CREATING A COMMUNITY OF INQUIRY IN A HEALTHCARE ORGANISATION

By

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DECLARATION

The author hereby declares that, except where duly acknowledged this thesis is entirely her own work.

This thesis is not one for which a degree has been or will be conferred by this or any other university or institution.

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October 2014

ABSTRACT

This insider action research study was undertaken in a national healthcare organisation in Ireland over a twenty-eight month period from 2010 to 2013. The focus of the research was to study the establishment of a quality patient safety audit (QPSA) team, created to fill an assurance gap for clinical and social service at corporate governance level in the observed healthcare organisation. This audit team, once recruited, consisted of fifteen individuals with varied professional experience (both clinical and administrative/ management) and levels of seniority from different geographical locations within the studied organisation. The primary aim of the research account was on the learning that was generated internally by establishing the aforementioned team, underpinned by a critical action learning ethos. This project sought to document the creation of a suitable team environment and to track this team from establishment through to the observed evolution of a community of inquiry (COI) in the practice of audit.

Using the stages within the experiential learning cycle (Kolb 1984) to guide team interventions and the researcher's own critical reflection, this approach was the antithesis to subject-led teaching approaches to management, and ignited transformation dialogue and actions that facilitated individual and team engagement, immersion and growth when completing audits and working within the audit team. The action research (AR) methodology contributed to the researcher's own learning and when used to underpin the practice of the audit team, ensured quality in inquiry. Furthermore, findings that emerged from each AR cycle were fed back directly into practice with the aim of bringing about sustained improvement. A key contribution of this research is that COI theory acted as an organising principle, underpinned by a critical action learning ethos in this study, resulting in a 'favourable voice climate' that allowed voices to be heard and acted upon. Notably, this created a tension as before team members could hear anything worth hearing, they needed to contemplate the power dynamics of the space they operated in and social actors therein and examine their own willingness to hear and be heard. Fundamental to this approach was that the grounding of learning in practice, combined with exposure to new perspectives and interpretation of organisational and managerial situations, tapped into the collective insights of individuals to inform practice.

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DEDICATION

This thesis is dedicated to the members of the Quality and Patient Safety Audit team who followed my humble vision, made it real and developed it way beyond my imagining. We did not wait for great people to light the fire, but together we have created a change in the organisation that is making a difference to quality and patient safety.

> *I do not separate my scientific inquiry from my life. For me it is really a question for life, to understand life and to create what I call living knowledge-knowledge which is valid for the people with whom I work and for myself.*
>
> (Reason 1996, p.7).

LIST OF ABBREVIATIONS

AL   Action Learning

AR   Action Research

CAL   Critical Action Learning

CEO   Chief Executive Officer

COI   Community of Inquiry

COP   Community of Practice

CAO   Chief Accounting Office

CAP   Controls Assurance Process

CAS   Controls Assurance Statement

DBA   Doctorate of Business Administration

HSE   Health Service Executive (Ireland)

IAR   Insider Action Researcher

NHS   National Health Service (United Kingdom)

QPSA   Quality Patient Safety Audit

QPSD   Quality Patient Safety Division

SIC   Statement of Internal Control

GLOSSARY OF TERMS

Action Learning (AL): An approach to development that puts the emphasis on people learning through close involvement with real managerial situations, using all the resources available to understand them, taking action in those situations and learning from interpreting the consequences (Trehan and Pedler 2011, p. 2).

Action Research (AR) (working definition): A participatory democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities (Adapted from: Reason and Bradbury 2008, p.1; Coghlan and Brannick 2010).

Assurance: Confidence, based on sufficient evidence that internal controls are in place, are operating effectively and objectives are being achieved (NHS internal audit standards 2010).

Community of Inquiry (COI): An organising principle surrounding a community of inquirers with shared aims who systematically and intentionally explore and consider information from research, from experts and from each other; so that methods can be developed and tried in support of inquiry, decision-making and problem-solving (adapted from: Peirce 1839-1914; Shields 2003; Earl and Katz 2005; Dewey 1938).

Community of Practice (COP): A COP is a group of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Wenger et al. 2002).

Controls Assurance Process (CAP): The process undertaken on a yearly basis to circulate to and ensure that all staff at a senior grade sign a controls assurance statement, to provide reasonable assurance to the Chief Accounting Office that the controls to manage the risks are in place and are being managed (adapted from Management Controls Handbook 2013, Statement of Control).

Controls Assurance Statement (CAS): The CAS, as part of the annual controls assurance process, is a signed statement required from all senior managers in the HSE. Managers are required to confirm that they can provide reasonable assurance that the internal controls framework of the HSE has been fully applied in their area of responsibility. They are also required to identify issues, which would significantly impact on the Statement of Internal Control for the HSE in their Risk Register (adapted from: Management Controls Handbook 2013, Statement of Control, p.33)

Critical Action Learning (CAL): CAL affords an opportunity to examine the politics that surround and inform organizing. To comprehend these politics it is often necessary to question these political choices and decisions, both consciously and unconsciously and the various ways in which learning is supported avoided and prevented within sets and in organisation through relations of power (adapted from: Rigg and Trehan 2011; Vince 2012).

Critical Optimism (CO): Critical optimism is the faith of sense that if we put our heads together and act using a scientific attitude to approach a problematic situation, the identified problem has the potential to be resolved arising in the evolution of this team into a community of inquiry (Shields 2003, p. 514).

Doctorate of Business Administration (DBA): The DBA programme provides education in research, and focuses on the application of theoretical knowledge to the advancement of management and business practice. It is designed to develop analytical, conceptual, and critical thinking skills of senior business and management professionals and combines workplace and professional engagement with scholarly rigour of academic institution (Professional Doctorate in Business Administration Induction Handbook 2010).

Health Service Executive (HSE): The HSE (Irish: *Feidhmeannacht na Seirbhíse Sláinte*) is responsible for the provision of healthcare providing health and personal social services for everyone living in Ireland. The HSE is supported with public funds. The Executive was established by the Health Act, 2004 and came into official operation on 1 January 2005. It replaced the ten regional Health Boards, the Eastern Regional Health Authority and a number of other different agencies and organisations. The Minister for Health has overall responsibility for the Executive in Government. The

HSE is Ireland's largest employer with over 67,000 direct employees, and another 40,000 in funded health care organisations. It has an annual budget of over €13 billion, more than any other public sector organisation in the country.

Insider Action Research (IAR): When a complete member of an organisation seeks to inquire into the working of their organisational system in order to change something in it (Zuber –Skerritt and Perry 2002; Dick 2007; Coghlan and Brannick 2010).

Insider Action Researcher: An action researcher defined in terms of wanting to remain a member within a desired career path when the research is done (Zuber – Skerritt and Perry 2002; Dick 2007; Coghlan and Brannick 2010).

Internal audit: An independent, objective assurance and consulting activity designed to add value and improve organisations' operations. It helps an organisation accomplish its objectives by bringing a systemic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance process (NHS 2012, p. 5).

Learning Set: A set of individuals incorporating the following criteria - (1) consists of about six people**;** (2) action on real tasks; (3) tasks are individual rather than collective; (4) questioning as the way to help participants proceed with tasks /problems; (5) facilitators are used (Johnson 2010).

Learning Set (Practice Variation): In this IAR project, while adhering to Johnson's (2010) learning set principles, the practice variation is; (1) the 'learning set' is the 15-member audit team; (3) tasks and problems are individual, team and organisational; (5) while the QPSA Director acts as facilitator, the team are allowed to develop their own learning via problem solving (Johnson 2010, p. 269)

National Health Service (NHS): The NHS refers to the four public health services of England, Northern Ireland, Scotland and Wales, individually or collectively, though only England's 'NHS' officially has this title.

Participatory World View: A systemic, holistic, relational feminine, experiential view. Its defining characteristic is that it is participatory; our world does not consist of

separate things but of relationship which we co-author **(**Reason and Bradbury 2006, p. 7).

Quality Patient Safety Audit (QPSA): this term refers to the team under study. The QPSA title is based on the Quality Patient Safety Directorate (now called Division 2013) in which the team reports to the National Director and also describes the function within the remit of patient safety and quality.

Quality Patient Safety Division (QPSD): The role of the Quality Patient Safety Division within the HSE is to provide leadership, and be a driving force, in quality and patient safety by supporting the statutory and voluntary services of the HSE in providing high quality and safe services to patients, their families and members of the public. The Division delivers on this role in collaboration with the HSE Divisions responsible for the delivery of services (QPSD Report 2013).

SECTION ONE:

RESEARCH OVERVIEW
AND
STUDY CONTEXT

1. INTRODUCTION

This insider action research (IAR) study was undertaken in a national healthcare organisation in Ireland over a twenty-eight month period from 2010 to 2013. This organisation is *"responsible for the provision of healthcare providing health and personal social services for everyone living in Ireland, with public funds"* (Health Act 2004). The objective of this research was to study the establishment of a quality patient safety audit (QPSA) team, created to fill an assurance gap for clinical and social service at corporate governance level in the observed healthcare organisation. This QPSA team, once recruited, consisted of fifteen individuals with varied professional experience (both clinical and administrative/ management) and levels of seniority, who came from different geographical locations within the studied organisation. This IAR project sought to document the creation of a suitable team environment and to track this team from establishment through to the observed evolution of a community of inquiry (COI) in the practice of audit. The primary focus of the research account was on the knowledge that was generated internally by establishing the aforementioned team, underpinned by a critical action learning (CAL) ethos (Rigg and Trehan 2004; Vince 2004, 2012), using the stages within the experiential learning cycle (Kolb 1984) to guide team interventions and the researcher's own critical reflection.

The researcher is referred to as 'I' throughout this thesis, as is the convention in insider action research. I had dual roles in this study. One is my professional role as QPSA Director where I had responsibility for the design, recruitment, establishment and management of this team. I am a complete member of the organisation where I undertook this doctoral research study through applying an IAR approach in and on my own organisation (Coghlan and Brannick 2010). I simultaneously fulfilled a researcher role where I carried out this IAR as part of a professional doctorate in business administration (DBA), pursued part-time over four years, documented via a cumulative paper series, which are reproduced in this thesis for ease of reference. The value of the DBA was, and is, engagement with theory while considering practice; in undertaking this research I sought to generate actionable knowledge, that could be useful to both academic and practitioner communities and could foster my own development as a research practitioner (Coghlan and Davis 2007; Coghlan 2007; Raelin and Coghlan 2007).

2. RESEARCH OVERVIEW

Community of inquiry is a powerful idea developed by classical pragmatists that has wide application to many contexts (Shields 2003). In consideration of the audit team function in the studied healthcare environment, COI is defined as;

> An organising principle surrounding a community of inquirers with shared aims who systematically and intentionally explore and consider information from research, from experts and from each other; so that methods can be developed and tried in support of inquiry, decision-making and problem-solving

> (adapted from: Peirce 1839-1914; Shields 2003; Earl and Katz 2005; Dewey 1938).

The notion of COI has its origins in the work of Charles Sanders Peirce (1839-1914) who originally conceived of pragmatism as a philosophy of science with inquiry at its centre (Pardales and Girod 2006). Inquiry, for Peirce, was embodied in the scientific method of arriving at conclusions through synthetic reasoning (Shields 2003), while COI is the model for the production of knowledge that will lead us from doubt to belief and eventually to the 'real' (Pardales and Girod 2006). Of note is that Peirce's COI model describes not only communities of scientific inquirers, but also communities of historical inquirers, philosophical and psychological inquirers and other discipline-based communities.

The COI is a conceptual tool that practitioners, such as those within the QPSA team, can use to help them interpret and shape experience (Shields 2003; Lipman et al.1980). To Peirce, the scientific method unlocks or at least leverages the power of individualism as people work together to address problems. This approach is distinguished from all other methods of inquiry by its cooperative or public character (Buchler 1955, cited in Shields 2003). Thus, the COI approach is conducive to making mistakes and making progress, as is essential in this work-based change programme and the IAR study within. As awareness and practice of participatory democracy is under-developed in the public sector (Shields 2003), the application of the COI concept in this study can provide a useful lens to see how a more participatory approach can enter and influence the field of public services.

The observed community is a team of auditors and the inquiry is a method for team engagement, interaction and the practice of audit, which required auditors to develop skills of individual and collective inquiry and apply them in practice. Thus, establishing a team knowledge transfer-integration process was an essential step in the inquiry process. This approach also formed part of a process enabling ethical inquiry, and afforded multiple perspective inquiry (Lewin 1947; Kolb 1984) as the team evolved into a COI over time. Considering the task of learning is applied in practice, catalysts of inquiry needed to be applied, which in this case amounted to action learning (AL) cycles, defined as;

> an approach to development that puts emphasis on people learning through close involvement with real managerial situations, using all the resources available to understand them, taking action in those situations and learning from interpreting the consequences
>
> (Trehan and Pedler 2011, p. 2).

AL is by definition; learning which is integrated with working experience, making it a good example of 'situation learning' (Brown et al. 1989). In this research, AL was the catalyst to promote the generation of knowledge and to inform the incremental evolution of the audit team into a COI. While adhering to AL's fundamental principles and core essence (Johnson 2010), the practice variation in this IAR study was (1) the establishment of a 'learning set' involving all members of the QPSA audit team; (2) tasks and problems were considered at individual, team and organisational level; (3) while I as QPSA director acted as facilitator, the team were allowed to develop their own learning via problem solving (adapted from: Johnson 2010).

As the observed audit team worked in the space of corporate governance and were required to make sense of and work within, not removed from, the politics and culture of the organisation, I applied critical action learning (CAL) as opposed to conventional AL in this study, as CAL;

> affords an opportunity to examine the politics that surround and inform organising. To comprehend these politics it is often necessary to question these political choices and decisions, both consciously and unconsciously and the various ways in which learning is supported avoided and prevented within learning sets and in organisations through relations of power
>
> (adapted from: Rigg and Trehan 2011; Vince 2012).

CAL afforded an opportunity to examine the politics that surround and inform organising and thus sought to comprehend these politics through necessary questioning of these political choices and decisions, both consciously and unconsciously (Rigg and Trehan 2011).

3. ORIGINS OF THE RESEARCH STUDY

Context is an intrinsic aspect of the IAR method in that it is carried out by the people directly concerned with the social situation being researched. Often, practitioner researchers 'felt a need to initiate change' (Elliott 1991, p. 53) prior to commencing action research, a reality that was emulated in this study. Having contemplated this research approach, I was encouraged by Somekh (1995, p. 342) who stated that "*AR can make economies of time by using some parts of the research process as opportunities to take strategic action*". Thus, I was aware of the AR method's suitability when members of the executive board posed a question to me as a senior executive, regarding a 'red hot' issue for our organisation (Coghlan and Brannick 2010).

In 2010, when this project and research commenced, there were a number of internal and external reports highlighting concerns relating to governance at corporate level in the studied organisation (for example; key external reports include Rebecca O' Malley cited in HIQA 2008; Mid Western Regional Hospital Ennis cited in HIQA 2009; Mallow Hospital cited in HIQA 2011; Adelaide and Meath Hospital Dublin cited in HIQA 2012). These reports referred to a lack of clarity concerning governance and accountability across the health services, particularly those concerned with clinical and social services. The underlying assurance challenge was also evident in regard to the internal controls, specifically the existing controls assurance process for the organisation, as assurance on compliance to clinical and social care standards was not included with financial assurance. Notably, service managers, senior clinicians and nurse managers were <u>not</u> required to sign the annual Controls Assurance Statement (CAS), a key tool of accountability within the organisation through which managers:

> … confirm that they can provide reasonable assurance that the internal control framework of the HSE has been fully applied in their area of responsibility. They are also required to identify issues, which would significantly impact on the Statement of Control for the HSE in their Risk Registers

> (adapted from the Management Controls Handbook 2013,Statement of Control, p.33).

Of further relevance in this study, service managers were only required to provide assurance on finance and human resources when signing the statement of internal control, as is required by legislation (Health Act 2004 Section 34).

As senior executive with responsibility for assurance standards, I was required to seek assurance for clinical and social services and was concerned with the 'gap' in the assurance for these services at corporate governance level in our healthcare organisation. I brought this concern to the board. To raise the profile of the assurance framework within the organisation and to fulfil the requirement to provide this assurance at corporate governance level, I sought to establish a small audit team to complement the mature financial process for internal assurance. This internal audit team acts as:

> an independent, objective assurance and consulting activity designed to add value and improve organisations' operations. It helps an organisation accomplish its objectives by bringing a systemic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance process
>
> (NHS 2012, p. 5).

Informed by my initial research and engagement with relevant literature as part of my doctoral studies, I proposed and was then directed to establish a QPSA audit team to deliver a new internal audit service in the organisation to provide this assurance. When considering the 'assurance gap' and the team composition, I was encouraged by Balding et al.'s (2008) Australian study as they found that by positioning clinical governance as a key area of health service corporate governance, with all the attending accountabilities and legal ramifications, the assurance framework slowly cemented corporate accountabilities for clinical care.

As QPSA team director, I was required to report at corporate governance level on the team findings. Therefore I envisaged developing an integrated assurance process to include clinical and social services equal to that of finance, I set the key objective of the audit team:

> to provide independent internal assurance, for clinical and social services, to inform decision making as part of the quality process
>
> (QPSA procedure document 2014, p. 3).

Of note was the overriding health service reform programme implemented at the governance level within the studied healthcare organisation from team inception in 2010 to the end of the IAR study in 2013. In 2011, the Health Minister of a newly elected government set out a new strategy for the Health Service Executive (HSE). The Minister requested that the HSE Board be "stood down" and he appointed an interim *"Board in its place… under the leadership of the Director General of the Department of Health and Children"* (Priority questions Dail[1] Debate, May 2011). This created a challenge as to who I, as QPSA Director, should report audit findings to. In 2012, the Chief Executive Officer (CEO) of the HSE resigned and was replaced by a Director General of the HSE. The interim board was replaced in 2013 by a new HSE Directorate. Finally, the HSE Governance Act (2013) was passed in July 2013, which gave the legislative basis for the change in governance and management structures that had commenced in 2011. This is a transitional measure as the ultimate intention is to dissolve the HSE and replace it with a Healthcare Commissioning Agency and Universal Healthcare Insurance, *"bringing a greater focus on service delivery and accountability during the time the HSE continues in existence"* (HSE Annual Report, 2013, p. 3). It is against this backdrop that the QPSA team was established.

Gaining permission to recruit staff for the QPSA team took some time within the organisation, as the management team were trying to agree the recruitment methodology considering team members would need to be recruited internally and moved from their current post. Once the process of 'expression of interest' was agreed, under the terms of this reassignment, staff who moved to be part of the audit team could hold their existing terms, conditions and locations. This approach was quite complex, as membership of this audit team needed to be voluntary and filled with existing organisational members from various disciplines, grades and experience across the services. These services would lose staff and budgets and they could not be replaced, due to the recruitment embargo and wider financial constraints faced by the HSE and the Irish government during the global financial crisis (2008-13). It was also agreed that the number of personnel to be released onto the audit team would be restricted to a maximum of twenty.

When members were interviewed, found to be suitable for the role and agreed to move to the QPSA team, I needed to negotiate each individual's release with their line

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[1] The Dail is the name given to the Irish Parliament.

manager. This process crossed a range of differing human resource practices adding to the complexity of team recruitment. While a number of individuals were invited to join, some of those wishing to join did not get released in spite of my best efforts and some declined and ultimately, the team consisted of fifteen members.

This recruitment process would not have being possible without "*tacit and explicit knowledge*" (Coghlan and Brannick 2010, p.114) about the organisation, and a pre-understanding of the power and politics and lived experience therein. As an experienced professional with decades of experience in the public health services domain, I had acquired 'tacit and explicit' knowledge as to the culture of the organisation that uniquely offered benefits as an insider action researcher in this setting. It is unlikely that a researcher who did not have this depth of tacit understanding and access would have gained full comprehension of the complexity exhibited in this AR project.

Once established, the team's engagement with fulfilling this complex audit role and its evolution to a community of inquiry was the primary focus of this study.

4. RESEARCH AIMS AND OBJECTIVES

As stated above, this insider action research study was undertaken in a national healthcare organisation in Ireland over a twenty-eight month period from 2010 to 2013. The aim of the research was to:

> Study the learning that was generated internally by establishing a quality patient safety audit (QPSA) team in the observed healthcare organisation, underpinned by a critical action learning ethos.

The underlying objectives were to:

1. Track the QPSA team from establishment;
2. Explore the elements, influences and barriers that inhibit or promote critical action learning;
3. Contemplate the tools of voice as a means of generating a community of inquiry;
4. Observe the evolution of a community of inquiry in the practice of audit;

5. Consider the dual role of practitioner researcher.

5. OVERVIEW OF THE RESEARCH PROCESS

As an insider action research (IAR) project, this study engaged a number of action research cycles in which the researcher followed a process of "*constructing, planning action, taking action, and evaluating*" (Coghlan and Brannick 2010, p. 10), as presented in figure 1.1.

Figure 1.1: Action Research Cycles – Current Study

Having acknowledged a clinical and social services assurance gap at Board level as discussed in section 3 (above), cycle 1 incorporated the establishment of a quality audit team. Membership was voluntary and the team ultimately included 16 existing organisational members from various disciplines, levels of seniority and experience across the services. As noted previously, this process was quite complex and required members' to release their preceding assumptions regarding the audit function. As such, the first AR cycle was constructed in a manner that allowed a culture of inquiry to be

embedded in the team (Coghlan and Brannick 2010). Within the organisation, the norm was to send team members on generic training programmes, held outside the organisation or alternatively, to have a consultant 'tell' us what to do. In this cycle, the decision was made to 'plan' a customised training programme and to 'take action' where the audit team members could influence the content and process of training. This approach was adopted to address team-identified training needs and to 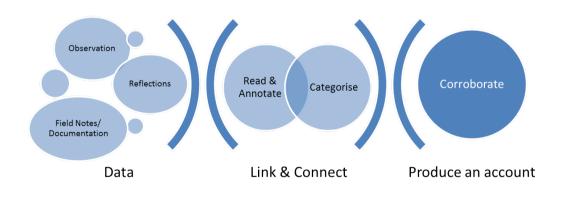involve team members in the construction of a critical action learning (CAL) environment through which they would subsequently deliver the audit service.

When considering the next AR cycle, I as QPSA Director/ researcher sought to ensure that each auditor had in the first instance an independent view, then had equal input in the collective team forum with the ultimate goal to reach agreement prior to signing each audit. Thus, in cycle 2, the first order of business following audit team training was to engage the team with a policy and procedures document from another jurisdiction (the National Health Service in the UK) and to adapt this document to the needs of the observed organisation. This provided a basis to plan and take action in the form of internal quality audits, which would be signed off by each involved member. Each audit involved a number of interventions when performing audits including the pursuit of a standard audit approach. During each audit, each team member maintained a practice-based reflective log within which they noted observations regarding the audit content and process as directed by the audit procedure document. Three team members were responsible for analysing these logs, initially at 3 month intervals and subsequently at 6 month intervals. They then performed a matching exercise against the procedures documents and anomalies between the documentation and the auditor notes were considered via a two-day development event involving the entire audit team at each interval. Changes were made to the documentation if deemed appropriate, thereby embedding the community of inquiry (COI) ethos within the audit team.

In cycle 3, the research focus was on critical reflection in the embedded community of inquiry. As power and politics had the potential to overwhelm team members, particularly when combined with the different levels of seniority within the team and among those being audited, each auditor needed the confidence to carry out a fair audit without influence, and to trust their QPSA Director. As such, I, as QPSA Director, sought to encourage equal 'voice' (Mead 2006) among audit team members, regardless of level of seniority. Furthermore, in the interests of auditor autonomy, I only intervened when requested and only then to ask/ pose questions rather than to provide

a 'solution'. This did present the challenge of 'negative voice', which needed to be addressed in the same open manner as described above. Actions and interactions within this cycle were therefore characterised by the four imperatives; *be intelligent, be attentive, be reasonable and be responsible* (Lonergan 1992). Notably, constant engagement with the literature was vital to ensure I was equipped with the necessary knowledge to navigate these challenges, and opportunities as they arose.

When reflecting on the totality of the IAR project (figure 1.1), I acknowledge the fact that these auditors could not as such 'opt out' of the research project thus I sought to ensure transparency around the research study and around the evolution of the audit team into a COI over the 28-months of the IAR project. In each cycle, data was gathered and collated from a variety of sources including formal meeting minutes, researcher notes and observations, audit team member conversations, and reflective diaries. Having identified emergent themes in the earlier AR cycles, I made notations throughout the research process in an intuitive way, wherein analysis was a circular process of describing, connecting and classifying (Dey 1993), in constant interaction with the literature (figure 1.2).

Adapted from: Dey 1993

Figure 1.2: Data Management and Analysis

As an IA researcher using this inductive process, and in the quest for quality and authenticity in the research, I needed to be *intelligent, attentive, reasonable and*

responsible (Lonergan 1992) in the generation of useful knowledge. When contemplating the data management and analysis process (figure 1.2), I considered the use of analytical software in context. While using such software tools has been thought by some to add to the rigour of qualitative research (Richards and Richards 1991), I considered the debate of whether or not using a software analysis programme such as NVivo distances the researcher from their data (Bong 2002, as cited in Bergin 2011), particularly when the data was coming from a number of sources. In particular, I considered Welsh's (2002) perspective that to understand how themes knit together, it is first necessary to analyse individual themes, and *"that using Nvivo to do so is difficult"*. Additionally, I was guided by Gibbs (2004) who advised that it is not the computer that interprets the text but the person. Reflecting on this, I considered that as I was engaged as a practitioner/ researcher using COI as an organising principle underpinned by CAL ethos within the QPSA team, this depth of research engagement could help me to interpret and shape experience (Shields 2003; Lipman et al. 1980). This approach formed part of a process enabling ethical inquiry, and ultimately afforded multiple perspective inquiry as I became, in essence, the central research instrument.

