutrality that is unobtainable within any research method. In this project, where I openly declare my researcher role as a joint participant whose ideas and impressions become part of the data, use of the first person adds to the accuracy and the credibility of the written report. Also claiming ownership of the ideas I have generated, and presenting them in the first person is a very self empowering activity.

Language

While recognising the need to meet a high academic standard, I have chosen to keep my use of formal language to a minimum in order to maximise the understanding of nurses in practice. This coincides with my goals of making research 'user friendly' to nurses.

Unless otherwise stated, the discussion about health care and specifically community nursing is related to New Zealand.

Technical Features

The data were coded in a way that preserves anonymity in the presentation of recorded information from the nurses. Each participant has self chosen initials. When attributing data from individual interviews, the format is the chosen initial, the number of the interview and the page number of the transcript e. g. (TS 2, p. 9).

When quotations are from a group meeting, these are coded with GM, the number of the group meeting, initials of the participant and the page number of the transcript e.g. (GM 2, KO, p. 7).

A weekend workshop held involved five separate sessions. Quotations from these are coded with WS, the number of the session, initials of the contributor and the page number of the transcript e.g. (WS 3, KB, p. 6).

Structural Features

This thesis is divided into six chapters. Chapter One follows with an overview of the study, summarising the process and the results. Chapter Two describes the study background placing community nursing and specifically District and Public Health Nursing into their historical, political and social contexts. The Action Research method and the chosen theoretical basis of Critical Social Science are the foci of Chapter Three. Chapter Four gives a description and an analysis of the research process while Chapter Five presents the outcomes and a theoretical discussion. Chapter Six concludes with a brief overall summary.

CHAPTER ONE

OVERVIEW

This chapter presents an overview of the study. Topics introduced here are expanded in subsequent chapters.

This study used Action Research and the philosophy of Critical Social Science to facilitate change in how nurses work within a small rural multidisciplinary Community Health Team. Two Public Health Nurses and four District Nurses, who had distinct and separate roles, worked as co-researchers with the researcher as facilitator, to develop ways of working together more closely. Theorising through the processes of reflecting, planning, implementing and evaluating strategies, they created and tested a model for rural community nursing that they now use as a theoretical framework for practice. The project has met the goals of Action Research by bringing about change and developing theory. It also exemplifies Critical Social Science by raising the awareness of this group about their value as nurses and enhancing their ability to make their own decisions about their practice.

Instigating Factors

Five factors influenced the instigation of the study. These include:

Increased Community Nursing: The nature and scope of community based nursing is increasing. This is influenced by a world focus on Primary Health Care through the World Health Organisation and the local promotion of community care in the New Zealand Health reforms. However the fragmented delivery of community health nursing remains a concern.

The New Zealand Health Reforms: The Government health reforms had been implemented in 1993, six months prior to the beginning of the study. Before these reforms, the Area Health Board(AHB) that employed this Community Health Team

were directly funded by the Government for their service provision. Separating the funder from the provider of service was the main thrust of the health reforms. The Area Health Boards were disestablished and new entities known as Crown Health Enterprises (CHEs) were formed. The one that employed this Community Health Team, changed its structure in order to deal with submitting tenders to a Regional Health Authority (RHA) that now holds Government health funds. The RHA decides who best can provide a designated service. A new Community Health Manager of this CHE, who hereafter will be identified as the 'Community Services Manager', closely guided this team through the implementation of these health reforms. In particular there was a need for the team to examine their service for effectiveness and efficiency in order to maintain a competitive profile in contract negotiations.

Developing a Rural Focus: At the same time, this multidisciplinary Community Health Team, were involved in a process of formally identifying and establishing themselves as a more independent rural service rather than continuing as a satellite of the nearest urban centre. Previously, the rural nature of the team's work had not been well recognised and most of their policy directives were based on city needs. However the team wanted to develop their service in a way that better suited their clients and the staff. To this end, the Community Health Management appointed a District Co-ordinator for this rural team, their first local management position. The appointee, who had worked in the team as a social worker, now took on direct line responsibilities to the CHE management and also became responsible for ensuring that this community is served by appropriate health care staff, within a designated budget. Under his direction, rural community health care is being addressed and relevant policies are being designed. The team, along with the 'Community Services Manager' based at the urban centre, planned to meet regularly to discuss this rural focus, and what it would mean to their work and roles.

Generic Nurse Proposal: During discussions on the impact of the current health reforms and the rural focus, the 'Community Services Manager' suggested that the nurses of this team integrate their distinct roles and work as 'generic' or 'generalist' community nurses. She considered that this change could be more efficient and cost effective, and would enable the service to survive. Being a 'generic' nurse had no appeal to this

nurse group as each valued their specialist role. However, they were willing to look at ways of working differently.

Need for a Thesis Topic: At this time, I was looking for a topic for my thesis. I suggested to the nurses that we work together in a research project that would give them a structure for looking at alternatives to their existing way of working. I was keen to do research within a framework that brought research, practice and theory closer together and had meaning for participants. To achieve all these goals, I chose to use Action Research guided by Critical Social Science.

Study Outline

I met with the two Public Health Nurses and four District Nurses of this team, both individually and in groups, over a period of ten months. Together, they described their practice worlds, and we examined and theorised about them in their broad social, political and organisational contexts. As well as reinforcing the distinct nature of their roles, some common work related to health promotion and client education was also revealed. Using those commonalities, they created a new model for community nursing practice that maintained their separate roles and also enabled them to share aspects of their work. With the model as a theoretical framework, they devised implemented and evaluated plans to work more closely together.

At regular intervals throughout the research process, the whole Community Health Team along with the 'Community Services Manager', met to discuss the team's rural service development. The nurses' own progress, which they chose to report, was brought to these meetings.

My role was to facilitate the change process, and to collect and analyse data. The majority of data were gathered in five separate group meetings and a weekend workshop with the nurses. Two individual meetings with each nurse were also held, one at the beginning of the project and one close to the end. I audio-taped conversations and debates throughout the facilitated process. In total there were thirty-

four hours of transcribed data. My note-taking from formal and informal observations of the group in action and the personal journals kept by all participants were also used as data.

Analysis of data involved examining both the group process, and the process of theory building that contributed to the outcomes. Process analysis focused on group dynamics and the role each member played. Issues or themes that facilitated or inhibited the change were identified as they arose. This enabled me to keep pace with the group and also enhanced the change process by addressing the issues with the group, as they surfaced. The analysis of the theory building process examined how the Action Research spirals of reflection, planning, acting and evaluation provided the structure for isolating and relating concepts. They then moved on to relate these concepts and produce new situations for the nurses' practice.

Outcomes

The rural nature of the nurses' work was described by them and their understanding of what they saw as the salient features of their rural area has increased

From the Action Research process, the nurses developed a model and a local theory that consisted of new strategies that enabled the two distinct groups to work more closely together while maintaining their specialist roles. This model and theory have potential to be generalised to other community nursing groups. The process of its implementation may vary depending on the nature of the nursing group employing it and the context of their working world.

Management fully supported this research. During this time the group's perception of management changed from 'them versus us' to one of working on goals together. This active participation of the nurses in team plans has brought more relevant change for them and more ownership of that change. It has also encouraged professional growth and enlightenment. This nursing group has moved from being fragmented, disorganised and unfamiliar with each other's work and talents, to one that is more

cohesive. They share common goals, a greater knowledge of each other, and a genuine spirit of mutual support amongst themselves and within the Community Health Team.

CHAPTER TWO

BACKGROUND TO THE STUDY

This chapter summarises historical, political and social factors influencing this community nursing study. It includes the varied types of community nursing existing in New Zealand and specifically outlines the separate roles of the District and Public Health Nurses in this study. Some factors that maintain their separateness are outlined, however a historical review shows how these nurses' roles evolved into two distinct jobs over time. Changing to an integrated role has been seen as desirable and has been trialed in the past but with limited success. The potential for managing change using a more participative style is discussed.

Community Nursing Today

In New Zealand today, community nursing is delivered through a variety of roles and organisations. These groups include:

Plunket Nurses who care for families with children under 5 years of age and are funded by government and voluntary donations.

Occupational Health Nurses who are employed by industry to oversee the health and safety of their employees.

Practice Nurses who are associated with General Practitioners and partially or fully subsidised by government.

Midwives, though separate from nursing, who provide community ante and postnatal care, either as independent practitioners or as employees of a Crown Health Enterprise(CHE).

Independent Nurse Practitioners who provide holistic health care, assessment and education and are self employed. They may receive Department of Health funding (Macdonald, 1989).

District Nurses who provide domiciliary nursing care (treatment for people in their homes) and are employed by a CHE.

Public Health Nurses who cover health promotion and disease prevention for primary and secondary school age children as well as for the community in general, and are employed by a CHE.

The nurses involved in this study were District and Public Health Nurses and their abbreviated job descriptions are seen in Figures 1 and 2. These confirm their distinct areas of work. Other factors also influence their separateness. These include:

The Crown Health Enterprise(CHE) Structure: The organisation which employs these nurses divides its community care delivery structure into two teams, the Child & Family team in which the Public Health Nurses work, and the Home Health and Disability team which includes the District Nurses. Prior to the appointment of the District Co-ordinator, six months before the study began, there was no close common managerial link between the two teams, except for the overall Manager of Community Services. Each nursing specialty also had its own clinical practice supervisors as shown in Figure 3. This situation has been partially alleviated by the appointment of the District Co-ordinator who now provides a local organisational link for these nurses (see Figure 4).

Union Membership: While both these nursing groups would consider the New Zealand Nurses Organisation as their professional body, that organisation only negotiates wages and conditions for District Nurses. Public Health Nurses have their conditions negotiated by the Public Service Association.

Until this study, there was little reason for these two disciplines to get together, and little common day to day work to discuss. A historical review shows that this separateness has evolved over time.

September 1993

JOB TITLE:	District Nurse
DEPARTMENT:	Home Health Services/District Nursing
DIRECTLY MONITORS:	The health needs of service users and the response to treatments interactions and information.
PRIMARY OBJECTIVES:	To provide safe and effective nursing care to consumers in their homes to meet identified needs and service objectives, in accordance with accepted standards of practice.
KEY TASKS/RESPONSIBILITIES:	
1.	To provide nursing assessment to all clients.
2.	To provide nursing care to identified clients.
3.	To work with clients and other health care workers to meet the clients' needs.
4.	To undertake health education activities with clients.
5.	To undertake teaching and training of new staff and students.
6.	To maintain personal and professional development to enhance practice.
7.	To participate/contribute in Quality of Service Activities.
8.	Other such duties as mutually agreed with the District Co-ordinator of Home Health Care Services and/or Clinical Practice Nurse Co-ordinator.

Figure 1. Abbreviated Job Description for District Nurse

1 July 1993

JOB TITLE:	Public Health Nurse
DEPARTMENT:	Child and Family
DIRECTLY MONITORS:	The health status of individuals and communities and works with people of all ages to make choices about lifestyle practices, formulate their own priorities, access resources and care to enhance/improve health. Assist with community development.
PRIMARY OBJECTIVE:	To undertake the health maintenance, health promotion and disease prevention activities as prioritised by the service manager in accordance with public health nursing standards of practice and district protocols.
KEY TASKS/RESPONSIBILITIES:	
	<ol style="list-style-type: none">1. Provide assessment and follow-up for client families with special needs and/or in at risk situations.2. Provide School Health programmes to meet the needs of specific children.3. Develop and manage specific programmes for promoting healthy lifestyles/ health promotion priorities.4. Act as a resource person and advocate for families, community groups and projects.5. Undertake surveillance and follow-up of clients with communicable diseases and initiate appropriate action as per protocol.6. Undertake immunisation programme and other disease prevention activities as prioritised by the health service.7. Maintain personal and professional development to enhance practice and inter-personal relationships.

Figure 2. Abbreviated Job Description for Public Health Nurse

The History of Community Nursing

Reports of health care in New Zealand begin with the formal colonisation by the British in 1840. However, 'nursing' i.e. administering to the sick, had been done informally by colonists since Europeans first arrived at the turn of the nineteenth century. Maori, residents of New Zealand when Europeans arrived, had their own traditional means of healing, but diseases brought by the European had a devastating effect on the native population. Missionaries, as early as 1814, tended to the health needs of Maori and some set out their own geographical territory visiting regularly on foot (Burgess, 1984).

Most of the early written history of health care in New Zealand centres around the development of hospitals. Four were set up in 1846 with money from the British Government. These hospitals were eventually staffed by nurses who were trained in England under the Florence Nightingale system, begun in London in 1860. First records of formal nursing in New Zealand begin with the arrival of these nurses in the 1880's. Nursing education programmes were established by these nurses beginning at Wellington hospital in 1883 (Burgess, 1984).

History shows that community nursing, in England, was also influenced by Florence Nightingale. She encouraged entrepreneurs, such as Rathbone of Liverpool, to fund separate training for community work. These projects expanded to London by 1874 (Monteiro, 1991). In addition to taking up social concerns such as slums, prostitution and crime, Nightingale saw the role of community nursing as educating and co-ordinating individual care in the home, teaching family and friends how to care for the patient and engaging help to maintain cleanliness (Dingwall, Rafferty & Webster, 1988). All these principles became part of New Zealand's early community nursing.

Nightingale's influence in nursing also included a philosophical ethos which stated that "to be a good nurse, you have to be a good woman" (Rodgers, 1985, p. 154). These womanly qualities included patience, endurance, forbearance and obedience. Rodgers found that this ethos had been incorporated into New Zealand's nursing education. In this study, it was revealed that aspects of this ethos were part of the belief system of some of the participants. This issue was addressed in the research process.

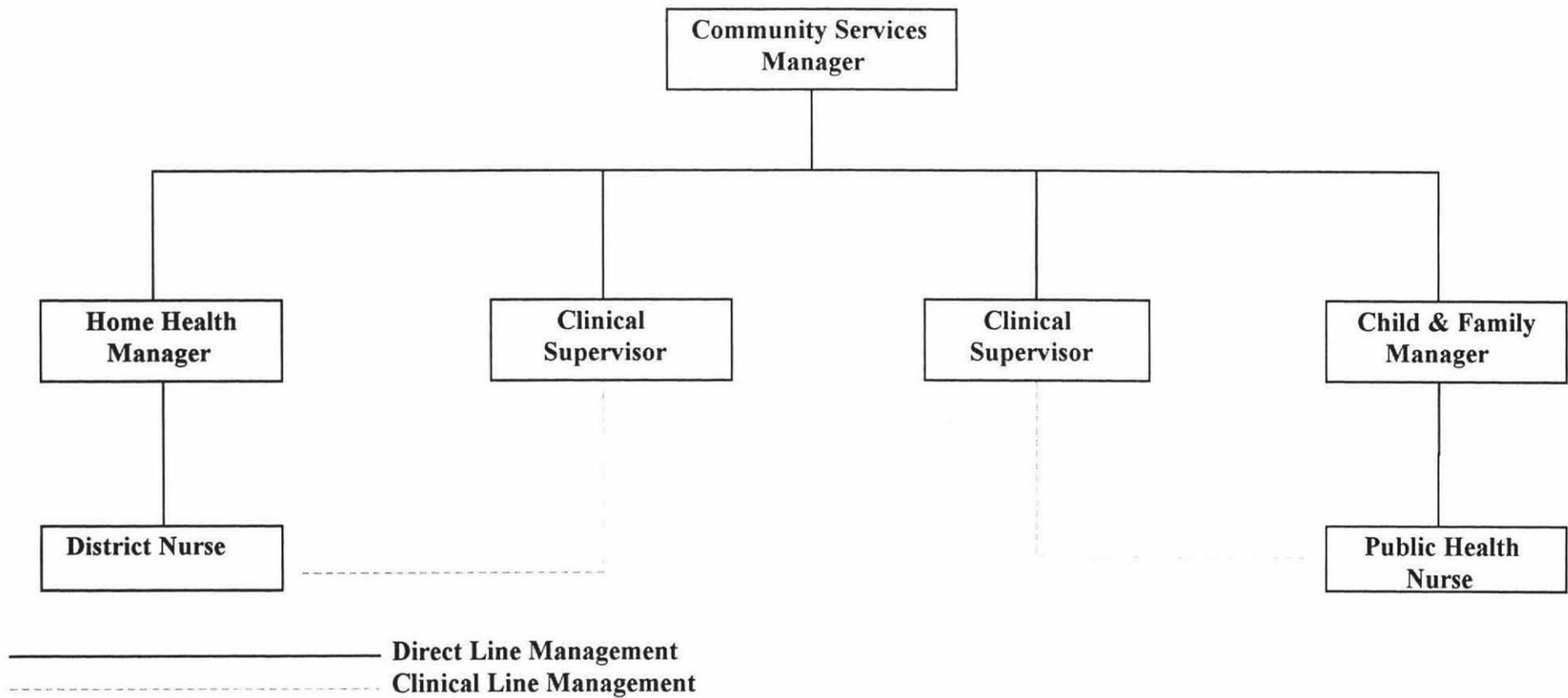


Figure 3. Organisational Structure Before Appointment Of District Co-ordinator

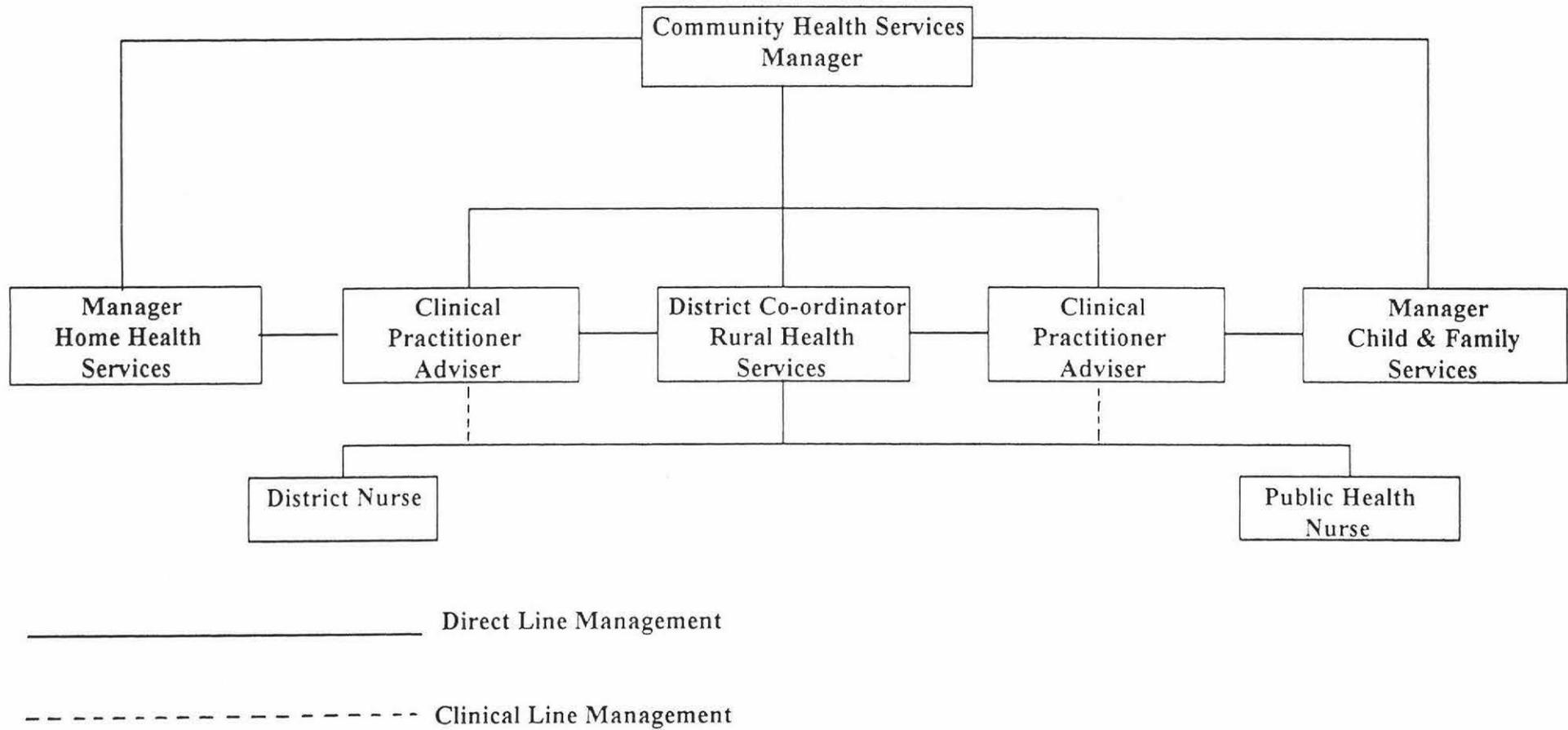


Figure 4. Organisational Structure After Appointment Of District Co-ordinator

The colony of New Zealand was initially formed by those wanting to find a more humane and egalitarian society than the one they had experienced in Britain. However, McCarthy (1972) concluded that when setting up social structures, including health, in the colony, before the late 1930's

... it was not always easy to ascertain why things were done. Certainly we found no social principle or political theory dominating the course of events in New Zealand. Rather legislative (and social) actions taken ... could more readily be seen as attempts to meet objectives which then seemed necessary or desirable (p. 13).