Therefore, the data were looked at individually, then collectively and then presented in a narrative form in each of the cumulative papers in the DBA paper series, supported by statements and behaviours recorded in meeting minutes, field notes, diaries and observations, audit team and Board debrief meetings and performance management meetings and observations. The writing of the DBA papers was also a learning experience. It was the incremental synthesis and integration of this data that allowed an emergence of meaning to form (figure 1.2) and as I reflected, it became an AR project in itself. I engaged in an inductive process, coming out of my meta-learning of reflecting in the implementation of the AR cycles with members of the QPSA audit team. Thus, the data linking and connecting (Dey 1993) continuously occurred during these reflective moments within the AR cycles (Grundy and Kemmis 1981; Coghlan and Brannick 2010). Furthermore, as I was concerned with the meaning [rather than the text itself], I was constantly reading, annotating and categorising in liaison with the literature, creating a circular relationship, in order to make sense of the data. In essence, I was reflecting on a collective journey, and therefore needed to incorporate *"disparate elements into a coherent whole"* (Dey 1993: 237), in order to produce an account

(figure 1.2), which was adequate from a research perspective as well as accessible to the reader.

6. THESIS STRUCTURE

This thesis is structured as follows;

Section One: Research Overview and Study Context, provides an introduction to the IAR study aims and objectives and the healthcare organisation context in which the study was carried out over a twenty-eight month period. The dual role of the practitioner researcher as an insider action researcher is outlined.

Section Two: Cumulative Paper Series, provides a bound copy of the four papers produced during the DBA programme;

- Paper 1: *Creating a Community of Inquiry in a healthcare organisation, conceptual paper.* This paper explores the creation of a community of inquiry as an organising principle, using action learning as the catalyst to promote team and organisational learning. It also seeks to inform the incremental evolution of an audit team into a community of inquiry via the application of a 'learning set' to generate knowledge in the new team. This paper focuses on the design, recruitment and management of this audit team that has responsibility for addressing a clinical and social services assurance gap at corporate level in the studied healthcare organisation. Within the paper, I explore the notion of COI as my conceptual lens underpinned with action learning (AL) as the catalyst to generate the knowledge that could inform the incremental evolution of the audit team into a COI. This approach forms part of a process enabling ethical inquiry, and ultimately affords multiple perspective inquiry.

- Paper 2: *Applying an action research methodology in creating a new service in a Healthcare Organisation.* Having considered other methods in light of the research focus, IAR was deemed appropriate as it is based on the fundamental notion that human systems could only be changed if one involves the members of the system in the inquiry process itself (Coghlan 2004; Reason and Bradbury 2008; Coghlan and Brannick 2010; Shani et al. 2012). Undertaking this research as an IA researcher was a natural role for me. This methodical approach flowed

logically from an epistemological underpinning, which focused on exposing interests and enabled emancipation and participation. This was essential to engaging the auditors as co-researchers and enabling their voices to be heard to inform both the practice and research process. In contemplating this challenge, I was aware that I needed to integrate theory, practice and research (Coghlan and Brannick 2010) throughout the study. While I was not always consciously aware that I was integrating the dual aim of action (to inform change) and theory (Dick 2007), I was instinctively using my experience, understanding and judgement to inform my actions. I now realise this process equates to an AR cycle (Coghlan and Brannick 2010, p. 10); I was *constructing, planning action, taking action, and evaluating*. Thus, the value of the IAR was, and is, engaging with theory while considering improved practice.

- Paper 3: *Learning in Action: Creating a community of inquiry in a healthcare organisation, findings.* The focus of the research account is on the learning that was generated internally by establishing the QPSA team underpinned by critical action learning ethos (Rigg and Trehan 2004; Vince 2004, 2012). The IAR also observed creation of a suitable team 'voice' environment, using the stages with the experiential learning cycle (Kolb 1984) to guide team interventions and my own critical reflection.

- Paper 4: *Learning in Action: Creating a community of inquiry in a healthcare organisation, reflections.* Of significance here is that each team member maintained a work-based reflective diary to record 'insights from practice' and that this became a way of working for the team, including myself, as co-researchers (McNiff and Whithead 2002). Thus, the final paper in the series reflects on the team insights gained from establishing a QPSA team as collected by an external facilitator and collated by myself.

These papers were assessed at agreed intervals by DBA examiners based on an acceptable standard being reached. The papers document the steps taken by the QPSA team, underpinned by a critical action learning ethos, from inception through its evolution into a community of inquiry in the practice of audit. The preface offered prior to each paper offers reader insight into the evolution of the IAR project and the application of reviewer recommendations at each juncture.

<u>Section Three:</u> Conclusion and Recommendations. The focus of the research was on the learning generated internally by establishing a QPSA team and through its observed evolution into a community of inquiry. Using the IAR method of 'constructing, planning action taking action and evaluating' the goal was to co-generate knowledge to inform the parallel process of completing audits and evolving into a COI as a way of working in the practice of audit. This approach adds to the body of knowledge on using the empirical method to ensure quality in practice and research (Shani and Passmore 1985; Somekh 1995; Heron 1996; Fisher et al. 2000; Zuber-Skerritt and Perry 2002; Reason 2006; Dick 2007; Coghlan and Brannick 2010).

A key contribution of this research is that COI theory acted as an organising principle, underpinned by a critical action learning ethos in this study. The challenge was to simultaneously generate voice and debate in order to ensure a move from 'I' to 'we' in this learning set (Rigg 2008), resulting in a 'favourable voice climate' that allowed voices to be heard and acted upon. Notably, this created a tension as before team members could hear anything worth hearing, they needed to contemplate the power dynamics of the space they operated in and social actors therein and examine their own willingness to hear and be heard. The research also revealed valuable insights into the elements, influences and barriers that inhibit or promote knowledge generation in the evolution of a team into a COI, including; interpersonal relations, reconciliation of multiple views, and reflection in practice and research.

The insights gained as an IA researcher in managing the three interlocking challenges of pre-understanding, role duality and organisational politics (Coghlan and Brannick 2010) are also worthy of mention. As a practitioner, I set out to extend theory through engagement with practice by identifying concepts which explained what I was seeing in practice and subsequently offering these practice-based insights as a basis for analysis and ultimately, improved practice. Fundamental to this approach was that the grounding of learning in practice, combined with exposure to new perspectives and interpretation of organisational and managerial situations, tapped into the collective insights of individuals to inform practice.

<u>Section Four</u>: *Research Log extracts*. In keeping with the ethos of reflective practice (Coghlan and Brannick 2007) and guided by Lonergan's (1992) presentation for authenticity as characterized by the four imperatives; be intelligent, be attentive, be

reasonable and be responsible, I maintained a reflective log throughout the IAR project. The research design and my dual roles were interwoven as my research role informed my executive role and vice versa. Both the team and I were learning in action (Trehan and Pedler 2011), while reticent of the power and politics dimension thereby naturally pursuing a critical action learning (CAL) ethos. I have used my research log as a means of attending to my experience, being intelligent in my understanding, being reasonable in my judgement and being responsible in my decision making throughout the research and doctoral process. Notably, the writing of the cumulative paper series was a reflective process in itself and I concur with Foster's perspective: *"How can I tell what I think until I see what I say?"* (Foster 1962, cited in Somekh 1995, p. 352). Thus, extracts from my reflective diary are illustrated in the form of *vignettes* displayed within the papers as well as within section four (reflective log extracts) as I consider these as pivot points in the choices I made. Each offers insight into my theoretical exploration and evolution as both as a practitioner- IA researcher during this research journey.

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SECTION TWO:
CUMULATIVE PAPER SERIES

PAPER 1

PREFACE

In this first paper in the cumulative paper series, I as a practitioner researcher, set out the context of my research in a national healthcare organisation, at a time of unprecedented change transitions and severe financial constraints (2010-13). The research is concerned with establishing an organisation-wide quality audit team while this paper focuses on the design, recruitment, establishment and management of this team; whose role is to act as an internal audit function for clinical and social services within the studied healthcare organisation. This team has specific responsibility for addressing an 'assurance gap' at corporate level, while my executive responsibility is to manage this audit team.

When considering the building of the audit team, I, as architect, had to consider a number of criteria including team membership, structure and learning focuses. Having studied relevant literature, I realised that I needed to adopt a pluralist learning approach based on multiple perspectives (as advocated by Lewin 1947 and Kolb 1984). Therefore, the learning process was constructed around how to catch these assumptions 'in action' (Coghlan and Jacobs 2005). Consequently, team knowledge transfer processes were essential to this inquiry process and corresponds to what Peirce (1839-1914) termed communities of inquiry.

Within the paper, I explore the notion of COI as my conceptual lens underpinned with action learning (AL) as the catalyst to generate the knowledge that could inform the incremental evolution of the audit team into a COI. This approach forms part of a process enabling ethical inquiry, and ultimately affords multiple perspective inquiry. In defining the COI concept I discuss the philosophical underpinning of COI as a powerful idea that has its origins in the work of Charles Sanders Peirce (1839-1914) and consider the evolution and influences of this concept through the work of Lipman et al. (1980), Shields (2003) and Pardales and Girod (2006), among others. Common to all, the focus on a problematic situation is the catalyst that helps or causes the community to form and provides a reason to undertake the inquiry (Shields 2003).

Following on from this exploration, I go on to define a COI and consider the fundamental notion of critical optimism, as it refers to public administration, within which the observed health organisation resides. This is the 'faith of sense' that if we put

our heads together and act using a scientific attitude to approach a problematic situation, the identified problem has the potential to be resolved (Dewey 1920-1948 cited in Shields 2003:p. 9).

In using AL as the catalyst I explore the many definitions of AL and offer Trehan and Pedler's (2011) perspective as most relevant to this project and research, as it is close to Peirce's (1839-1914) scientific attitude; that AL is a science in which the collective members learn about everything they can that is connected to the problem and can help solve it. I go on to consider the potential of critical action learning (CAL) in this study as it is concerned with power, politics and emotions (Rigg and Trehan 2004; Vince 2004; Trehan and Pedler 2009). Under the CAL umbrella, I discuss and defend why I use a variation of a 'learning set' (Johnson 2010) and apply the principles of 'voice' (Mead 2006) when building audit team member engagement.

I go on to explore the potential for using CAL as a catalyst for critical reflection in the COI, drawing on Reynolds' (2011) assertion that the contribution of AL as a vehicle for critical reflection was that the focus is on the collective and contextually specific process. I also found that CAL is a very cost effective way to tap into the collective insights of the individual and community within the organisation to inform practice (Rigg 2008), particularly as the audit team became embedded in activity.

At this early stage of the research process, I had considered COI as a potential 'stepping stone' for the audit team, who I assumed would then move to become a community of practice (Wenger et al. 2008). Thus, I discuss the proposed evolution of the COI into a COP, in this paper as I was attracted to Wenger et al.'s (2008) assertion that a social theory of learning is not just to inform academic work, but is also relevant to our daily actions.

Finally, I outline the next stage in this insider action research (IAR) project and propose future steps in context.

Creating a community of inquiry in a healthcare organisation

Conceptual Research paper
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Waterford Institute of Technology
December 6-7th 2012

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Examiner panel result: Recommended

ABSTRACT

This paper explores the creation of a community of inquiry as an organising principle, using action learning as the catalyst to promote the generation of knowledge. It also seeks to inform the incremental evolution of an audit team into a community of inquiry via the application of a 'learning set' to generate knowledge in the new team. Using action learning in this manner is based on the most recent theorising on the potential of critical action learning philosophy. This approach is very much the antithesis to subject-led teaching approaches to management. Key to this approach is that the grounding of learning in practice is combined with exposure to new perspectives and interpretation of organisation and managerial situations, thus it is a very cost effective method to tap into the collective insights of individuals to inform practice. This research offers opportunities for further research using the action learning format in practice. It is the author's intent to carry out further research based on the knowledge generated by establishing a healthcare audit team, and through the observed evolution of this audit team into a community of inquiry as a new audit service.

Key words
Community of inquiry, critical action learning, healthcare

1.   INTRODUCTION

The public services today are under increasing pressure and public scrutiny, to deliver services in the most efficient manner, to deliver 'more with less' financial and human resources. At this time of unprecedented change transition and severe financial constraints, (2010-2013) the Irish health service must meet its audit requirements in more efficient and effective ways. This research is therefore concerned with establishing an audit team, with responsibility for addressing a clinical and social services 'assurance gap' at corporate level in a healthcare organisation. As a practitioner researcher, I[2] will make reference to this audit team in the form of *vignettes* to give life to my theoretical development. The focus of the research is on the knowledge and learning that was generated internally by establishing the aforementioned audit team, and through the

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[2] As an action researcher, I, as author, propose speaking in the first person as is the accepted convention when applying this methodology.

observed evolution of this audit team into a community of inquiry. Therefore, the aim of this paper is to explore the creation of a community of inquiry (COI) as an organising principle, using action learning (AL) as the catalyst to promote the generation of knowledge. It is assumed that the knowledge gained can create conditions of collaborative inquiry to enhance the learning (Rigg 2011) of the individual, community and the organisation; and to improve the quality and safety of the services provided.

The paper structure is as follows: I begin with the research context, before discussing the philosophical underpinnings and core Principles of COI and AL. It is argued that AL acts as a catalyst to generate knowledge in action, not merely as a small group process to problem solve, but as a collective community process which informs practice for the individual, the team and the organisation (Rigg 2008). I go on to argue that the knowledge generated from this practice and experience will ultimately support the COI's incremental evolution into a community of practice (Wenger et al. 2001). I draw some early conclusions and argue that the knowledge that emerged from these insights have the capacity to be actionable; that is at the service of both the academic and practitioner communities (Coghlan 2007). Finally, I outline the next stage in this insider action research project and propose future steps in context.

2. CONTEXT

This paper focuses on the design, recruitment, establishment and management of an audit team; whose role is to act as an internal audit function for clinical and social services within a healthcare organisation. This team has specific responsibility for addressing a clinical and social services 'assurance gap' at corporate level in this healthcare organisation, while my executive responsibility is to manage this audit team. This work is also the subject of my research as an insider action researcher (Coghlan and Brannick 2010) as part of a professional doctorate. Coghlan (2007), in addressing the action research doctorate, specifically lays out the context of practitioner research as the strategic and operational setting that executives confront in their managerial working lives. Furthermore as the community in this case is the team of auditors and inquiry is the basis for team interaction and the practice of audit; the practice of audit requires auditors to develop skills of inquiry and apply them in practice. Thus, the team needs to develop these audit skills both individually and as a community. In practicing this process of inquiry in the auditing team, we also seek to create knowledge for the

wider organisation, thereby pursuing a core aim of the community of inquiry (Peirce 1939-1914). The focus of the research is on the knowledge and learning that I hope will be generated internally by establishing the aforementioned audit team, and through the observed evolution of this audit team into a community of inquiry.

When considering the building of the audit team, I, as architect, had to consider a number of criteria including team membership, structure and learning focuses. Barden et al. (2009) point out that the most important hedge against fallibility is to adopt a pluralist learning approach based on multiple perspectives (as advocated by Lewin 1947 and Kolb 1984). Thus, once established, I sought to ensure the team had interactive engagement with those within and outside the team. Consequently, team knowledge transfer processes were essential to this inquiry process and corresponds to what Peirce termed 'communities of inquiry'. This approach also formed part of a process enabling ethical inquiry, and afforded multiple perspective inquiry. Therefore, the learning process was constructed around how to catch these assumptions 'in action' and develop the skills of having consistency between what is espoused and what is enacted (Coghlan and Jacobs 2005).

Argyris et al. (1985) distinguish between espoused theory and theory-in-use and argue that theory-in-use is not changed by better or future espoused theory. Thus, when pursuing theory in this manner, there is no division between those who produce the knowledge and those who use it (Friedman 2001). Argyris et al. (1985) express this integration of thinking as "*creating of communities of inquiry in communities of social practice*", thus the COI's central activity is the creation of knowledge, and ultimately learning, in the studied environment. Finally, this approach forms the basis for the action learning cycle proposed in this paper, thus action learning lies within the studied community of inquiry (Revans 1998; Coghlan and Pedler 2006).

3. PHILISOPHICAL UNDERPINNING

The community of inquiry is a powerful idea developed by classical pragmatists that has wide application to many contexts (Shields 2003). Pardales and Girod (2006) point out that the notion of 'community of inquiry' has its origins in the work of Charles Sanders Peirce (1839-1914) who was both a scientist and philosopher; and they suggest that these dispositions had a major impact on Peirce's work as he sought to bring the method

of science to philosophy. Peirce originally conceived of pragmatism as a philosophy of science with inquiry at its centre. Inquiry, for Peirce, was embodied in the scientific method of arriving at conclusions through synthetic reasoning (Shields 2003). Moreover, to Peirce, the scientific method unlocks or at least leverages the power of individualism as people work together to address problems. Buchler (1955, cited in Shields 2003) states that science is distinguished from all other methods of inquiry by its cooperative or public character. Furthermore, Peirce vehemently rejects the idea that we can achieve any significant insights or reliable knowledge from introspection.

Pardales et al. (2006), in discussing Peirce's comments, argue that this is a reaction to the Cartesian view in modern philosophy, a view supported by Murphy (1990). Peirce (1958) offers a specific criticism of the 'spirit of Cartesianism', in which he rejects the notion that philosophy must begin with universal doubt: "*we cannot begin with complete doubt. We must begin with all the prejudices which we actually have when we enter upon the study of Philosophy"* (p.229*).* Shields' (2003) appears to agree with this perspective, and posits that "*belief is a state that allows for action and confidence, eventually turning into the 'real', which can be applied in the community of inquiry*", (p.107). Smith (1983) reinforces this trajectory, and argues that between doubt and belief lies inquiry. Hirschhorn and Barnett (1993) provide a further perspective on this, suggesting that anxiety and fear are an integral part of manager's working life, and are part of the management condition associated with their daily encounter with new tasks and risks. Rigg (2011) argues that thus, individuals bring their anxieties and fear to social encounters within and across organisational networks. Of note is Peirce's (cited in Shield's 2003) perspective that communities of inquiry are difficult to form if members are fixed in their belief systems and impervious to fresh evidence, suggesting that fear, anxiety and pre-set belief are barriers to the creation of a community of inquiry.

These are important insights as we begin to understand the development of Peirce's notion of community of inquiry (Shields 2003; Pardales et al. 2006) Peirce believed a community of inquiry is the model for the production of knowledge that will lead us from doubt to belief and eventually to the 'real' (Pardales et al. 2006) In fact, Peirce's COI model describes not only communities of scientific inquirers, but also communities of historical inquirers, philosophical and psychological inquirers and other discipline-based communities. Matthew Lipman and Anne Sharpe, founders of 'Philosophy for

children', were some of those who adopted the COI philosophy directly from Peirce. They gave this extended treatment in their 'Philosophy for Children' literature as a means of perseverance in self corrective exploration of issues that are felt to be both important and problematic (Lipman et al. 1980). Moreover, Lipman et al. (1980) and Pardales et al. (2006) connect this back to Peirce, stating that an inquiry is a sustained exploration of a topic or issue that is of interest to 'students', and that community members participate in inquiries in the hope of understanding the many ways of thinking about an issue and the production of knowledge. Furthermore, a COI attempts to follow the inquiry where it leads rather than being penned in by boundary lines of existing disciplines (Lipman et al. 1980; Pardales et al. 2006) thereby allowing the scope and flexibility to generate new knowledge.

3.1 Defining the COI concept

From Peirce's perspective (cited in Murphy 1990; Shields 2003), the term community of inquiry refers to 'community' and 'inquiry' as a group of individuals (most often scientists from his perspective) employing an interpersonal method for arriving at results. Peirce states *"when people come together in agreement, one can speak of knowledge truth and reality, but these concepts will be grounded in the community of inquirers, not in the individual consciousness"* (p. 12). Thus, inquiry is a process that has direction and organisation, and as Dewey (1938) points out, it is a controlled or directed transformation of an 'in-determined situation' that the transformation converts the original situation into a 'determined situation'. Earl and Katz (2005) include inquiry as one of their list of seven key features underpinning network learning communities and define it as *"the process for systematically and intentionally exploring and considering information from research, from experts and from each other, in support of decision-making and problem-solving"* (p.6-7). Moreover, Peirce (1916, cited in Cassidy et al. 2008) posits that those within a COI will have shared aims in common and these aims may themselves evolve in the course of the inquiry.

Common to all, the focus on a problematic situation is a catalyst that helps or causes the community to form and provides a reason to undertake inquiry (Shields, 2003). Aristotle (1955 cited in Cassidy et al. 2008) points out that the manner under which the inquiry is conducted should in all cases be rigorous, methodical, probing reflective, analytical and disciplined with a view to coming towards understanding or a satisfactory

answer as opposed to a clear cut conclusion. Moreover, as is relevant to this research, Shields (2003) states that COI is not a method, rather it is an organising principle that provides fertile ground for methods to be developed and tried. It is conducive to making mistakes and making progress, as is essential in this work-based project and research study within. In consideration of the audit team function in the studied healthcare environment, I have defined a COI as "*an organising principle surrounding a community of inquirers with shared aims who systematically and intentionally explore and consider information from research, from experts and from each other; so that methods can be developed and tried in support of inquiry, decision-making and problem-solving*" (adapted from: Peirce 1839-1914; Shields 2003; Earl and Katz 2005; Dewey 1938).

As discussed earlier, Peirce believes a scientific attitude is a core element of COI, and as the context of this study is a public health service, it is helpful to focus on the essential components of COI as they relate to public administration (Shields 2003).

3.2 Community of Inquiry components in public administration

Shields (2003) asserts that there are three essential components or key ideas, common to all communities of inquiry and these components do not stand alone but reinforce each other (Fig. 1).

Component	Key Authors
Problematic Situation	Dewey 1929; Stivers 2000; Webb 1999, 2000
Scientific attitude	Dewey 1929; Webb 1999, 2000
Participatory democracy	Adams 1910, 1930; Dewey 1929; Campbell 1981; Seigfield 1996

Source: adapted from Shields (2003)

Figure 1 Community of Inquiry

Shields (2003) found that these components were not identified by either Addams (1930) or Dewey (1929); rather each element is found consistently within their published works and actions. Shields distilled these components based on their relevance to public administration theory and practice. Similarly, Cassidy et al. (2008) found in the educational context, that seven themes emerged from the literature namely

(1) dialogue and participation; (2) relationships; (3) perspectives; (4) structure and context; (5) climate; (6) purpose; (7) control. In this research, these themes do emerge but are interwoven into the discussion as is relevant to the study. The components as outlined by Shields (2003) are more useful in this public administration healthcare context, as Shields asserts that COI is not a method, rather it is an organising Principle that provides fertile ground for methods to be developed and tried. It is a conducive to making mistakes and making progress, as is essential in this project and research.

3.3 Critical Optimism

Prior to moving to a more detailed discussion of action learning, as an intervention in this project and research, I considered the fundamental notion of critical optimism, as it refers to public administration. This is the 'faith of sense' that if we put our heads together and act using a scientific attitude to approach a problematic situation, the identified problem has the potential to be resolved (Shields 2003) posits that critical optimism avoids the pitfalls of both optimism and pessimism and moreover asserts that optimism un-tempered by criticism, "*declares that good is already realised and as a result glosses over the evils that concretely exist*" (p.178). Dewey (1920, 1948) defines critical optimism (meliorism) as the belief that the "*specific conditions which exist at one moment be they comparatively bad or comparatively good in any event may be bettered*" (p. 179). Shields' (2003) goes on to assert that if a public administrator is not a critical optimist, as defined by Dewey (1920) they have no business being a public administrator. She states that "*critical optimism orients the practitioner towards his obligations to his duty and his obligations to his supervisor*" (p. 515). This is similar to that argued by Bright (2009) and Ludema et al. (2001) that a manager's role is to set the tone of 'the positive', to ignite transformative dialogue and action. Moreover Bright (2009) argues that it is not a matter of focusing exclusively on the 'positive emotions' (e.g., creativity, innovation, positive attitude) but also to provide team members with the skills to function in dynamic relationships with so called 'negative emotions' (e.g., conflict, avoidance, pessimism). In developing a new service as a COI in a healthcare organisation, a sense of critical optimism was important for me as leader of this team, and for the individual team members in the addressing the *problematic situations* arising in the evolution into the community of inquiry, as highlighted in the following vignette (1):

In this research as the community is the team of auditors and the inquiry is the methodology for team interaction and the practice of audit, the practice of audit required auditors to develop skills of inquiry and apply them in practice. When first established, the audit team faced a *problematic situation*. As an initial task post-training, it was necessary for the team to amend the practice procedures from another jurisdiction to be applied in their own setting. This was done in small sub-teams as part of the practice of auditing, building both skills and knowledge in a proactive way. The procedures were amended 'in practice' and the data to inform this practice was collected by the team using diaries, based on what worked well and what needed to be amended (Argyris et al. 1985). The data was collected and discussed by the team as a whole. I attempted to ensure that all voices were heard in light of the critical optimism perspective, and robust debate based on evidence was encouraged at the team meetings.

Vignette 1: Building a community of inquirers among a healthcare audit team

As can be seen in Vignette 1, establishing a team knowledge transfer process is an essential step in the inquiry process and corresponds to what Peirce termed 'communities of inquiry'. This approach also formed part of a process enabling ethical inquiry, and afforded multiple perspective inquiry as the COI evolved. However, for this to happen, catalysts of inquiry needed to be applied, which is this case amounted to action learning cycles.

3.4 Defining Action Learning

Action learning can be seen as resting on two particular perspectives; critical realism and pragmatism (Burgoyne 2010). From a critical realism perspective, it rejects positivism assumptions that the world can be known, measured and predicted with precision, but also eschews a purely social constructionist viewpoint that reality is no more than the language and discourse that we use to communicate (Rigg and Trehan 2011). Moreover, it dispels the notion that our knowing can only be through the language we have to communicate about it. Therefore, Coghlan and Pedler (2006) argue that AL takes a distinct approach to the process of learning and knowing, which rests upon the pragmatic tradition in philosophy and is an experimental approach to learning. Furthermore, Trehan and Pedler (2011) in discussing this perspective argue that the debt to pragmatism is evident in the characteristic AL question asked in pursuit of best

practicable solutions that enable people to make meaningful changes in their organisations, communities and societies.