The New Zealand Nurses' Association (NZNA, 1980) confirms that community nursing "has developed in a somewhat haphazard fashion, one specialist service after another has emerged in an effort to meet crisis situations and observed needs as these arose" (p. 2).

The distinction between the roles of Public Health Nurse and District Nurse was formalised in 1953, when the title Public Health Nurse was introduced. However since colonisation in 1840, the work that served both community health education and domiciliary care had developed under a variety of titles such as Native Health Nurse, District Health Nurse, School Nurse, Back Block Nurse and District Nurse (NZRNA, 1956).

Public Health Nursing developed, primarily in response to government policy and/or legislation to maintain the health of the wider community, whereas formal District Nursing began more in response to a recognised local need for home based care. This is one of the key differences between their services today.

The Development of Public Health Nursing

As provincial hospitals were being set up in the 1840s, public health concerns became evident, and successive governments legislated in response to them. The first Public Health Act (1872) set up separate provincial boards of health to monitor and control smallpox and venereal disease. In 1876, these boards amalgamated to become one Central Board Of Health for the whole country. The threat of Bubonic Plague at the

turn of the century resulted in a revised Public Health Act, and the creation of the first Department of Public Health in the Commonwealth. This Department began to employ nurses in the community, because of their concern for the health of Maori. Known as Native Health Nurses, their role was educative as "women were taught food preparation and how to care for the sick" (Pybus, 1985, p. 219). They also coped with epidemics and expanded to become involved with non-Maori

Nurses were also funded through the Department of Education in 1917, to monitor child health in schools (Pybus, 1985). They assisted medical officers who, since 1913, had been pioneering preventative medicine by examining all children in Standard Two and any primary school child for whom the teachers had concern. Many of their health problems were linked to conditions of poverty (Lambie, 1956). The funding for these school nurses changed to the Health Department in 1920, and in 1930, the roles of the Native Health Nurse and the School Nurse amalgamated (Campbell, 1976). These nurses were originally given the name of District Health Nurse and employed by the Department of Health. This name changed to Public Health Nurse in 1953. Sanitation, infant feeding and welfare were their initial areas of priority (Pybus, 1985). In 1989, Public Health Nurses moved from being employed by the Department of Health to working for Area Health Boards, the same employer as the District Nurses.

The Development of District Nursing

The present District Nursing Service had different origins. Two of its great leaders and founders were Mother Mary Joseph Aubert and Sibylla Maude. Mother Mary Joseph, as early as 1871, cared for Maori and European in their homes. She began her service in Napier, moved to Wanganui in 1883, and then to Wellington in 1899, where she is attributed with the setting up the Wellington District Nursing Service (NZRNA, 1963). In 1896, Miss Maude founded the District Nursing service in Christchurch (Burgess, 1984). Both women responded to the needs of those who were either isolated geographically from medical care, or were confined by illness to their homes. The beginning of formal District Nursing in other areas grew from these initiatives and, in 1901, the District Nursing Association was formed. These nurses travelled on their bicycles around urban areas treating individuals and their families in their homes. This

service was originally funded in a variety of ways. The St John Ambulance Association provided the funds in Dunedin in 1906, and in Palmerston North, in 1909. The Hospital and Charitable Institutions Act of 1909 gave Hospital Boards the responsibility to fund care outside their institutions. The first District Nurses to use these funds were in the rural area of Taranaki where they were known as 'Back Block Nurses' (Burgess, 1984; Pybus, 1985).

The Social Security Act of 1938, passed by the first Labour Government, had a significant impact on the delivery of community nursing throughout the country. This act marked "the adoption of a unified and comprehensive approach to the problems of health, income maintenance and general welfare of the community" (McCarthy, 1972, p. 46). It included the free delivery of medical and hospital treatment to all who required it, and other benefits to maintain and promote health and general welfare in the community.

Regular Government funding, from 1938 through to 1993, contributed to the consistent growth of both District and Public Health Nursing services. This growth has more recently also been positively encouraged by the World Health Organisation's focus on Primary Health Care.

Primary Health Care

The nurses in this study are part of a community team which espouses Primary Health Care. The global commitment to Primary Health Care has been most comprehensively set out in the World Health Organisation's (WHO) declaration from their 1978 international Alma Ata conference. Primary Health Care focuses on the importance of health in the growth of nations, and the rights of individuals and families to accessible and affordable health care. It advocates "addressing the main health problems in the community, (and) providing promotive, preventive, curative and rehabilitative services accordingly" (WHO, 1978, p. 4). This relies on "practitioners ... to work as a health team, and respond to the expressed needs of the community" (Ibid, p. 5).

Articles V and VIII of the Alma Ata Declaration stress that each government is responsible for the health of its people, and this can only be fulfilled through the provision of adequate health and social measures by "formulating national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system ..." (Ibid, p. 5).

Response to these initiatives at a government level in New Zealand was seen in 1978, when the ruling National Government's mandate emphasised community health care, with prevention and health promotion featuring throughout its policy statements (Pybus 1985). It continued to take precedence in the New Zealand Board of Health's statement on Primary Health Care in 1988. From 1978 to today, the percentage of the nursing workforce employed in the community has gradually increased (Dept. of Health, 1990). These community figures include Practice, Plunket and Occupational Health Nurses as well as the District and Public Health nurses.

Vuori (1984) points out that Primary Health Care was not invented at the Alma Ata conference. Its past existence and growth in health care is evident in the historical review of District and Public Health Nurses, though Boyd & McCormick (1992) do point out that "specialisation and an increasing value placed on heroic medicine led to a temporary undervaluing of Primary Health Care in the 60's and 70's" (p. 5). However, Vuori does give the Alma Ata conference credit for making Primary Health Care a "household word" positing it "as an alternative to current high technology, hospital oriented main stream of health care in the industrialised countries" (p. 221). The current New Zealand Health reforms have kept Primary Health Care a priority.

New Zealand Health Reforms

The health services have been in a state of proposed and actual reorganisation since the 1974 Labour Government's white paper "A Health Service for New Zealand" (Dept. Of Health, 1974). However, the current health reforms introduced in the 1991 budget by the National Government, were designed "to overhaul the public health system" (Louisson, 1992, p. 11). "The primary objective of the reform process must be to

secure for everyone access to an acceptable level of health care" (Upton, 1991, p. 1). One goal is to distribute funds more fairly with emphasis on primary and preventative health care rather than cure (Ibid). At this time, Glennie (1992) reported that 73% of public health expenditure was consumed within hospitals. More recently, the current Minister of Health has also advocated less emphasis on the "bricks and mortar syndrome" where all the focus is on the value of the hospital. She promotes more emphasis on primary community-based services, not as an alternative to hospital services but as an integration of the two. This, she envisions, will result in "interdisciplinary collaboration and more community-managed care" (Shipley, 1994, p. 2).

One major thrust of the 1991 health reforms was to separate funding from the provision of service. This involved setting up separate bodies called Regional Health Authorities (RHAs) and giving them Government health care funds to purchase services. In the process, the existing Area Health Boards were disestablished and new organisations called Crown Health Enterprises (CHEs) came into existence. CHEs now compete with other provider agencies for the health care dollar.

The nurses in this study are employed by a CHE and new words such as contracting, budgeting, cost efficiency and competition have entered their nursing and health care language. From the announcement of these reforms to the formal setting up of the CHEs, feelings of unease and potential threat were expressed by all of the Community Health Team members. These feelings closely identified with what Rodrigues (1992) has named "change fatigue" or "new initiatives". The feelings are characterised by a "deep seated suspicion of any proposed change to a previously accepted practice, fear of role loss, antagonistic tendencies towards suspected role poachers, and a pessimistic view of the future of community nursing" (p. 363).

The need to compete for service contracts from the funders brought change to health care providers and professions. Each professional group was prompted to examine their practice in relation to other providers. This reflection was essential because contracts require an itemisation of each service and a knowledge of gaps and overlaps in service provision. The subsequent tender must also compete for quality, cost

effectiveness and efficiency. It was against this background of change, contracts and competition, as well as the Community Health Team's new focus on their identity as a rural health service, that the 'Community Services Manager' suggested the District and Public Health Nurses combine their practices for efficiency, and to ensure their survival as a community nursing service.

Integrating Community Nursing Services

Combining community nursing services is not a new idea. Concern about this "tangled web of nursing functions in the community, whereby preventative functions are carried out by one group, maternal and child health by another, and domiciliary care by yet another" has been mooted for some time (Pybus, 1985, p. 232). This fragmentation was compounded by the splintered system of primary care, with separate Public Health and Hospital Board jurisdictions, and competing agencies that thwarted even limited service development. The 1974 Health Report recommended that all nurses working outside hospitals be seen as one group, and be known as community health nurses (Dept. of Health, 1974). Also, the 1976 report of the Health Centre Advisory Committee makes a suggestion that the variety of community nurses should become part of a community health centre (Dept. of Health, 1976). The New Zealand Nurses' Association's report on Community Health Nursing (NZNA, 1980) also advocated that immediate action be carried out to ensure that a fully functional and objective integration of community nursing services takes place. Today, fifteen years on, discussion around redesigning the work of community nursing continues. O'Connor (1994) cites examples of questions that the New Zealand Nurses' Organisation is asking "Should community health nursing be integrated? Is better integration simply a cost cutting measure? How can nurses protect their professional autonomy in the new health environment? How can specialist skills of different community nurses be respected and valued with closer integration?" (p. 25). All of these questions were also raised by the nurses in this study.

In the 1980s, pilot projects were set up to test the viability of integrating Community Nursing Services. MacInnes and Glover (1985) reported on a project undertaken in

Johnsonville in 1981-2. This involved the integration of District and Public Health community nursing services in a specified geographical area. It had three teams of nurses with a combination of the two groups to carry out an integrated role. The project was considered a success and concluded that "Integration of roles could be achieved and service levels maintained ... and this would be one way of using resources effectively in the continuing development of community nursing" (p. 46). In spite of that reported success, the Johnsonville area still maintains a separate District and Public Health Nursing service.

Kinross (1987) reported on a study which integrated the community nursing role in an urban area. In this case, there was one nurse who did both roles, in a designated geographical area, with a mixed population of families and older people. The result was that the immediacy of District Nurse/domiciliary work dominated her workload. It was also noted, but not elaborated upon, that there was a philosophical difference between the work of the Public Health and District Nurses. Kinross concluded that the geographical area and the mix of its population would dictate the success of an integrated nursing role, and that "where there is a mix of young and ageing clients together with educational and /or industrial institutions, generalist nurses are unlikely to be able to give the specialised preventive/promotive aspects of their care the attention they deserve" (p. 197).

The nurses in this current research group, familiar with these past studies, and their feelings of 'change fatigue', greeted management's idea of combining services with "some disquiet" (GM 1, KO, p. 2). However, they also expressed interest in addressing the issues of efficiency and survival for themselves, and being involved in creating any change required.

Managing Change

The value of nurses' participation in redesigning their work cannot be overestimated. Wolf (1990) sees this type of empowerment as essential for excellence in practice to

occur. It can also ensure that the formal job description more closely matches the actual practice of the nurse (Takarangi, 1983).

The National Interim Provider Board (1992), set up by the government to advise on health reforms, stated that it aimed "to develop a structure where, within a framework of improved accountability, health professionals will have the freedom and autonomy to exercise independence and initiative at every level, to achieve a continuous upgrading of the quality and efficiency of health care provision" (p. 7). This proposed autonomy would suggest the necessity for a management structure that is less directive and more encouraging to professional participation in organisational decisions.

Working together with management, especially in a time of change, is important. As Keith (1992) states "There has to be a match between those making the management decisions and those at the coalface" (p. 6). This theme of a closer worker/management link is evident in the review of literature that focuses on organisational change in hospital nursing, nursing education and community nursing. In the past four years there has been an increase in articles written using terms such as 'shared/collaborative governance' (Gomberg & Sinesi, 1994; Hibberd, Storoz & Andrews, 1992; Houston & Green, 1993), 'participative management' (Black, Everett, Green, Krilyk, Van-Berkel, 1994), 'intrapreneurship' (Nugent & Lambert, 1994), and 'planned change theory' (Tiffany, 1994; Tiffany, Cheatham, Doornbos, Loudermelt, & Momadi, 1994).

Though survival and efficiency were the foci of the 'Community Services Manager's' suggestion that the nurses combine their roles, Damant (1994) states that

economic survival in a climate of finite resources cannot be regarded as merely materialistic. Market forces will determine the kind of community nursing service that survives and develops. It would be regrettable if this happens for expediency rather than as part of a collaborative, constructive and systematic change process (p. 102).

Against this background, I offered to facilitate a collaborative change process for the nurses in this rural Community Health Team in the form of this Action Research study.

CHAPTER THREE

THE RESEARCH METHOD:

ACTION RESEARCH AND CRITICAL SOCIAL SCIENCE

This chapter outlines the decision to use the method Action Research and the philosophy of Critical Social Science in this study. In more detail, it shows the development and uses of Action Research, outlines the background and key concepts of Critical Social Science and shows how the two interrelate. The researcher/participant role and the specific concerns of ethics and rigor are addressed. Overall, it proposes that this method and this philosophy, best met the purpose of this project.

Choosing a Method

"The choice of methodological technique ... depends on what kind of description/explanation is being sought. There is no ultimate description or explanation apart from purposes or intents" (Allen, Benner & Dieckmann, 1986, p. 36). Because the intent in this study was for the nurses to look at different ways of working within their rural setting, the research method chosen was Action Research with its fundamental goals of firstly, change in practice and secondly, theory development (Greenwood, 1994a). The process involves the collaboration of participants in the identification of areas of concern, and the facilitation of change from within the group. This results in a democratically decided outcome, which is seen as important for group change to be effective (Nolan & Grant, 1993). The process took participants through spirals of reflecting, planning, acting and evaluating changes in their work (see Figure 5).

The Critical Social Science philosophy chosen to guide this project, also contributes to promotion of effective change because it looks at what influences situations from broad social, political and personal contexts. It has been said that "nursing cannot be understood without some critical consideration of the socio-political conditions and relationships in the settings in which it occurs" (Hickson, 1989, p. 9). Critique and subsequent understanding raised the awareness of the nurses in this study to factors that

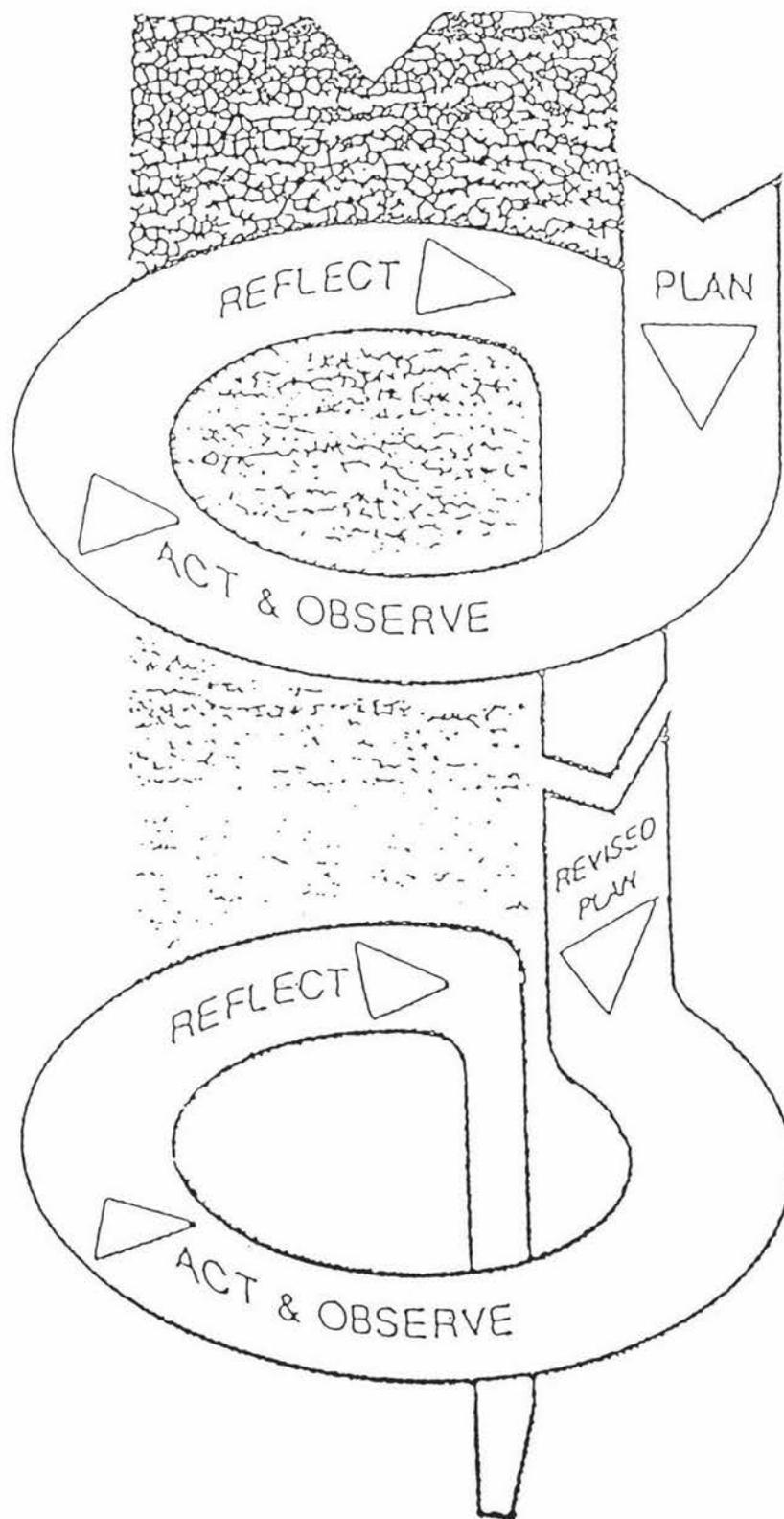


Figure 5. Action Research Spiral
From *Action Research Planner* (p.11)
by S. Kemmis & R. McTaggart. Melbourne. Deakin University.

both positively and negatively affected their practice. This empowered them to plan and implement change.

This method and philosophy also closely link research with theory and practice. The perceived gap between theory, research and practice is widely discussed in the nursing literature. It has been stated that nurses do not use research in clinical practice, are unaware of its value and some are even hostile to it (Bircumshaw & Barron McBride 1990; Hunt, 1987; Lindsey, 1991). This study helped minimise this gap by involving the nurses as co-researchers in their own project, and by encouraging them to theorise about their work which resulted in their creation of a new model for practice.

Action Research and the Three Paradigms

Action research has its documented beginnings in the United States with Lewin in 1946, and almost concurrently in Britain with researchers from the Tavistock Institute (Holter & Schwartz-Barcott, 1993). Lewin, as a social psychologist, sought ways of addressing the social problems of his day by using change theory. He identified three basic steps in change as unfreezing, moving and refreezing. Unfreezing involves recognising a need for change and looks for alternative solutions. Moving involves planning and initiating a change. Refreezing involves integrating the new changes and stabilising them (Welch, 1979). The Tavistock Institute were psychoanalysts and maintained change should be based on people's understanding of their situation.

The main principles of Action Research are collaboration, problem identification, change and theory development. In a research project, participants address a problem area in their practice in collaboration with the participant researcher, with the goal of bringing about change. Theoretical knowledge is developed through analysis of both the process of that change and the information generated about the practice itself (Holter & Schwartz-Barcott, 1993).

The development and analysis of theoretical thinking is always guided by some philosophy which incorporates theoretical assumptions, laws and techniques adopted

by members of a particular scientific community. These theoretical stances are called paradigms (Kuhn, 1970). Different paradigms do co-exist but one paradigm can dominate another. The choice depends on the interests and goals of those adopting it, on the indications that other approaches are inadequate for researching a chosen topic, and on scientific trends. Habermas(1972) has categorised three paradigms as technical, practical and emancipatory. Action Research has been used to generate knowledge within each of these paradigms (Holter & Schwartz-Barcott, 1993).

Technical knowledge is derived from the positivist philosophy of the natural sciences. It facilitates people's control over their world, and objectively generates rational scientific explanations which aid technical advancement. Action Research, in this paradigm, may involve a researcher and participants collaborating to address a problem by testing a preconceived framework in a work setting. If successful it is then integrated into their practice. The knowledge generated is predictive, arrived at by a process of deduction, in that participants hypothesise before they start about whether or not the trial will work. Lewin's approach to change, with his focus on experimental psychology, was more technical and fits in with the positivist paradigm that was the scientific trend of his time (McNiff cited in Meyer, 1993).

Practical knowledge is derived from the hermeneutic/interpretive philosophy. It facilitates people's interpretive understanding of their world and generates subjective accounts. This clarifies the conditions necessary for meaningful communication which can inform and guide practical judgement. Action Research in the practical, interpretive paradigm focuses on collaboration between researcher and participants to identify problems in an area of mutual interest. Within this context participants, through interaction, interpret their situation and reach a mutual understanding that contributes to planning interventions. The knowledge generated in this way is generally descriptive and inductive, in that it is derived from the experiences and perceptions of the participants. The work of the Tavistock Institute fits this paradigm with its focus on psychoanalysis and interpretive understanding (Holter & Schwartz-Barcott, 1993).

Emancipatory knowledge is derived from the philosophy of Critical Social Science. It facilitates people's reflection and critical examination of what influences their social world. This raised awareness generates knowledge which brings about emancipation and change (Carr & Kemmis, 1986). Action Research in this paradigm extends the approach to a problem by the participants exploring, both individually and/or with a group, the assumptions and values that are part of the context of the problem. This critique of the ideology that socially constructs many aspects of the participants' culture contributes to changing that social construction. The enlightenment gained from this critique. produces emancipatory knowledge This study adopts this paradigm.

The use of Action Research within each of the above paradigms is more commonly associated with educational research, but is currently growing in nursing (Meyer, 1993). This growth also accompanies a trend to use the method more within the emancipatory paradigm, as it moves beyond the prescription of practice for others to trial, to "self reflective enquiry ... to improve ... understanding of their practices and the situations in which those practices are carried out" (Carr & Kemmis, 1986, p. 180). Change can then occur based on this emancipatory knowledge.

Emancipatory Knowledge and Critical Social Science

The Critical Social Science philosophy had its beginnings in the 1920s, when a group of interdisciplinary social scientists and philosophers known as the 'Frankfurt School' advocated that approaching problems and developing knowledge in rational and technical ways creates the illusion of an 'objective reality' over which people have no control. They believed that humans are social beings, and problems and knowledge are socially constructed and influenced by a person's social context, along with their perception of their place in it (Kemmis & McTaggart, 1988). Reflecting on problems in this broad social context, a person has the ability, by their own actions, to emancipate themselves by making changes to their social world (Carr & Kemmis, 1986). Emancipatory knowledge is the goal of Critical Social Science. Friere (1972), a leading educationalist, also supported the idea that "knowledge is derived from the active participation of people transforming their social and natural worlds" (p. 99).

These ideas have been fostered by groups with emancipatory interests. However, Fay (1987) while advocating that Critical Social Science can “simultaneously explain the social world, criticise it and empower the audience to overthrow it” encourages philosophers to guard against a utopian view of the science. We must take into account the limits of human reason, and see that humans are traditional, historical and embedded creatures which can limit their enlightenment and empowerment (cited in Emden, 1991, p. 24). As such he maintains that the science itself must be prepared to be subjected to its own critical analysis.

This theoretical thinking encompasses the concepts of discourse and reflection and the goals of change and emancipation.

Discourse/dialogue

Discourse, in the form of liberatory dialogue, is part of the process of critical theorising which affirms the "freedom of the participants to re-make their culture" (Fleming, 1991, p. 63). It is more than just conversation. Rather, it includes a structural and ideological critique of, in this case, the practice world of the District and Public Health Nurses. "Discourse reconstructs meaning and provides basis for revised plans" (Kemmis & McTaggart, 1986, p. 13). Moloney(1992) points out that, in ideological debates, the purpose is, “not to reject the system and all its elements ... but to break it down to its basic elements and then sift through past conceptions to see which ones... can serve to express the new situation. Once this is done the chosen elements are finally rearticulated into another system” (p. 36). This study closely reflected this process. The nurse participants did not want to throw out their existing ways of working, but through a series of group meetings and individual interviews with the researcher, they broke down the components of their two distinct jobs, theorised about the philosophy behind each, and went on to establish a common philosophy and a framework which guided a closer working relationship.

The conditions for such open dialogue to take place must be unrestrictive and tolerant, so that individuals can feel free to express their perceptions and experiences, and to be challenged. This is what Habermas (1974) refers to as an ‘ideal speech situation’

which is achieved by the participants' commitment to both dialogue and collaboration. In this study, reminders of some of these conditions were given at the start of the group sessions (see Figure 6). Items 1 and 2 particularly pertain to the free speech environment. However, the overall goal for bringing about change is collective agreement. Carr & Kemmis (1986) advocate that "any consensus achieved in this environment can be regarded as true consensus" (p.141). Much of the dialogue in this study was reflective, because it involved thinking about and clarifying practices as well as evaluating and challenging them within the changing context of health care delivery.

Reflection

Reflection is defined as "examining the unquestioned and largely unchallenged ... assumptions, values and beliefs that underpin our actions, as well as the institutional practices around us" (Smyth, 1986, p. 3). As such it is both a potential learning tool and a means of integrating theory and practice (Atkins & Murphy, 1993). The goal is consciousness raising and enlightenment. In this study reflection was a process that needed to be accepted as valuable, and needed to be learned. Once accomplished, it generated the knowledge which contributed to change.

Change/Praxis

Change is an outcome of critical theorising as well as being part of the process of Action Research. Within Critical Social Science change is more than simply altering or making different. Change is better described as 'praxis' a Greek term which Carr & Kemmis (1986) describe as "informed action" which, by reflection on its character and consequences, changes the knowledge base which informs it (p. 33). Praxis then is closely connected to the knowledge from which the action is derived. Therefore praxis connects thought with action, and theory with practice, in a dialectical relationship.

Emancipation Through Enlightenment and Empowerment

Emancipation is a key goal of critical social science. It is achieved through empowerment by recognition of how social and historical influences shape our world.

1. **This is a forum for open discussion in a semi structured meeting about developing your role as a rural health nurse.**
2. **Each person participating will be able to express her ideas without interruption, keeping in mind that being concise will help maximise our meeting time.**
3. **Confidentiality must be respected outside of the group. You, as a group, will decide what information will be presented at the larger team meeting designed to discuss rural health development.**
4. **If any member of the nursing group should decide not to initially participate or should choose to drop out of the research process there will be no repercussions for that person.**
5. **I will function as a researcher in these meetings working alongside you to work out your rural nursing role.**
6. **In the larger team meeting I will function as a Social Worker and not represent the nursing group.**

Figure 6. Criteria for Group Meetings

Both emancipation and empowerment are popular words. The definition of empowerment in the literature varies, as each person defines it within the context of their personal experience (Gibson, 1991). It is more commonly associated with mobilising oppressed groups such as indigenous people, women and homosexuals. In these instances, those seeking emancipation experience powerlessness, and claim that historical, social and political structures are contributing to their oppressed position. For them, revolution must occur to attain emancipation.

Nurses have also been described as an oppressed group. This is based on their "lack of autonomy, accountability and control over the nursing profession" (Roberts, 1983, p. 26). My perception of the nurses in this study was that they were not oppressed. Each worked autonomously in the community, was accountable for the independent decisions she made and as a group stretched some rules and organised some of their rural practice outside the guidelines set by their urban administrators. Revolution was, in my opinion, not required.

Within this research I considered that the emancipatory and empowering aspects, at the outset, were related to the participants' abilities to make their own plans and create a new way of working. As such it coincided with the following definition of empowerment by Fay (1987).

The paradigm case of power is not one of command but one of enablement in which a disorganised and unfocused group acquires an identity and a resolve to act in light of its new-found sense of purpose. I call this sort of situation one of empowerment (p. 130).

According to Gibson (1991) "empowerment entails a process of helping individuals develop a critical awareness of the root causes of their problems and a readiness to act on this awareness" (p. 356).

The emancipatory knowledge generated by Action Research is both descriptive and explanatory. Greenwood (1994b) also advocates that Action Research results in predictive and prescriptive knowledge in the form of situation-producing theories. In

this study a local situation-producing theory was created. The study describes the emancipatory processes involved in creating change and, through observation and analysis of data, describes and explains some of the physical and ideological factors that both frustrate and promote change in the nurses' practices. The collaborative nature of the study puts it in the realm of Participatory Action Research.

Participatory Action Research in this Rural Health Service

Participation in change is advocated because " ... persons as autonomous beings have the right to participate in decisions that claim to generate knowledge about them. Such a right ... protects them ... from being managed and manipulated" (Heron, 1981 in Lather, 1991, p. 55).

Kemmis & McTaggart (1988) set out the spirals of Action Research (see Figure 5, p. 24 of this thesis) and state that the process begins with a general idea that some kind of improvement or change is desirable and there is an identified "thematic concern" (p. 8). In this case, the initial concern was developing the nursing role in a rural community health service. The 'Community Services Manager' had stated that some reorganisation was necessary in order for the service to survive in the changing health care environment and suggested that the nurses combine their roles. Because the idea to change was instigated by management and not the nurses themselves, it could be argued that this type of Action Research falls into the category of "commissioned intervention where the approach to action assists externally determined change putting the participants in the position of subjects of change" (Greenwood, 1994b, p. 88). However, these nurses took on the concern for the survival of their service themselves and developed their own solution. Through the research process they decided how they would achieve their goals and have also professed to owning the outcome. Therefore, this adds weight to the view that the process was indeed Participatory Action Research (Ibid).

The research process encouraged the nursing group in this study to examine their situation in the broad context of political, social and personal influences in their

working world. Based on that reflection, a plan of action was proposed, which included three different projects through which the nursing group could work together.

Data was collected to monitor both the process of the research and the outcomes.. Presentation of data in this Action Research study is descriptive and interpretive in nature. The description shows the progress of reflection, planning, action, and evaluation. Issues that arose, as the group progressed, were interpreted by the participants together and individually by critiquing the ideology on which they base their own practice (Carr & Kemmis, 1986). The overall goal of the project was to achieve change which was monitored in the language, activities and social relationships of the participants (Kemmis & McTaggart, 1988). Data from formal and casual observations of the group and the content of the transcripts that the participants have agreed could be part of the study, were examined to see if such change occurred. While, in the long term, the process could result in a critical theory about the nurses' practice itself, the initial purpose of this study was to work through the process, over a six month period, to create new ways for the participants to practice nursing in their rural community.

Researcher Role

My role as researcher/participant in this method was varied and important. The procuring of meaningful data was accomplished through my ability to establish a rapport with the group, and to create a free speech environment which encouraged active discussion. The overall goal was to develop a self reflective community. The researcher's role required self knowledge and creativity, along with the ability to stimulate exploration of political and social issues. The group was then able to reflect on these in relation to practice, and devise ways of implementing, monitoring and evaluating change with the guidance of the researcher. Overall my roles included that of facilitator, observer, teacher, encourager, analyser, validator, enlightener, liberator and learner.

Heron (1989) describes facilitation in a free environment where there is collaboration with participants to meet mutual goals. He categorises the relationship between such a group and its facilitator in a way which paralleled my relationship with this research group. The categories are those of hierarchy, co-operation and autonomy. Heron suggests that any group will require a different balance of the three roles and that there is a progressive nature to the modes which starts with hierarchical and finishes with autonomous.

The hierarchy mode is one in which the facilitator takes charge of events, and tends to make decisions on behalf of the group, because of their learning or process needs. Heron points out that this mode is done with group consultation and consent. In this project, much of the structure and timing of the group and individual meetings was done within this mode. We shared a common goal and, with that in mind, I devised an overall plan for the whole project from the outset. It was modified throughout the process, based on the progress of the group's thinking and information that came out of the groups.

The co-operative mode involves increased collaboration with the group, so that they are more actively involved in the direction of the research, and they have a common vision and commitment that takes them through to the end. In this project the group's decision making and self direction increased as we progressed.

Most of the research time was spent within these first two modes and both were used concurrently within each encounter before moving on to the more autonomous mode.

The autonomous mode is moving the group to be self-directing. Separating myself from the group took longer than anticipated. The nurses needed encouragement to take over their own facilitation. I underestimated their dependence on my direction and organisation. Their main anticipated concerns, though in retrospect unfounded, were deciding what to talk about, and their ability to keep on track in a meeting. I suggested as part of the transferring process that I attend a meeting which they would run and I would only pass comment when asked or if I saw a need. The meeting was chaired by one of the District Nurses who showed great organisational and leadership skills.

Following that meeting they felt capable of 'going it alone' and now are in charge of the entire process.

Though my goal was to empower the group to be independent, I did have some feelings of regret that I would no longer have an active part in the camaraderie, energy and growth that this group was experiencing.

Insider Research

There are ongoing debates about the advantages and disadvantages of conducting research from within your own environment (Lipson, 1989; Wilde, 1992). For me the advantages outweighed the disadvantages. One disadvantage was that I went into the research with some preknowledge of the individuals and their group dynamics. I was aware of the need to isolate what was happening in this project, from other preformed ideas I had, and that was not always easy. For example, I knew that the group did not handle conflict well and I anticipated that I would be somewhat protective if conflict arose in the group. However from a positive viewpoint, this preknowledge of some group dynamics, meant that I had a head start in anticipating ways that would facilitate the group to reach their goals. Also time was not required to establish relationships of trust as they existed before the study began. Because of my personal involvement and knowledge of their dedication to their work, I had an overwhelming feeling of obligation to do justice to these nurses' ideas and goals, and this kept me motivated.

Being a member of the Community Health Team, but not employed as a nurse, meant I was able to stand back from the process and evaluate its progress from a different perspective. However, my practical and theoretical knowledge of nursing contributed to my ability to fill some of the knowledge gaps in the group and guide them through their theoretical thinking. As a team member and a researcher, with a personal and research interest in how the health reforms would affect us, I found that I was keeping up with management's decisions in relation to the reforms. As a result I was often a liaison between management's ideas and that of the nursing group and kept the group informed. Hart(1995) names this role "interface management", as Action Researchers are required to work across professional and status boundaries (p. 7).

Also as a team member, I was available to the group between sessions which meant that they came to me with ideas and questions rather than using their own resources. However more often than not, I would suggest that they make notes in their journal so we could discuss them later. On the other hand, this proximity gave me a chance to observe the implementation of some their ideas, and how they operated as a group during their everyday work. I could remind them of goals or ideas they had expressed in meetings and this enabled them to keep on track.