There are many definitions of AL. Johnson (2010) alludes to AL being shrouded in obscurity even from its early beginnings. Part of the difficulty, as Pedler (2011) and others have observed, is that Revans (1980) offered no single definition, specifying only *"what action learning is not"* (p.77). Trehan and Pedler's (2010) definition of AL as *"an approach to development that puts the emphasis on people learning through close involvement with real managerial situations, using all the resources available to understand them, taking action in those situations and learning from interpreting the consequences"*(p.2) is relevant to this project and research. This is similar to Peirce's COI scientific attitude, that AL is a science in which the collective members learn about everything they can that is connected to the problem and can help solve it (Marquardt and Waddill 2004).

Whilst recognising that the term encompasses a variety of applications (Brooks and Watkinsm 1994; Raelin 2009), essentially all forms of AL share the element of real people resolving and taking action on real problems in real time, and learning through questioning and reflection while doing so (Marquardt and Waddill 2004). Coghlan and Pedler (2006) elucidate this simply as *"the first requirement of (AL) is to take action to change the world as a means of understanding it"* (p. 129). Fundamentally the attraction of AL is its power to simultaneously and resourcefully resolve challenges and develop people and organisations at minimal cost to institutions (Rigg 2011). Moreover, its uniqueness is its wide-ranging application to both learning and action for individuals, teams and organisations (Pedler 1997; Marquardt 1998; Dilworth and Wills 2002; Marquardt and Waddill, 2004).

Considering the above AL debate, I concur with Pedler's (1997a) remark that *"action learning may be a simple idea but only at the philosophical level"* (p. 248). Therefore, before considering an applied definition in the context of this research, I pondered the evolution of the concept. Essential to this study, Brook et al. (2012) point out that as AL has travelled in some new directions it should now be recognized as an evolving practice. In this literature they offer advice to researching practitioners (Simpsons and Bourne 2007); *"be explicit in (your) personal understanding of the term and in doing so make informed choices about practice and assist academics in sense making, especially*

in their research" (p. 183). Thus, I have considered the potential of AL as it draws from critical action learning (CAL) in this project and research.

3.5 Critical Action Learning

CAL takes a critical perspective that can further elucidate the potential of AL to provoke learning about working across boundaries, as well as learning how to collaborate (Trehan and Pedler 2009). Criticality enters the fray when explicit recognition is accorded to the manner in which context, power and emotion shape the scope for learning, as is the case in this study (see vignette 2).

> The audit team is required to interact with the power structures in the organisation, as its service is part of the governance process. The knowledge gained from these active interactions is critically reflected upon by the individual and the team in consideration of 'better practice', and once this learning is formulated; the knowledge gained is taken back into the organisation in the form of recommendations to the service areas to inform practice. These recommendations challenge the "taken for granteds" and may be resisted, at the highest level. It is my responsibility as audit Director to explain, defend, and challenge resistance in context. as a catalyst for a quality improvement process. In effect the audit team is enacting new organisation practices, by critically examining old ways and subsequently bringing new ways of organising into being through changing patterns of behaviour within the team and the organisation.

Vignette 2: The impact of context on learning

Trehan et al. (2010) posit that CAL is a development of conventional action learning because it aims to promote a deepening of critical thinking of participants. As explained by Rigg and Trehan (2011) "*it affords an opportunity to examine the politics that surround and inform organizing, to comprehend these politics it is often necessary to question these political choices and decisions, both consciously and unconsciously*" (p. 74). Moreover, Ram and Trehan (2010) state that through the process of interactive governance, "*collaboration allows the practical intelligence of groups of actors to be pressed into service in order to resolve matters of concern to them in order to collectively propagate change within their organisations and systems*". Key to this process is the emphasis on collective as well as individual reflection. Moreover it

attempts to supplement an individual's experience of AL with the reflection of existing organisational, political and emotional dynamics created in action (Trehan and Pedler, 2011), as highlighted in vignette 2.

4.0 ACTION LEARNING AS A CATALYST IN ESTABILISHING A COMMUNITY OF INQUIRY

Pardales and Girod (2006) highlight that inquiry is embodied in the scientific method of arriving at conclusions through synthetic reasoning moreover, they argue that this kind of reasoning is inductive in its character as it moves from old beliefs, through experience, to new beliefs. This is similar to Rigg's (2008) perspective that AL is induced through a cycle of new ways of thinking, talking and inter-relating in order to bring new ways of organising into being (see vignette 2). Furthermore, Trehan and Pedler (2011) found that some practitioners and academics believe AL has most value when practiced in conjunction with other related strategies that also produce knowledge from collaborative action on challenging issues. In using COI as a conceptual lens, with the AL philosophy and practice as a catalyst to support the generation of knowledge by the audit team, I have used a different practice interpretation to that proposed by Johnson (2010). Johnson (2010, p. 269) suggested the following characteristics for using AL "(*1) Set of about six people; (2) Action on real tasks or problems at work; (3) Tasks are individual rather than collective; (4) questioning as the way to help participants proceed with tasks /problems; (5) facilitators are used"*. In this project and research, while adhering to AL's fundamental principles and core essence, the practice variation is; (1) the '*learning set'* is the 16-member audit team; (3) tasks and problems are individual, team and organisational; (5) while the team director acts as facilitator, the team are allowed to develop their own learning via problem solving (see vignette 1). In using a different variation from that proposed by Johnson (2010), I am encouraged by Trehan and Pedler (2011) who assert that in current times, there are many varied interpretations and applications for AL across the world.

4.1 Learning Sets in Action

As *learning set* members take action in the practice of audit and develop new ways of thinking, they do so through social interaction with other organisational members. Through experiential interactions, new ways of thinking, talking and inter-relating, the

set bring new ways of organisation into being and personal identities are changed as a result (Rigg, 2008). I concur with this perspective and that the 'set' can be seen as a microcosm of the organisation from which members are drawn (vignette 3).

> Members of the audit team were recruited from different professional backgrounds clinical and administrative/ management and service divisions in the organisation. They were allowed to create a new service with new ways of acting, new behaviours values and procedures. This new audit service for clinical and social services, as part of a quality improvement process, brought a new social order and accountability mind-set in addressing the 'assurance gap' in the healthcare organisation.

Vignette 3: The learning set in action

Yapp (2006) found that the fragility of team relationships in a learning set mirrored many of the features of the external organisation. Blackler and Kennedy (2006) describe this as 'parallel process', such as those observed in the audit team. The COI became both a source of learning about organisational issues as well as a site to experiment with new practices, as required by the audit team in the practice of audit. Smith (1983) adds insight to this position, by postulating that "*the community of investigators purporting to be scientific is defined by the willingness of each individual member to sacrifice what is personal and private…in order to follow the dictates of an interpersonal method that involves free exchange of views and results*" (p.50).

Finally, Johnson (2010),Coopey (1994) and Buchannan (2008) each assert that the *learning set* needs to be free of workplace politics with minimal role conflicts between set members (a view supported by Mintzberg 2004). In this study, auditors and the team director are not free of work place politics (see vignette 2). In this I am encouraged by Vince (2004) who asserts that critical action learning (CAL) affords an opportunity for managers to examine the politics and the surround and inform organising. Thus, it is often necessary to question the political choices and decisions, both consciously and unconsciously to comprehend these politics.

4.2 Enacting new ways of organising as a 'parallel process'

The audit team's COI is giving 'voice' to each team member as they encourage and challenge each other (Mead 2006) and as part of the practice of auditing, these members are in turn giving voice to the services being audited. Rigg (2008) asserts that in this way it is conceivable that citizens (service users) will benefit from the new order. Considering *"the clever man will tell you what he knows; he may even try to explain it to you. The wise man encourages you to discover it for yourself"* (Revans 1980, p.9), I would argue that in giving 'voice' in this manner is vital for the evolution of the COI. Furthermore, while Revans (1971) did not advocate the permanent use of facilitators, he did however nominate management values and the value system of the enterprise as the factor most likely to hinder effective action and learning; *"where those in charge do not know by what marks they are trying to navigate, they cannot delegate responsibility"* (pp.65-67). Therefore, the leader's capabilities, worldview and philosophy as they are aligned to that of COI is paramount, as they perform the role of manager, mentor, facilitator, and coach. Moreover, should that leader be *"fixed in their belief systems, unwilling to confront evidence they do not expect, unwilling to listen and uncomfortable with uncertainty and doubt",* then they will undoubtedly *"undermine the formation of a COI"* (Shields 2003, p. 526).

Key challenges include a manager's ability to manage the combined roles of mediator, facilitator coach and deliver on the quality and time pressures as are required in the organisation. In this case, the confidence to create conditions of collaborative inquiry, to allow the community of inquiry process to develop, and to let individual team members have voice and enable change to happen under the pressures demanded of managers in the public services at this time, is very challenging. Furthermore Rigg (2010) points out this process of working in collaboration with others who have differing organisational cultural norms and systems are not straightforward in practice. Importantly, Reynolds (2011) asserts that critical reflective practice is not going to be welcomed by everybody (including managers), particularly if it involves challenging 'end as well as means' and posing questions that have implications for power structures underlying existing policy and practice.

4.3 AL as a catalyst for Critical Reflection in a COI

Marsick and Watkins (1990) argue that as a consequence of opportunistic and incidental learning provoked by taking action and reflecting systematically within the AL set; participants develop meta-skills such as self-insight, wider organisation-political understanding and influencing abilities, as well as skills for learning how to learn. This can be understood further from the perspective of social learning theory, AL creates a setting where peers challenge and learn through interaction with one another, thereby encouraging double loop learning (Argyris and Schön 1978). Moreover, Marquardt (2004) argues that because AL utilizes theories, principles and practices of each of the five major learning orientations[3], it bridges the meta-theories and offers a compelling opportunity for individuals, teams and organisations when critically examined.

Willmott (1994) sees AL as particularly well suited to a critical approach, while Reynolds (2011) asserts that the contribution of AL as a vehicle for critical reflection is that the focus is on the collective and contextually specific process. This in turn promotes inquiry into actual and current organisational situations within the COI's specific situation. Donald Schön's (1983) idea of a 'reflective practitioner' foregrounds the more tacit element of learning in ways which underline the importance of reflection, not just as a retrospective process but as part of the ongoing way in which understanding and experience relate. Reynolds (2011) states that this process not only involves the application of knowledge but the development of ideas which we carry with us into future situations, this is the essence of reflective practice and a core process with action learning.

Kolb (1984) Schön (1983) and Reynolds (2011) each argue that reflection needs to be more than a consideration of the technical and organisational aspects of presenting problems. It should also mean raising social, political and cultural issues, questioning purpose and intentions and, if necessary, challenging the assumptions and '*taken-for-granteds*' on which organisational policies and practices are based. Thus, reflection can be the critical link between concrete experience, interpretation, and taking further action (Schön 1983; Kolb 1984) and this process of thoughtfully examining experience is informed by ideas that are capable of helping us make sense of social and political, not just technical process (Reynolds 2011). Authors such as Vince (2004), Trehan and

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[3] Congnitivists, Behaviourists, Humanists, Social learning, and Constructivists.

Pedler (2009), and Ram and Trehan (2010) argue that engaging in reflective practice which is organically situated captures the long standing value of learning from experience of work and working with others. This, when combined with the incremental approach with a focus on specific processes proposed by Alvesson and Willmott (1992), forms the practice of the audit team members.

5. THE EVOLUTION OF A COMMUNITY OF INQUIRY INTO A COMMUNITY OF PRACTICE

Shields' (2003) argues that a mature COI (one infused with a spirit of critical optimism) should mitigate for or steer even selfish impulses towards results of general benefit; as a pragmatist one would never count on self-motivation alone to accomplish this goal. As such, the members need to be encouraged to embrace the COI key components - problematic situation, scientific attitude and participatory democracy, and consider how these reinforce each other. Shields' (2003) further asserts that COI has a special appeal to public service management because it is an orientation that uses a democratic approach to problem definition and interpretation of consequences.

This suggests that a participatory worldview is essential for managers such as myself and is the most profound component of COI and AL for public administrative practice (Shields 2003; Marquardt and Waddill 2004; Pedler et al. 2005). A participatory world view is *"systemic, holistic, relational, feminine, experiential, but its defining characteristic is that it is participatory; our world does not consist of separate things but of relationships which we co-author"* (Reason and Bradbury 2006, p.7). This is further asserted by White (2004) who argues that human systems can only be understood and changed if one involves the members of the system in the inquiry process itself. I concur with this and have found that adopting Willmott's (1997) incremental approach with a focus on specific process is the most constructive approach in context it fits well with the practice of AL in pursuit of knowledge generation to support the incremental COI evolution into a community of practice (see figure 1).
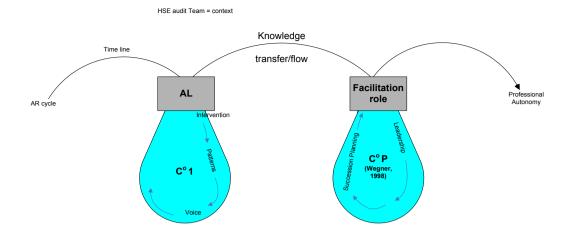
Figure 1: of the evolution of COI into CoP

Figure 1 illustrates the visualisation of the AR cycle of *constructing, planning action, taking action, and evaluating* (Coghlan and Brannick, 2010, p.10) in practice. Through the application of the AR cycle stages and using AL as the catalyst to generate knowledge to inform the team in the audit of practice, the team slowly moves towards a community of inquiry. Over time, AR interventions allow for patterns to be exposed within the team while the embedded voice facilitates inquirer engagement within the team. Ultimately, continuous knowledge flow/ transfer permits the team director a less direct, more facilitated role within the team, ultimately allowing for succession roles within the team. This evolution continues to be enabled through appropriate patterns of behaviour and voice, while leadership training provides a catalyst to generate the knowledge to inform and enable team members' professional autonomy. This empowers the evolution of the audit team into a community of practice, in the development of the audit service in the healthcare organisation.

Most recent theorising of the potential of AL in public administration draws from critical action learning, communities of practice as well as other areas of organisation theory such as actor-network theory and organisational discourse (Trehan and Pedler 2009). Wenger et al. (2001), in discussing a social theory of learning, argue that it is not just to inform academic work but is also relevant to our daily actions. To this end Wenger et al (2001). used the concept of *legitimate peripheral participation* to characterise learning. They did this to broaden the connotations of the concept of apprenticeship from master/ student to that of changing participation from periphery to centrality in a community of practice (CoP). Based on this apprenticeship model, the CoP ethos seeks opportunities for workplace learning as a process through which

communities are joined and personal identities are changed (Wenger, 2008), as highlighted in figure 1 above.

6. SOME EARLY CONCLUSIONS

In drawing some conclusions based on insights from the experience of my project and research to date; I argue that in the context of the public services, using COI as a conceptual lens with AL as the catalyst to promote the generation of knowledge and to inform the incremental evolution of the COI into a CoP has much to offer a manager, and an organisation, in the formation of a new service or indeed the refiguring of an existing service. I have found that the learning philosophy of CAL does act as the antithesis to subject-led didactic teaching approaches to management in this context (Revans 1982; Pedler 1991). Furthermore, this is a very cost effective means to tap into the collective insights of the individual and community within the organisation to inform practice (Rigg 2008). Moreover it involves real people resolving and taking action on real problems in real time, and learning through questioning and reflection while doing so (Marquardt and Waddill, 2004). In this way it has real credibility amongst those involved. For the academic, when pursuing theory building in this manner, there is no division between those who produce the knowledge and those who use it (Friedman 2001). Argyris et al. (1985) express this integration of thinking as the 'creating of communities of inquiry in communities of social practice', thus the COI's central activity is the creation of knowledge.

7. NEXT STEPS – RESEARCH AND PRACTICE

The knowledge generated to date as discussed in this paper will inform the evolution of further action research (figure 1) that will address the role of manager/ leader of a COI incrementally emerging into a CoP. Recent studies (Benningtom and Hartley 2009; Gibney and Murie 2008; Rigg 2010) indicate that improved system working is dependent on different thinking about leadership qualities and behaviour, as encapsulated by the term 'leadership of place'. These are of interest in the context of this research and context, as this new thinking on 'qualities and behaviour' concerns the qualities and practices required to manage the creation and sustainability of new services. In using AL as a catalyst in context, it is of note that Johnson (2010) challenges *"this rather nebulous approach to action learning"*. I am encouraged

however by Pedler et al. (2005) who *"question whether we should welcome these variations in action learning as evidence of growth, proliferation and health life of action learning practice, or deplore these dilutions, departures and deviations from the classic Principles"* (p.62).

I therefore see this research as an opportunity to make a contribution at the service of both academic and practitioner communities (Coghlan 2007). This offers an opportunity for further research in areas of practice using a critical action learning approach in different practice format as used in this research and practice. Based on the apprenticeship model, the CoP ethos seeks out opportunities for workplace learning as a process through which communities are joined and personal identities are changed (Wenger et al. 2002). I as researcher will seek the opportunity to use the knowledge generated from this experience to help the audit team evolve into a CoP (figure 1). I intend to track this evolution in a future action research cycle in this study. The next steps in both the research study and my organisational role, is to focus on building momentum towards a community of practice. Finally, as discussed above the co-generated knowledge created through this action research project seeks to be actionable, by which I mean it is robust for scholars and actionable for practitioners.

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PAPER 2

PREFACE

This paper discusses the application of the IAR method as applied to this research study, which focused on the learning that was generated internally by establishing a quality patient safety audit (QPSA) team in the observed healthcare organisation, underpinned by a critical action learning ethos. The underlying objectives were to;

1. Track the QPSA team from establishment;
2. Explore the elements, influences and barriers that inhibit or promote critical action learning;
3. Contemplate the tools of voice as a means of generating a community of inquiry;
4. Observe the evolution of a community of inquiry in the practice of audit;
5. Consider the dual role of practitioner researcher.

As a practitioner-researcher, I am a complete member of the organisation under study and thus had dual roles in this research; one was my executive role as audit team director while the other was the research role as IA researcher.

Having considered other methods in light of the research focus, aim and objectives, I was drawn to IAR based on the fundamental notion that human systems could only be changed if one involves the members of the system in the inquiry process itself (Coghlan 2004; Reason and Bradbury 2008; Coghlan and Brannick 2010;Shani et al. 2012). Having engaged with the AR method, I initially contemplated the concepts of 'practical knowing' and 'participatory worldview' (Reasons and Bradbury 2008, p.1) in pursuit of 'worthwhile practical purposes' (Heron 1996, p.41), although as the research progressed I found that Shani and Passmore's (1985) more refined definition of AR as 'an emerging inquiry process' described the research more succinctly.

I then considered the study's design in light of Coghlan and Brannick's (2010) argument that knowledge and practice that is generated comes from research-in-action (third person) and this is grounded in an individual practitioner and furthermore, the researcher's own learning in action which is exhibited in both individual (first person) and collaborative (second person) activities (figure 1).
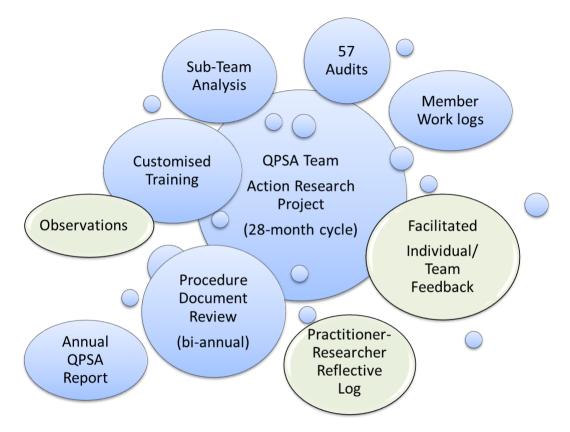
Figure 1: IAR-CAL project integrated research design

As a team of auditors, we mirrored the AR methodology in the practice of audit to co-generate knowledge and to inform the incremental emergence into a Community of Inquiry (figure 1). The underlying research challenge was to create a favourable learning environment where we as a team could engage with tacit knowledge (Rigg 2008), using our combined experience, understanding and judgement to inform the team's development and emergence into a team of auditors, thus each of these nuances are considered in the research design. Of significance here is that each team maintained a reflective diary to record 'insights from practice' and that this became a way of working for the team and I as co-researchers as we co-constructed realities and identities (McNiff and Whithead 2002). I was aware at this time that in adopting this approach there is no one way or no quick fix and would therefore require a great deal of hard work (Coghlan 2011) but believed it worthwhile in light of the COI goal. Based on this premise of a multi-faceted research environment (figure 1), undertaking this research as an IA researcher was a natural role for me as this methical approach flowed logically from an epistemological approach which focused on exposing interests and enabled emancipation and participation. This ethos was essential to engaging the auditors as co-learners and co-researchers and enabling their voices to be heard to inform the CAL/ AR process. In applying this approach, I could focus research attention

on experience, understanding and judgement, which lead to action; thus providing a methodology through which I and the team could affirm 'what and how we know'. Thus, the forthcoming paper outlines my research philosophy based on the AR cycles of *constructing, planning action, taking action, and evaluating* (Coghlan and Brannick, 2010, p.10).

In constructing this research, it is worth noting that this project began not as an academic question posed for the purpose of a research study but began with a question posed to me as a senior executive, from the board. The resulting remit to design, recruit for, establish and manage an audit team presented certain challenges due to very limited available resources to provide education and training for the new team. The action for the audit team was to deliver the best quality audits within the timelines set down by the risk committee, thus I designed an 'orientation training programme' to facilitate initial understanding within and among the team. Based on Revan's (1980) advice, team members evaluated the programme approach and value on each evening of the three-day programme and the programme was refined to reflect their inputs. We also included auditor presentations in the research design and the resultant audit team process document to allowed auditors to discuss what worked well, challenges faced and how they overcame these challenges to help decipher meaning for us as individuals and as a team (Rigg 2008; Coghlan and Brannick 2010), and in practice, robust debate was encouraged through this individual team reflection process.

At this stage of the research design, my dual roles were interwoven as my research role informed my executive role and vice versa; both the team and I were learning in action (Trehans and Pedler 2010), thereby naturally pursuing a critical action learning (CAL) ethos. Of note is that one of the benefits of engaging with a doctoral tutor who is not directly involved in my work environment includes the consideration of each of these steps in action. Writing this paper was an AR project in itself as I needed to pay attention to my understanding of this experience and my own judgement, which provided me with a methodology to help affirm what and how I know. In the quest for quality and authenticity in the research, I needed to be *attentive, intelligent, reasonable and responsible* in the generation of useful knowledge, which could then produce outcomes of value to others, and ultimately facilitate the incremental merging of the team into a COI.

The next steps in both the research study and our organisational roles in the audit team was to focus on building momentum within the COI as a team of IA researchers as we pursued the learner embeddedness required to evolve into a COI. Furthermore, I was reticent of the fact we were also a team, collaborating on addressing the challenges facing us as a new service provider in a transforming organisation.

Applying an Action Research methodology in creating a New Service in a Healthcare Organisation

Action Research Methodology paper
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Examination Panel Result: Recommended

ABSTRACT

The aim of this paper is to discuss the application of the insider action research method, which focuses on the creation of an audit team to address an internal 'assurance gap' in a national healthcare organisation. This research approach also seeks to inform the incremental evolution of this audit team into a community of inquiry via the application of a learning set to generate knowledge in the new team. The research is concerned with the knowledge and learning emerging from this new team process of "taking an attitude of inquiry" The project is the executive responsibility of the insider researcher who is a "complete member" of the organisation. This research is undertaken as part of a practitioner doctorate programme where the author is undertaking a doctoral research study through applying an action research approach in and on her own organisation.

Key words:

 Insider action research, community of inquiry, Healthcare

1. **INTRODUCTION**

This insider action research (IAR) study was undertaken in a national healthcare organisation in Ireland over a twenty-eight month period from 2010 to 2013. The focus of the research was to study the establishment of a quality patient safety audit (QPSA) team, created to fill an assurance gap for clinical and social service at corporate governance level in the observed healthcare organisation. This audit team, once recruited, consisted of fifteen individuals with varied professional experience (both clinical and administrative/ management) and levels of seniority from different geographical locations within the studied organisation. The primary aim of the research account was on the knowledge that was generated internally by establishing the aforementioned team, underpinned by a critical action learning ethos. This project sought to document the creation of a suitable team environment and to track this team from establishment through to the observed evolution of a community of inquiry (COI) in the practice of audit.

The origins of action research (AR) are broad, although many writers trace the methodology back to the social experiments of Kurt Lewin and other social science researchers who emerged towards the end of World War II (Reason and Bradbury 2008; Coghlan and Jacobs 2005). Lewin's contribution to social psychology is well documented and described in numerous papers (for example, Moreland 1996; Weisbord 2004; Coghlan and Brannick 2010; Coghlan and Jacobs 2005). Of particular relevance to this paper, Coghlan and Jacobs (2005 p. 444) point out that for Lewin; *"it was not enough to try to explain things; one has also to try and change them and one has to involve others in that process of understanding and change"*. Reason (2006) points out that this methodology is in the liberationist perspective, as exemplified in Freire's (1970) work on liberal humanism, pragmatism, phenomenology and critical theory; while White (2004) asserts that Lewin and others found that working at changing human systems often involves variables that could not be controlled by traditional research methods, developed in the physical sciences.