The importance of observing the action, in action research rather than merely capturing reflective accounts of it, is emphasised by Greenwood (1994b). Observation ascertains if the actions observed are actually reflective of the espoused beliefs or plans. This observation is different from participant observation described in other methods. Rather than being immersed in the situation and recording every detail of behaviour and activities, I observed and listened casually outside of the group's formal meeting times.

Ethics

Protection of Participants

Informed Consent: Information relating to the project and the rights of participants was given to all potential participants in both verbal and written form (see Appendix A). Once the nurse understood and agreed to participate, a formal consent was signed (see Appendix B). This remained valid unless the participant chose to withdraw. It was made clear to each participant that she could withdraw from the study at any time.

Confidentiality: Confidentiality was both the responsibility of the researcher and the participants. All agreed that information gathered as a result of the research process would not be shared outside the group or individual sessions without the permission of the participant(s). When sessions were taped, participants knew they could request that the tape recorder be shut off at any time or any information on it could be deleted from the study. In this project, though the location of the study was not named, the close

involvement of other team members and management meant that total anonymity could not be guaranteed. Because of this, the nurses were sensitive to some opinions being expressed and published. Even though some of this detail was omitted from the analysis and publication, it did not affect the overall change or the goal of the research as the participants still benefited from reflecting on these sensitive matters and increasing their awareness.

The transcripts and the tapes were coded with initials chosen by the individual participants to protect their anonymity. All information was stored in a locked cupboard away from general access. After the thesis is evaluated, the tapes will be erased and the group notes will be destroyed. Transcripts from individual interviews are the property of each nurse concerned to use as she wishes.

Minimising Harm: No form of coercion was used in requesting the nurses to participate, or with any group member who chose to eliminate any of their data from the study. I had planned that if individual emotional issues or group conflicts arose which were not resolved within the research process itself, some outside guidance would be sought in consultation with my thesis supervisor. This was not required.

Initially the potential number of participants was ten. The essential criterion for me was that every member of the team be invited to have the opportunity to be part of a process that could eventually result in a change to their practice as a group. Because the philosophy of the method is also that individuals should be empowered and their voices heard, it was important to invite each nurse, to allay the possibility that some nurses may think their potential contribution was not valued..

However, it was also important to emphasise the individual's free choice to participate without any coercion by myself or by the other nurses. This was discussed with each nurse at the time that formal information about the research was given. These conditions were also reinforced at the beginning of the first group meeting and presented as part of the written criteria for group meetings (see Figure 6, p. 30 of this thesis). If any nurse initially chose not to participate but later decided that she would like to join in, I proposed that she be allowed to do so and a consent form would then

be signed. This consideration takes into account change theory which advocates that participation in change is on a continuum of resistance to acceptance and individuals may move along that continuum at different rates (Bernhard & Walsh, 1981). This did not happen in this study.

Rigor

The goal of every researcher is to avoid as much error as possible. Quantitative methodologies within the positivist paradigm suggest that 'good science' has been achieved by defending the criteria of reliability and validity. Reliability refers to the replicability of a study which if conducted again would yield similar results. Validity is established when the instruments used in the study are designed to measure what the project endeavours to discover (Waltz, Strickland & Lenz, 1986). The establishment of similar criteria for qualitative methodologies continues to be actively debated (Lather, 1986; Lincoln and Guba, 1985; Sandelowski, 1993). Because qualitative methods take in the contextual aspects of their area of study and no two situations can be alike, reliability in the positivist sense is unachievable. Validity also, as originally defined, is illusive as the 'instruments' are the participants and what is 'measured' are their ideas, perceptions and in this study, their plans. The outcome is unpredictable and not always generalisable. So the kind of 'rigor' for qualitative methods must take a different form and is, in part, directed by the philosophy on which it is based. Some within the debate have used the general term "trustworthiness" as a substitute for the word rigor (Lather, 1986, p. 268; Lincoln and Guba, 1985, p. 290; Sandelowski, 1993, p. 2).

There is an inflexibility and an uncompromising harshness and rigidity implied in the term rigor that threaten to take us too far from the artfulness, versatility and sensitivity to meaning and context that mark qualitative works of distinction (Sandelowski, 1993, p. 1).

The presentation of the process and outcomes "becomes a matter of persuasion whereby the scientist is viewed as having made (her) practices visible and therefore auditable" (Sandelowski, 1993, p. 2). Trustworthiness was gained in this study by representative sampling, facilitation of self reflection, accurate collection and

presentation of the data, comparison of analyses with outside literature, and demonstrating that a change has occurred.

Sampling

Sampling must select a group which is "representative of the culture, role, or position needed for the study" (Brink, 1991, p. 170). The nurses who participated in this study are all members of the nursing staff in their community health team. The range of their nursing experience with this team in this rural area is from just over three years to eighteen years at the time the project began. All have been residents of the community for at least four years. As such, they have been part of the situation under examination and have experiences and knowledge about it on which to reflect. Those who had nursed in the area the longest enriched the process through their historical reflections, capturing the health changes over time and seeing how the current plans fit within that broad perspective. Most acknowledged that some change in the way their nursing group worked was timely and, as such, actively participated in the process.

Self Reflexivity

In praxis oriented research "our best tactic ... is to construct research designs that demand a vigorous self reflexivity" (Lather, 1991, p. 66). Self reflexivity is required of both the researcher and the participants. This process and its value needed to be learned by this group. After two group meetings and their individual interview each nurse understood and was more skilled in the process. By the time of the workshop they were able to more easily critically examine their world in a self reflexive way. The subjective nature of the data and acknowledged bias are acceptable (Fleming, 1989).

The Data

The data must appear credible and be presented as an accurate account of participants' ideas. Tape recording and precise transcribing of meetings and interviews was done by

me. Each session was filed and catalogued carefully to prevent confusing each participant's contribution.

The transcribing, though time consuming, was also very rewarding as the exposure to every detail made me very familiar with the data. I also experienced renewed excitement about the ideas and changes these nurses were experiencing as I listened alone in my office. The laughter and conviviality of the group was a great motivating factor. The content of the transcripts were brought back to subsequent meetings and interviews to give the participants an opportunity to delete any information they did not want to be published and to "negotiate (that the interpreted) meaning" was congruent with the meaning they intended (Tripp, 1983, p. 40).

Personal journals were kept by each participant as well as by myself to document ideas between meetings. The use of multiple data sources enhances validity as they can be compared (Brink, 1991). In this case, data from the groups were compared with that of individual interviews and what was disclosed from their journals. Themes relating to issues discussed were also be compared with existing literature. Observation of planned activities also enhanced my ability to check whether what was said in interviews was actually carried out in practice. This establishes the relationship between their espoused theories and their theories in action (Agyris & Schon, 1977).

Literature Searches

Literature searches and collecting information that contributed to discussion as issues arose was done by some of the participants and myself. Care was taken that these works were discussed and critiqued openly in the light of the participants' own self reflections. This ensured that other values and ideals were not imposed on the participants which could possibly contribute to dominating their thinking rather than enhancing it (Lather, 1991).

Tripp(1983) discusses data ownership in a collaborative research project. All participants, including the researcher are 'shareholders' of the data but Tripp sees the researcher as the majority shareholder. Through negotiation with the researcher,

participants verify the content and meaning and give permission for the data to be used in the published research. Once permission has been given the data then becomes the property of the researcher for analysis. All shareholders, including the researcher, are entitled to criticise the published study publicly.

Change

The goal in praxis oriented research is empowering change through enlightenment. Lather (1991) uses the term 'catalytic validity' as one measure of trustworthiness in this method when individual and group change can be demonstrated. This "represents the degree to which the research process reorients, focuses and energises participants toward knowing reality in order to transform it, a process which Friere(1973) terms conscientization" (Ibid, p. 68). In this study, change did occur for individual participants, the nursing group and their practice.

Summary

The choice of Action Research and the philosophy of Critical Social Science for this study was made because this approach most adequately addressed the situation for these nurses. In the context of political change, the nurses have taken up the challenge of redesigning their work which they hope will meet the needs of their community, their profession and their organisation. Such change involves an understanding of the philosophies and interrelationship of each of these areas to make the change effective. The positivist approach is inadequate because of its focus on control and prediction in its search for 'a truth' and ignores the complex and interactive nature of human beings and their situations (Schultz & Meleis, 1988). The interpretive practical paradigm is also inadequate because, although exploring participants interpretation of their situation, it ignores the ideological underpinnings of that interpretation (Lather, 1993).

Action Research and Critical Social Science has provided a rigorous and ethical method which addresses the process and the outcome of change while enlightening those who participated. It also achieves that closer link between theory, research and

practice. Confirmation is found in the following chapters which describe and analyse the research process in more detail.

CHAPTER FOUR

DESCRIPTION AND ANALYSIS OF THE STUDY PROCESS

This chapter describes the study process and analyses process issues that arose. Attention to process as well as outcomes yields information that is part of Action Research analysis (Hart,1995). The chapter sketches the general plan for the nurse groups from the proposal through to the final research group meeting. In more detail, the gradual evolution of the nurses' ideas which culminated in a new rural nursing model, is revealed. Plans were made, based on this model, and evaluated by the nurses. The gradual progress of the empowerment of this nursing group was seen in the process analysis.

The amount of study description is governed by three purposes. One is to give readers the "essence of the phenomena", rather than flooding them with so much detail that they are left with hardly a perception of the phenomena at all (Sandelowski, 1993, p. 3). The second is that with enough detail, those who wish to replicate the study can do so. The third is that the detail about the process and the reflective nature of the participants' thinking may promote, for readers, a "surrogate experience" from which they can then decide the applicability of the described situation to his/her area of study or practice (Fleming, 1991, p. 83).

Moving beyond description to analysis is important as "it is the analysis of ... [the process] ... of action and action theories which permits their reconceptualisation and reconstruction" (Greenwood, 1994b, p. 91). Analysis occurred concurrently with the study process using observation, note taking and group discussion. This resulted in process issues being addressed and some barriers to change reduced.

The Proposal

General approval for the research project was given by the District Co-ordinator of the Community Health Team, who wrote a letter of support to accompany the proposals to

the Human Ethics Committee of Massey University and the Ethics Committee of the local Regional Health Authority. This proposal outlined a plan to meet the nurse participants, as a group, on several occasions. The purpose of these meetings was to encourage the participants to reflect on the suggestion of integrating their practices, and the possibility of creating a different way of working in their rural community. These semi-structured meetings were to be audio-taped and transcribed by myself. I proposed to guide them through a critique of their practice world that would assist them to make plans. The process and outcomes of putting those plans into action were to be observed, evaluated and analysed by myself and the group in their social, political, and organisational contexts.

I proposed also, to individually interview each nurse twice. These interviews were to be held near the beginning and close to the end of the process. The first was designed to establish rapport, to explore each nurse's thoughts about management's proposal for change, and to discuss their perception of the differences between rural and urban practices. The purpose of the second interview was to discuss each nurse's evaluation of the research outcome and explore their experience of the research process.

The formal written proposal was then approved by the two ethics committees. The time between the initial idea from management that the nurses change their practice, through to writing the proposal and receiving formal ethical approval was approximately two months. During this time, the nurses were already informally sharing ideas. Over the months that the research was being conducted, the whole Community Health Team had also planned regular meetings to work through how they would establish the rural focus of their service. At these meetings the nurses could share their growing ideas generated in the research as part of the team planning process.

Selection of Participants

Each member of the nursing team in this community organisation was approached individually and invited to be part of the research. This included the permanent staff and those employed on a casual basis i.e. called in when needed. The potential number

of participants was ten. Formal consent from participants was then sought. Explanation of the research in more detail, and the roles of the researcher and the participants were undertaken. An information sheet was given to each prospective participant (see Appendix A). Once it was apparent that the nurse understood the details and agreed to participate, a consent form was signed (see Appendix B).

Initially, all ten potential participants verbally expressed enthusiasm about the project. Nine signed consent forms. In the first week, all three casual nurses chose not to participate. One felt that the distance required for her to travel to meetings, and her infrequent days of work made participation impractical for her. The second casual nurse signed a consent form but withdrew before the first meeting, citing too many other outside commitments. The third casual nurse withdrew following the first meeting, saying though she really believed what we were doing was great, her outside life was just too busy. She also added that at this time of change, with so many other meetings taking place that she had to choose only some to attend. This left a group of seven who were all regularly employed members of the Community Nursing Team. One of these nurses attended only the first meeting. For the second scheduled meeting, she had to attend a work related family conference. Unfortunately, she was later absent from work on extended leave of three months to take a course. Though invitations were extended to her for all the activities, she did not attend. She did not formally withdraw from the study and now takes part in the new structures created as a result of the research.

Description of the Research Group

The Nurses

The group of nurses who participated as co-researchers in the whole process, comprised of two full-time Public Health Nurses and four regular part time District Nurses. Though these nurses are effectively members of the same team, the rural nature of their extensive geographical area means they do not all work from the same office. Three District Nurses and one Public Health Nurse work from the central base. The other

Public Health Nurse has her base twenty kilometers away. The fourth part time District Nurse lives and works on an off shore island. She also does casual work at the central base.

These nurses trained between twenty-four and thirty-two years ago, and have worked in this local area from between three and eighteen years. Their range of professional experience, as a group, is extensive and includes work in laboratories, hospital surgical and medical wards, accident and emergency, intensive care, coronary care, agency nursing, rest home nursing, midwifery, occupational health, practice nursing and Plunket Nursing. Some have experience as Charge Nurse in the hospital setting. Most have participated in community based inservice education and the two Public Health Nurses have succeeded in tertiary study, one recently completing the Advanced Diploma of Nursing and the other a course in Health Promotion in Community Health.

The Researcher

I have been a member of this community health team for the past three and a half years, being employed first as a casual District Nurse and then as the Social Worker operating from the main base. I graduated as a nurse twenty-six years ago and have lived in this community for eight years. My work experience is predominantly in the areas of mental health both in the community and in hospitals, interspersed with periods of time in a wide range of hospital specialist settings work both in New Zealand and overseas. I completed a B.A. in Nursing in 1990 and am currently a Masters student for which this research is conducted.

Analysis of the Research Group

Group Dynamics/Group Culture

In the first individual interviews some participants spontaneously acknowledged that the team in which they worked was a supportive one.

They were such a really neat supportive team there was really no problem (DAL 1, p. 4). describing being a new team member.

My experience of the nursing group, when working as a casual District Nurse, was similar to that expressed above. Individuals were very sociable, and some time at the beginning of each day was spent catching up on some of each others' personal news. Prior to this study, the Public Health Nurses were not often active participants in this socialisation. As each of the District Nurses works part time, this conviviality was rarely experienced altogether.

In our second group meeting the importance of maintaining and nurturing that mutual support was recognised. The discussion arose from a comment that one of the District Nurses made at the first meeting.

In the past, Public Health Nurses of any kind anywhere do not like doing baths ... it's traditional. I'm not pointing at anybody ... we'd have to be on our last legs before we'd ask a Public Health Nurse to do a bath (GM 1, TP, p. 11).

A Public Health Nurse replied,

Well it wouldn't worry me if that was part of the job I had to do (GM 1, KO, p. 11).

This discussion continued at the second meeting

The problem globally is that nurses don't support nurses. In general, District Nurses, Public Health Nurses and Practice Nurses don't really understand what the other person does and so they don't support each other ... If we could really break down those barriers and understand the other person... I'm sure we can do it in a group like this. It's important that we do it (GM 2 TS p. 4).

The need to be supportive was generally agreed upon, but at times it seemed it came at the cost of dealing with issues that could create conflict. Another characteristic of this group was that handling conflict was difficult for them.

It's good that you can do that in a group (blend ideas and styles together co-operatively) without anyone getting upset ... I can't imagine anyone doing that ... I hate upsets (DAL 1, p. 11).

This reticence to experience conflict in the process was discussed with individuals towards the end of the study. I shared with one participant that

I think there is a general feeling that people really wanted to make it (the change in practice) work so it makes it more difficult to be critical (of the others' ideas) (MJ 2, RE, p. 10).

MJ replied-

... exactly, that's exactly right ... but what we've gained is that closeness of spirit ... and I think we have it enough to be honest about the process which is what we're doing now (MJ 2, p. 10).

As the process evolved, the comfort of individual members grew as did their ability to deal with differing ideas. The supportive nature of the group also helped one participant feel that, after the research, she could be more open and honest both with herself and others.

I never would have said (before) gosh I think I stuffed that up ... (but now I can) be more truthful about how things are ... but now we all do it and that is very supportive (TS 2, p. 3).

Roles

Though the group members eventually enhanced their ability to deal with potential conflict. In reality conflict. was less evident because of the balance of roles that made decision making a relatively co-operative exercise. The predominant role each participant played was identified and described by most of them in their last individual interview.

These are:

Visionary:

I'm visionary, and I think I was a catalyst . In some respects I often felt that I was the leader ... basically because of the knowledge I gained last year (KO 2, p. 9).

Clarifier:

Maybe I helped to clarify things because of my lack of understanding ... I needed others ... to explain a particular part ... which probably helped to clarify it for the rest. I helped get things from the theoretical or hypothetical down to the practical (DAL 2, p. 11).

Practical Encourager:

I felt ... I could encourage ... I felt my role was more of a practical one rather than a brainy one (FC 2, p. 15).

Supporter:

A supportive role more than anything, rather than coming up with dynamic ideas ... there was some good basic stuff that went in from me (TS 2, p. 10).

Practical Co-operator:

I'm a practical person rather than an initiator or challenger (KB 2, p. 12).

With MJ, I discussed the balanced nature of the group.

There aren't two people that are so similar that they are in competition with each other or so opposite that they clash (MJ 2, RE, p. 11).

Yes, that's (our) strength ... and I feel really positive about our group (MJ 2, p. 11).

This last participant's role I identified as

Philosopher and Analyst: She contributed ideas for discussion from a widely read background and expanded the group's thinking.

My facilitative roles as described in Chapter Three, varied depending on what the group was experiencing and what was required to meet their goals.

The group dynamics then, were co-operative with one particular person taking on a leadership role, another who questioned many of the issues that arose, another who stimulated philosophical thinking and others who actively participated with their own ideas and supported the direction that plans were going. This support in the group and the varied, but nonconflicting, roles of its members all contributed to an atmosphere of free dialogue and collaboration.

The Ideal Speech Environment

The ideal speech environment, as discussed in Chapter Three promotes consensus. Though it could be argued that this group's initial reluctance to deal with issues of conflict compromised this free speech environment, there was little discrepancy between the overall ideas decided on in the group, and what was expressed as desirable in the individual interviews. This conferring between the two sources adds weight to the belief that true consensus was reached.

The need to explore ways of resolving conflicts was addressed at the end of the research process. It was recognised by the group that if they were to continue to work together effectively, conflict resolution was an area that needed some work.

One process issue that could also have compromised the ideal speech situation was that the group members often talked over each other, or answered for each other. This seemed to be a group 'habit' that at times made transcript deciphering more difficult and may have affected how much each individual gained from the meeting. However, even though individuals may have missed some of the process by communicating this way, it did not appear to affect the overall outcomes.

Activities

The research group mutually agreed that the setting for the first two nursing meetings would be in a private area of the community health centre. These meetings took place after work. I devised a semi-structured agenda for each meeting around which the

nurses developed their own ideas. Each agendum was based on a balance between the overall philosophy and goals of the research and the progress of the nurses' thinking. Though processes overlapped, they most closely followed the action research spiral of reflection, planning, action and evaluation.

Phase (i) Reflection

Repeating the definition from Chapter Three, reflection is "examining the unquestioned and largely unchallenged ... assumptions values and beliefs that underpin our actions, as well as the institutional practices around us" (Smyth, 1986, p. 3). It is also seen as a learning tool. The nurses engaged in reflection from the beginning.

Reflection in Meeting One

The agendum for the first session was to explore the nurses' impressions of forming a rural health service and management's idea for the nurses to combine their roles. Reflecting on each of their roles was undertaken. "Obtaining a complete picture should be the first step in the process of change" (Nolan & Grant, 1993, p. 308). From the outset they described their District and Public Health roles as inherently different and specialised. Combining them seemed impossible. Overall, there was an aversion to the idea.

It just frightens me combining the roles ... I just have the feeling and I know research has said ... that Public Health is the one that would go by the board (KB 1, p. 11).

I would feel quite incompetent (in PHN role) ... I would find it quite daunting (MJ 2, p. 6).

Differences

As well as their reactions to management's suggestion, reflections and conversations in both this first meeting and in the first individual interview raised the nurses' awareness about what distinguished their practices.

... the nursing approach to Public Health is slightly different to the approach to District Nursing ... the needs of our client are often unknown (GM 1, KO, p. 2).

There is a diversification between the process of the work ... our (District Nursing) work is set out as task oriented things, that have to be done everyday. The day is preplanned with a patient load, record keeping, equipment upkeep whereas Public Health Nurses are more able to plan their work and have more control over their workload (GM 1, MJ, p. 8).

Comments such as these were collated by me into the categories of philosophy, client, role and working mode which emerged from the data. For each role the content of each category was different (see Table 1).

Table 1

Participants' Comparison of District and Public Health Nursing

Category	District Nurse	Public Health Nurse
Philosophy	Treatment of individuals and promoting self care.	Client centred health promotion. Education establishes personal priorities and choices.
Client	Initially an individual with an illness. Care can extend to include whole family.	Focus on whole community groups with certain health needs e.g. immunisation.
Role	Assessment of health needs, carrying out prescribed treatment throughout illness.	Assessment, education, health promotion and illness prevention.
Mode	Reactive to referrals. Work load unpredictable. Task oriented but nurses say work extends beyond task.	Work is often self directed and preplanned. Usually starts with a collective need and moves to group or individual care.

In their individual interviews, it was clear that some of these nurses chose their area of work because of their individual desire to work in either the District Nurse mode of hands on care or the Public Health Nurse mode of education and health promotion. They also expressed reservations about their ability to perform the others' specialist

role. Being a nurse doesn't mean that either wants to do, or is capable of doing, the other's work.

I've always felt that to be a full person you had to be rushing here and there ... (everything I do) ... is hands on ... it's never a philosophical thinking sort of thing (DAL 1, p. 10).

(Our District Nursing work) has an entirely different outlook - an entirely different focus ... It's more the curing side of it. Hands on care. Once you're into that (the preventative side) it changes the person as a nurse. They don't have that willingness to do that hands on work ... what we do is more personal (TP 1, p. 3).

This impression appeared to be confirmed when I observed, at one of our last meetings, a Public Health Nurse shaking her head fervently, with apparent aversion, when one of the District Nurses stated that doing personal care for the terminally ill was, for her, the essence of nursing.

Similarities

As well as the described differences, some similarities between the two types of nursing were also revealed in these early stages.

Assessment: Assessment of health and nursing needs was a major part of their work, and both groups saw it as a very important part of care that required time to be done properly.

Basic Education: Their basic common education was recognised and, because of this, there seemed to be an acceptance that it is easier for a Public Health Nurse to incorporate some of the more basic tasks of District Nursing work into her day, than vice versa as Public Health work has not been part of these nurses' basic training.

I think we would find it easier to do a District Nursing job, a simple one, I'm not saying something that we haven't been trained for, but a simple type dressing than they would find, say, doing health education in ... schools (KB 1, p. 7).

Professional Growth: They recognised that each individual had grown professionally from that common education base, depending on their work experience. As the total group experience had been so varied, this made considering working as a multiskilled team a more viable prospect.

The group agreed that educational updates in many areas would be required to combine their work. They saw this as time consuming and costly for the organisation.

... my mind boggles at the need for us all to have the same knowledge and training and to me, resource wise and budget wise that's nonsense (KO 1, p. 9).

However, overall they saw the importance of the client getting consistent health messages from all the nursing team.

Need for change

Most of the group saw a need for some general change and a desire to have a say in it.

Yes the whole service needs it - it needs to be more geared to the community needs (KO 1, p. 5).

We want to be such a good service that everybody wants us (DAL 1, p. 1).

We need to be more autonomous and self governing ... (as a rural group) (MJ 1, p. 8).

There's a lot that needs changing ... (we) can save on two people going to the same area ... if we could work together it would be better for the community (KB 1, p. 7).

I want to have a say in change ... (so that they) don't take away expert areas (TS 1, p. 8).

Reflections in Meeting Two

Though the group actively engaged in reflection in the first meeting, conversation in the second session indicated that their knowledge of the activity and its value was not

clear. The discussion revolved around an article about reflective practice (Darbyshire, 1993) that most of the group had read. The nurses offered their own personal critique of reflection considering whether or not they felt they could do it, and whether or not they considered it beneficial. Part of my role here was to teach them about the process.

I was sort of laughing at it (the article) really because I thought it went too far in trying to explain something that's just about unexplainable i.e what nurses do (GM 2, DAL, p. 5).

That's my trouble and I agree to a certain extent that it's stating the obvious (GM 2, MJ, p. 6).

I responded that

It can be obvious to you and part of you but not to everyone else and I think that's where nursing is developing - making their knowledge visible so it's beyond what's in their heads (GM 2, RE, p. 6).

I 'm just saying that it sounds like it's forced artificial - I mean contrived (GM 2, DAL, p. 7).

The Public Health Nurse who had done the Advanced Diploma in Nursing last year was 'schooled' in reflective practice and advocated both its implementation and its value.

I think one of the benefits of reflective practice is that it's an affirmation of who you are and what you do and we don't often do that. I mean we know we do these things (GM 2, KO, p. 8).

Another participant described why she thought reflective practice was uncomfortable for her but she could also see its benefits.

... because we internalise all those values and all that experience and all that wealth of stuff and we keep quiet about it ... but it's actually what sets us apart. (GM 2, MJ, p. 9).

One participant had her individual interview following this meeting and had thought more about reflection

I am more inclined to thinking that it probably is quite important that we think about how we do things ... well I've just never really thought about it and that's the whole trouble (DAL 1, p.9).

Individual reflection

Reflection by individual participants also occurred through reading the transcripts. This increased their awareness about how much had been discussed and the progress they had made. The process positively reinforced their individual contributions.

I was surprised how much had gone into them (the meetings) (GM 2, FC, p. 1).

Initially I thought I didn't (contribute much) but reading a lot of the stuff (transcripts) afterwards I realised that I did (TS 2, p. 10).

My own reflection on the process was accomplished by taking notes about observations I made, keeping a personal diary, and by reliving the groups through the audiotapes. The latter kept alive my enthusiasm for the project as I relistened to the changes that the group were undergoing. These observations were shared with the group and individual members. This enhanced their understanding of both how the group and they as individuals were progressing and contributed to their individual reflection. My own reflection was also aided by discussing issues with my academic supervisor.

Analysis of Reflection

The group engaged in reflection from the beginning. It was a process that needed to be learned and accepted, and thereafter it was used more consciously in the research process. Reflecting on their practice enabled the group to think through their feelings of aversion to combining roles and look to change some aspects of their practice. It served as a learning tool, brought theory and practice together and contributed to the process of empowerment.

Phase (ii) Planning

Creating Models

While reflection was accepted as a useful tool, other aspects of the Action Research process also needed to be understood. These included the interrelationship of concepts as they are developed in theoretical thinking, and the creation of models to illustrate these relationships. To accomplish this, I led the group through a group teaching/learning session which explored these areas and increased their understanding. They then were able to develop a model to illustrate their current situation (see Figure 7). It was noted that it was the rural community, in which both groups lived and worked, that united them the most. With this visual representation, the nurses saw that the division of the clients into Home Health and Child and Family Services, and the further division of nursing into one group for each of those teams was inadequate in addressing nursing needs in the community. They reflected on a recent health day that was organised through the Home Health Team and was held without informing the Public Health Nurses, even though it addressed health promotion issues and was set up for the community in which they worked. These separate services were also seen as not conducive to combining roles or working in a multiskilled way. The nurses concluded that categorising both clients and care inhibits specialists from working across boundaries. Creating a new rural community nursing model then became the goal of the group.

To do so, plans were made for a weekend 'workshop' at the home of the District Nurse who lived on the offshore island. This was seen as a necessary step in pursuing our goals, as the nurses recognised that a continuous period of time was needed to think deeply and develop ideas. Before going the nurses had some questions for management about what they meant by multiskilling and what their motives were for the proposed change. These were presented at a meeting with the Community Health Team and the 'Community Services Manager'. In reply, the 'Community Services Manager' reinforced the organisation's impetus for efficiency and explained the structural changes that the new health reforms have produced. She reiterated that in the competition for contracts, our need to be efficient was essential for survival.

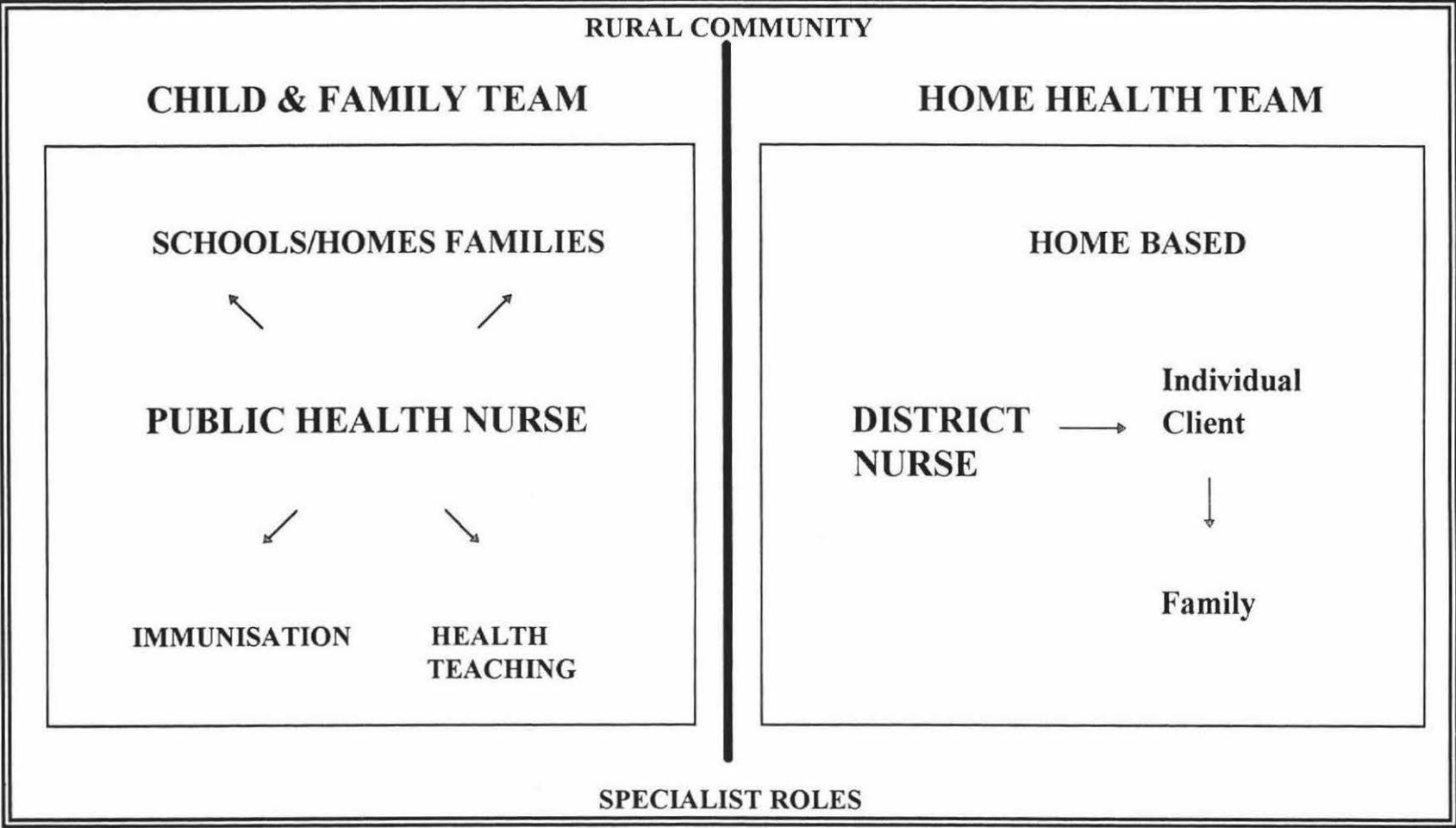


Figure 7. Specialist Roles of District and Public Health Nurses

Incorporated in her talk were a list of the Health Reform Goals and the CHE Objectives (see Figures 8 & 9). The nurses considered these when making their plans.

The Workshop

In order to stimulate theoretical thinking prior to the workshop, I requested that each nurse write and bring with them their personal definitions of nursing's four basic concepts: health, nursing, client and (rural) environment. With this as a foundation, we explored different philosophies and discussed their interrelationship as they saw them in their work. Some time was spent on identifying the essential features of their rural work. Informal time was spent telling nurses' stories that served to consolidate their philosophy and their role (Sandelowski, 1991). Common philosophical values of a client centred approach and a health and wellness focus emerged. They used these to make plans to work more closely, while keeping their specialities.

Commonalties

The common features these nurses agreed upon were that they

- are primarily client and health focused.
- see an individual client as a physical, emotional and spiritual being.
- consider the person in the context of his/her support networks.
- can focus on the whole community as their client.
- listen, observe, assess interpret and negotiate with clients to establish their needs, and ways of assisting.
- encourage self reliance and independence for clients to the best of their capabilities.
- are client advocates.
- through continuous assessment, adapt responses to clients with each encounter in a 'therapeutic partnership'.
- experience practising and living in their rural community which creates a common bond between them.
- have assessment skills, flexibility of relating to clients, seeing clients in their own environments and client advocacy as four of their most common and important assets.

HEALTH REFORM GOALS

- **Better clinical performance**
- **Improved access to health care**
- **Rationalisation of duplicated services**
- **Reduced waiting times**
- **More choice for consumers**
- **Greater focus on primary health care**
- **Efficiency, flexibility and innovation**
- **Performances to be measured**

Figure 8. Health Reform Goals

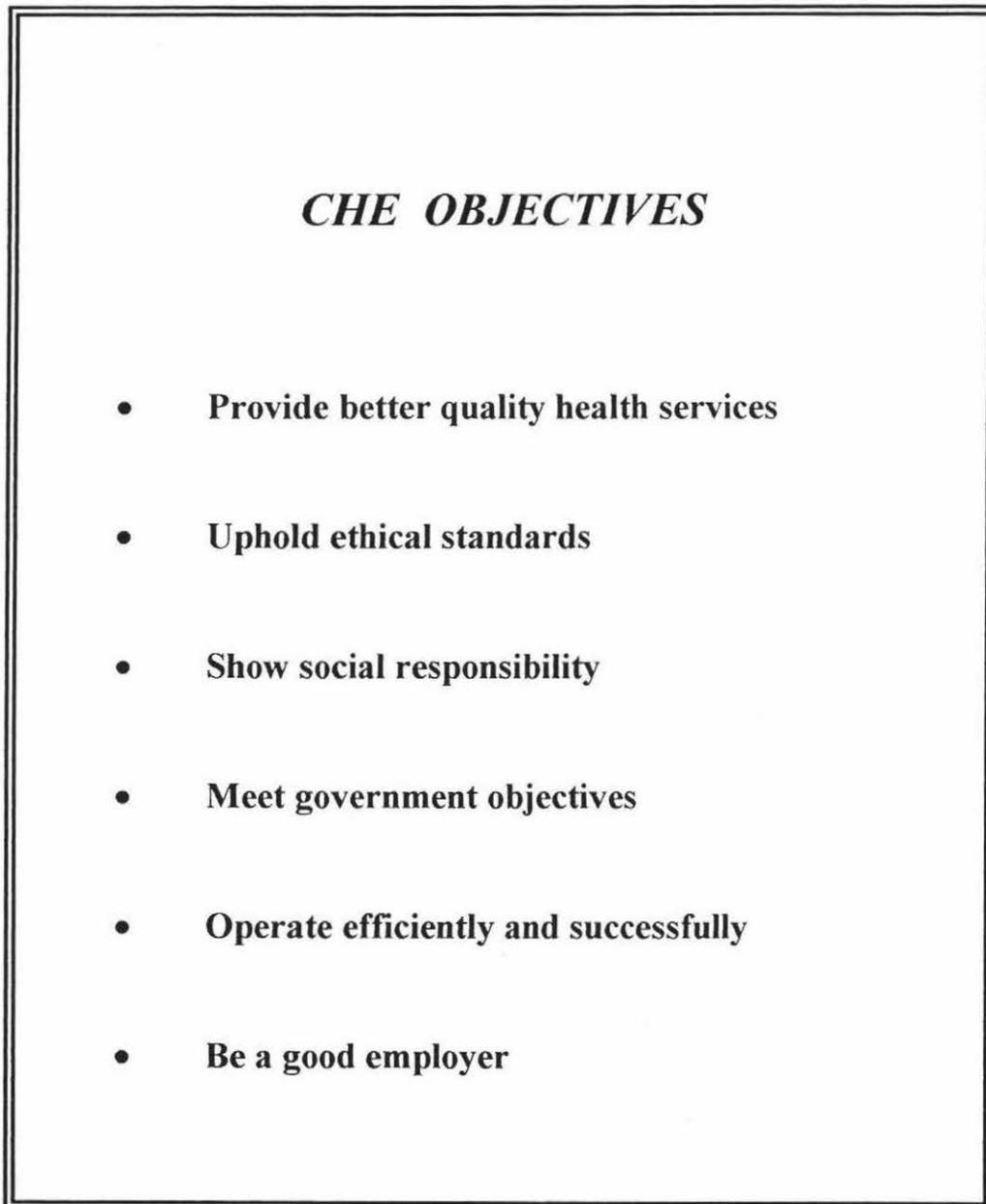


Figure 9. Crown Health Enterprise Goals

Based on these commonalties the group developed a new nursing model (see Figure 10). The shaded area indicated where they would share their work and the unshaded area illustrated their existing specialists roles. This model was an organisational one showing only the nursing group within their community team. As such it did not include the client, even though the client was always their stated focus of work.