Elliott (1991) asserts that the main difference between AR and other research methods is that it is a precondition of AR that the practitioner researcher feels *"a need ... to initiate change"* (p. 53). This insight led to the development of AR and the fundamental notion that human systems could only be changed if one involved the members of the system in the inquiry process itself (Reason and Bradbury 2008; Coghlan 2004; Shani et al. 2012). I[4] concur with Coghlan and Brannick (2010) that there is no short answer as to what AR is; in practice, AR is a family of approaches *"which sees itself as different from other forms of research" (*Reason and Bradbury 2008, p. xxii).

In seeking a definition for this research, I find Reason and Bradbury's (2008, p.1) working definition useful: *"Action research is a participatory democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview"*. This definition includes 'practical knowing' and 'participatory worldview', thereby *"addressing worthwhile practical purposes, with the primacy of the practical" (*Heron 1996, p. 41), a view that is similar to my own philosophical approach to research. I do not propose to formulate a definition of AR for this research as I found as the research progressed, Shani and Passmore's (1985) more refined definition of AR described this research successfully:

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[4] As an action researcher I, as author, propose speaking in the first person as is accepted convention when applying this methodology.

"as an emergent inquiry in which applied behavioural science knowledge is integrated with existing organisational knowledge and applied to solve real organisational problems. "It is simultaneously concerned with bringing about change in organisations, in developing self-help competencies in organisational members and adding a scientific knowledge" (p. 439). Shani and Passmore's (1985) definition, as supported by Shani et al.'s later work (2012), captures the critical themes that constitute AR; as '*an emergence inquiry process*' it engages in an unfolding story where data shift as a consequence of intervention.

I am encouraged by Reason and Goodwin (1999) in undertaking an insider action researcher role, as these authors' assert that good AR does not come fully fledged in a clear design separate from the main stream of life but evolves over time as teams evolve into communities of inquiry. Reason (2006) supports the view that the inquiry process begins at the initial moment of inception, however tacit that may be, and continues well after any formal research is complete.

As defined above, this research is: *"undertaken in a spirit of collaboration and co-inquiry"* by a team of auditors working in collaboration in an action research cycle *of constructing, planning action, taking action and evaluating action* (Coghlan and Brannick 2010). This collaboration involves me as both researcher and practitioner liaising with the audit team working together to generate knowledge 'in action'; concerning ourselves as individuals, as members of the team and of the organisation (Rigg 2008). This approach is very useful when pursuing a democratically and socially constructed research approach.

The paper is structured as follows: I begin by discussing the definition of action research before setting out my philosophical approach to my research. In this I concur with Peter and Olsen (1983) that a researcher's epistemological and ontological perspectives legitimise their own distinct ways of doing research. Next I discuss my research approach and how the methodological approach of insider action research flows logically from my philosophical stance. I reflect on my journey as an insider action researcher to date as I engage in AR cycles of construction, planning action, taking action, and evaluating action, and consider if, when and how I am 'attentive, intelligent, reasonable and responsible' (Lonergan 1992) as my skill of inquiry evolves along with the audit team's evolution into a community of inquiry. Next I discuss the

challenges encountered in this research in relation to pre-understanding, role-duality and organisational politics, before drawing some conclusions on the AR process to date.

2. RESEARCH PARADIGMS

In presenting my epistemological and ontological approach to research I am using a paradigm as defined by Deshpande (1983 p. 101) *as "overall conceptual frameworks within which some researchers work, that is, a paradigm is a worldview or a set of linked assumptions about the world which is shared by a community of scientists investigating the world"*. Johnson and Duberley's (2000) table is useful in that it illustrates how the epistemological approach influences our approach towards reflexivity and our focus of research (Table 1).

Epistemological Approach	*Approach towards reflexivity*	*Focus/ Issues*
Positivism and Neo-positivism	Methodological reflexivity	Improving methods and their application
Critical theory/ Critical Realism	*Epistemic reflexivity*	*Exposing interests; Enabling emancipation through self-reflexivity; Participation of those being researched; Importance of praxis.*
Postmodernism (1)	Hyper-reflexivity	Reflexive deconstruction of own practices; Danger of relativism.
Postmodernism (2)	Impossibility of reflexivity	Recognition of the impossibility of 'true' knowledge; Conservatism/ silence

Source: Johnson and Duberley 2000, p. 191

Table 1. The various epistemological approaches and their implications

Placing myself in the critical research realism paradigm aligns with my concept and understanding of AR, as it allows room to utilise the full range of methodological techniques available (Reason 2006; McLennan 1995) in pursuit of understanding. Coghlan (2007) advises that as a critical realist I need to transcend my own subjectivity through the quality of how I am attentive to data, intelligent in my understanding, reasonable in my judgement and responsible in my actions (Lonergan 1992; Reason

2006). Additionally a sense of critical optimism (Shields 2003) was essential for me as researcher and leader of this team, and for the individual team members in the addressing the *problematic situations* arising in the evolution of this team into the community of inquiry in a healthcare organisation.

3. INSIDER ACTION RESARCH

Over the past decade, the phenomenon of insider action research (IAR) has become established as an important way of understanding and changing organisations (Coghlan 2001 2011; Fisher et al. 2000; Coghlan and Holian 2007). When complete members of an organisation seek to inquire into the working of their organisational system in order to change something in it, they can be understood as undertaking IAR (Coghlan and Brannick 2010; Dick 2007; Zuber-Skerritt and Perry 2002). Complete membership is contrasted with those who enter a system temporarily for the sake of conducting research; it may be defined in terms of wanting to remain a member within a desired career path when the research is completed. Coghlan and Brannick (2010) argue that the knowledge and practice that is generated comes from research-in-action (third person) that is grounded in an individual practitioner. Furthermore, the researchers' own learning in action is both individual (first person) and collaborative (second person). In applying an IAR approach, I can focus attention on experience, understanding and judgement, which leads to action; thus providing a methodology through which I can affirm what and how we know.
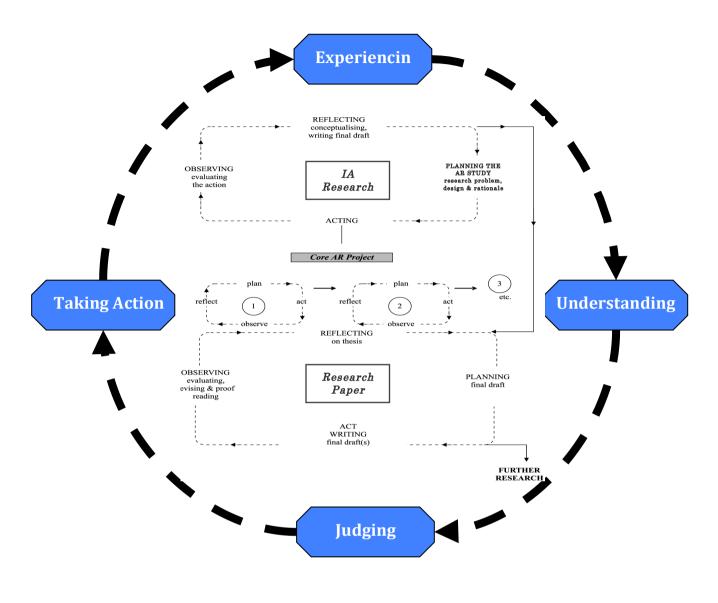
I have been a member of the health services sector for over 30 years, during which time I have had many roles, the most significant of these being; occupational therapist, clinical manager, educationalist, organisational change and quality and risk manager and my current role as QPSA[5] Director. My management style is based on many years as an occupational therapist whose role was to facilitate patient/ client recovery potential with their full participation. The QPSA Director role is similar to that of a facilitator both at individual and group level, and prior professional knowledge aided in the design of the current QPSA team. I also completed specialist training in facilitation and worked with organisations to facilitate large and small changes. I drew on this knowledge and my participatory worldview allowed me to draw on techniques and

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[5] QPSA title is based on the 'Quality Patient Safety Directorate' in which the team reports to the National Director and also describes the function within the remit of patient safety and quality. This is a new service, similar to Internal Audit, to provide assurance in Clinical and Social services.

knowledge of social science and to frame these within a human context (Reason and Bradbury 2008). The establishment of the QPSA team is my executive responsibility and I am a complete member of the organisation under study. The development of this AR project is also part of my professional doctorate studies. In considering this as an IAR study, it fulfilled Reason and Bradbury (2008)'s view of AR as a participatory, democratic process concerned with developing *practical knowing* in the pursuit of worthwhile human purposes. It also sought to bring together action and reflection, theory and practice, in participation with my doctoral tutor and with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.

4. ACTION RESEARCH CYCLES – LEARNING IN ACTION

If we start from the idea that creating knowledge is a practical affair, we will, in Reason's (2006) view, start not from an interesting theoretical academic question, but from what concerns us in practice. Specifically, Reason (2006) cites Freire (1970) who states that "*The starting point…must be the present, existential, concrete situation, reflecting the aspirations of the people…{we} must pose this…to the people as a problem which challenges them and requires a response - not just at an intellectual level, but at a level of action*" (p.75). Therefore, I focused on what was required for this new function to become a community of inquiry (COI), and contemplated this challenge in the context of what came before, in this and other organisations, and through the lens of prior research. I was encouraged by Somekh (1995) who asserted that AR is something that you learn to do in practice rather than by following a prescribed method or technique. Therefore, in telling the story of my IAR project, I strive to contribute to the practice of AR for the cosmopolitan community of scholars (Bradbury-Huang 2011) There is also value to practitioners by documenting how I used my experience, understanding and judgment to inform my actions, using an applied variation of Coghlan and Brannick (2010) and Perry and Zuber-Skerritt (1991) models (Figure 1).

Adapted from: Perry and Zuber-Skerrit (1991, p.76),
Coghlan and Brannick (2010, p.142).

Figure 1: Applied Research Method

Figure 1 illustrates the interrelationship between the core AR and the work-based project and how I, as a practitioner researcher, focused attention on experience, understanding and judgement within the AR cycles that ultimately lead to understanding of 'what and how we know'. The research follows the AR cycle of *construction, planning action, taking action, and evaluation* and how we use our *experience, understanding and judgment* to inform our *actions* (Coghlan and Brannick 2010). As a team of auditors we mirrored this methodology in the practice of audit to co-generate knowledge, to inform the incremental emergence into a community of inquiry (COI).

4.1. Constructing

This project began with a question posed to me as a senior executive, from the board, *"can you provide us with assurance that the assertions of senior management concerning patient safety and quality are in place?"* My response was *"no, I cannot provide this independent assurance"*. The resultant remit to design, recruit, establish and manage an audit team whose role is to act as an internal audit function for clinical and social services within the studied healthcare organisation was my responsibility. I was still recruiting this audit team from different professional backgrounds including nursing, allied health, professionals, scientists and management when I was inaugurated onto a professional doctorate programme, thereby providing the catalyst for this IAR study. This team joined me based on my vision of how this team would work as a COI adapting an "attitude of inquiry" in the practice of audit, mirroring this approach to facilitate the evolution of the team as co-researchers to inform this new practice and service. As *"knowledge including technical knowledge is often transferred between people by stories, gossip and by watching one another work"* (Pfeffer and Sutton 1999, p. 6), the challenge for me was to create an environment where we as a team could engage with tacit knowledge (Rigg 2008), using our combined experience, understanding and judgment to inform the team's development and emergence into a team of auditors.

In establishing a new service, we needed to engage with both theory and practice together so there was no division between those who produce the knowledge and those who use it (Freidman, 2001). We were setting out to 'learn in action' similar to Schön's (1995) notion of reflective practice as captors of knowledge in action and reflection in action. Lonergan (1992) suggests that insight emerges through questioning this experience. Therefore, I, as Director, needed to combine advocacy with inquiry (Coghlan 2012) in order to be able stand back to allow space to create conditions of collaborative inquiry. To achieve this, I was conscious to adopt a stance of self-scrutiny and self-challenge (Elliott 1993); to pay attention to how I experienced my own inquiry and resultant actions (Reason and Torbert 2001) and to combine my own inferences, attributes, opinions and viewpoints as open to testing and critique by the team and others (Argyris et al. 1985; Ross and Roberts 1994; Coghlan and Brannick 2010). I was aware that in adopting this approach there is no one way, no quick fix and would therefore require a great deal of hard work (Coghlan 2011).

As we constructed the team, each member maintained a reflective diary. This was difficult to do initially as it imposed a new discipline on each of us (McNiff and Whitehead 2002). A reflective diary was also a requirement for the doctoral programme, which reinforced this discipline for me as practitioner researcher. I found I moved from a reflected diary to a critically reflective diary over time (McNiff and Whitehead 2002), thus the diary impact was similar to that stated by Argyris et al. (1985 p. 449) as it was *"iteratively moving forward from a more proactive orientation towards a more reflective one"*. I used the diary as a means of attending to my experience, being intelligent in my understanding, being reasonable in my judgement and being responsible in my decision making. Furthermore, each team member provided insights 'in practice' and procedures were amended using data collected by the team and recorded in individual diaries, based on what worked well and what needed refinement (Argyris et al. 1985). This became a way of working for the team and I as co-researchers as we co-constructed realities and identities (McNiff and Whitehead 2002) in 'taking an attitude of inquiry' (Marshall and Reason 2007) in the process of auditing.

4.2 Planning Action

One of the key tasks was to build and maintain cohesion in the audit team. As the team members learned the practice of audit, we also began to build our skill-set as a team of inquirers. My role focused on setting the vision of the future by asking the questions to prompt discussion and by adapting a stance of opening the debate and standing back to allow the conversation to develop. This was not an easy way for some people to work as they were uncomfortable with this style of management and looked to me to be more directional in my approach. While I had undertaken the initial research to inform the establishment of the service, I was not an expert in the area, thus we needed the combined experience of the team to co-generate knowledge and to inform the COI. This approach did cause frustration in those who preferred me, as Director, to make decisions prior to discussion; as the COI process involved a number of cycles, of constructing, planning action, taking action, and evaluating action as we set about *learning about learning* (Argyris 2003) within each cycle.

This new service 'to provide assurance for clinical and social services' was not a tightly controlled change (Coghlan and Brannick 2010) and I had full autonomy concerning the method applied in the team setting, within the defined regulations and guidelines of the

organisation. This allowed us to guide this change together. For example, I applied an action learning model when working on the procedure document, guided by Rigg (2011) who found that knowledge gained in this manner creates conditions of collaborative inquiry to enhance learning. In this way we were 'learning in practice' as together we were managing the transition from the present to future state to deliver audits and simultaneously addressing individual doubts and fears (Shields 2003) as team members had given up their old jobs and the new role had not yet fully materialised.

4.3 Taking Action

The action for the audit team and I was to deliver the best quality audits in the timelines set down by the risk committee. I designed and developed an 'orientation training programme'; it was delivered by me with invited speakers over three one-day modules. In this I considered Revans' (1998 p.9) advice that "*the clever man will tell you what he knows; he may even try to explain it to you. The wise man encourages you to discover it for yourself*", therefore, team members evaluated the training at the end of each day, and the programme was refined to reflect their inputs. This approach is similar to that asserted by White (2004), who found that human systems can only be understood and changed if one involves members of the system in the inquiry process itself.

At this initial stage my dual role; as director, responsible for guiding this change, and my role as researcher, were interwoven as my research role informed my executive role. My research gave me as practitioner the extra confidence, to move the auditors and I from a state of doubt to confidence. In this I was encouraged by the work of Peirce (1839-1914) and Shields' (2003 p.107) who posit that: "*belief is a state that allows for action and confidence, eventually turning into the 'real', which can be applied in the community of inquiry*". Hirschhorn and Barnett (1993) provide a further perspective on this, suggesting that anxiety and fear are an integral part of a manager's working life, and are part of the management condition associated with their daily encounter with new tasks and risks. The issues that were emerging for me and the team began to move the team, and my research, towards the area of community of inquiry as it fit well with my philosophy and practice. We were also 'learning in action' (Trehan and Pedler 2011), thereby naturally pursuing an action learning methodology, by taking "*action to change the world as a means of understanding*" (Coghlan and Pedler 2006, p.129).

4.4 Evaluating Action

Evaluating action was a natural cycle of our quality improvement process. We met as a team once monthly with a set agenda that was sought from the team members. In practice the issues arising for auditors were discussed and robust debate was encouraged. I endeavoured to ensure all voices were heard, and consensus was pursued to amend practice. This was difficult initially as discussed earlier, as this was not a usual way of working for some team members. Encouraged by Harper (1987 as cited in Pfeffer and Sutton 1999) who asserted that essential knowledge is often transferred between people by stories and gossip; these meetings and teleconferences were not all work, but allowed auditors time to have informal meetings and discussions to share stories and exchange views on the organisation and their experiences. Personal positive stories and a sense of humour were encouraged in these interactions, although stories of both a positive and negative nature were exchanged. We also had a formal presentations by the two auditors assigned to each audit, as each audit was completed. The auditors presented their audit, under general themes; what worked well, challenges and how they overcame these challenges. This became a very useful way of sharing knowledge and opening discussion and we began to focus on questions such as; what happened?, how do we make sense of what happened? and so what? to help decipher meaning for us as individuals, as a team and as members of the organisation (Rigg 2008; Coghaln and Brannick 2010).

Meetings were minuted and were mostly divided into business and educational sessions, which occasionally included an external speaker who spoke on a topic agreed by the team as an area of interest. Some of these meetings were very tense and uncomfortable, as there were differing viewpoints and backgrounds. I was the most experienced practitioner at those meetings but as a trained facilitator, and conscious of my researcher role, I endeavoured to allow all voices to be heard and as far as possible to let the team reach agreement. Scharmer (2001) was useful here as he offers a process for organisational conversation, although this was often difficult as each member came from a different background, education focus and level of experience. Their knowledge of different areas was important for us to maintain for auditing in contexts; however, in order to develop an attitude of inquiry in practice the team also needed to co-generate knowledge from practice to inform the evaluation of the practice and theory. We amended the standard procedures document, which all auditors must comply with, on this basis. In allowing this process to emerge I was seeking to enable team members to

evolve as auditors, to think more critically about themselves, to see multiple interpretations and constructions of reality and to work with others to achieve collaboration and ethical goals. As this process progressed we began to emerge into a community of Inquiry with action learning as the catalyst.

5. REFLEXIVITY IN ACTION

When considering my role as pragmatic realist action researcher, Lonergan's (1992) presentation of authenticity as characterized by four process imperatives; be attentive, be intelligent, be reasonable and be responsible is integral to the development of my IAR skill-set. This can be partly achieved through how attentive we are to the data, how reasonable we are in our judgement and how responsible we are in our actions. I was also conscious that I needed to confront issues pertaining to pre-understanding, role duality and organisational politics (Coghlan and Brannick 2010), and that I needed to take a critical realist approach which challenged me, and others involved in the project, to transcend our own subjectivity (table 2).

Operations	Activities	Process imperatives
Experience	Attending, sensing imaging	Be attentive
Understanding	Inquiring, understanding	Be intelligent
Judgement	Reflecting, weighing evidence judging	Be reasonable
Decision	Deliberating, deciding, acting	Be responsible

Adapted from: Coghlan and Brannick, 2010, p. 24

Table 2: Applied Critical Realist Action Research Method

This transcendence provided the criteria for a rigorous epistemology and quality research (Lonergan 1992). Thus, the capacity to *"challenge the guiding assumptions of the culture, to raise fundamental questions regarding contemporary social life, to foster reconsideration of that which is 'taken for granted' and thereby furnishing new alternatives for social action"* (Gergen 1982 p.136) is particularly relevant in the studied environment.

Shani and Passmore (1985) and Bradbury-Huang (2011) each suggest ways in which quality may be judged in terms of how the context is assessed and understood in an AR project (Table 3). In this IAR, the concept of emerging inquiry was ever present in the early stages of individual team development. The team ethos centred around taking action to bring about change, thus the choice points of quality afforded the IA researcher a tool of engagement in context (Table 3).
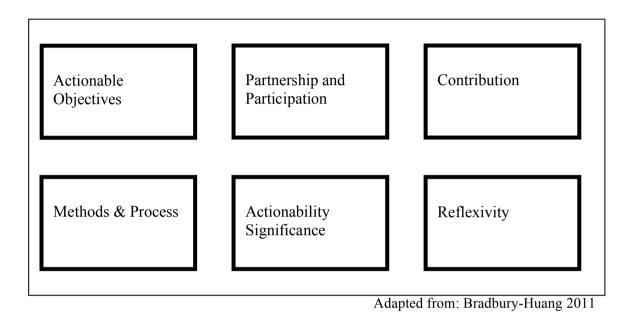
Actionable Objectives	Partnership and Participation	Contribution
Methods & Process	Actionability Significance	Reflexivity

Adapted from: Bradbury-Huang 2011

Table 3: Choice points for Quality in Action Research

I have used these quality choice points (Table 3) throughout this IAR study as a means of considering positionality and my ethical standing. As the QPSA director and action researcher in this project, I have extensive experience of working in the studied organisation in many different roles; thus I am aware of Lewin's (1997b) advice that "*even first-hand experience does not automatically create correct concepts*" (p.52). Coghlan and Jacobs (2005), in commenting on Lewin's statement, argue that experiencing alone does not create learning. They go to cite Lewin's (1997a) perspective that learning involves "*a spiral of steps each of which is composed of a circle of planning, action and fact finding about the results of the action*" (p.146). Of note is that one of the benefits of engaging with a doctoral tutor who is not directly involved in my work environment includes the consideration of these steps in action, as we each challenge the others' pre- and misconceptions relating to the team under study and the resultant data as it emerges. These interactions also facilitate active learning between myself, my tutor, my team and others as I consider new ways of thinking,

talking and inter-relating (Rigg 2008) in my own research, an unexpected gain of the research cycle.

As this research also forms part of a professional doctorate programme, I am encouraged by Heron (1996) where he states *"A first characteristic of action research then is that it is concerned with addressing worthwhile practical purposes, with the 'primacy of the practical'* [at its centre]*"* (p.41). Such research aims at generating actionable knowledge, which can be defined as knowledge that is useful to both the academic and practitioner communities. Having access to those from each community (academic and practice) helps me to consider others' perspective throughout the study. Coghlan (2007), in discussing practitioner doctorates, states that the knowledge generated comes from the actor in the process engaging in the experiential learning cycles of experiencing, reflecting, conceptualising and experimenting in real life situations.

Reynolds (2011), in building on foundations provided by Kolb (1984) and Schön (1983), argues that reflection needs to be more than a consideration of the technical and organisational aspects of presenting problems; therefore, the operational element of AR involves engaging in cycles of action and reflection. It should also mean raising social, political and cultural issues, questioning purpose and intentions and, if necessary, challenging the assumptions and 'taken for granteds' (Gergen 1982) on which organisational policies and practices are based. As Raelin (2009) argues, reflection must be brought into the open whereby privately held assumptions are tested publicly and made explicit so that how they are constructed can be seen and critiqued. This approach is close to the inquiry required by the observed auditors in their practice and our reflections via our individual diaries, both as a team member and as an emerging COI.

6. CHALLENGES OF INSIDER ACTION RESEARCH

In my research journey to date there have been many opportunities and challenges, which I have attempted to approach and frame through *attention to experience, understanding and judgement* (Lonergan 1992) as a basis for engaging in IAR in a rigorous manner and as a means of confronting the challenges of *pre-understanding, role duality and organisation politics.* I use these pivot points to attempt to make sense

of dual-role dilemmas and potential conflicts between my executive role and my researcher role.

6.1 Pre-understanding

Gummersson (2000 p.57) states that: *"pre-understanding refers to such things as peoples' knowledge, insights and experience before they engage in a research programme"*. Coghlan and Brannick (2010) assert that this pre-understanding applies not only to the theoretical understanding of the organisational dynamics but also to the *"tacit and explicit knowledge"* (p.114) resulting from lived experience in one's own organisation. This offers a significant opportunity for me as I have extensive 'lived experience' of my organisation. I know implicitly the everyday jargon; the legitimate and taboo phenomena and what can and cannot be talked about in this setting (Nielsen and Repstead 1993). As a senior executive with considerable experience of working in different roles across the organisation I know where to seek knowledge and information and where to follow up on knowledge to obtain richer data (Coghlan and Brannick 2010).

The challenge for me was to establish the audit team in this environment, with very limited resources to provide education or training for the audit team. The conflict here was to be mindful that these constraints did not stand in the way of allowing the team to express their frustrations and opinions. I therefore needed to build on my 'lived experience' but also not to assume too much in order to allow all team members to 'voice' differing opinion and to capture these insights to inform the emerging community of inquiry. Taking an attitude of inquiry (Marshall and Reason 2007) is a natural state for me, as discussed earlier I am confident in my career and position, however I also needed to use my pre-understanding of the organisation to navigate and negotiate on behalf of the auditors to make it safe for them to carry out the practice of audit. Finally, as an insider action researcher, I needed to combine the closeness I have with the setting, while, at the same time create distance from it in order to see things critically and enable change to happen (Reason 2006; Coghlan and Brannick 2010).

6.2 Role Duality

In consideration of my executive responsibility as QPSA Director, I chose to distance myself from my previous work and colleagues to ensure 'independence in my auditing'. This detachment was difficult, even before I undertook the additional role as IAR, which compounded the need for a more detached reflective theoretic position (Coghlan 2007). As I initiated this change in the organisation, I needed to take on the role as researcher to inform my practice (Elliott 1991) to tap into my *tacit and explicit knowledge* and to transfer my philosophy to achieve my objectives grounded in my participatory worldview with my colleagues and those managed by me (Reason and Bradbury 2008). As a senior practitioner time pressures were considerable in undertaking a separate stream of research, balancing this with my personal roles, and the demands of my executive role. It was therefore imperative that the team of auditors become co-researchers in order to generate the knowledge needed to inform practice, using AL as the catalyst. Furthermore, it is important that the data collection process needed to inform this process and the evolution of the team is also the data to inform the research. This interdependency of roles made the research possible. I was encouraged in this by Somekh (1995 p.342) who stated that: "*AR can make economies of time by using some parts of the research process as opportunities to take strategic action*".