From this model and their desire to more adequately meet the community's health needs, the nurses planned a series of activities which both groups would share.

Plans for Action

The plans they made were:

- for all the nurses on duty to meet briefly at the start of each day to discuss their day's work to see if any could be shared.
- to run community health days together.
- to have a nurse at the clinic, one half day a week, so clients could informally drop in.
- to have regular nursing meetings to keep their combined role evolving and to set group objectives.

They stated that they understood the need to start with a few projects and slowly develop their collaboration.

The morning meeting

The anticipated benefits of the morning meeting were that

- both groups would be aware of what the other had planned for the day and this would increase their knowledge of each other's roles.
- if geographical areas for visits overlap, some of the work could be combined.
- the District Nurses' heavy workload could, in part, be alleviated by the Public Health Nurse doing some visits she feels comfortable with, especially assessments.
- by sharing some of the load, the District Nurse may have time to visit a school with the Public Health Nurse or be available to be in the health centre on the half day designated.

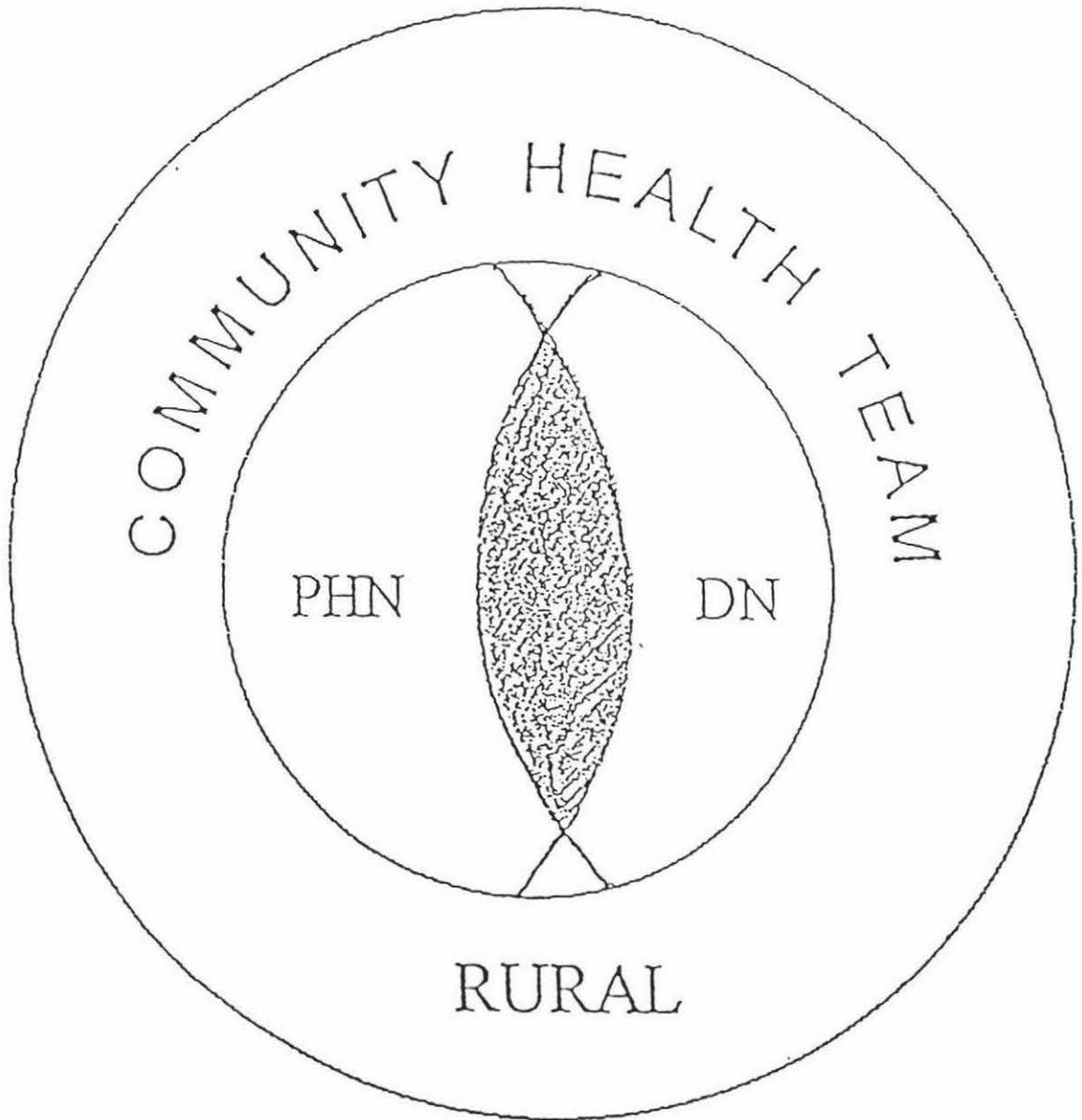


Figure 10. The Initial Nursing Model of Integrated Roles

Health days

The anticipated benefits of the Health Days were that

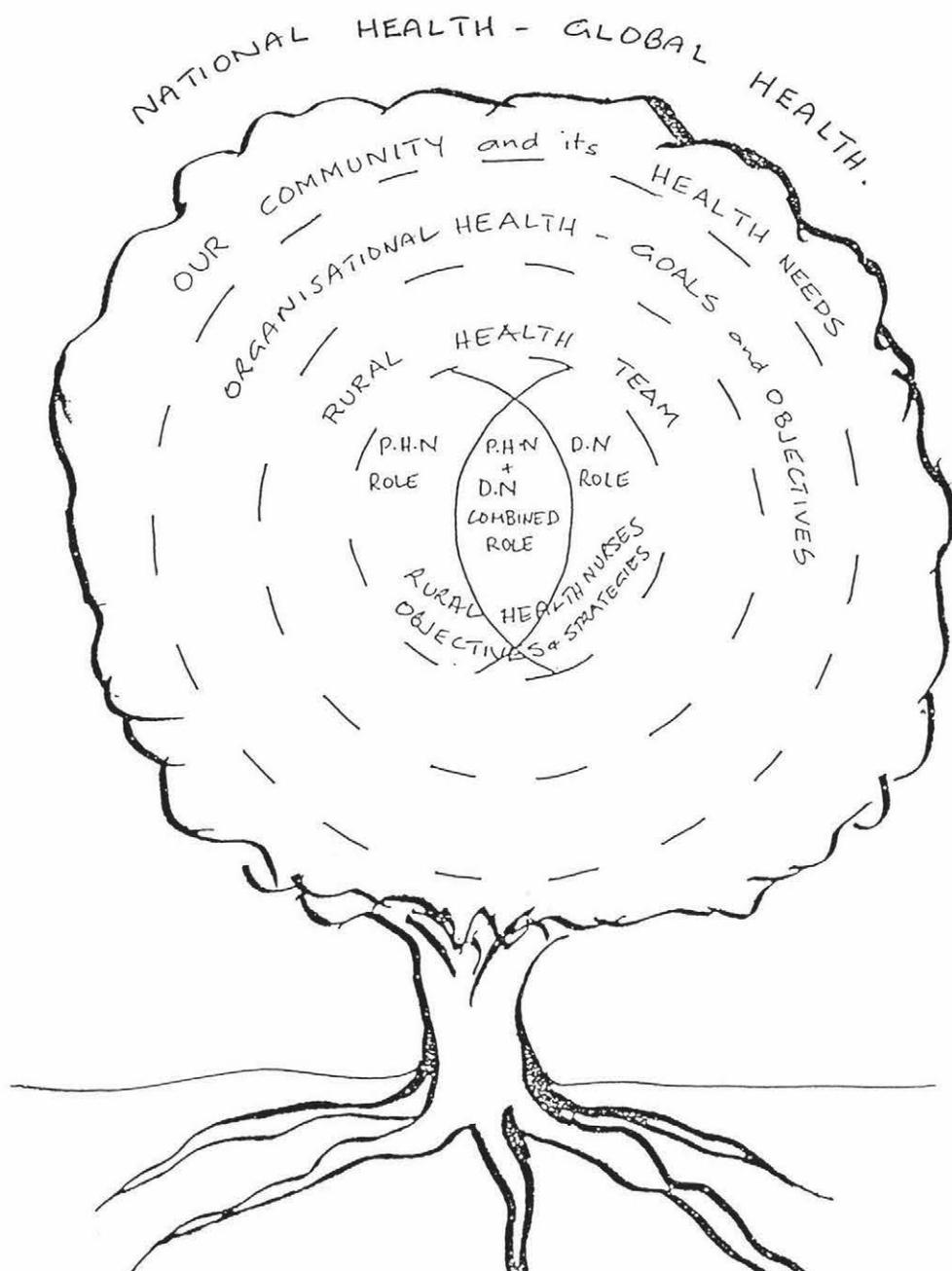
- they could be a forum for listening to the needs of the community and could establish knowledge of patterns or common needs.
- they could be a forum for health promotion, early detection and education.
- they could raise the profile of the Rural Health team by seeing it in action.
- with information people would be better equipped to monitor their own health.
- they could be organised around health issues such as asthma, diabetes or around population groups such as women's health or over 50s.
- by inviting other appropriate community groups to contribute, clients would better understand the varied roles of other providers.
- a record could be kept of issues/problems encountered as part of a community profile.
- Specialist clinics could be arranged if a need was seen.
- a summary could include what was discussed and recommended and General Practitioners could see how many were referred to G.Ps. This may alleviate what the nurses sense as G.Ps feeling threatened by health days.
- future health days could be enhanced by an evaluation form being given to participants.

The clinic day

The anticipated benefits of the clinic day were that

- they would serve as an informal information point for members of the community.
- they would raise the profile of the Community Health Team.
- they could deal with or refer on to appropriate personnel any issues that were presented.
- information gathered could add to a community profile for further health planning.

A Public Health Nurse introduced to the group, the World Health Organisation focus on health promotion and the Ottawa Charter (WHO, 1986). After the workshop, this same nurse expanded the original integrated model (see Figure 11). It was accepted by the group at a subsequent meeting. The plans and the model were presented to the 'Community Services Manager' and the whole Community Team, who were enthusiastic about the results. The 'Community Services Manager' was already



The tree depicts life, growth and strength. The roots symbolise the rural history its solidarity and dependability. The gaps in the circles show openings for communication among the different groups.

Figure 11. The Expanded Nursing Model of Integrated Roles

organising for the Public Health Nurses to 'broadcast' the results to their colleagues in the CHE.

Analysis of Planning

Integrated thinking

The plans made revealed that the nurses were very much thinking in a collaborative manner. This did not just include some integration of their two roles but also the intention to work with the team and other community groups for the purpose of better meeting the community's health needs. Expansion of the model extended this integration to include a wider world focus. Politically, they recognised that this integrative thinking was in contrast to the competitive philosophy of the Health Reforms. However, comparing their goals and proposed changes with the CHE objectives and Health Reform goals that the 'Community Services Manager' had presented (see Figures 8 & 9 on p. 60 & 61 of this thesis), the group found them 'encouragingly' compatible. This also confirmed for them the importance of developing their plans within their political and organisational contexts.

Broadcasting

Broadcasting of research progress is part of Action Research and differs from other methods where data and outcomes are kept 'underwraps' until publication. "As ... (Action Research) develops, it is expected that a widening circle of those affected by the practice will become involved in the research process" (Carr & Kemmis, 1986, p. 165). Sharing information with the whole team and the 'Community Services Manager' was a positive experience for the nursing group, as their ideas were listened to and for the most part supported. For me there was some initial uneasiness, in spite of the group agreeing what would be discussed, as I had been educated in other approaches where confidentiality is emphasised and it is unethical to be revealing the outcomes before the project is finished. There was also pride that we had achieved as much as we had.

When the 'Community Services Manager' organised broadcasting outside the team, the nursing group expressed, to each other, feelings of having our work 'hijacked' before we had had a chance to feel ownership of it ourselves. It seemed that management were 'in control'. Examining these impressions, we discovered that our uneasiness was also based on our awareness of how incomplete the process was, as none of our ideas had been trialed. Management were encouraging us to 'sell' the structure we had created to a wider audience, before we knew whether or not it would work. Once we established the basis for our reservations, the two Public Health Nurses and I presented our progress to date and stated that it was still unfinished.

Some of the nurses' ideas about their future plans and their perception of their rural environment were 'broadcasted' as part of a public presentation by management at the opening of our new premises, which occurred midway through the research process. This was a confirming factor for the nurses who felt that their ideas had really been heard. Broadcasting to the team, to CHE members and the general public, all helped to consolidate what we had accomplished and created a strong foundation for the next phases of acting and evaluating

Phases (iii and iv) Action and Evaluation

Description

At this point, though I was keen to pursue our group meetings, it was apparent that the nurses needed some time away from the research process. The Community Health Team, advancing their rural service, was moving to larger, more central and more modern premises. As well as maintaining their services through the physical shift, there was also an early morning blessing of the building by the Maori community and an official public opening, all of which took energy and commitment.

For the next two months, the nurses held their morning meetings and planned a health day. They collected information to plot their progress, and I also made observations, sometimes formally and sometimes casually, as the nurses went about their daily work.

The morning meeting and health day

To record data from these meetings, a form was devised for making brief notes (see Figure 12). The 'outliers' are those staff who will influence their day, but are not in the health centre or not officially part of the team. These include the Public Health Nurse twenty kilometers away who kept in contact each morning by phone, and the Hospice Nurse who attended the meeting. I attended some of the meetings to observe the process. The health day was planned and carried out together.

Bimonthly meetings

The last planned research group meeting was held on September 30th, five months from our initial meeting. It was held in work time. This was the beginning of the regular nursing meetings that had been proposed by the group. Having it in work time was an acknowledgement by management of the value of the process not only for the nurses, but for the team itself. It had also been negotiated that all nurses whether on duty or not, would be paid if they attended these meetings.

During this meeting, we evaluated progress to date. The expanded community nursing model was discussed and some slight modifications were made as the group recognised that their creation was continually evolving. There was a general consensus that the research had given the group a sense of combined purpose and power. A general plan for keeping the group momentum going was established. They planned to meet bimonthly. One meeting would be used to share inservice and educational information, that any one of the nurses may have gathered in the past month. The other would be to keep up the momentum of their evolving role by focusing on group plans and objectives.

Evaluation of morning meeting

In evaluating the morning meeting in relation to the anticipated benefits, it was found that their knowledge of each others' roles and skills had increased. Sharing of information and cross referral of clients based on knowledge of others' skills had

NURSES' AM MEETING

Who participated	Duration	Contact with Outliers	Outcome
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NURSES' AM MEETING

Who participated	Duration	Contact with Outliers	Outcome
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NURSES' AM MEETING

Who participated	Duration	Contact with Outliers	Outcome
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Figure 12. Data Collection Form For Morning Meeting

begun. A movement towards multiskilling was occurring. In some instances geographical areas had overlapped and a Public Health Nurse had been able to visit some District Nurse clients. However, the conclusion was that it was one-sided as the District Nurses were too busy to help the Public Health Nurse. An issue related to sharing work was that the Public Health Nurses would only take on District Nursing work that they felt capable of doing. As District Nursing work has become increasingly technical, there were quite a number of things for which the Public Health Nurses felt they needed more training. Although sharing the day's work was one of the goals of the meeting, the District Nurses rarely wanted to initiate a request for help, but would rather wait for it to be offered. At times, though busy, they also would automatically say they could cope with their load as they felt a personal responsibility for their own work.

Evaluation of health day

A health day was held in September. Evaluation of it, in relation to the anticipated benefits described earlier, showed that the health day was planned and carried out by the nurses as a group, and progress on the format and compiling of information was achieved. The outcome for the nurses was assessed. All involved felt they were working in a health promotion, illness prevention role. However this way of thinking, they said, was not as a result of the research but the structure of the day and the predominantly 'well' people they were attending. A District Nurse who had participated in past health days before the research project began stated that her health promotion focus for both that health day and the more recent one was the same. However having the two groups working together was new and beneficial. because each contributed their different skills and knowledge.

Evaluation of clinic day

The clinic day was never formally discussed after the workshop. No plans to implement it were undertaken.

That was the end of the formal research process. The nurses were somewhat reluctant to continue without a facilitator but did manage to do so. I asked the nurses' permission to attend some of their subsequent meetings, when I might need to clarify some of the research data or to follow up their evaluation of plans not yet implemented. The meetings attended later were constructive and lively.

Analysis of Action and Evaluation

Though the group was progressing well, observations of the group in action during the research indicated that some group processes were creating barriers to change. Two processes observed I have named 'encapsulated thinking' and 'values conflict'.

Encapsulated thinking

Observation of the bimonthly meetings revealed a communication gap that was a potential barrier to the attainment of the group's goals. I pointed out that some ideas that had been formulated in their meetings were not being remembered or acted on outside the meeting room. It appeared that each meeting was treated as an 'encapsulated' episode that began and ended within the allotted time frame. Thus the ideas were, figuratively speaking, left in the room when the meeting finished.

I compared this way of approaching meetings with the way the District Nurses described their work. They see each client individually, and deal with all that is required on that day for that person. The chart is then filed and they go on to their next client, problem or challenge. As such, their client group is rarely seen as a whole and there is rarely need to connect one episode of care with another.

A similar process takes place with meetings. The meeting 'task' is dealt with in the room and, as it were, filed there. When my observations were shared with the group, the District Nurses, though knowing that they treat each client's situation thoroughly, stated that the structure of their work into tasks does create a 'thinking habit' related to their work that is geared to episodes and time allocation. The pressures of time and the

work load inhibited them from thinking in depth beyond the 'task'. This process was different for the Public Health Nurses.

Just because of the way we all think as DNs ... tick, done. It's something that DNs ... have to learn to do - not to be so time oriented - but how can we do that? (FC 2, p. 10).

One of the difficulties in District (Nursing) is constantly the number of things that have to be done in that day that preclude any in-depth thinking about them (GM 1, MJ, p. 12).

They (Public Health Nurses) have more openness in their jobs and not fixed into these strict boundaries and when you work with these restrictions in time you have blinkers on whereas, these girls (Public Health Nurses) have time to think things through whereas we haven't (FC 2, p. 10).

Clearly, the District Nurses see the structure of their work and their heavy client load as inhibiting their ability to think beyond episodes of care, and in depth about their practice. To help amend this 'thinking habit' in meetings the group sought a form that would record their progress and could be referred to at subsequent meetings. The team co-ordinator had such a form and the nurses incorporated it into their meeting structure (see Figure 13).

'Encapsulated thinking' also seemed to be closely linked to the internalising of ideas that are discussed and decided upon in meetings. Ideas are not used outside the meeting room if they have not been internalised by those attending the meeting. This was an important revelation for me and I think, if it had not been dealt with, the change process could have been jeopardised.

For example, at the first Team Meeting following their first research group, the nurses were asked to begin the meeting by contributing the ideas that they had formulated. There was silence. The nurses were unable to talk about the ideas they had generated, even though I had given them each a summary of what we had discussed just before the meeting began. I had assumed that the nurses would grasp the summarised information quickly and this did not occur. The situation was also compounded by me wanting to adhere to the ethics committee suggestion not to confuse my roles. I maintained my

ITEM	COMMENTS	ACTION REQUIRED	BY WHOM	BY WHEN	FOLLOW-UP

FIGURE 13. Form To Record Group Meetings

team role as a Social Worker and I did not assist the nurses to describe what had happened. This created a disempowering experience for the nurses.

Reflecting on this episode, and with their awareness of encapsulated thinking, the group devised strategies that would help prevent a recurrence. For future meetings, a summary of their ideas was given to all the nurses well in advance so they were able to review their created ideas and actively contribute to the meeting. In team meetings, I decided I could participate in either my role as Social Worker or as group facilitator, if it was necessary, being aware of which role I was taking on. Further reflection revealed that this nursing group was used to being directed in organisational matters and meetings. They did not anticipate that they would be asked to 'go first' with sharing their ideas.

These strategies helped the nurses to consolidate the ideas they had created. Also they experienced, in subsequent meetings, that their ideas were appreciated and for the most part supported, both by the team and by management. This was reinforcement for themselves that their ideas had merit and also the beginning of their changing perception of their relationship with management.

Internalising of ideas is also related to the second barrier to change I observed, 'values conflict'.

Values conflict

At the end of November, a nursing group meeting took place which I attended to discuss with them my interpretation of the data. Circumstances meant that only the District Nurses attended. There, many of the ideas about these new nursing meetings designed to maintain nursing consistency and their evolving role, were verbally negated. It had been a pressured day of work, and there was the usual flurry of presummer/Christmas activities. The nurses concluded that the frequency and length of the meetings was not worth it for them, because it intruded so much into their day. The plans that had been agreed upon so eagerly during the research process were now being discounted. I suggested that we meet in the New Year to discuss this phenomenon.

Reflection in this later meeting revealed some deeper ideological issues and some conflict in values that were affecting the nurses' proposal to reduce their meetings. The District Nurses described that, for them, the value of the meetings was in question. Reflection revealed that the District and Public Health Nurses had different views about meetings.

The District Nurses see them as:

... an interruption to our flow of work (GM 6, DAL, p. 1).

Whereas the Public Health Nurses who are used to meetings stated:

... to me (avoiding meetings) is wrong priorities ... because without having your meetings your work isn't enhanced. (GM 7, KO, p. 3).

... really built into our job. Historically we have to structure them into our work so it's a different way of working (GM 6, KB, p. 5).

... valuable for sharing ideas and knowledge and building the team spirit. It gives me an understanding about what's happening in the community and about the workload that others have and what illness patterns are emerging in the community (GM 6, KO, p. 4).

Though the District Nurses stated that they did find the meetings valuable, they agreed that tradition and guilt prevailed when they were not busy attending to clients.

... because we trained in hospital ... if you're not busy constantly you were not seen to be working. I guess we've always made patient priority our priority ... I find it hard to prioritise them (the meetings) and find the time for them (GM 6, TS, p. 5).

They also attributed these traits to their social status as women, and their upbringing.

... maybe our family structures ... my mother never took any time for anything (GM 6, TS, p. 6).

... they are the last ones to give up something for themselves, the children, husbands come first ... (GM 6, KB, p. 6).

... or the one to be there for everyone else (GM 6, TS, p. 6).

These perceptions closely resemble the Nightingale ethos described by Rodgers(1985). Nightingale reinforced that to be a good nurse one must be a good woman. As such, nursing was a natural extension of the role of woman. Some of the womanly qualities she reinforced as necessary were nurturance, forbearance and obedience. Rodgers explored the history of nursing education in New Zealand and found that the Nightingale ethos was adopted as a fundamental premise in our formal nursing. All the nurses in this study trained in hospitals prior to 1970. The District Nurses acknowledged that this influenced how they think about their work today.

The reality for these District Nurses is that they are very busy and meetings are often over and above everything else they have to do. However, they also admit that on the odd day that they aren't so busy, they are likely to spend more time with each client than to use the time for reading or catching up with administrative matters.

This reflection raised their awareness and they started looking for ways of thinking differently.

It's really the problem that as District Nurses we can't get our mental act together (GM 6, DAL, p. 5).

Other District Nurses in general agreed.

We need to recognise that the meeting is equally important(GM 6, TS, p. 6).

The dilemma of attending meetings and establishing their value reveals a discrepancy between the District Nurses' ideology that they developed earlier in the research process and their ability to carry it out. Compared with their perceived values of meeting regularly, they found that there were other more established values that were inhibiting their ability to follow through with their plans. Fleming(1991) discusses similar discrepancies using Marxist theory saying that "attitudes, beliefs and values embodied in social practice serve to retain the status quo"(p.64). The discrepancy between their original goals and putting them into practice showed that there was still a gap between ideology, personal understanding and practice(Powell, 1989). Closing

such a gap is one of the criteria for the use of Action Research in social enquiry (Greenwood, 1994b).

The District Nurses decided they needed to get used to attending meetings and to ascertain the value of them for themselves. They still wrestle with this value concept but have resumed their bimonthly meetings and report any relevant information derived from them to the regular team meetings.

Process of Empowerment

Initially, considering the goal of empowerment within this research study, I anticipated that Fay's (1987) definition of enabling a disorganised group to focus on a new sense of purpose, was all the empowerment needed for this group to achieve their goals. However, analysis of the research process showed that the group moved beyond enablement. Enlightenment of ideas, enhancement of practice and empowerment in the sense of revolutionising their group were achieved.

From the end of the first meeting the empowering process was beginning.

I think we have to have a bigger voice ... much louder in what we want (GM 1, FC, p.19).

We've got to be more knowledgeable concise and vocal (GM 1, KO, p.19).

Proactive - we've got to do something rather than just say we should do something (GM 1, KB, p.19).

The researcher plays an integral part in the process of empowerment. Reflecting on the data, empowerment was achieved by facilitating an environment of free dialogue in which participants were encouraged to express ideas that made them more confident in their own thinking. We shared knowledge and I taught the group about theory and models so they could create their own. The nurses' awareness was raised about the value of their profession and about ways we gain our knowledge with examples of

instinct and experience both work and life's, and how much of our knowledge is hidden in practice. Empowerment also evolved from their changing discourse about management being in control.

At the end of the research this comment was made:

We're a force to be reckoned with (GM 5, TS, p.5).

The research process empowered individuals as well as the group. Each person made some comment to indicate this. The research

... was enlightening ... because it makes you think and you're picking up on everyone else's information/knowledge ... It's when you start to question it goes on and on ... I discovered I wanted to know more and more ... It just makes you think and I really enjoyed it (FC 2, p. 9).

... has heightened my awareness of nursing and I feel more collegial with the doctors because of it (TS 2, p. 8).

... has made me more aware of nebulous influences on my work ... and that we can be more responsible for our own actions of getting from A to B rather than relying on the hierarchy (DAL 2, p. 2).

... has created an ownership of the service we provide. It reaffirmed my previous knowledge and stretched it further (KO 2, p. 3).

... helped me learn how much potential there is for information from the group (MJ 2, p. 1).

Summary

The description and analysis of the research process in this chapter has shown that many factors contributed to the results. The group dynamics and the balance of roles enhanced the free speech environment. The group worked through the Action Research process, learning as they progressed. Reflecting on issues raised the awareness of the group to ideological factors that had the potential to inhibit change. Addressing them aided in the empowering process of the research and led to its successful outcomes.

CHAPTER FIVE

OUTCOMES

The goals of Action Research are to facilitate change and to generate and test theory (Greenwood,1994a). In this chapter these goals are discussed as they pertain to this study including the levels and limits of theory development. The changes made were based on knowledge the nurses gained about their rural nursing practice. Analysis of the Action Research process has also contributed to knowledge about change.

Change

Changes occurred both for the research group as a whole and the individual participants. Analysis of the change outcomes in Action Research can be categorised within language and discourse, activities and practices, and social relationships and organisation (Kemmis & McTaggart, 1988, p. 15). Because of their interrelationship information within these categories can overlap.

Language and Discourse

Analysis of language and discourse around the thematic concern of integrating the community nursing roles shows that the discourse evolved from one of fear and threat to one of acceptance. Initially the language showed that members of the group opposed the idea.

I really have a feeling of absolute disquiet about combining Public Health and District Nursing (GM 1, KO, p. 2).

(combining) frightens me ... Public Health would go by the board (KB 1, p. 11).

The Public Health role did tend to diminish when the two roles were combined in the pilot projects and discussed in Chapter Two. The immediacy of domiciliary work takes

priority over the preventative, educational aspects of Public Health Nursing work (Kinross, 1987; MacInnes & Glover, 1985).

Discourse around, and raised awareness about, the philosophies behind their distinct roles is discussed in Chapter Four. This established commonalities and a basis from which they could work together. It therefore "reconstructed their meaning and provided a basis for ... plans" (Kemmis & McTaggart, 1988, p. 13).

Discourse about the nature of their work also raised the nurses' awareness of the value of their profession and the comprehensive way in which they approach client care. However this awareness did not alter the District Nurses' description of their work as 'task oriented'. This is despite recounting numerous conversations and nursing stories, that clearly outlined a broad approach to their work that encompasses more than just performance of a 'task'.

Activities and Practices

These nurses used critical theorising to change their activities and practices which resulted in 'informed action' or 'praxis'. As a consequence of the research experience, they have reaffirmed their specialist roles. As well, they have confirmed areas in common to which both can contribute in order to meet the health needs of the community, their own professional needs, and the needs of their organisation. To keep in touch with these common areas, they meet each morning to discuss the day's work and share their knowledge about particular situations and conditions. They may also share some of the work. The group also meets every two weeks for two hours to discuss nursing issues in common, to share educational experiences, to work on common nursing team goals and to plan for mutual health projects. Ideas about nursing are brought to the team meetings. Their actions now are more connected with theoretical thinking and there is a stronger link between theory and practice.

Social Relationships and Organisation:

Discourse about change in both their relationship as a group, and with their organisation was apparent throughout the research process.

The group indicated that, in one way or another after the research, they felt more a part of the nursing team and that there was a team spirit and collegiality that was not there before. This was demonstrated in statements such as:

It's been a real team building exercise (KO 2, p. 3) .

We're a lot closer and understand each other better (MJ 2, p. 2).

It's brought us all together as a team (KB 2, p. 1) .

I learned a lot about other people involved and feel less of an outsider (FC 2, p. 13).

That closeness in spirit - we won't lose that. It's something we've gained out of the whole process (MJ 2, p. 10).

All agreed that they are now more aware of each other's knowledge and skills, and this has resulted in more cross referral of clients.

Their discourse around organisational decision making showed that they felt empowered to be more involved. They changed from having a 'them versus us' attitude, to one of working together towards the same end. The feeling that their ideas were respected was a major change.

I'm more aware of how policies are made and how much goes into a decision. We are more responsible for our own actions now rather than relying on the hierarchy ...(DAL 2, p. 2).

Things are more negotiable than they've ever been before (TS 2, p. 11).

The boundaries that were fixed by us don't have to be there (FC 2, p. 10).

Changes in discourse, about their relationship with management, occurred partly because of being more organised and empowered as a group to present their ideas, and also because of the positive responses received when they did so.

One nurse described the change in her perception of management which had been influenced both by the appointment of the District Co-ordinator and her involvement in the research.

She stated that before these changes,

...when we'd bring concerns to management, we were greeted with more of a 'yes .. but' attitude (MJ 1, p. 13).

The more involvement you had with the powers that be, the more you were conforming and they're pulling the strings (MJ 1, p. 9).

After these changes when the nurses ideas were presented to, agreed upon, and used by management this same nurse stated,

...at least they have listened. They have reiterated and affirmed what we have said and that's the first time that's really happened. Yes, we have to work at those old images we have of management and I do feel much more positive about that and our ability to be honest for the first time really (MJ 2, p. 13).

Her perceptions were confirmed by others.

Yeah decisions are ours now (DAL 2, p. 9).

I find (the co-ordinator) very supportive of anything we want to do that's going to promote health in the community (KO 2, p. 7).

This was also confirmed by a 'Quality Quiz', unrelated to this research project, which was conducted by the CHE soon after the research finished. Community health staff in all areas were invited to respond. To the questions, 'Can you make improvements to your service when you want to?' and 'Do you feel supported by your management?' the rural community workers responded yes to both in much higher percentages than other urban CHE areas.

The organisation has benefited by the nurses now bringing debated issues and conclusions to the rural team, and actively contributing to the team's plans from a nursing perspective. Other team members, such as the receptionist/clerk, have stated that the communication from the nursing team is more consistent and clear, which makes her work much easier.

Change for Individuals

While the group was the focus of Action Research as an activity, individuals also can change their own personal thinking in a way which may contribute to the collective interest of the group. Each individual nurse discussed this in their personal interviews with me. Some comments were:

It's just from going to these meetings ... thinking about what you do for people and why- I've never thought about things so much (DAL 2, p. 1).

It has increased my enthusiasm and interest in work because it has increased my awareness how important our role is as a team of practitioners and how we make changes in people's lives. It's the most I've had since my training (TS 2, p. 1).

The nurse who worked on the offshore island used the research to clarify aspects of her work that had evolved as a result of her isolation. Some practices, such as having oxygen available and keeping some of the more common medications on hand, were beyond the established guidelines for community work set out by the CHE or the previous Area Health Board. She also recognised that her ongoing educational needs were different from those of other nurses. Her discussion about this, with me and the group, raised her awareness about the need for legal sanction from the organisation for these less common practices. She felt she needed a formal means of getting the education she needed approved. By setting out her concerns in writing to the District Co-ordinator, a more direct pathway for communication was achieved for her individual professional goals.

It has clarified my practice. I never had the opportunity to talk about it before (FC 2, p. 12).

Outside Influences

The group recognised that there were influences outside the research process that contributed to their positive and empowered feelings about themselves and their work. They all agreed that the appointment of their local district co-ordinator had mobilised the whole team. He has been instrumental in placing promotional features in the local paper, including the services provided by the rural team. He also achieved the transfer of the team's offices from a remote area of town to a newer and more central location. This move has raised the profile of the whole team, and has given them pleasant working conditions. This 'fresh start' was conducive to the whole team 'thinking change'. Local management also means that there is a direct line of communication for ideas and concerns that arise in the nurses' discussions. This influences their incentive to plan and create, knowing that the potential for seeing some of their ideas through is greater than it has ever been.

Theory Development

Using Action Research, knowledge was generated in two main areas. The first was in the change process itself, which contributed to change theory. The second was in community nursing which contributed to nursing theory.

Action Research and Change Theory

Analysis of this Action Research change process showed how it contributed to change theory. The main features were the role of reflection, the process of stabilising change and the contribution of participative decision making.

Importance of Reflection

Action Research with its spirals of reflecting, planning, acting and evaluating follows the problem solving approach to change, that is common to most change theories. All involve a recognition that there is a problem to address, that alternative solutions need

to be created and trialed, and a new way of working to be implemented (Olson, 1979). Lewin's change theory, which served as the foundation of Action Research, named these steps as 'unfreezing, moving and refreezing' (Welch, 1979). Though this is a progressive process, the steps are not necessarily distinct and can overlap. In this study, reflection was used in varying degrees throughout, rather than being a separate stage. Meyer (1995) cites Winter who points out that "reflection is a crucial process by which we make sense of evidence" (p. 27). As described in Chapter Four, the nursing group used reflection to become aware of the theoretical underpinnings of their work from which they could make plans for a more integrated approach to community care. Reflection then, contributed to the theoretical understanding of their existing practices and provided the theoretical basis for their more integrated role. Reflection, therefore, provided the knowledge required to make the changes.

The refreezing stage in the change process involves stabilising the change, and integrating the new responses into the value system of those involved (Brooten, 1984). It was at this stage that the barriers of 'encapsulated thinking' and 'values conflict' were identified (see p. 71 & 76 of this thesis). The reflective process was used to overcome these barriers. Reflection, therefore, was also integral in stabilising change.

Stabilising Change

As part of change theory Olson (1979) recognised that new behaviours are tentative and before stabilisation can occur practice is needed to reinforce new ways of working. The District Nurses more than the Public Health Nurses needed this 'practice' in attending meetings that were an integral part of their ongoing plans. However, practice may not have been enough to consolidate this change. Critical reflection on some of the organisational, social and personal factors, including their socialisation as women and nurses, influenced the District Nurses' thinking about attending meetings. Thus stabilisation of change, did not depend on just adhering to the created structure of bimonthly meetings but was also positively influenced, when the group was more aware of, and could overcome their socialisation barriers and integrate the value of the meetings into their own value system. They learned that meeting together enhanced their feelings of empowerment. Greenwood (1994b) states that "... once a nursing team

becomes empowered in terms of their own practice, action research in their area becomes cyclical and continuous. This means that the chances of effecting enduring change is enhanced” (p. 89).

This issue of stabilising the new practice of regular meetings arose after the formal research had finished. Because I was an insider researcher/change agent, I was available when the group was losing track of their goals. This reinforces the value of having the process facilitated by someone who is either closely associated with the changing group or at least available to be recalled by the group if necessary.

Participative Decision Making

Meeting regularly, the nursing group generated ideas about how they wanted their integrated practice to evolve. Takarangi (1983) has argued that when nurses are directly involved in discussions about their role and practice there is more scope for their nursing decisions to filter back into the system, directly influencing the expectations of the agency, the users and other health providers. "If each community agency pursued this approach answers to purported gaps and overlaps would be in found in practice co-ordination not role amalgamation” (p. 36). This particular nurse group is already experiencing that their ideas are valued by management and are finding that they have more say in how their work is organised.. At this stage of writing, the nurses continue to meet and the importance of them being part of the overall team decision making process is being reinforced.