This dual role challenge took some time to master. I concur with Sundgren (2004) who describes the dynamics of IAR inner role conflicts and the need to create an internal support system. I initially had some internal organisational support but on their retirement, I lost this. I also liaised with an external expert but possible issues arose concerning confidentiality so that was ethically not possible to continue. My supervisor on my DBA programme became a very important strength to me to challenge me in pre- and misconceptions relating to the team under study and the resulting data as it emerged (Coghlan 2007). Writing for the two roles (researcher and practitioner) proved a further challenge as in effect this means I am writing for two different audiences - an academic audience of researchers, and a practitioner audience in my workplace. As Somekh (1995 p. 352) points out this challenge inevitably leads to problems of "*discordant discourses*" in transferring style for one role to the next in short time spans as demanded by both roles. I concur with Somekh and also Coghlan and Brannick (2010) who each assert that writing makes a special contribution to the learning resulting from AR because of the precision of thought required to construct a text. Finally, in the process of

becoming more reflective, I appreciated Foster's perspective: "*How can I tell what I think, until I [have] seen what I say?*" (1962 cited in Somekh 1995 p.352). This process was also very useful to me in managing the challenges arising from organisational politics.

6.3 Organisational Politics

For this research and project to survive, I needed to be politically astute, what Buchannan and Badham (2008) refer to as a 'political entrepreneur'. As an IAR, I had a pre-understanding of my organisation's power structures and politics and am able to work in ways that are in keeping with the political conditions without compromising the project or my own career (Coghlan 2007). I also had experience in managing the political dynamics surrounding the space we operated in at corporate governance level, to enable the team of auditors to feel safe to confront and challenge *the taken for granteds* on which organisational policies and practices are based (Reynolds 2011). Pettigrew (2003) asserts that there is a fine line between acting in an astute manner and acting unethically. In this it was important for me to have created the vision, values and ethics in which we would work within the audit team so we could consistently demonstrate this approach to the organisation.

As a mature woman my philosophy is also influenced by feminist perspective writing, I would see my position over the years as giving "voice" to those who have none in the organisation. This is similar to Freire (1970) and Reinharz (1992) who observe that by dealing in voices we are affecting power relations. While "*to listen to people is to empower them*" (Way 1997 p. 706. cited in Maguire 2001) empowering approaches advocated by the feminist perspective puts new demands on researchers (Reinharz 1992). In this study, I needed to create a 'democratic space' (Reason 2006) to allow the auditors and those they audited to have voice, creating additional tasks in my professional and research roles. Of note is that the seniority of my position (as senior as I wish to be, not interested in promotion) allowed me to manage organisational politics and safeguard the audit team to work in a highly charged area with relative ease.

7. INSIDER ACTION RESEARCH – CONTRIBUTION TO PRACTICE AND THEORY

Coghlan and Jacobs (2005) and Argyris et al. (1985) distinguish between espoused theory and theory-in-use and argue that theory-in-use is not changed by better or future espoused theory. As QPSA Director, I could use the inside knowledge of the organisation (Bjorkman and Sundgren 2005) and I had the position and opportunity to use and diffuse the research results. In undertaking this IAR, I was guided by Coghlan and Brannick (2010 p.60) who assert *"that AR begins with what we don't know and seeks to find what we don't know, what we don't know that we don't know is the particular fruit of AR"*. Thus, when pursuing theory and practice in this manner, there is no division between those who produce the knowledge and those who use it (Friedman 2001). Argyris et al. (1985) express this integration of thinking as the 'creating of communities of inquiry in communities of social practice', thus the COI's central activity is the creation of knowledge and ultimately learning in the studied environment.

This approach formed the basis for the action learning cycle and the inherent AR methodology applied in the observed audit team, to allow them to follow as co-researchers mirrored in the practice of auditing. As an IAR, I sought, in interaction with my academic tutor and in conjunction with the audit team, to explore this theory in practice. This approach supports Levin's (2004) argument that AR's contribution to scientific discourse is not a matter of sticking to the rigour-relevance polarity but of focusing on vital arguments relating to participation, real-life problems, joint-meaning construction and workable solutions. The knowledge and practice that is generated comes from research-in-action that is grounded in the practitioner/ researcher's learning in action, an activity that is both individual and collaborative through the audit team. This congruence of theories and observed practice (Argyris et al. 1985; Argyris and Schön 1974) and the testing of our claims to knowledge against evidence derived from practice (Whitehead 2000) is where value lies.

8. CONCLUDING REMARKS

Writing this paper was an action research project in itself. I needed to pay attention to my understanding of this experience and my own judgement, which provided me with a

methodology to help affirm what and how I know. For myself as researcher-practitioner, I needed to draw together the complexities of all my experiences in my insights which integrate my own personal learning as well as what took place in the creation, development and management of the QPSA team. In my quest for quality and authenticity in the research, I needed to be *attentive, intelligent, reasonable and responsible* in the generation of useful knowledge, which must produce outcomes of value to others, and ultimately facilitate the incremental merging of the team into a community of inquiry. The next steps in both the research study and our organisational roles in the QPSA team is to focus on building momentum within the community of inquiry as a team of insider action researchers collaborating on addressing the challenges facing us as a new service in a transforming organisation. Finally, the co-generated knowledge created though this AR project both within the workplace and between the academic and practice communities seeks to be actionable (Coghlan 2007), by which I mean it is robust for scholars and actionable for practitioners.

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PAPER 3

PREFACE

The aim of this paper is to present the findings pertaining to the IAR project concerned with establishing an audit team, with responsibility for addressing a clinical and social services 'assurance gap' at corporate level in a healthcare organisation.

While there are tangible outputs relating to the QPSA team performance (summarised in table 1 and fully described in the QPSA Annual Report, appendix D), the focus of the research account is on the creation of suitable learning environment and the knowledge generated through the observed evolution of the newly established team into a Community of Inquiry (COI) underpinned by a critical action learning (CAL) ethos.

	2011 Target	2011 Outturn	2012 Target	2012 Outturn	2013 Target	2013 Outturn[6]
Audits Commenced	20	21 105%	24	26 108%	24	17 71%
Audits Completed	17	17 100%	20	23 115%	20	17 85%

Source: QPSA Service, End of Year Report 2013

Table 1: Targets vs Performance, 2011-2013

When established, the Quality Patient Safety Audit (QPSA) team consisted of fifteen members who came from different internal functions and geographically spread locations within the studied healthcare organisation, and who had varied professional backgrounds and experience (both clinical and administrative management) and levels of seniority. When bringing this team together, I was reticent of the need to create new knowledge grounded in real issues concerning patient safety and quality. Thus, I considered Smith's (1983, p.50) view that "the *community of investigators… follow the dictates of an interpersonal method that involves free exchange of views and results"*, when contemplating the team configuration and the approach to member engagement. This was my vision for the QPSA team guided by the assumption that the knowledge gained would create conditions of collaborative inquiry to enhance learning in a public

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[6] Although the target number of audits commenced and completed fell short of the expected targets in 2013, there are a number of reasons for the shortfall, which can be studied in greater detail in appendix D of this thesis.

service environment (Rigg 2011). As such, this team would not just be another way of doing things, but would seek to make a difference in a worthwhile cause (Reason 2006).

From a CAL perspective, the cyclical approach of *"taking action…and learning from interpreting the consequences"* applied in this study paid homage to the ethos that we cannot say that we know something until we have tried to act in the light of any new 'knowledge' (Revans 1998; Coghlan and Pedler, 2006: Rigg 2011) Therefore the team vision of *'what could be'* needed to be based on accumulative knowledge of the team, research and the evident experience within the newly formed team, thus this is how the findings are presented in the forthcoming paper. The findings are chronological, presenting the team interactions post-training through to the end of the observed AR cycle, spanning twenty-eight months. As an initial task post training, it was necessary for the QPSA team to amend the practice procedure document from another jurisdiction (the NHS, appendix A and B). The data to inform this practice was collected by small QPSA team sub-groups using practice diaries, based on what worked well and what needed to be amended in the practice of audit (Rigg 2008). This data was then discussed at a full team meeting and the practice procedure document was amended based on this work, providing an ethos of both CAL and continuous improvement within the team (Revans 1998; Reynolds 2011; Vince 2012). The CAL practice within the team also contributed to the creation of a standard audit process (appendix C). This approach became a way of working within the team and was repeated initially after six audits were completed and then on a six-monthly basis.

Having honed the ethos of inquiry in the initial year of team engagement during which time we completed seventeen audits; and reviewed the experience of the auditors in undertaking these audits, the team needed to continue to embed the audit service in the businesses of the organisation in subsequent audit cycles. Using the AR method of 'constructing, planning action, taking action and evaluating' our goal was to co-generate knowledge to inform the parallel process of completing audits and evolving into a COI as a way of working in the practice of audit. Thus, QPSA team members were encouraged to think creatively and question ways of working by 'taking an attitude of inquiry' (Marshal and Reason 2007) which was not something that team members were traditionally encouraged to do as employees of this organisation.

A critical task at the onset was not only to encourage equal 'voice' (Mead 2006) among team members in order to tap into all members' knowledge and seek to motivate an inquiring community to listen, share, learn and persuade (Broom 2000) but also to set the tone of the positive to encourage different members of the team to move to a more 'positive' can do attitude in order to ignite transformative dialogue and action, and to facilitate individual and team resilience when interacting with negative emotions. It is noteworthy that as the team evolved, most members gained confidence, despite various levels of experience and seniority, resulting in new power relations which I needed to manage as they were having an impact on both CAL and COI. The forthcoming paper attempts to make explicit the tacit elements of this engagement between team members and myself as team director, but in doing so, is reflected through my own process of understanding as the IA researcher.

Learning in Action: Creating a community of inquiry in a Healthcare Organisation

Findings

DBA Cumulative Paper Series: Paper 3

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ABSTRACT

The aim of this paper is to discuss an insider action research project concerned with establishing an audit team, with responsibility for addressing a clinical and social services 'assurance gap' at corporate level in a healthcare organisation. The focus of the research account is on the knowledge that was generated internally by establishing the aforementioned team underpinned by a critical action learning ethos, and through the observed evolution of this team into a community of inquiry. Using the stages within the experiential learning cycle (Kolb 1984) to guide team interventions and my own critical reflection, I[7] have dual roles in this study; one is my professional role where I have responsibility for the design, recruitment, establishment and management of this audit team; while the other is a research role where I am performing this study as part of a professional doctorate. The knowledge that emerged from this study and the learning therein has the capacity to be actionable, that is, at the service of both academic and practitioner communities.

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1. INTRODUCTION

This paper reports on the establishment of a Quality Patient Safety Audit[8] (QPSA) team, consisting of fifteen individuals who have come from different functions and geographically spread locations within the studied healthcare organisation, and who have varied professional backgrounds, experience (both clinical and administrative/management) and levels of seniority. The QPSA service was developed to fill the 'assurance gap' for clinical and social service at corporate governance level in the studied healthcare organisation. The main focus is on the creation of a suitable team environment and the knowledge generated through the observed evolution of this newly established audit team into a community of inquiry (COI), underpinned by a critical

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[7] As an action researcher I, as author, propose speaking in the first person as is the accepted convention when applying this methodology.

[8] The QPSA title is based on the 'Quality Patient Safety Directorate' in which the team reports to the Assistant National Director (the author) and also describes the function within the remit of patient safety and quality. This is a new service, similar to Internal Audit, to provide assurance in Clinical and Social services.

action learning (CAL) ethos. Using the stages within the experiential learning cycle (Kolb 1984) to guide team interventions and my own critical reflection, I have dual roles in this study; one is my professional role where I have responsibility for the design, recruitment, establishment and management of this audit team; while the other is a research role where I am performing this study as part of a professional doctorate.

As QPSA Director I was responsible for scripting the proposal to design, recruit and establish the QPSA team to act as an internal audit function for clinical and social services. My first task was to recruit prospective auditors who would move to the QPSA team, who, under the terms of the reassignment process, could hold their existing employment terms, conditions and location. Membership of this team was voluntary, therefore while specific internal candidates were solicited to join the team, there was no requirement for candidates to provide reasons as to why they either accepted or declined the invitation. The particular challenges associated with inter-dispersed team activity were not addressed in this research study. The nature of the recruitment was that QPSA members were available incrementally and needed to be actively engaged in the interim while others were being recruited onto the team. This process was carried out over a four month period, and ultimately, the team consisted of 15 people - all but two had not worked together before.

The key objective of the audit team was *"to provide independent internal assurance, for clinical and social services, to inform decision making as part of the quality improvement process"* (QPSA procedures document 2010). One of the core team initiatives was to pursue compliance with clinical governance policy and guidelines and a requirement for clinicians and managers to sign a 'Controls Assurance Statement', thereby providing an initial team focus. This new practice offered clinical managers opportunity, many for the first time, to have 'voice' (Mead 2006) and participate in the corporate governance process in a way that was equal to financial managers. This requirement for internal assurance for clinical and social services embeds in the new structures the level of assurance that the QPSA team were commissioned to provide to close the 'assurance gap' for clinical and social service at corporate governance level in the studied healthcare organisation.This gave early confidence to the team members as to the value of their work and the security of their future careers.

Reason (2006) posits that the quality of the inquiry comes from the awareness of and the transparency about choices open to you, along with those decisions that you make at each stage of the inquiry and how you articulate quality rules as you proceed. Thus, I needed to pay attention to the quality of the process in 'taking an attitude of inquiry', as required in practice and when applying the action research (AR) method. While there is no short answer to what AR is (Coghlan and Brannick 2010), Reason and Bradbury's (2008, 1) offer a working definition.

> "*A participatory democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview which I believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities*"

This definition appealed to me, particularly when considered in unison with a CAL approach to team development as discussed below. Therefore, I communicated these objectives and the vision of how the team would work together to each applicant prior to joining the team. Each member was seconded onto the team based on their acceptance and understanding of the purpose of the QPSA team and proposed team working. This was a difficult process and required persistence on our part and on those accepted onto and wishing to join the team, as the services that they were leaving were not only losing this staff member but also their position number and budget, thus they have not been able to replace them. Furthermore, members leaving their positions to move to a new service with no track record required a 'leap of faith', a decision based primarily on the team vision I had communicated to them.

2. ESTABILISHING A COMMUNITY OF INQUIRY WITHIN A HEALTHCARE AUDIT TEAM

As this was to be a new team, providing new services, I took this opportunity, as informed by my philosophy and experience, to work with these individuals to create a COI. This concept has its origins in the work of Peirce (1839-1914)[9] and was later extensively developed by Lipman (1991), Dunne (2012) and Dunne and Kelliher (2013).

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[9] Charles Sanders Peirce (1839–1914) credited founder of American pragmatism who 'urges us to follow the successful sciences in trusting to the critical conversation of a community of inquirers' (http://www.academicroom.com/topics/charlessanders-peirce).

Peirce used the terms 'community' and 'inquiry' to refer to a group of individuals (most often scientists) employing an interpersonal method for arriving at results, a view supported by Smith (1983, p. 50) who postulates that "*the community of investigators ... follow the dictates of an interpersonal method that involves free exchange of views and results*". This was my vision for the QPSA audit team.

Initially, I invited the audit team to join me in creating new knowledge that was grounded in real issues concerning patient safety. Guided by the assumption that the knowledge gained could create conditions of collaborative inquiry to enhance learning in a public service environment (Rigg 2011), this team would not just be another way of doing things, but would seek to make a difference in a worthwhile cause (Reason 2006). I articulated my participatory worldview and allowed potential team members' time to reflect on this perspective and some came back on a number of occasions seeking clarification, for example; *"Will we get training?", "How will we work?", "Will we have to travel much?"* and *"Will we report directly to you* [QPSA director]*?"* For a number of people, this was not an attractive way of working from their perspective and they did not join us; for some it was an escape from a poor work environment where their education and skills were underutilised, and for others it was an exciting new challenge.

This was an audit team, so individuals needed to be auditors with incumbent skills and knowledge associated with the role in order to successful contribute to the QPSA team. Therefore, I designed the induction, training and orientation programme as lead architect, in consultation with internal auditors in the National Health Service[10] (NHS 2012) using their training programme based on internal audit practice and standards (see appendix A). I considered the design from an AL perspective (Revans 1998; Coghlan and Pedler 2006), as this offered "*an approach to development that puts the emphasis on people learning through close involvement with real managerial situations, using all the resources available to understand them, taking action in those situations and learning from interpreting the consequences*" (Trehan and Pedler 2011, P.2) for the purposes of this project and research. The result was a holistic training programme customised to the organisation and our team requirements and facilitated by ourselves, with input from internal and external experts. For the purposes of clarity, internal auditing is defined as:

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[10] The National Health Service is the UK equivalent of the Health Service Executive (HSE) in Ireland.

"An independent, objective assurance and consulting activity designed to add value and improve organisations' operations. It helps an organisation accomplish its objectives by bringing a systemic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance process"

(NHS 2012, p. 5).

The value of providing the audit function via a team structure is that the knowledge generated by collective inquiry goes beyond that of individual audit expertise. The training programme was delivered in modular format, each of three-days' duration. Each module was evaluated by all involved and, based on the outcome of this evaluation, was amended to reflect the team members' skill development and evolving training needs as inquiry deepened among the community Evaluation comments partially reflected the type of training participants had been undertaken to date and in particular, an organisational emphasis on certified training; *"Is there certification?" "I don't feel confident without a formal training course", "We should attend a course in college".* Other comments/ feedback considered the post-training environment *"How will we work as a team?"* This intimated some nervousness as to the workings of the QPSA on the part of team members, so I invited a team facilitator to work on team-building exercises on the next training modules. This intervention raised comments relating to prior experience: *"Why are group values so important? We never did that before in our work".* I responded to each of these questions at subsequent sessions, not only for clarification but also to ensure team members were 'heard'.

Future training would be delivered on an incremental basis as identified by team members and facilitators to address the challenges exhibited in the inquiry journey, similar to that argued by White (2004) - that human systems' can only be understood and changed if one involves the members of the system in the inquiry process itself. This training programme did not lead to auditor certification for team members as they did not attend a certified course. As team members were accustomed to a professional certification approach, some struggled with placing a value on non-certified training; *"How can we be validated without certification?"* Others felt that trust may be eroded in the absence of certification *"Who will trust us without formal training?",* and that the mandate for the team could be unclear as a result: *"What mandate have we without formal training?"* Team members also expressed concern that without certification,

they had no protection in fulfilling their role: *"What if we get it wrong will we be in trouble without certification?"*

Of note is that tension in the observed environment centred around the requirement for *extractive* training, such as external certified courses and *integrative* training that focuses on practice and seeks 'points of leverage' at which design can support learning to build on learning opportunities offered by practice. This approach very much reflected the differing backgrounds and experience of the individual team members where I sought to manage the tension between maintaining close interaction between experience and the building of competence to ensure a fertile ground for learning. As the team evolved, the desire for formal certification in relation to on-going training dissipated as members' began to appreciate the intrinsic value of collective knowledge sharing within the evolving COI.

From an AL perspective, this cyclical approach of *"taking action ... and learning from interpreting the consequences"* paid homage to the ethos that we cannot say that we know something until we have tried to act in the light of any new 'knowledge' (Revans 1998; Coghlan and Pedler 2006; Rigg 2011). Therefore, the team vision of 'what could be' needed to be based on the accumulated knowledge, research and the evident experience within the newly formed team. I was also conscious of developing a team in turbulent times[11] similar to that highlighted by Bright (2009) who stated that it is not a matter of focusing exclusively on the "positive emotions" (e.g. creativity, innovation, positive attitude) but also to provide team members with the skills to function in dynamic relationships with so called "negative emotions" (e.g. conflict, avoidance, pessimism). I found there was a value in framing our comments, questions and suggestions in the 'positive' to encourage different members of the team to move to a more positive 'can do' attitude. There was also a reflective value in discussing these experiences with my doctoral research supervisor and interpreting these interactions from a research perspective. Thus, a critical task at the outset was to set a tone of 'the positive' (Bright 2009) within the team and to ignite transformative dialogue and action to facilitate individual and team resilience when interacting with negative emotions.

As an initial task post-training, it was necessary for the QPSA team to amend the practice procedures from another jurisdiction (the NHS). This was done in small sub

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[11] This Team was established during significant restructuring programme at the HSE (2010).

audit -teams, building both skills and knowledge in a proactive way. The procedures were amended 'in action' (Rigg 2008) and the data to inform this practice was collected by the team using professional diaries, based on what worked well and what needed to be amended. The data that was collected was discussed by the team initially in an intensive two-day meeting lead by two team members. I (as QPSA Director) attempted to ensure that all voices were heard and robust debate was encouraged (Mead 2006), albeit in a 'positive' tone. The practice procedures were amended based on this work, providing an ethos of both CAL and continuous improvement within the team (Revans 1998; Reynolds 2011). This process of evaluation was repeated after each of the first six audit cycles, and again repeated at the end of the first year of the QPSA team's existence; based on the collective experience of the team in practice.

The QPSA team practiced the ethos of a 'second pair of eyes' and we adopted this approach of two auditors for each audit. This required team members to consider evidence separately in the first instance and to critically evaluate their interpretations of reality via a reflective log. These reflective logs of practice were used by the auditors to reflect on how the audit procedures could be applied and adopted from another jurisdiction, in this case from the NHS to the HSE. The NHS Standards and Procedures (Appendix A) were focused on financial and human resource legislation thus the audit team needed to transfer the relevant aspects of these standards and procedures to clinical and social service policies and guidelines. Individual logs helped to identify relevant aspects of the NHS criteria in the HSE context, and considered its potential impact on clinical and social care standards and guidelines, in the practice of a quality patient safety audit. These logs were submitted and reviewed by QPSA procedure sub group leads to extract the learning prior to each team workshop. The team then discussed their individual insights as a collective in order to establish a final 'truth' to be mutually agreed among all team members.

This multi-layered approach and underlying individual-team process was carried out over a number of audit cycles. This allowed members to act as practitioners who were not simply problem solvers but also researchers, critically examining their practice. The use of Reynolds (2011) and Rigg's (2008) insights were useful here as they provided a base for each team member to consider whether we were being *attentive, intelligent, reasonable and responsible"* (Coghlan and Brannick 2010, p. 23) in our efforts as both researchers and practitioners. Robust debate was encouraged in the QPSA team and the

individual audit sub-teams and where agreement was not reached, either myself as Director or another member of the wider team was consulted in pursuit of consensus.

The team were also encouraged to look beyond the technical and organisational aspects of presenting problems, and to use this engagement as a means for raising social, political and cultural issues, questioning purpose and intentions and, if necessary, challenging the assumptions and 'taken-for-granteds' on which organisational policies and practices are based (Reynolds 2011). As auditors needed to be very explicit as to what evidence would consist of, they needed to pose questions that prompted people to ask the questions of themselves and others concerned with the area being audited. The formulation of these questions raised the awareness of the need for services to work collaboratively to provide the evidence required by the QPSA directorate and to prompt implementation of changes/ improvements when necessary. Of note is that a number of audits were closed (i.e. they were not able to proceed) as these was no evidence that audit guidelines had been implemented. This was a finding in itself and prompted action concerning governance and accountability at all levels in the studied organisation. Finally, team members were reminded of the absolute necessity of only signing an audit report when you personally understood it and when together the audit team was satisfied as to the report's integrity. This approach helped develop QPSA team member skills of inquiry for their audit work. Each member also became more aware of, and responsible for, their role.

Working together in this way exposed standards by which the team could work and also exhibited a team 'norm': that the team could only deviate from these criteria by consensus in subsequent team interactions. In this way, the team engaged in a process of collective inquiry through which the team could evolve into a COI. Furthermore, the team of auditors, in forming and developing a new service and a new code of practice using a model from a different speciality, were setting out to build theory from practice. I was informed in this approach by the literature. These activities are founded in Coghlan (2011) and Rigg's (2008, 2011) perspectives who state that, from their experience of action learning, what is paramount in creating knowledge is the quality of the conversation and the interaction that it creates among the learning cohort. These authors suggest that the move from individual insight to collective action involves both a focus on the whole rather than the parts and the forms of conversation in order that learning may take place. When this AL approach was adopted in the practice of audit in

the QPSA team it placed *"the emphasis on people learning through close involvement with real managerial situations"* at individual, sub-team and collective level and by doing so supported the team's incremental emergence from distinct CAL-induced experiential learning cycles into a COI.

3. EMBEDDING CRITICAL ACTION LEARNING IN AN EVOLVING COMMUNITY OF INQUIRY

It is important to remember at this juncture that the QPSA service was developed to fill an assurance gap for clinical and social service at corporate governance level in the studied organisation. Therefore, CAL's core purpose was to facilitate co-generation of knowledge to inform the evolution of the team into a mature COI and externally to continue to embed the service in the corporate governance structure of the organisation. Of note here is that while audit was the main responsibility of the team, each QPSA team member also had additional roles. These roles included proof-reading, financial management, data base management, a continual education group and a communication group including website and template design and an information resource for the QPSA. Finally, we also liaised with outside experts who provided support for the team.

Having honed the ethos of inquiry in the initial year of team engagement, the team needed to continue to embed the audit service in the business of the organisation in the subsequent audit cycles. This required working internally with the audit team as a COI using critical action learning (CAL) as the catalyst. Nevis, Di Bella and Goulds' (1995) definition of organisation learning was useful here as my goal in year two was to provide *"the capacity or process within an organisation to maintain or improve performance based on experience"* (p.5). In line with our working practice, we started year two with a two-day session to evaluate our performance in year one and plan for year two. We completed seventeen audits in year one, so we first reviewed the experience of the auditors in undertaking these audits. We used the AR empirical method of '*attentive, intelligent, reasonable and responsible*' (Coghlan and Brannick 2010, 23) action to frame these discussions to which is added the responsibility when we seek to take action (Coghlan 2012). Our goal was to co-generate knowledge to inform the parallel processes of evolving into a mature COI and as a way of working in the practice of audit. Therefore, I attempted to ensure that all voices were heard, applying the same method as described earlier (Mead 2006). The procedure document

(Appendix A) was amended based on individual insights, with reference to their practice reflective logs, thereby drawing from their experience and understanding. We also attempted to reach agreement by using our collective judgements on these insights to amend procedures.

Informed by my experience in year one, I continued in year two to piggyback on the mature assurance process for financial governance within the studied firm, collaborating with the finance personnel. As I was working to position clinical governance alongside financial governance, I was informed and encouraged in this by the work of Scally and Donaldson (1998, p. 61) who state that

> "*The resonance of the two terms is important, for if clinical governance is to be successful it must be underpinned by the same strengths as corporate governance; it must be rigorous in its application, organisation – wide in its emphasis, accountable in its delivery development in its trust, and responsive in its connotations*"

Scally and Donaldson's (1998) perspective is reinforced by the work of Balding (2008) and Braithwaite and Travaglia (2008) each of whom found that by positioning clinical governance as a key area of health service corporate governance with all attending accountabilities and legal ramifications, organisations are slowly cementing corporate accountabilities for clinical care. This collaboration led to an integrated approach to the controls assurance process. Additionally, by providing managers with the assurance they required to demonstrate good clinical governance and to sign the controls assurance statement[12] as required by legislation; this demonstrated the absolutely necessity for QPSA and the audit team to exist as an assurance service.

My continued use of the AR method of 'constructing, planning action, taking action and evaluation' informed by 'our experience understanding and judgement to inform our actions' (Coghlan and Brannick 2010) was helpful at this stage of the COI evolution. Members were encouraged to think creatively and question ways' of working, taking an 'attitude of inquiry' (Marshall and Reason 2007) which was not something that team members were usually encouraged to do as employees. As Director, I needed to tap into all the team members' knowledge and seek to motivate an inquiring community to listen, share, learn and persuade (Brom 2000) and in this I concur with Senge (1990,p.

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[12] Service managers are required by legislation to provide assurance on finance and human resources to the chief accounting office when signing a statement of internal control (Health Act, 2004, S34).

4), it is not possible "to figure it out from the top". In my role as an insider action researcher (IAR), Maguire (2001) advises that participatory research is about the "right to speak". I needed to ensure that members understood that they had the right to speak, but in doing so I found that in withholding my own opinion to allow space for other team members to speak, I forced the other to carry the burden of speaking or acting, a challenge anticipated by Chataway (1997, cited in Maguire 2001). I also found that there were members who initially did not feel comfortable or wish to speak out and share their views in a team environment, but shared in differing ways i.e. written feedback or in direct feedback to inquiries.

As the COI matured moving from *uncertainty to certainty* and as each member gained confidence and 'voice', this empowerment created considerable tension in the group. Each team member had very differing experiences and backgrounds, and this presented its own challenges as anticipated by Maguire (2001) - before you can expect to hear anything worth hearing, you have to examine the power dynamics of the space and social actors. I was encouraged by Rigg and Trehan's (2004, p.150) premise that: "*tensions, contradictions, emotions and power dynamics inevitably exist with groups*". I realised that I needed to manage these emerging power relations and their impact on both CAL and the COI. These were somewhat compounded by underlying tensions, inter and intra-personal conflict and negative emotions; as differing previous experiences lead to differing "*understanding of what happened, how we made sense of what was happening and what we would do about it*" (Coghlan and Brannick 2010, p.23). The nature of this shifting dynamic challenged me and I needed constant renegotiation to survive in my dual roles as IAR and as an Executive accountable and responsible to deliver a quality service within strict timelines.

Noteworthy were the tensions and conflicts arising from differing grade and negative influences. I constantly emphasised that all members were equal but the reality was there were different grades, with differing pay scales and very varied experiences; these grades did not necessarily represent individual competencies but were legacy from previous differing management structures in the organisation. Vince (2012) was useful here as he points out that we are not equal in CAL sets and "*that if we continue with this fantasy, then we will never be able to engage with differences that make a difference*" (p.217) in accepting this reality. In practice I was still able to ensure all voices were heard and all inputs into discussion were considered but that some would play a bigger

role based on their previous experience, skills, attitude and education. Furthermore, I could not, and would not, ask those on lower grades to take on the same duties and responsibilities as more senior grades, however they volunteered to do so based on their previous experience and expertise. This proactive approach went some way in reducing the grade hierarchy, thereby leveraging the power of individualism as the team worked together to address challenges as they arose (Shields 2003). Therefore, we all learned that through exploration of tensions or the *"grit in relationships"* (Willis 2012, p. 175), engaging with the contradictions concerned with CAL has the potential to improve its impact and effectiveness (Vince 2012).

On a separate note, negative emotions partially propelled by fear were repeatedly voiced by some members: *"what if we get things wrong, we could lose our credibility and individual reputation"*. These sentiments began to undermine the team confidence and were difficult to manage in my roles as manager, facilitator, IAR and as an individual. The dilemma for me was to allow voices to be heard, while accepting that these voices are influenced by their previous experience (Vince 2012). Some meetings were very difficult and I feared at times that this negativity would undermine the whole team structure and that I would lose members and not deliver the audits required, in essence that the project would fail. I found adopting a spirit of critical optimism (Shields 2003) of value in context. In an attempt to move this issue forward, I was encouraged by Russ Vince's 2012 work on CAL where he points out that

> *"CAL seeks to reveal how power relations are part of action learning.*
> *... and that CAL is not only on the empowerment of the individual*
> *learner but also on the various ways in which learning is supported*
> *avoided and prevented within sets and in organisation through*
> *relations of power"*(p.215) .

I realised that I needed to create a safe environment (Shani and Mitki 2000) for the audit team by *"providing support and encouragement for learning norms that reward innovative thinking and experimentation and that legitimises making errors"* (p.912). For members to feel safe in disclosing issues and mistakes, I sought to provide a sense of confidence that others will not reject or punish them for speaking up (Edmondson 2002). To achieve this I needed to have members trust me to support them when they made errors accepting that mistakes were an inevitable part of this process. I persisted in my behaviour, vocal motivation and interactions with the team, to demonstrate to the team that this was a service engaged in inquiry, mirrored both in the audit process and

in the team interrelationships. As Webb (2000 p.519 cited in Shields, 2003) stated "the knowledge yielded by this process - is not infallible, simply the best currently available", thereby offering the team solace that we provide 'reasonable assurance'[13]" in our auditing.

In an attempt to gain a greater level of comfort with and trust within the team, I sought to provide a means through which we could get to know each member better. As I had to meet with all auditors individually as part of the performance management process, as required by the organisation for senior grades, I included all team members as part of the process. We discussed *"What was good for them as part of the team? What they needed assistance with? What were the challenges for them if any?"* We also considered *"areas for development and what they expected of me, and what I expected from them?"* These meetings did appear to help individuals move on from their uncertainty and gave me a good insight into the differences between team members and the need to maintain these differences for the benefit of inquiry. In a sense, this exercise promoted   *"a shared belief that the team is safe for interpersonal risk taking"* (Edmondson 2003, p. 3). Members did make mistakes and I did support the individual auditors when the need arose. This action and reaction helped team trust and confidence grow over time and as we reflected on these experiences we learned and matured as a COI. I learned to engage with the differences and not to *"overemphasize togetherness"* - we are not all the same in doing this and I needed to ensure that I am not controlling members as I pretended to facilitate them, avoiding conflicts and differences that make change happen (Vince 2012).

I also found that I needed to balance my passion and avoid dominance where others dare not offer their own opinion (House and Howell 1992). Recognition that all team members need to have voice and be heard even if what they have to say makes me, and others uncomfortable had to occur as *"if you try to control this it will get in the way of the learning"* (Vince 2012, p. 218). Therefore, despite severe financial constraints, which curtailed the team's ability to meet face to face, we conducted teleconferences where each audit team presented their 'learning' from the previous audit and circulated slides in advance. The teleconference provided for team discussion and agreement on the '*so what*?' for the presenting audit team, offering a useful exercise for team learning.

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[13] "Reasonable assurance is less than absolute assurance. The objective of a reasonable assurance engagement is the reduction in an assurance engagement risk to an acceptable low level…as the basis for a positive form of expression of the practitioner's conclusion" (IFAC, 2005, 127).

While managing this evolution as COI facilitator, I concur with Shields (2003) who found that it is important for managers to keep the big picture in mind as the inquiry proceeds and to be a mediator in order to build bridges between differing points of view and differing references in the practice. Over time the team moved through several cycles of audit and gained confidence in taking an 'attitude of inquiry' as auditors. While this was often 'painful work' (Coghlan 2011), the negative voices eventually subsided as the actions demonstrated the positive side of CAL in practice.

4. REFLECTIONS ON KEY FINDINGS

In developing this team of auditors there were many challenges in the first twenty eight months of existence, the duration of the IAR study. The most significant of these were recruiting, establishing and embedding a new service in an organisation at a time of severe financial restraints and service cuts to front line services. The QPSA function was recruiting an expensive and expert staff resource and needed to very quickly demonstrate 'added value' to the observed healthcare organisation, both at corporate governance level and at the service levels who lost staff and budget to this initiative. This demand for immediate practical outcomes put considerable pressure on the quality of the inquiry and on the time needed for the QPSA team to evolve into a COI. This resulted in a number of competing demands; I needed to produce the agreed number of completed audits to deliver on our key performance indicator and to balance this with the quality of our team activity and the resultant audits, which in turn depended on the quality of our inquiry. This in effect meant that our sense of quality needed to reach wider than *does it work?*

I also needed to consider progress towards an effective COI (Reason 2006) in our QPSA activities. Insight into whether questions of power were being addressed, whether the inquiry had been liberating, and whether it offered evidence of deepened experiential understanding (Rigg 2008) were required. These challenges demanded that the team apply 'practical knowing' (Coghlan 2011) in their interactions, thereby encouraging us to consider experiential learning cycles (Kolb 1984) in context. Each cycle engages with concrete experience, before the learner reflects on that experience and considers the learning therein (abstract conceptualisation) after which they actively experiment with this new learning in future action. Although Kolb (1984) considered individual learner cycles; team members worked on audits both individually and

collectively in this study using the procedures they had previously seen work in practice (Dixon 1999), an experiential learning approach underpinned by an action learning ethos (Coghlan and Pedler 2006; Revans 1998). Auditors also considered what they needed to change following each audit experience and this was shared with the QPSA team at meetings and on teleconferences. Over time, members' experimental interactions provided new ways of thinking, talking and inter-relating, which in turn brought new ways of organising into being (Rigg 2008); thereby creating a work environment within which experiential learning could flourish. Furthermore, the procedure document and practice was subsequently amended based on team insights, a cycle which developed our own theories in practice regarding both quality and performance standards (Revans 1998).

This knowledge sharing was both transformed into a new audit procedure and into the practice of the team and this 'knowledge in action' informed the team and the services, who each benefited from the team interventions and insights. Shani et al. (2012) point out that these activities eventually occur within a COI as it seeks to know the issue from within its own perspective. As the team gain confidence through completion of progressive learning cycles (Kolb 1984) built on the principles of CAL, this collective inquiry is also achieved together with other communities (for example the clinical and social services that were audited) as they jointly explore meaning, develop shared strategies and ultimately act as a collective COI. This approach provided interconnectivity between knowledge and action (Dixon 1999), leveraging prior learning in iterative team activities and acknowledging the fact that not only is individual learning *"dependent on the collective"* but the collective is *"dependent on the individual"* (Dixon 1999,p. 41). In doing so, it offered a means to address the joint challenges of producing an audit product (that is, the number of 'audits completed') while simultaneously protecting the ethos of a quality inquiry in the observed environment. Of note is that the professionals who were recruited to join the observed audit team have had to continuously redefine their role in response to the QPSA objectives, thereby mirroring the experiential learning cycle (Kolb 1984) in action. This team is also giving 'voice' to each member (Mead 2006) and, as part of the practice of auditing, are in turn giving voice to the services being audited. The observed organisation also gained from parallel processes as both a source of learning about organisational issues as well as a site to experiment with new audit practices, similar to the AL gains highlighted in Rigg's (2008) work.

Of further relevance is the fact that team members joined the audit team in a state of uncertainty and doubt, and needed to be moved to a state of certainty, or 'belief', as part of the process of emerging as confident auditors co-existing in a community of inquiry. Both Peirce (1839-1914) and Smith (1983) reinforce this trajectory, arguing that between doubt and belief lies inquiry. As the community in this case is the team of auditors and the inquiry is the methodology for team interaction; the practice of audit required team members to develop skills of inquiry and apply them in practice. This proved difficult and required considerable change for some members and in many cases, resulted in deep learning (Argyris and Schön 1974). This process is on-going and will need to be approached using different learning mechanisms depending on the observed impediment, although learning has been achieved through team interaction with members of the services that they audit, thereby applying new ways of organising through changing patterns of interacting (Rigg 2008). The team also sought to create knowledge, and learning, for the wider organisation. Consequently, establishing team knowledge transfer processes was an essential step in the inquiry process and corresponded to what Peirce termed 'communities of inquiry'. This approach also adopted a pluralist learning approach based on multiple perspectives (Kolb 1984, Dixon 1999), which the team sought through interactive engagement within and outside the team - ultimately facilitating the emergence of a QPSA 'community of inquiry'.

5. CONCLUDING REMARKS

The aim of this paper was to discuss an IAR project concerning the creation and evolution of a quality patient safety audit (QPSA) team in a healthcare organisation over a twenty eight month period. It sought to document how the team was initiated and how it developed in the practice of audit. This record tracks how I, as practitioner researcher, created the conditions to facilitate the emergence of a community of inquiry over time. Initially, relevant generated knowledge was transformed into the product, 'audits completed' and the team achieved the QPSA service objectives within the organisation. By year two, the QPSA team was well established in the organisational setting and was perceived as a professional team of auditors.

As the COI matured, we used CAL as the catalyst to generate knowledge and learning to support the move from uncertainty to certainty and embed the QPSA service in the studied organisation. This was a difficult process as we navigated the impact of

political dynamics, and the emotional dynamics of learning, as we are not separate from the organisation in which we work, we need to survive and produce audits. This also required that I continued to work on the corporate governance assurance process and the QPSA director role in providing the assurance for clinical and social services. In using CAL we were also developing as leaders (Rigg and Trehan 2006). In this study a number of team members have developed leadership skills. In considering succession, these individuals have the potential to be future Directors of this (QPSA) and other teams, in the event that I am required to move to another area. I am confident one of them will lead the team as a mature COI and continue to use CAL to improve on the work to date in cycles of AR as quality improvement cycles.

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APPENDIX A: NHS PROCEDURES DOCUMENT (EXTRACT)

The following extract relates to the HSE procedure[14] of Auditing Practice for Quality Patient Safety audit. This document adopted the NHS Internal Audit Standards[15] as a baseline of inquiry and the studied audit team subsequently developed an adapted version in their application of auditing standards. This adaptation has been refined to the needs of the HSE audit function through six AR cycles over the research-led programme of engagement (2010-2013).

QPSA Service: Procedure for Conducting a Quality and Patient Safety Audit (extract)

Document reference number	QPSA003	Document developed by	Quality and Patient Safety Audit Team
Revision number	6	Document approved by	Director of Quality and Patient Safety Audit
Approval date		Responsibility for implementation	Quality and Patient Safety Audit Team
Revision date	28th May 2013	Responsibility for review	Quality and Patient Safety Audit Team

Policy Statement

The Quality and Patient Safety Audit (QPSA) provides assurance to the National Director Quality and Patient Safety, by auditing the degree to which standards for health and social care activity are met across the system. The audits identify reasons why they are not met and make recommendations to implement change and achieve the required standard/best practice.

Purpose

The purpose of this procedure document is to provide guidance for all auditors on how to successfully complete QPS audits. It provides a standardised methodology which will help facilitate the consistency and reliability of the audits conducted by the QPSA team. All QPSA staff have familiarised themselves with the procedures herein.

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[14] www.hse.ie/go/qpsa
[15] https://www.gov.uk/government/publications/nhs-internal-audit-standards

Scope

This procedure is applicable to the Director QPSA and the QPSA team.

Legislation

This procedure document complies with the following Acts:

> ➢ Data Protection Act 1988 and 2003

> ➢ Freedom of Information Act 1997 and Amendment Act 2003

> ➢ Health Act 2004

Glossary of Terms and Definitions

These include definitions for Assurance, Reasonable Assurance, Audit, Criterion, Guidelines, Policy, Procedure and Protocol.

Roles and Responsibilities

Details relating to the role of Director, Lead Auditor, Auditor, Expert Adviser, Service User are included in the guidelines.

QPSA Audit Procedures

This section consists of the core procedures for undertaking and delivering a QPS audit efficiently and effectively. This document is supported and enhanced by QPSA templates and guidance referenced throughout the text. The section is sub-divided into three key areas:

- Audit Planning

- Audit Fieldwork

- Audit Post-Fieldwork

PAPER 4

PREFACE

This paper reflects on the team insights gained from establishing a QPSA team created to fill an 'assurance gap' for clinical and social services at corporate level in a national healthcare organisation.

A multi-layered approach and underlying individual team process was established where team members first considered audit evidence separately in their role as auditor before discussing their individual insights as a collective team. Each member also critically evaluated their interpretations of reality via a practice reflective log and collectively explored team tensions, as each member gained confidence and 'voice' (Deter and Burris 2007). Thus, having created a safe environment for the team to evolve into a COI, a cyclical approach of taking action and learning from interpreting the consequences ensued (Kolb 1984) underpinned by a team-based 'attitude of inquiry' (Marshall and Reason 2007). This approach ignited transformation dialogue and actions and facilitated individual and team resilience when completing audits.

The forthcoming paper focused on the insights gained from each member, reflecting on the key findings resulting from the use of critical action learning (Trehan and Pedler 2011; Vince 2012) as a basis for team learning. Of note is that the findings from each AR cycle were fed back directly into practice with the aim of bringing about change (Somekh 1995) and this aspect of the IAR study is reflected in the forthcoming paper.

Following completion of this 28-month IAR study, QPSA reflections were gathered by an external facilitator whom I invited to work with the team with their permission. By including the insights of the team members reflecting on their experience as a member of this audit team, it adds richness and validity to the reflection on the findings. At our next meeting, I outlined the methodology of how the facilitator and I worked on the prompts for the team, based on my findings to date as an executive and IA researcher using a CAL ethos as we moved to a mature COI. Sustaining this collective ethos, I presented a brief 'look back' that focused on the highlights and significant events from QPSA inception to current status, and our contribution to the organisation to date. I found this to be an emotional experience as I had also experienced the emotions and tensions as part of the evolution of the team from inception into a mature COI. In doing so, I opened up to my own purposes, assumptions and sense making, and patterns of

action to reflection in taking an attitude of inquiry (Marshall and Reason 2007; Coghlan and Brannick 2010).

When reflecting on the team culture, we each needed to consider the incumbent culture of a grade hierarchy and professional differences in the QPSA team. I wanted members of the team to engage with the facilitator process and reflect and answer the prompts honestly and openly. Therefore I needed to lead by example in striving to develop a 'favourable voice climate' within the team and to apply the values of participatory action research to myself during this reflective process. In my absence, team members considered the prompts together with the facilitator and responded by email in confidence to the facilitator. These reflections anonymised by the facilitator were forwarded to me and by request from the team, I subsequently circulated these reflections to the team and we discussed them at our next meeting.

This paper presents these team reflections under '*creating an audit team*', '*vision*', '*the right to speak*' and taking a '*critical action approach in the practice of audit*'. I reflected on the team reflections as they provided insights to '*building a favourable voice climate*', the different way people communicate, the apparent influence of '*taking an attitude of inquiry*', the need for a '*participatory worldview*' when pursuing a COI' and a reflection challenges this approach created for the team. We reflected on these themes as a team and agreed actions to progress as an embedded COI in the future. We also agreed that while it was a useful exercise, we now needed to act and move on.

The paper goes on to consider my roles as an IA researcher, reflecting not on what I did but why I did it. My dual role in this study was based on my learning (first person), as the audit team leader (second person). I also considered my experience as part of a doctoral programme in working with my supervisor which provided outsider-insider collaboration which brought another perspective into the dialogue (Coghlan 2007). When the establishment of the QPSA team became a research project, it addressed a wider academic audience (third person) through presentations at colloquia (Dunne 2012) and the DBA cumulative paper series; and in preparing papers for submission to academic journals (Dunne and Kelliher 2013), thus the IAR project needed to be more than just problem solving in a single environment.

This paper and underlying reflective practice documented within (Cunliffe 2004, 2013) has afforded the team and I the value of insight in the final stage of AR cycle, that of reflection. Therefore the reflective process documented in this paper sought to guide the team reflections in order to look at our collective experiences over the previous twenty-eight months and to check the learning set against our plans and objectives. Notably, I am reticent of Reynolds (2011) and Vince's (2012) cautionary tales that in using critical reflection there is a darker side that we need to be aware; we found we were not all equal in the observed 'learning set' due to 'grade hierarchy' and how we use 'voice' in collective team environments.

As I complete this IAR project, the QPSA team is now embedded in the organisation as an assurance function for quality patient safety. The knowledge that has emerged from this study and the learning therein has the capacity to be actionable, that is at the service of both academic and practitioner communities

Learning in Action: Creating a community of inquiry in a Healthcare Organisation

Reflections

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ABSTRACT

This paper reflects on the researcher and team insights gained from establishing a Quality Patient Safety Audit (QPSA) team, created to fill an assurance gap for clinical and social service at corporate governance level in a national healthcare organisation. Using Insider Action Research (IAR) as a methodology when establishing the QPSA audit team project; the main focus of this paper is on the knowledge and learning emerging from this team and its evolution into a community of inquiry (COI). Following completion of this twenty-eight month IAR study, QPSA audit team reflections were gathered by an independent facilitator as part of the reflection process and these reflections, along with those of the IA researcher are reported in this paper. By including the insights of team members reflecting on their experience as a member of this audit team, it adds richness and validity to the reflections on the findings. The paper goes on to consider the IA researcher role, an activity that involved stepping back from the process in order to reflect 'not on what I did, but why I did it'. Finally, the paper focuses on how and why the team learned within each AR cycle.

1. INTRODUCTION

This paper reflects on the insights gained from establishing a Quality Patient Safety Audit[16] (QPSA) team, created to fill an assurance gap for clinical and social service at corporate governance level in a national healthcare organisation. The main focus of this twenty-eight month insider action research (IAR) study is on the knowledge and learning emerging from this team and its evolution into a community of inquiry (COI) via the application of a learning set to generate knowledge in the new team. The aim of the research was to:

> Study the learning that was generated internally by establishing a quality patient safety audit (QPSA) team in the observed healthcare organisation, underpinned by a critical action learning ethos.

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[16] The QPSA title is based on the 'Quality Patient Safety Directorate' in which the team reports to the National Director (the author) and also describes the function within the remit of patient safety and quality. This is a new service, similar to Internal Audit, to provide assurance in Clinical and Social services.

The underlying objectives were to;

1. Track the QPSA team from establishment;
2. Explore the elements, influences and barriers that inhibit or promote critical action learning;
3. Contemplate the tools of voice as a means of generating a community of inquiry;
4. Observe the evolution of a community of inquiry in the practice of audit;
5. Consider the dual role of practitioner researcher.

As an insider action researcher, I[17] have dual roles in this study; one is my professional role as QPSA Director, where I had responsibility for the design, recruitment, establishment and management of this audit team, while the other is a research role where I am carrying out this study as part of a professional doctorate.

Established over a four-month period, the QPSA team consists of 16 individuals who came from different functions based in geographically spread locations within the studied healthcare organisation. These individuals have varied professional backgrounds, experience (both clinical and administrative/ management) and levels of seniority. The team's key objective is *"to provide independent internal assurance, for clinical and social services, to inform decision making as part of the quality improvement process"* (QPSA procedures document 2013) while the initial focus was to pursue compliance with clinical governance policy and guidelines and a requirement for clinicians and managers to sign a 'Controls Assurance Statement'. Using their learning from a customised on-going training programme based on internal audit practice and standards, the team created new knowledge that was grounded in real issues concerning patient safety. A multi-layered approach and underlying individual-team process was established where team members first considered audit evidence separately before discussing their individual insights as a collective. They also critically evaluated their interpretations of reality via a reflective log, and collectively explored team tensions as each member gained confidence and 'voice' (Deter and Burris 2007). Thus, having created a safe environment for the team, a cyclical approach of taking action and learning from interpreting the consequences ensued (Kolb 1984), underpinned by a team-based 'attitude of inquiry' (Marshall and Reason 2007) which ignited

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[17] As an action researcher I, as author, propose speaking in the first person as is accepted convention when applying this methodology.

transformative dialogue and action and facilitated individual and team resilience when completing audits.

The remainder of the paper focuses on the insights gained from each member of the team reflecting on the key findings resulting from the use of critical action learning (Trehan and Pedler 2011, Vince 2012) as a basis for team learning. I considered the research design from this perspective as it offered *"an approach to development that puts the emphasis on people learning through close involvement with real managerial situations, using all the resources available to understand them, taking action in those situations and learning from interpreting the consequences"* (Trehan and Pedler 2011, p. 2). Thus, critical action learning (CAL) acted as the catalyst to promote the generation of knowledge and inform the incremental evolution of an audit team into a COI. Following completion of this IAR study, QPSA audit team reflections were gathered by an independent facilitator as part of the reflection process and these insights are discussed below. The paper goes on to consider my role as an IAR researcher, reflecting not on what I did but why I did it. This activity involved me stepping back from the process in order to reflect on how I used AR as a methodology when establishing the QPSA audit team project, when encouraging inquiry therein and when pursuing my research study. Finally, the paper focuses on how and why the team learned within each AR cycle.