Action Research and Nursing Theory

Examination of nursing practice in this research project elicited information that reinforced existing theory about rural and generic nursing, highlighted issues about integrating District and Public Health Nursing practices and resulted in the research group creating a theoretical model for their rural community nursing practice.

Rural Community Nursing Theory

Recognition of the rural nature of their community and their service provision was part of the impetus for change in this group. The essential features of their rural environment were discussed in the research workshop and are summarised below.

For these nurses the rural environment means that

- they have personal community knowledge and affiliations.
- the client can be anyone with whom they come in contact. Going to the supermarket can be a place of consultation. People seek advice or information from them wherever they meet.
- it is small, isolated, mostly farming, with a town base. It is slower, quieter and has less public transport and fewer services to choose from.
- the people are predominately but not exclusively friendly, caring, conservative and connect with each other. Compared with an urban area, people are less sophisticated and more self reliant.
- there are several generations in one area and a sense of history.
- people have knowledge of their neighbours and share much in common. This can have positive and negative consequences.
- people are influenced by the agricultural seasons which dictate their lifestyle.
- dominant groups such as religions or political parties have a greater influence in a smaller community.

Theory about rural nursing is growing and this difference between urban and rural nursing, and between residents and their health needs, is noted in the literature (Bigbee, 1993; Curtiss, 1993; Nichols, 1989). Though most of the studies are conducted in the USA, the results closely relate to the experiences of the nurses in this study. Some differences highlighted in the literature are the distance that nurses travel to see their patients, residents isolation from city services, the knowledge of close knit communities that can be tapped for resources and the 'rugged independence' of rural people for whom health teaching and provision of care may need careful negotiation. However, the literature also admits that ruralness is not clearly defined. One description is to perceive it on a continuum of remoteness and isolation at one end and densely populated on the other. The continuum also takes into account the number of health services available to the area (Bigbee, 1993). When services are limited, a generalist or generic nurse is more likely to be employed to deliver District, Public Health and Plunket Nursing to their community (Dept. of Health, 1985).

The rural environment and the generic nurse

In some rural environments a generic nurse may be the only health professional available. Descriptions of such nurses, and their various abilities from delivering babies to trimming a boat, are found in the New Zealand's nursing history (Lambie, 1956; Rutherford, 1953; Stonehouse, 1972; Wise, 1949)

An instigating factor for this study was management's request that the nurses work as generic nurses in establishing the rural focus of their service. However, the nurse participants work in their community with the support of other community nurses such as Plunket and Practice Nurses and Midwives. At a recent New Zealand Rural Health Care Conference, members of this rural team, saw themselves as one of the least rural of those who attended. They see themselves as less isolated and they have a number of other health care providers and services to share health care delivery in their region. This contributed to their view that the 'all in one nurse' was impractical.

The District Nurse who lives on the offshore island, and took part in this study has, however, more generic expectations of her. She pioneered this island service in response to a request from the residents. The role has been in place for approximately five years with the nurse rostered to work one day a week. In reality, like other rural nurses in isolated areas, she is always on call and works much more in the summer months. As the service has evolved, she has developed new roles in response to local and sometimes emergency need. She sees herself working outside the usual domain of District Nursing.

When you think about it what District Nurse finds that she suddenly has to cut down trees for helicopters to land? (FC 1, p. 6).

Apart from these more dramatic episodes, she describes her regular role as diverse. It includes working as a Practice Nurse, in association with the General Practitioners, a Midwife delivering babies, a Public Health Nurse involved with immunisation and the well health of the island's children, and a District Nurse walking around the island to treat people in their homes.

It is apparent from this study and from the literature that the need for a generic role in rural nursing has traditionally depended on what other services are available. Nurses tend to fill in the community health service gaps with whatever talents they have. Working generically is rare when other specialist nursing services are available. In this study it was important to these nurses to maintain their specialist orientation and they were adverse to total integration of their roles.

Integrating Public Health and District Nursing Roles

The success of these nurses working more closely together came through a critically reflective change process. The group is small and covers a defined but large geographical area. However, if general concern about the fragmentation of community nursing services continues, this study has shown that any move to totally integrate Public Health and District Nursing roles poses problems for the nurses.

Though the nurses in this study recognised their common basic training, each has developed their nursing knowledge and skills along different paths. This coincides with Kinross' (1987) findings. "District nurses and Public Health nurses have some overlapping skills and a common knowledge base, but both develop expertise in particular areas and both have specialised knowledge and experience" (p. 199). Each role has developed separately with a different focus, and there is an interrelationship between the structure of each job and the person who does it. Through reflection, this study revealed that each nurse chose her role because of her desire to work in either 'hands on care' or 'education and prevention'.

Kinross (1987) found, as did this study, that "there is also a different pace of approach and thought patterns" between the two roles (p. 199). The historical review showed that these differences were inherent in each role from its inception. The 'task' approach to hands on care and 'the process' approach to health education have been maintained as the roles developed. Currently the District Nurses react and respond more to treating immediate individual need, whereas the Public Health Nurses focus on issues over time with larger family or community groups, and are more closely governed by health legislation and policy. Whether or not the pace and pattern of the work is individual

choice as well was not discussed in this study. However, nurses who chose the 'task and respond role' enjoy being busy but their heavy workload seems to negatively influence their ability to reflect and think critically about and beyond what they do. The nurses who choose the process and educative approach seem to have more time for this critical reflection and have a need to be in touch with organisational and political change. The structure of each job affects how broadly the nurse looks beyond the immediate world of practice. If change is desired, and participative change based on reflection is seen as effective, time and encouragement for reflection within the job is important.

For now, the goal of these nurses is to use the model they have created as a framework for their practice. This results in them working as a nursing team on health promotion projects for the benefit of educating the community, sharing educational updates, and to actively contribute to the work of their community health team from a nursing perspective. As well each group maintains its specialist role.

Action Research and the Process of Theory Development

Titchen & Binnie (1993) state that "The fundamental aim of action research is to improve practice rather than to generate theory ... with the result that methodological accounts of how theory is generated and tested in action research are rare"(p. 4). However, Greenwood (1994b) proposes that when accounts of theory are generated by Action Research, they are "the most complex and sophisticated that an agent can construct"(p. 86).

A basic definition of nursing theory is "(a) statement(s) that purport(s) to account for, or characterise some nursing phenomena" (Stevens, 1984, p. 1). Meleis (1985) extends this definition. Theory is "... an articulated and communicated conceptualisation of invented or discovered reality ... pertaining to nursing for the purpose of describing, explaining, predicting or prescribing nursing care"(p. 29). Theories organise existing knowledge and extend what is known.

In general, the literature advocates that theory develops through various levels of sophistication (Dickoff, James & Weidenbach, 1968; Stevens, 1984; Greenwood, 1994b). Description is the first level of theory development. It “determines what entities will be perceived as the essence of the phenomena under study” (Stevens, 1984 p. 3). Dickoff et al. (1968) name this stage, “factor isolating”(p. 419). Explanatory theory is the next level. It tells how or why these given entities relate to each other (Stevens, 1984). Dickoff et al. (1968) call this “factor relating” (p. 419). To test these factors or explanatory theory, a prediction is made about those relationships. This stage is called “situation relating” producing predictive theory. Once tested, and there is confidence that the same intervention, in the same situation would produce the same results, a situation -producing theory is established (Dickoff et al., 1968).

It is with these levels in mind that Greenwood (1994b) proposes that Action theories are the most complex. They are situation producing theories which presuppose the existence of the other less sophisticated theories.

In this study, analysis of the Action Research process and the information it elicited showed that the participants theorised through each of the levels described. Factor isolating and relating was done during the initial reflections. They described their existing nursing roles and the relationships within them and then moved on to look at interrelationships between their distinct jobs.

Situation relating was accomplished by looking critically at the organisational, political and personal influences in the environment in which they practice. With this as a basis they were able to produce an organisational model for planning (see Figure 10, p. 63 in this thesis). These plans were accompanied by predictions/hypotheses of anticipated benefits.

These hypotheses were tested during the acting and evaluating stages of this Action Research which had potential to result in a situation-producing theory.

Situation- Producing Theory

An analysis of the level of theory development in this study can be done by comparing the outcomes with the three essential ingredients of a situation producing theory set out by Dickoff et al. (1968). These are (1) a goal content which specifies both the characteristics of the situation to be produced and the conceptualisation of the value of the goal, (2) directive prescriptions for some specified agents to perform the activities to produce such situations and (3) a survey list to supplement the prescriptions (p. 422).

The first two ingredients were met by this group establishing that their goal was to work together to more efficiently meet the health needs of their rural community and by outlining a number of strategies to achieve their goal. (health days, morning meetings, and bimonthly meetings). The third ingredient, the survey list

... aids the identification of other theories at whatever level which will assist in the realisation of the intended goal and ... assists in the identification of relevant aspects of activity which are inadequately conceptualised ... and require elaboration and refinement (Greenwood, 1994b, p. 86).

The nurse participants met the above criteria of the survey list with guidance from myself and some literature they brought to the workshop. They explored some of the theoretical underpinnings of their thinking, goal setting and planning.

The relevant aspects of the activity that Dickoff et al. (1968a) describe are summarised by Greenwood (1994b) and include:

Agency- who performs the activity?

Patiency- who is the recipient?

Framework- in what context is it performed?

Terminus- what is the end point?

Procedure- what is the guiding procedure or protocol?

Dynamics- what is the energy source of the activity? (p. 86).

The answers to the above were not specifically discussed in the context of 'the survey list' by this nursing group but some of the answers were apparent in the data as each activity was planned. Some of the answers were inferred. Though an Action Research goal is to raise the consciousness of the participants, Greenwood (1994b) states that answering the survey list "need not go on consciously in the minds of human agents" (p. 86). Consciousness raising through the evaluation of their activities revealed the barriers of 'encapsulated thinking' and 'values conflict' which were addressed. For this group a local descriptive, predictive and prescriptive situation-producing theory was developed.

Generalisability

A situation producing theory also purports that the same action in the same situation will produce the same results. It assumes that once tested, this theory in which District and Public Health Nursing work together on aspects of health promotion and education while maintaining their specialist roles could be generalised to other community nursing groups. Generalisability was also assumed by the 'Community Services Manager' when she asked the group to 'broadcast' their results to other community groups. However, no two situations are alike. Though the model itself may be utilised as a framework for other groups, the process of how it might be implemented and the subsequent outcomes may differ.

Generalisability as discussed in Chapter Three (p. 38) is not always achievable or expected in qualitative methodologies and does not necessarily reduce the level of theoretical attainment. Holter & Schwartz-Barcott (1993) advocate that using Critical Social Science as a philosophy with Action Research can produce a 'local theory'.

Local theory emerges from reflective discussions between the researcher and practitioners. Changes are focused on personal and cultural norms and tend to have a lasting character as the negative forces of the organisational unconscious can be dissipated and a meaningful change can be achieved and sustained. Hence the emerging patterns of new practice and new theoretical insights stem from the new culture of practice (p. 302).

Using the above explanation, this nursing research group have developed a local theory which is descriptive, predictive and prescriptive for their own group.

Summary

This chapter has discussed the study outcomes in relation to the goals of Action Research to facilitate change and develop theory. Change occurred both for the group and the individual participants. Knowledge was also generated that contributed to change theory, rural nursing theory and the integration of Public and District Nursing roles. Analysis also showed that the process of Action Research in this study was conducive to theory development as it took the group through the levels of theorising which culminated in a local theory.

CHAPTER SIX

SUMMARY

This Action Research study was instigated by a suggestion by Community Health management that the District and Public Health nurses in a rural team combine their roles. The nurses, though averse to the idea, agreed to look at their practices with a view of finding new more efficient and effective ways to work. Using the Action Research spiral of reflection, planning, action and evaluation, and the philosophy of Critical Social Science, the group critically examined their rural practice and created a new theoretical model which represented a combined nursing practice, while maintaining their specialist roles. They made plans based on this model, acted on them and evaluated them.

Analysis showed that many factors enhanced the change process, but observation also revealed that some group dynamics had a potential to inhibit change. When analysed in the group, the nurses recognised that there was a relationship between these dynamics and their job structure, socialisation as women and their indoctrination as nurses. It also highlighted differences between these District and Public Health Nurses in the way they think about their work and their roles. This critical reflection increased their understanding and ensured that planned change was more likely to be stabilised.

The participants ongoing interactions with management contributed to their understanding of political changes and to their overall relationship with the organisation. The research process enabled the group to create and value their own ideas and the participative style of management created a receptive environment for the nurses ideas to be heard.

Limitations of the Method

Though it has been shown that the process of Action Research is conducive to theory building, the depth of analysis at each of these theory levels in this project could have been increased. Three restrictions to more in-depth development of a theory were

apparent. One was the limited experience this group had in thinking theoretically, and in critically analysing their world. Car & Kemmis (1986) state that even if "not explicit (practitioners) must already possess some theory that serves to explain and direct their conduct" (p. 111). Though this eventually became apparent, it took a considerable portion of the research time for the group to learn about and be comfortable with theorising.

The reluctance of some of the participants to recognise their 'intellectual' contribution i.e. "*not such a brainy one*" (FC 2, p. 15) and "*no dynamic ideas*" (TS 2, p. 10) indicated that the introduction theoretical thinking was a challenge for some of these nurses.

Asking these same two nurses (FC & TS) about whether defining the four theoretical concepts of nursing helped them with their thinking they said that it didn't. However one stated that the research process had

rekindled a lot of stuff for me and maybe it's the most I've had since my training (TS 2, p. 1).

Others in the group were more aware of what influence theoretical thinking had for them. Some stated that

... it was very important. It gave us a structure to work from (DAL 2, p. 11).

... it highlighted for me the common areas of our work ... to ultimately arrive at the end goal (KB 2, p. 12).

... it was essential. I don't think we could have done the exercise that we went through without that because to me these are the things that you hang what you do on (KO 2, p. 4).

The second limit to in-depth theorising was the constraint of the academic year that limited the amount of time I could spend with this group, to facilitate and document their theorising. Towards the end of the project the group were more comfortable with critical analysis and used it more in their groups in a reflective way.

The third limitation is that the tools of analysis for Action Research are less clearly defined than other qualitative methods. Meyer (1995) reinforces this limitation by advocating that Action Research is more of an approach to research rather than a specific method. Emphasis is on practitioners as researchers, the importance of self reflection and the development of a critical science through empowerment (p. 25). Though these goals were part of this study from the outset, both the process and content analyses were more the responsibility of the researcher than the participants. This was done as the study evolved as well as retrospectively. The lack of clear analytical guidelines meant for me that the analysis was more dependent on my knowledge and choice of direction. This often raised uncertainties about which analysis track I was taking.

Benefits of the Method

The benefits of this research method are many. For the participants, they shared continuously in the research process which is part of the philosophy of empowerment on which the method is based. They were part of the orientation that solicited their co-operation. They provided the information gathered in group or individual interviews. They shared with the researcher their impressions of the ongoing analysis which ensured the accuracy of interpretation and helped formulate the steps of the study's direction. They were also the ones to actively implement changes. With self reflection and honesty they were able to examine their attitudes and change some of their ideas. "Its participatory, situation-specific and problem-focused style offers a way to integrate emerging theoretical ideas into the provision of care and to evaluate and improve the outcomes" (Hart, 1995, p. 10). For the consumer of the results, the study may improve her/his level of understanding and enlightenment because the in-depth information described and analysed may be in harmony with the reader's experience. The relevance of such findings may raise the reader's awareness of the many dimensions of that experience and enhance what might previously have been only tacit knowledge (Lincoln & Guba. 1985) .

This Action Research study has been conducted in a rigorous and ethical manner and overall has achieved its goals of change, empowerment and theory development.

Overall, as well as developing a new way of working, the process was also conducive to affirming the value of nursing and establishing a greater personal rapport amongst group members. The empowering process was evident as this group has moved from feeling very threatened two years ago because of the health system changes, to feeling ready to meet the challenge of change and ensure a place for their specialist skills.

Epilogue

At this time of writing, nine months after the last group meeting, the spirit and closeness of the nursing group continues. The model is being utilised and the original plans of meeting each morning and twice monthly continue. The CHE management has introduced a peer review system that promotes open and honest evaluation of their own and each others' work. This is enabling them to deal with group process and conflict issues. The nurses continue as a cohesive, reflective and planning group that actively contributes to their Community Health Team plans from a nursing perspective.

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APPENDIX A

INFORMATION FOR PARTICIPANTS

My name is Maggie Cornish and I am enrolled in a Master of Arts programme at Massey University. I am inviting you to participate in a research project as part of my qualification for this degree.

In your position as District or Public Health Nurse in your community health team, you will be involved in the development of a proposed rural health service. Your team plans to meet regularly to explore this new health service focus for your community. As you go through this process, I would like to meet with you, as a nursing group, monthly and individually on two occasions, over a period of six months. The purpose of these sessions is to discuss your current practice and to explore ways of changing it, to accommodate this rural health perspective. The research method chosen is Action Research. It is a facilitative and collaborative process in which I, as researcher, will work along side you, as a co-researcher to discuss ways of developing the role of a rural community health nurse.

It is planned that I will audiotape and transcribe the group and individual sessions. The times that the tape will be on and off will be negotiated. The tapes will be stored in my home. The group meeting transcripts will be reviewed by the group and each transcript from individual interviews will be discussed with the person concerned before information from them is used as data. Issues raised in individual interviews will not be brought to the nursing group meeting by the researcher without your permission. Once approved some verbatim accounts will be used in the research report. At the end of the research I will erase the tapes. The group transcripts will be destroyed. Transcripts from your individual interviews will become your property to be used as you see fit.

As participant, you have a right to:

- (a) ask any questions about the process.

- (b) refuse to discuss anything you don't wish to.
- (c) withdraw from the study at any time.
- (d) expect confidentiality at all times.
- (e) give approval to transcribed group and own individual data before it is used for analysis.
- (f) expect anonymity in the reporting of the findings by the use of pseudonyms for individual references.
- (g) access to the results of the study.

I wish to emphasize that I am not personally evaluating your practice performance in this research process.

Please contact me at any stage if you have any questions.

APPENDIX B**CONSENT FORM FOR PARTICIPANTS**

I _____ have read the research information sheet and have had the project explained to me. I agree to the use of a tape recorder for both the group meetings and individual interviews. I understand that the times that the tape is on or off can be negotiated. The research process at present is clear to me and I know I can ask further questions at any time.

I understand that I have the following rights:

- (1) Information I give that becomes the data for the study will not be personally attributed to me, ie my identity in published material will be anonymous by the use of a self chosen pseudonym.
- (2) Any request by me to not publish some information that I have contributed and find sensitive will be respected.
- (3) I may withdraw from the research process at any time.

Under these conditions and those of the information sheet I agree to participate in this study.

Signed _____