2. FACILITATING PROJECT REFLECTIONS

Reflecting on our findings, we, the audit team, generated practical knowledge and 'situational understanding' (Dreyfus 1981) in how we overcame challenges in practice and how we found workable solutions. As an IAR project underpinned by a CAL ethos (Coghlan and Pedler 2006; Revans 1998), we pursued AR cycles of *"constructing, planning action, taking action and evaluating action"* (Coghlan and Brannick 2010, p.10) when embedding QPSA standard practice. Thus, the findings from each AR cycle were fed directly back into practice with the aim of bringing about change (Somekh 1995). As part of our practice, at the end of the AR project, the QPSA sought to reflect on the experience, using the stages within the experiential cycle (Kolb 1984) to guide team reflections and look at our collective experience over the past twenty eight months to check these reflections against our objectives, plans and actions.

To facilitate true reflection, we needed to tap into each team member's experience and knowledge of the project, in order to motivate an inquiring community to share, listen and persuade (Brom 2000). Therefore, following completion of AR cycle two (project cycle three) I elected to offer all team members *"time and space to speak"* to share their views and opinions confidentially in order to *"examine the politics that surround and inform organizing … [and] to question these political choices and decisions, both consciously and unconsciously"* (Rigg and Trehan 2011, p.74). I invited an external facilitator to work with the QPSA team, with each member's permission. I shared my research findings to date, the team's procedure documents and an end of year report with the facilitator. The facilitator drafted a set of questions for the team meeting based on this information (appendix A) which she and I amended in discussion. At the subsequent team meeting, I introduced the facilitator to the team, and I presented a 'look back' that focused on the evolution of the team from its inception, highlighted the significant events that occurred throughout its existence and outlined insights and findings based on my experience of leading the team. I found this to be an emotional experience, as I spoke honestly and openly to the team. I reflected on my own experiences and articulated what each one of the team had achieved, as they moved from uncertainty to certainty (Shields 2003) and gained confidence to fill the assurance gap. I also spoke about how significant a contribution that the COI had made in the organization over that time.

When I had completed my presentation I left the room and the facilitator, who was present for my presentation, spoke with the team and shared the questions we had prepared (appendix A) and asked them to individually reflect on these. Subsequently, the facilitator emailed that: *"they* [the audit team members] *really studied the questions and stated they were happy with them and requested an additional question be added to the list."* Members had also *"demonstrated the ability to critically analyze their practice and to make the necessary amendments to move forward, even when they found it uncomfortable to do so"*. The questions were then sent to each team member by email and responses were to be returned to the facilitator, who *"reiterated to them that their comments would be totally anonymous unless they choose to identify themselves"* (facilitator comment). Thirteen members completed the anonymous questionnaires, the results of which were collated and circulated to all team members.

3. TEAM REFLECTIONS

Reflecting on the creation of the audit team, members commented that while *"starting a new service would be challenging and difficult"* it proved to be *"ambitious but achievable"* and ultimately *"very progressive and very innovative"*. Members remembered being: *"excited as we would learn and grow together"*, although one member commented that *"in hindsight I am not sure I fully understood that we were starting from scratch when I agreed to join"*. Further insight can be gained from the general consensus that those who chose to join were *"very willing to take the risk"*, suggesting a positive attitude towards the goals and objectives associated with the proposed QPSA audit team.

The feedback from the team session suggest members' felt they had a right to speak (Maguire 2001): "[I] *speak openly on issues I have thoughts on"; "I feel I can debate and voice my opinions and have* [done so] *in reviewing evidence and writing reports"*. This approach appears to have created a favourable voice climate (Morrison 2011, Deter and Burris 2007) where members *"feel my voice is heard"* and that it is heard "... *as part of the team process"*. It was also noted that the team Director *"has created an environment wherein all voices are heard"*. Comments such as *"voice is openly facilitated"* and *"I feel members of the team are given many opportunities to voice their thoughts and opinions openly via meeting,* telecoms *or privately"* suggest that many individuals are skilled in this area of voice activation (Deter and Burris 2007) and many are able to assist those who are less confident in speaking out. While most agreed that *"all are able to give their views and are listened to"*, one team member noted that *"there is a distinct difference between one's voice being heard and one's voice being heeded"*. Thus, how team members choose to use their voice and how what is said is treated was important as it was necessary to produce the knowledge to inform the quality of the audit process.

The CAL approach also appeared to empower team members at a deeper level, and enabled them to see that they were capable of constructing and using their own knowledge (Freire 1970; Reason 2006) as the process *"enhances skills I already had"*. They also noted that this knowledge acquisition would assist in the development of individuals as skilled auditors and benefit their future careers: *"I have learned much ...*

and continue to learn with each audit" and that *"the experience ...will be valuable to me in any post I hold going forward"*.

As QPSA Director, I was guided by Marshall and Reason (2007) in taking an attitude of inquiry that allowed for *"people's right and ability to have a say in decisions which affect them and claim to generate knowledge about them"* (p. 373) and this approach appears to have influenced audit team engagement: *"I have certainly learnt many things from my colleagues"*, an approach that proved to be a unique experience for some members *"the DQPSA has delivered a participatory management style that I have not encountered in real life"*. This in turn motivated an 'inquiring community' (Brom 2000) to share, listen and persuade: *"I have developed my own personal skills of inquiry"*. This may sound simple, but in practice, this required a number of different approaches which proved quite complex and demanded considerable time and attention to keep building a 'favourable voice climate' within the team, which was still very dependent on individual temperament: *"this is partially due to my own personality"*. The variety of approaches increased complexity, with one auditor reflecting *"Sometimes I feel I am too vocal and caution myself to listen"* and another cautioning that *"difficulties arise if individuals take 'robust debate' personally"*, resulting in a situation where *"it was easier with some individuals more than others"*.

While a participatory worldview was valuable when pursuing a COI, it also presented challenges for the team. For example, allowing space for other team members to speak and particularly to gain the confidence to reach collective agreement as is required in formulating audit reports was not always seen as a positive and there was a *"steep learning curve for everyone"*. There was also the view that *"Sometimes* [team Director] *should be a little more forthright when it comes to decision time. Perhaps in an effort to show that everyone's views are welcome, there has been reluctance ultimately to prefer one view over another"*. The possibility of 'too much voice' (Morrison 2011, p. 401) was also brought up in the reflections and members considered whether one could *"become overwhelmed and experience difficulty reaching consensus"*. They also contemplated whether one could devote too much time to considering new ideas or individual opinions and not enough to task performance: *"...while they* [team meetings] *often generate discussion we seem to find it difficult to come to any decisions"*.

When reflecting on the various ways we communicated (e.g. yearly evaluation and planning, monthly meetings and bi-weekly team teleconferences) the team acknowledged that while: *"teleconferences are the only mechanism for the team to communicate on a fortnightly basis"* and offered a channel to share personal stories and good news stories (Harper, 1987 as cited in Pfeffer and Sutton 1999), this also took *"time away from the business of auditing",* suggesting that certain team members saw this approach as *"fine in theory but not sure if it is the best approach to a discipline like auditing".*

Building on Morrison's (2011) view that high quality relationships with one's supervisor increases the likelihood of employees engaging in discretionary effort on behalf of the organisation, members of the audit team were encouraged to think creatively and question ways' of working: *"I do think challenging your fellow auditors is a good thing, as it makes us all 'think outside the box' and question ourselves and our practices".* Reflecting on trust building, the team acknowledged the value of responding to their queries in a timely manner (within 24 hours) and also commented on the fact that they had direct access to me as QPSA Director. This appears to have given individuals encouragement and confidence to speak up: *"Members of the team are given many opportunities to voice their thoughts and opinions either openly or privately with* [team director]". Furthermore, auditors were required to discuss individual insights as a collective in order to establish a mutually agreed final 'truth' to be included in audit reports, and this does appear to be translating into practice: *"QPSA has a fairly flat structure and is encouraged to make decisions on debate and team discussion";* "yes, *I feel I can debate and voice my opinions as part of the audit team".*

The CAL approach allowed the team to engage with the effect that the organisation had on the learning set. Specifically, as the audit team worked in the space of corporate governance and were required to make sense of the work within the existing culture of the organisation, the team reflected on: *"the reality… that audit is a huge cultural change in the organisation".* Some opinions concerning changing practice were not perceived by the team as something they had influence over: *"I believe that my voice was heard but it has been my experience that this made very little difference to how we went about our business".* There was also awareness within the team that the audit approach could impact policy beyond the organisation: *"Audits I was involved with precipitated the development of national policy",* setting an internal/ external

perspective on the audit function. There was also an awareness of the importance of engaging with the personalities at corporate governance level *"QPSA needs to be openly supported from the highest echelons* [or] *we cannot become fully successful"* and the need for support from the senior management team was also acknowledged: *"QPSA has a way to go yet in getting better buy-in from top management"*. Thus, CAL afforded the team an opportunity to examine the politics that surround and inform organising, to comprehend these politics, and to question political choices and decisions, both consciously and unconsciously (Rigg and Trehan 2011).

It is interesting that the honing of this attitude of inquiry has being underpinned by the responsibility for signing audit reports resting on individual team members: *"the fact that my name is published naturally make me more conscious to ensure I have been rigorous in my inquiry"*. Moreover the practice of me as Director of QPSA signing all audit reports appears to give some comfort to auditors that they are supported: *"Knowing some of the responsibility rests with the DQPSA takes a small bit of the responsibility off individual auditors"*. This offered balance, which ultimately afforded scope for team members to learn in action, which on reflection: *"is the only way that we can generate knowledge and progress a team and service"*.

4. REFLECTING ON THE REFLECTIONS

The team discussed the above reflections at our next face-to-face team meeting. A discussion ensued concerning reflections on *'grade hierarchy'* and members agreed that some tended to stand back and let more senior grades take the lead: *"There are a lot of senior grades on the team we are not all equal… sometimes this holds me back"*; *"some situations are difficult as I think come from more senior grades …and feel they have some residual managerial authority"*. This is of concern as it may impact on the quality of inquiry, particularly if *"the strongest voice wins in the end"*. It was agreed that we all need to work on this perceived imbalance within the team to ensure that grade differences did not prevent *'robust debate'* concerning evidence and final agreement by auditors on an audit.

The topic of *'voice'* then ensued and it was agreed that while it *"is very clear that everyone had the right to speak, but some chose to exercise this in a different way, rather than speaking out at the big team meeting"*. It was agreed that this was a useful

exercise, while specific outcomes included that we would seek to strengthen our mandate based on our success to date in providing assurance for clinical and social services, as *"we are now a functioning auditing team with a good repository of audits"*. It was also agreed that we would revisit our team values as the exercise incorporated a high degree of reflection of both the conscious and unconscious meaning of individual intentions and action and their impact on others (Somekh1995). Finally, we agreed to develop a 'house style' in writing reports, and to consider ways to celebrate our achievements to date. By including the insights of the team members reflecting on their experience as a member of this audit team, it gives them 'voice' in this research and add richness and validity to the reflections on the findings.

5. SELF REFLECTION AS AN INSIDER ACTION RESEARCHER

One of the central principles of AR is that "the initiator of the research *learns* about her / his own practice" (Winter and Munn-Giddings 2001, p. 25). Therefore, as an IAR striving for balance and rigour within the research, I needed to open up to my own purposes, assumptions, sense making and patterns of action to reflection. I also needed to balance my 'dual role' (Coghlan and Brannick 2010) as Senior Executive/ QPSA Director with that of IAR. It is worth noting that this research project began not as an academic question posed for the purpose of a research study but began with a question posed to me as a senior executive, from the board, *"Can you provide us with assurance that the assertions of senior management concerning patient safety and quality are in place?"* My response was *"No, I cannot provide this independent assurance",* at which stage I was directed to find the best way to provide this assurance. From the outset my approach was one of inquiry (Lipman 1991) therefore I began by seeking external advice from a governance consultant and the National Health Service (NHS)[18] Heads of internal audits. I visited the UK to work with auditors and view their procedures in action and was invited to learn first-hand how this team provided this assurance. This experience afforded me an opportunity to hear first-hand the practice insights from the auditors' perspective and from those audited at corporate governance level. This empowered me at a deeper level to reflect and make sense of how this learning could be transferred to our organisation, that it would involve challenging ends as well as means by *"posing questions that had implications for power structures underlying existing policy and practice"* (Reynolds 2011, p.12). It also gave me the knowledge to construct

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[18] The National Health Service is the UK equivalent of the Health Service Executive (HSE) in Ireland.

a business case for "*integrating theory, practice and research*" (Coghlan and Brannick 2010, p. 293). On my return, I made a business case to the senior management team and board in my own organisation to recruit a number of staff from within our own organisational services to train as auditors to pursue/ provide the sought-for assurance as based on my UK experience. This approach offered the greatest likelihood of successfully establishing an audit team. Thus, creating knowledge in terms of recruiting for and building this team was a practical affair, starting not from an interesting theoretical academic question, but from what concerned us in practice (Reason 2006).

Around this time, I was inaugurated onto a professional doctorate (DBA) programme and began to reflect on what I was doing and had done to date. As a practitioner, the practice of 'designing the plane while flying it' (Herr and Anderson 2005, p.69) was a normal way of working for me thus I was not consciously aware that I was integrating the dual aim of action (to inform change) and theory (Dick 2007), rather I was instinctively using this process to problem solve. Furthermore, I was using my experience, understanding and judgement to inform my actions, a process which equates to an AR cycle (Coghlan and Brannick 2010) considering I was reflecting, planning action, taking action and reflecting on this assurance challenge to plan further action. Thus, the value of the DBA was, and is, engagement with theory while considering improved practice.

Once the audit team was recruited and training was complete, the next goal was to create an environment where it was safe to speak up and make mistakes (Shani and Mitki 2000). I was drawn towards the concept of 'community of inquiry[19]' (Peirce, 1839-1914) when establishing the team's knowledge transfer process in order to allow for the 'free exchange of views and results' (Smith 1983, p.50). Reflecting on the team feedback confirmed my own suspicions - by giving team members the right to speak, it also put pressure on them to carry the burden to speak (Chataway 1997) therefore as QPSA Director I needed to balance this dichotomy. This was a challenge, the solution of which was informed by a number of writers who directed me to 'balance my passion [and] avoid dominance' in order to 'allow voice even if uncomfortable' (House and Howell 1992, p.82). The alternative was for my voice to be the main sound within the audit team and this control could 'get in the way of learning' (Vince 2012, p. 218). Therefore, rather than lead from the front, I needed to be a 'mediator to build bridges

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[19] Peirce used the term 'community' and 'inquiry' to refer to a group of individuals (most often scientists employing an interpersonal method for arriving at results).

between differing points of view' (Shields 2003, p. 227) so that the ethos of inquiry could be embedded in the team. This created some resistance as highlighted in the team reflections as some members felt I "*should be a little more forthright when it comes to decision time*". Although initially unexpected, I found that I needed to deal with negative emotions, which arose among some team members, propelled in part by fear of failure and loss of reputation. This finding was echoed in member comments, as evident in the team reflections "*there are certain individuals that constantly display negative tensions towards the team and the team dynamics*"; "*We have fairly strong minded individuals who can be fairly immovable if they are very set on a particular way of doing audit*". Engagement with these members required sensitivity on my part to build member confidence and ultimately their trust. Of note is that this approach curtails full discourse in this paper, in order to protect the fabric of anonymity unless team members choose to divulge their view in their own reflections.

As we used critical action learning (Trehan and Pedler 2011, Vince 2012) as the catalyst to promote the generation of knowledge within the team, we created a 'learning set' in which we set individual, team and organisational tasks and problems. While I acted as facilitator, the team were allowed to develop their own learning via problem solving and team reflections (above) highlighted some 'tensions, contradictions, emotions and power dynamics [that] inevitably exist within groups' (Rigg and Trehan 2004, p.150). At this point in time, the reality that "*we are not all equal in CAL teams*" raised challenges, particularly as grade hierarchy meant that members were paid differently and were at different levels in the organisation despite performing similar tasks within the team, a fact that did not go unnoticed: "*there are a lot of senior grades on the team and we are not all equal in this way even though we all do the same work*". The challenge also presented itself as one of power-dynamic where "*some people come from senior grades and feel they have residual management authority …to impose a view or opinion*" and "*certain members feel they are above you in grades they automatically take control*". This was a lesson to me as while the range of experience and backgrounds on the audit team provided context knowledge as required to audit across a range of services, it also brought its own challenges. Therefore, within the learning sets, we needed to engage with these differences and 'not overemphasis togetherness' (Vince 2012, p. 216), as 'before you can expect to hear anything worth hearing, you have to examine the power dynamics of the space and social actors' (Maguire 2001). Knowing that there may be residual power imbalance between team members due to their

respective grade in the organisation, I implemented a flat hierarchy, all reporting to me directly, in an attempt to create a 'democratic space' (Reason 2006).

In theory, this should have allowed auditors and those they audited to have 'equal voice', however adapting to this approach created tension in the group, as articulated by a more senior grade in the group, "*This has merits but it also created an environment where some team members find it hard to take direction* [from a lower grade]" despite the fact that "*junior staff who have skills far more suited to audit than senior member*" were on the team. I needed to proactively manage this power dynamic in order to work with the emotions and power as it influenced learning (Vince 2010, 2012) so that the COI could emerge.

As this dynamic evolved over the twenty-eight month project, I was encouraged by Rigg and Trehan's (2004, p.150) premise that 'tensions, contradictions, emotions and power dynamics inevitably exist with groups and individual managers lives'. In hindsight, these strategies and my participatory management style have gone some way in reducing the tensions resulting from grade hierarchy over time: "*the team do communicate differently in terms of getting their voice heard*". Approaching and interacting with members as equals also seems to have gained traction and members "*feel genuine acknowledgement that this is OK*". Thus, when engaging with a COI approach to audit performance, we will need to continue to manage grade hierarchy, its impact on team dynamics and its possible impediment to learning.

As this is an audit service and we are striving for quality in our audit process, we needed to pay attention to the quality of the process in 'taking an attitude of inquiry' (Marshall and Reason 2007) as required in practice. Equality of voice and attitude of inquiry are essential elements of the audit process to address the problematic situation of evaluating evidence and formulating an opinion in agreement with co-auditors. However, in striving to ensure that all individuals had voice, we assumed that all voice adds value and this is not always the case. For example, in this study, "*there are certain individuals that constantly display negative tensions towards the team and team dynamic. They constantly criticise team members*". Thus, we need to consider the influence and impact of negative voices as experiences lead to differing 'understanding of what happened, how we made sense of what was happening and what we would do about it' (Coghlan and Brannick 2010, p.23). It is of note that the negative voices have

abated as the audit team evolved into a mature COI, as articulated by one team member *"tension in the team has eased off as we have all got to know each other better"*. So, while some negativity remains, the team as a mature COI is addressing this challenge as part of the ongoing process.

Individual reflections on using CAL as the catalyst to generate the knowledge to inform the audit process suggest that some embrace this approach as *"the only way that we could have generated knowledge and progress as a team"* and that this *"was a very positive way of working and evolve alongside the work we were charged with doing"*. Others believe that *"action learning has become the norm in our team wherein all knowledge, actions and skills are reviewed robustly in the team environment"*. Of note is that some of the initial tension in the observed environment centred around the requirement for extractive training: *"I think these skills can only be developed and nurtured through a structured process of training"* while others believed that: *"the QPSA team would benefit from formal accredited training"*, to which another member noted that *"in the absence of formal training and a robust procedure document, the stronger personalities tend to dominate"*. This varied feedback very much reflected the differing backgrounds and experience of the individual team members where I sought to manage the tension between maintaining close interaction between experience and the building of competence to ensure a fertile ground for learning (Dunne and Kelliher 2013). As the team now have a procedure document as a 'standard of practice' amended and developed in practice, the hope is that this *'robust procedure document'* has gone some way to alleviate the perception of dominance by some members of the team.

Based on these reflections, this has been a rewarding but difficult journey: *"overall it has been a steep learning curve for everyone"* and one that can result in significant personal and professional gains: *"the audit experience has being a very positive experience for me"; "we have also learned a great deal from each other"; "I think we have learnt far more than we even realise"*. Indeed we have lost team members (two to retirement and one to transfer) and may lose more who find this style of working not to their liking, as it is highly unlikely that one design would meet the needs of all participants in practice. While member departure had the potential to cause some uncertainty *"... disconcerting... I thought are they jumping ship before it sinks"* it also provided opportunity *"...new people joined and brought freshness to the team"*. Of note was that this natural movement did not appear to impact the majority of those who

stayed: *"I don't really have an issue"*; *"I see it as a natural progress within any team"* although there was a recommendation that: *"some sort of exit interview should be conducted"*.

6. REFLECTING ON THE ACTION RESEARCH PROCESS

My dual-role in this study was based on my own learning (first person), as the audit team leader (second person), and as part of a doctoral programme in working with my supervisor which provided outsider-insider collaboration and brought another perspective into the dialogue (Coghlan 2007). When the establishment of the QPSA team also became a research project it addressed a wider academic audience (third person) through presentations at colloquia (Dunne 2012 and the DBA cumulative paper series), and in preparing papers for submission to academic journals (Dunne and Kelliher 2013), thus the AR project needed to be more than just problem solving.

As academic quality, rigour and contribution needed to be considered, I was guided in how to achieve the multiple aims of participatory action, the implementation of change and the generation of knowledge to inform theory by Reason (2006), Bradbury-Huang (2011) and Coghlan and Brannick (2010), among others. As these authors emphasise that it is rare for AR to successfully reach on all the 'choice points for quality' (Bradbury-Huang 2011), I found that as an IAR, I needed to be transparent about the choices I made in this project. Taking Bradbury-Huang's (2011) advice, it was helpful to consider looking at these choice points as *'proceeds from praxis of participation… guided by practitioners concern for practicability… inclusive of stakeholders 'ways of knowing'* in order to help *'build capacity for on-going change efforts'* (p.99). Thus, this paper and the underlying reflective practice documented within (Cunliffe 2004, 2013) has afforded the team and I the value of insight in the final stage of an AR cycle – that of reflection.

Freire (1970) challenges us to contemplate the ways in which we understand not only 'learning' and 'knowledge', but, more fundamentally, what it means to be human; an ethos that is sometimes labelled 'critical optimism' (Balagopalan 2011). As a critical optimist, I was looking for team members who were open to new ways of working and not fixed in their beliefs and who could engage as a community to generate the knowledge and learning required to establish the audit team and nurture it as a COI. I

recruited the team based on this vision, and based on their reflections; many of those who joined appeared to embrace this ethos: "*it was very progressive and very exciting*", "*I was willing to take a risk*". As this was a new service with no track record it required a 'leap of faith' for each member to join, while seen by some as an "*exciting opportunity*" that was "*just what the* [health service] *needed*", others considered it "*challenging*" and likely to be an "*uphill struggle*". There was also a hindsight view that perhaps the vision was not fully articulated as it was concerned with '*how*' the team would work "*in hindsight I am not sure I fully understood that we were starting from scratch*".

CAL and critical reflection has being recognised as having the potential to disturb people or provoke dissonance amongst participants (Brookfield 1994, Rigg and Trehan 2004), the team reflections were encouraging in context: "*Some level of tension is good, once it takes place in a professional manner without creating an atmosphere filled with tension*". This is not something to shy away from (Vince 2010, 2012), rather members should focus on the contradictions mobilised by CAL and engage with the 'difference that make a difference'. Vince's perspective should be somewhat tempered with that of the audit team members, who pondered that "*there is an opportunity however, within such an environment if not managed properly, for over bearing people to proliferate*". Indeed Reynolds (2011) cautions on this approach, referring to the darker side of critical reflective practice where he states "*questioning 'taken for granteds' are functional and questioning them can bring about a sense of uncertainty*" (p.12). In reality, similar to Somekh's (1995) findings, this AR project took a highly pragmatic orientation and the difficulties encountered in encouraging participation and voice was a trade-off between the benefits of generating the knowledge to inform and to bring about change in practice.

7. CONCLUDING REMARKS

The purpose of this paper was to reflect on the multi-perspective insights gained from establishing a Quality Patient Safety team, reflecting not on what we did but why we did it. When reflecting on the AR cycles completed within this project, and as part of our practice at the end of the AR project, the QPSA audit team sought to reflect on the experience, using the stages within the experiential cycle (Kolb, 1984). From an action learning perspective, this cyclical approach of "*taking action … and learning from interpreting the consequences*" paid homage to the ethos that we cannot say that we

know something until we have tried to act in the light of any new 'knowledge' (Revans 1998; Coghlan and Pedler 2006; Dunne and Kelliher 2013). Therefore, the reflective process documented in this paper sought to guide team reflections in order to look at our collective experience over the previous twenty-eight months and to check the learning set against our plans and objectives.

We reflected as individual team members and then collectively as a team on prompts informed by key findings (appendix A) and prepared by an external facilitator in liaison with myself "*so as to make sense of them… with a view to informing future practice decision or actions*" (Reynolds 2011, p.12). The subsequent insights have highlighted initial internal tensions relating to grade hierarchy, inter-personal politics, progressive understanding and member's CAL and audit skill development. On reflection, it is important for me as QPSA Director and IAR to engage critically with the ways in which these factors undermine or promote QPSA learning and practice and how we can facilitate all contributions to be heard and heeded, even those we may not agree with. However, Reynolds (2011) cautions us in using critical reflection that learning set members may find themselves in conflict with colleagues as a result of critically questioning and furthermore, that shared understanding might be placed in doubt that could lead to individuals "*being marginalized because they were seen as disruptive or disloyal*" (p.12). Moreover, as we found that we are not all equal in this learning set due to grade hierarchy and willingness to use our 'voice' it is helpful to contemplate Vince's (2012, p. 216) perspective: "*if we continue to work with this fantasy, we will never be able to engage with the difference.*"

QPSA is now established and has adapted the AR empirical method underpinned with CAL in taking an attitude of inquiry in practice: "*We are now a functioning auditing team with a good repository of audits, we have learned a great deal from each other*". In terms of the future, as the team discussed the collective findings mentioned earlier, they decided that "*some level of professional tension is good once it takes place in a respectful manner*" therefore we agreed to review our team 'values', as a way of addressing our inter-personal relationships. Thus, although the IAR project may be finished, QPSA is now embedded in the organisation as an assurance service for quality patient safety and the knowledge that emerged from this study and the learning therein has the capacity to be actionable, that is, at the service of both academic and practitioner communities.

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APPENDIX A: REFLECTION SESSION FACILITATOR PROMPTS

Prompts used by reflection session facilitator based on Key Findings

- Thoughts on the vision for the QPSA team

- Joining a new service/ having to develop a procedure in practice; do you feel that your voice is heard as part of the team process?

- Do you feel the responsibility for reviewing evidence and for signing off the audit reports, enabled you to develop your own personal skills of inquiry?

- Do you think tension is good to keep in the team as auditors, to avoid over emphasising 'togetherness'

- How did you feel about different team members joining and leaving the QPSA team during the (28-month) time frame/ full lifespan of the project?

- What do you think has been the impact of your work on the organisation(s) you have audited?

- Please feel free to include anything you would like to add from your experience of working with this team.

SECTION THREE:

CONCLUSION AND RECOMMENDATIONS

1. INTRODUCTION

As stated previously, this insider action research was undertaken in a national healthcare organisation in Ireland over a twenty-eight month period from 2010 to 2013. The focus was to study the establishment of a quality patient safety audit (QPSA) team, created to fill an assurance gap for clinical and social service at corporate governance level in the observed healthcare organisation. The aim of the research was to:

> Study the learning that was generated internally by establishing the QPSA team, underpinned by a critical action learning ethos.

The underlying objectives were to;

1. Track the QPSA team from establishment;
2. Explore the elements, influences and barriers that inhibit or promote critical action learning;
3. Contemplate the tools of voice as a means of generating a community of inquiry;
4. Observe the evolution of a community of inquiry in the practice of audit;
5. Consider the dual role of practitioner researcher.

Using the IAR method of 'constructing, planning action, taking action and evaluating' the goal was to co-generate knowledge to inform the parallel process of completing audits and evolving into a COI as a way of working in the practice of audit. Thus, this insider action research is of interest to both academics and practitioners as it builds on the COI concept (Peirce 1839-1914; Shields 2003; Earl and Katz 2005; Dewey 1938) underpinned by action learning (Revans 1980; Coghlan and Pedler 2006; Burgoyne 2010; Johnson 2010; Trehan and Pedler 2011; Rigg 2011). The research offers specific insight through the use of critical action learning (Vince 2004, 2012; Rigg and Trehan 2011; Trehan et al. 2010) as the catalyst to generate knowledge in the initial stages of team formation and inform the evolution of a team into a community of inquirers in practice. CAL offered an opportunity to examine, comprehend and question the politics that surround and inform organising as it required both the team and I to engage in challenging organisational practices, power relations and norms while addressing and dealing with emotions within the QPSA 'learning set' (Brook et al. 2012). To the best of

my knowledge no research to date has considered using the COI and CAL concepts in this manner in the public service arena.

Applying IAR in this work setting adds to the body of knowledge on using this empirical method to ensure quality in practice and research (Shani and Passmore 1985; Somekh 1995; Heron 1996; Fisher, Rook and Torbert 2000; Zuber-Skerritt and Perry 2002; Reason 2006; Dick 2007; Coghlan and Brannick 2010). The insights gained as an IA researcher in managing the three interlocking challenges of pre-understanding, role duality and organisational politics (Coghlan and Brannick 2010) are also worthy of mention. As a practitioner leading the QPSA team, we set out to extend theory from practice by identifying concepts which explained what I was seeing in practice and subsequently offering these practice-based insights as a basis for analysis and ultimately, improved practice. When pursuing theory engagement in this manner, there is no division between those who produce the knowledge and those who use it (Friedman 2001) so each finding was fed back into the team with the aim of bringing about change (Somekh 1995) and in adherence to the experiential learning process (Kolb 1984). Argyris et al. (1985) express this integration of thinking as "*creating of communities of inquiry in communities of social practice*", thus the COI's central activity was the creation of knowledge, and ultimately learning, in the studied environment.

2. KEY INSIGHTS

This research revealed valuable insights into the elements, influences and barriers that inhibit or promote knowledge generation and ultimately learning in the evolution of a team into a COI.

2.1 *The complexity of interpersonal relationships*

This research concerns a team of people recruited from different backgrounds and experience and levels of seniority who were required to collaborate together to develop a new service in an organisation undergoing significant change. The QPSA team were also required to amend procedure from another jurisdiction in practice and in the process to become a Community of Inquiry. This was a difficult task as "*in practice collaboration with others who have differing organisational culture norms and systems in not straightforward*" (Rigg 2008, p.114). Furthermore, critical action learning acted

as a basis for considering the complexity and reality of the interpersonal relationships that often exist within learning sets (Vince 2004). Within the audit team we found that at times individual issues needed to be given priority and attention over the team outcomes (Rigg 2008). Based on this study, 'comrades in adversity' (Revans 1998) are equally likely to be adversaries with commonality (Vince 2004) and the emotions and politics experienced by people who attempt to learn from one another can sometimes be complex and difficult (Smith 2001).

2.2 Deepening understanding by reconciling multiple views

Knowledge generation was not a matter of focusing exclusively on positive emotions (Bright 2009) but also providing team members with skills to function in dynamic relationships with so called negative emotions such as resistance, conflict avoidance or pessimism. As such, my role was to set the team tone in the 'positive', and to ignite transformative dialogue and action to facilitate individual and team resilience when interacting with negative emotions both within and outside of the team. Notably, negative emotions, partially propelled by fear of failure and loss of reputation, were consistently expressed by a minority and engagement with these members required sensitivity on my part to build this confidence in the QPSA approach and ultimately their trust. Taking a critical optimism approach, I framed comments and questions around finding solutions and suggestions (Shields 2003) and sought to encourage different members of the team to move to a more positive 'can do' attitude (Bright 2009). Over time, the result was a more cohesive team who continued to debate, but in a progressively positive light, where challenges had the potential to be overcome.

2.3 Taking an attitude of inquiry

QPSA members were encouraged to take an attitude of inquiry (Marshall and Reason 2007) which was not something that the members were traditionally encouraged to do in the studied healthcare organisation. Thus, the use of reflective practice, which encompassed the compilation of work-based reflective logs by all team members, was particularly useful when engaging with this ethos. As co-researchers working as a COI in a healthcare organisation, we opened our purposes, assumptions, sense-making and patterns of action to reflection (Marshall and Reason 2007; Coghlan and Brannick 2010). Reflecting on the 'insights gained from action and learning from interpreting the

consequences' the QPSA team paid homage to the ethos that we cannot say that we know something until we have tried to act in the light of this new knowledge (Kolb 1984; Revans 1998; Coghlan and Pedler 2006; Dunne and Kelliher 2013). This approach also built on the work of Marshall and Reason (2007), who postulated that our insights from practice are a way of working to generate useful knowledge which can produce outcomes of value to practitioners and academics.

2.4 *Challenging organisational practices, power relations and norms*

Maguire (2001) pointed out that before you can expect to hear anything worth hearing, you need to examine the power dynamics of the space and social actors. In this IAR study, power dynamics emerged within the team, through grade hierarchy and negative emotions. Although not immediately transparent, it became evident that the team needed to address barriers to voice concerning grade/ experience hierarchy, member seniority within the organisation and different backgrounds including administrative and clinical roles, as these created certain *"tensions and contradictions, emotions and power dynamics"* (Rigg and Trehan 2004, p.150) within the team. Building on Vince's (2012, p.217) premise that we are not all equal in CAL sets and *"that if we continue with this fantasy, then we will never be able to engage with the difference that make a difference"*, I needed to make it clear that whilst there were different grades and experience coming into the team, this was a whole new experience for everyone.

2.5 *The challenge of creating and sustaining a favourable voice climate*

As QPSA director, I sought to set the team tone so that all voices were welcome and equal; while acknowledging that some would play a bigger role based on their previous experience, skills, attitude and education. To inform the research, we needed to allow for a *"free exchange of views"* (Smith 1983, p. 50) to motivate an inquiring community to listen, share, learn and persuade (Brom 2000) in order to tap into the expertise of all members of the team and seek to co-generate the knowledge that would inform the evolution of the team into a Community of Inquiry. By building a favourable 'voice climate' (Morrison 2011), I sought to encourage equal voice (Mead 2006), as team members needed to ask good questions, to reflect individually, and to speak up and share their individual insights as the team evolved in practice. Interestingly, in withholding my own opinion to allow for equal voice (House and Howell 1992), I put

unanticipated pressure on other team members to speak - a challenge anticipated by Chataway (1997, cited in Maguire 2001). Therefore, it was necessary to facilitate differing ways of giving voice to ensure that people were willing to say what they thought without penalty (Edmondson 2002) and to find ways to hear those who did not feel comfortable to speak out at larger meetings but who wished to contribute. We also needed an environment where members could change their views without penalty when genuinely persuaded that a different view was preferable based on the evidence reflected on (Dick 2007).

As the team moved from uncertainty to certainty each member did gain confidence and 'voice' and this empowerment caused considerable tension in the group (Maguire 2001). Learning set members found themselves in conflict with colleagues as a result of critically questioning the approach taken. Shared understanding also had the potential to be placed in doubt if an individual was *"seen as disruptive or disloyal"* (Reynolds 2011, p.12). Notably, the QPSA team believed that *"some level of professional tension is good once it takes place in a respectful manner"* suggesting an ongoing positive tension in the balance of 'voice' in this setting. Thus I needed to monitor these emerging power relationships and manage their impact on both CAL and COI as without them, we could become complacent. This led to the unexpected benefit of improved member skills as it helped to develop *"self-help competencies in members"* (Shani and Passmore 1985, p. 439) as the team members navigated the landscape of free exchange.

2.6 *Instilling reflection in practice and research*

Building on the conceptualisation of reflection (Schön 1983; McNiff and Whitehead 2002; Coghlan and Brannick 2010; Reynolds 2011; Cunliffe 2013) as I constructed the team as auditors and co-researchers, reflection became the link between action and research, and further action (Kolb 1984). All team members centralised reflection in the audit process, using a work-based reflective log as a means of attending to our experience. This was difficult to do initially as it imposed a new discipline on each of us (McNiff and Whitehead 2002) however, this practice engaged us in being attentive to the data, being intelligent in our inquiry, being reasonable in our judgement and being responsible in our decision making (Lonergan 1992) and provided us with a methodology to understand how and what we know. Furthermore, these logs allowed

each team member to provide insights 'in practice' and procedures were amended using data collected by the team and recorded in individual logs, based on what worked well and what needed refinement. As Raelin (2009) argued, this evolutionary process brought reflection into the open whereby privately held assumptions were tested publicly and made explicit so that how they were constructed could be seen and critiqued (Argyris et al. 1985) by the QPSA team.

A reflective log was also a requirement for the doctoral programme, which reinforced this discipline for me. I found I moved from a reflective diary to a critically reflective diary over time (McNiff and Whitehead 2002), thus the diary impact was similar to that stated by Argyris et al. (1985, p. 449) as it was *"iteratively moving forward from a more proactive orientation towards a more reflective one"*. This became a way of working for the team and I as co-researchers as we co-constructed realities and identities (McNiff and Whitehead 2002), in 'taking an attitude of inquiry' (Marshall and Reason 2007) in the process of auditing. Thus, reflection was more than consideration of the technical and organisational aspects of presenting problems (Schön 1983) by the team; we implemented the operational element of AR which involves engaging in cycles of action and reflection. This allowed the QPSA auditors to raise social, political and cultural issues, questioning purpose and intentions and, if necessary, challenging the assumptions and 'taken for granteds' (Gergen 1982) on which the organisational policies and practices are based.

In order to look at our collective experience over the previous twenty-eight months and to check the learning set against our plans and objectives, all team members shared their views and opinions confidentially following completion of the IAR project. The subsequent insights highlighted initial internal tensions relating to grade hierarchy, inter-personal politics, progressive understanding and member's Critical Action Learning and audit skill development, not only in relation to their impact on others, but in terms of the conscious and unconscious meaning of individual intentions and action (Somekh 1995).

2.7 *Mirroring quality in practice and research as a parallel process*

The value of providing the audit function via an 'individual, sub-team, team' structure is that the knowledge generated by collective inquiry goes beyond that of individual

audit expertise or even team expertise by providing numerous sets of eyes on a single challenge. For example, CAL provided a methodology to engage with and modify the QPSA's practice procedures from another jurisdiction (NHS), which the QPSA auditors must comply with (see appendix A for details). As a document developed in the practice of audit for a new service customised to the Irish health services, it can now form the basis for training for future healthcare auditors. In applying the AR empirical method of *constructing, planning action, taking action and evaluating* as part of our quality improvement process, the team continuously improved their practice and sustainability, as exemplified in the achievement of programme targets and performance indicators in the QPSA Annual Report 2013 (Appendix D, Table 1). Thus, the ethos of learning in practice (Kolb 1984) is combined with exposure to new perspectives and interpretations of organisation and managerial situations, via team insights into individual audit experiences.

2.8 Planning for member-leader autonomy

The concept of autonomous team leadership was presented early in the research cycle in light of the COI underpinning and was reflected in the evolving team dynamics where recently, we engaged a mentoring system when two new auditors joined two audit teams with the lead auditor acting as a mentor in each case (January 2013). These actions reflected the underlying CAL goal in increasing member leadership autonomy so that team members played an increasingly larger and more pivotal role in the QPSA community, based on their senior grade and previous experience. Using CAL in practice and adapting 'an attitude of inquiry', we intuitively honed leadership skills in these 'high potential' individuals and in other members of the QPSA team. This was challenging, as in the past, team members were not normally encouraged to develop leader skills in this manner. I was however encouraged by Rigg (2006) who argued that AR has much to offer the next generation of public service leaders; "*as the future needs transformational as well as transactional leadership not simply management in a command and control way….becoming more aware of how their values drive them*" (p. 206). Taking this perspective allowed me to watch for leader talent in individual team members and help them become '*more aware of how their value drives them*'. This approach was underpinned by the CAL ethos and values, which was consciously fostered within the audit team. In considering succession, these individuals have the

potential to be future Directors of this (QPSA) team or other teams within the public services.

3. CONTRIBUTIONS TO KNOWLEDGE

The purpose of this research was to study the learning that was generated internally by establishing a quality patient safety audit (QPSA) team in the observed healthcare organisation, underpinned by a critical action learning ethos. This research makes a valuable contribution to both practice and theory;

3.1 Practical contribution to knowledge

On a practical level, this research provides a detailed account of the creation and experience of a quality patient safety audit (QPSA) team in a healthcare organisation. Following the establishment of the team and subsequent AR cycles relating to focused training and engagement with procedural standards, the application of a CAL ethos among the team and the team's evolution into a COI, the QPSA audit service is now making a valuable contribution to the quality and patient safety agenda in the observed healthcare organisation. Practitioners, specifically those who operate in public healthcare environments may benefit from this study. Many healthcare managers in the studied organisation and elsewhere have expressed an interest in the research findings, and feedback from the studied organisation has been favourable, particularly in relation to the QPSA structured audit approach (the audit flowchart can be seen under appendix C), the service's annual report (appendix D) and the observed QPSA team environment. Further, feedback from the National Health Service in the UK has been positive in relation to the QPSA amended 'Internal Audit Standards' (appendix A) completed as part of this project, and have stated that they intend to adopt some of the amendments made by the QPSA team in their original standards.

A number of specific implications have arisen as a result of this insider action research study. In summary:

-   The QPSA team did not exist prior to this study. Its purpose was to fill an assurance gap for clinical and social service at corporate governance level in the observed healthcare organisation. It is believed to have achieved this goal.

- The interplay between individual, sub-team and QPSA team created a cycle of engagement and feedback which facilitated the inquiry ethos. Difficulties with individual audits were partially overcome through this interplay and over time, the auditor's commitment to the team and the practice of audit allowed for the evolution into a community of inquiry.

- Facilitating voice 'in the positive' at each point throughout this programme has had a direct positive impact on the QPSA team and how they approach individual interactions when performing internal audits within the observed organisation. Providing a team tone in the 'positive' ignited transformative dialogue and action to facilitate individual and team resilience when performing these audits.

- As stated previously, critical action learning acted as a basis for considering the complexity and reality of the interpersonal relationships that often exist within learning sets and the wider organisation. Specifically, the promotion of CAL where all can be questioned, regardless of rank or grade was a necessary albeit difficult process. Difficulties with balancing equal voice within a multi-grade team should not be underestimated and the subtle intervention of the team leader is vital. Auditors are unlikely to develop necessary criticality in the audit process without addressing these challenges within the team.

- The promotion of reflexive practice at each stage of the audit process offered insightful actions on the part of the auditors, learning sets, the QPSA team and those functions and facilities with whom they interacted. The action learning ethos facilitated a level of questioning necessary to successfully complete audits in this complex environment.

The above are not prescriptive actions that will guarantee critical action learning within a team or indeed, ensure the evolution of a community of inquiry. They are criteria resulting from an insider action research project that can provide practical insights to those CAL/ COI considerations when embarking on the creation of a new team in the public sector environment.

3.2 Theoretical implications

This insider action research offers insight into theoretical issues gleaned from the literature review, an activity performed throughout the research cycle. The incumbent 28-month IAR study allowed an investigation into how learning was generated internally by establishing a quality patient safety audit (QPSA) team in the observed healthcare organisation, underpinned by a critical action learning ethos. On a theoretical level, this study has highlighted new areas for description and the extension of existing theory;

3.2.1 New areas for description

Currently literature does not adequately explore the internal audit environment in large public healthcare environments. Furthermore, the interplay between individual, sub-team and team in an environment where seniority is dictated by grade has not been addressed to date. While critical action learning acted as a basis for considering the complexity and reality of the interpersonal relationships that often exist within learning sets (Vince 2004) and the wider organisation, it was the facilitation of voice and the embedding of reflexive practice that allowed for the community of inquiry to emerge (Cunliffe 2013; Dunne and Kelliher 2013). Furthermore, in this IAR project, while adhering to Johnson's (2010 p. 269) learning set principles, the practice variation allowed; a 'learning set' of larger dimensions (15-member audit team); the consideration of tasks and problems which were individual, team and organisational; the QPSA Director to act as facilitator, so that the team were allowed to develop their own learning via problem solving.

3.2.2 Extension of theory

This research is fortified by building on earlier research, specifically the pursuit of a community of inquiry as an organising principle surrounding a community of inquirers with shared aims who systematically and intentionally explore and consider information from research, from experts and from each other; so that methods can be developed and tried in support of inquiry, decision-making and problem-solving (Peirce 1839-1914; Shields 2003; Earl and Katz 2005; Dewey 1938). Within the audit team, the embedding of inquiry as an organising principal from the team inception enabled auditors to

develop individual and collective skills, ultimately moving towards a Community ethos (Peirce 1939-1914).

The application of a critical action learning ethos afforded an opportunity to examine the politics that surround and inform organizing in the studied environment. To comprehend these politics, it was often necessary to question these political choices and decisions, both consciously and unconsciously and the various ways in which learning is supported, avoided and prevented within learning sets and in organisations through relations of power (Rigg and Trehan 2011; Vince 2012). Balanced relations were pursued firstly through the individual and collective contribution to the NHS audit procedure document, and subsequently through iterative interaction with practice-based reflective diaries thereby facilitating the organic evolution of QPSA practice and procedures. As the QPSA team matured, the use of CAL allowed the team to embrace the power and politics both internally and externally and learn through the exploration of tension or the "*grit in the relationships*" (Willis 2012: 175). Furthermore, the audit procedures and resultant reports are openly available (see Appendix D for example); a culture of transparency facilitated through the CAL ethos.

What was paramount in creating knowledge in this environment was the quality of the conversation and the interaction that it created among the learning cohort (Coghlan 2011; Rigg 2008, 2011). By giving voice (Mead 2006) to all QPSA team members, the QPSA Director gave each auditor inherent permission to 'respectfully inquire' through a critical lens. This in turn facilitated the questioning of political choices and decisions (Rigg and Trehan 2011; Vince 2012), such that the QPSA team became embedded in critical action learning. Notably, facilitation of negative as well as positive voice was a key contribution in this study, as it highlighted the reality that all voices may not be in unison. For this to happen, I as QPSA Director needed to engage with all voices and not overemphasis "*togetherness*", as if I tried "*to control this it* [would have gotten] *in the way of learning* (Vince 2012: 218). Thus, in facilitating a favourable voice climate (Shani and Mitki 2000; Edmondson 2002), the effect was to also facilitate critical engagement within the COI and the wider organisation when completing quality patient safety audits.

Vince (2002), Trehan and Pedler (2009), and Ram and Trehan (2010) each argue that engaging in critical reflective practice which is organically situated captures the long

standing value of learning from experience of work and working with others. The use of practice-based diaries provided a means of reflecting in practice at an individual level and offered a catalyst for collective reflection, embedding reflective practice at the heart of the QPSA team. This approach provided interconnectivity between knowledge and action (Dixon 1999), thereby leveraging prior learning in iterative team activities and contributing to the ethos that not only is *"individual learning dependent on the collective"* but the *"collective is dependent on the individual"* (Dixon 1999: 41). Notably, critical reflective practice was not welcomed by everybody (Reynolds 2011), as it challenged predisposed views and posed sometimes unwanted questions, which in turn had implications for underlying political structures and voice structures.

Consideration of the 'critical optimism' ethos when operating in a large public health environment provided a faith of sense that if we put our heads together and act using a scientific attitude to approach a problematic situation, the identified problem has the potential to be resolved (Shields 2003, p. 514). In developing a new QPSA service with CAL/ COI at its core, this optimism gave the team the sense that we had the potential to make a difference and connect to the common good (Shields 2003). The underlying 'critical optimism' displayed by myself and the team was essential when dealing with the potential barriers and/ or opportunities that inhibit or promote critical action learning in a team of this nature. This process also involved an evolution of our own thinking – the QPSA team could manage stressful times through critical reflection; while critical optimism provided the team and I with a confidence in letting others have voice, even if they disagree, as it affords a confidence in one's 'self' as a thinking, experienced professional.

In regard to the dual role of practitioner/ researcher using COI as an organising principal underpinned by CAL ethos within the QPSA team, the depth of research engagement helped me to interpret and shape experience (Shields 2003; Lipman and Sharp 1980). In each AR cycle, I made notations throughout the research process in an intuitive way, wherein analysis was a circular process of describing, connecting and classifying (Dey 1993), in constant interaction with the literature. As an IA researcher using this inductive process, I was reflecting on a collective journey, and therefore needed to incorporate *"disparate elements into a coherent whole"* (Dey 1993: 237), in order to produce an account, which was adequate from a research perspective as well as accessible to the reader. It was vital to ensure transparency throughout as this

approach formed part of a process enabling ethical inquiry, and ultimately afforded multiple perspective inquiry. Thus, this research contributes to the body of existing knowledge concerning community of inquiry, voice, critical action learning, reflective practice, critical optimism and large scale public health organisations.

4. RECOMMENDATIONS: PRACTITIONERS and RESEARCHERS

The findings from this insider action research present itself as points of consideration for both academics and practitioners who have used, or are about to establish a new service, team or learning set, particularly if drawing people from differing levels of seniority experience and background, within the same organisation or from across the public services:

- When establishing a new service with limited available resources, CAL is a useful methodology and cost effective way to tap into the knowledge of individual team members. It is not only a way to generate the knowledge to solve problems and inform the procedures in which people will work, but it also empowers individuals at a deeper level, to show them that they are capable of constructing and using their own knowledge.

- Before undertaking this type of research-practice approach, the practitioner researcher and manager needs to be aware of their own capabilities, worldview and philosophy and how these are aligned to that of team/ COI they are engaging with in order to perform aptly the roles of manager, facilitator, coach and potentially, researcher. Therefore, as psychological safety for individual team members is fundamental to the development of favourable voice climate, managers and researchers should be honest about their ability to deliver this in a team setting.

- When recruiting team members to work in a COI, managers need to fully articulate the perceived values and vision for the team, and allow people time and space to consider whether these align with their own goals and ethos.

- It is important to acknowledge that *"we are not all equal in CAL"* (Vince 2012, p. 217). Whilst one can emphasise that all team members are equal, the reality is that there are often differing pay scales and very varied experience in a team of this

nature; and these grades do not necessarily represent individual competencies but are a legacy from previous differing management structures in the organisation. As practitioner-researcher, it is important to engage critically with the ways in which these factors undermine or promote team learning and practice and how we can facilitate all contributions to be heard and heeded, even those we may not agree with.

▪ Engaging team members as co-researchers gives the momentum of drawing people into the research process as they reflect on actions to inform practice. This reflective approach also contributes to the development of team values and norms over time. Practice-based reflective logs are useful to record individual experiences in practice and to support team understanding through facilitated discourse. However, learning set members may find themselves in conflict with colleagues as a result of critically questioning and shared understanding might be placed in doubt if an individual is "*seen as disruptive or disloyal"* (Reynolds 2011, p.12), a reality that should be carefully monitored by the practitioner-researcher.

▪ As a team moves from uncertainty to certainty and each member gains confidence and 'voice', this empowerment may cause tension due to emerging power relationships which will need to be carefully monitored by the practitioner-researcher to ensure progression to a COI is not halted due to disruptive interaction at this stage of the team evolution.

▪ In research and practice, the general empirical method of being attentive to data, intelligent in understanding, reasonable in judgement and responsible in taking action (Lonergan 1992) provides both a solid foundation for inquiring in action and a basis to evaluate how well one is learning individually and as a team member.

▪ In the dual role of practitioner-researcher, it is important to develop an internal support system such as a formal mentor or an informal colleague internal or external to the organisation and in this case (an academic supervisor) who can challenge 'taken for granteds' and misconceptions relating to the research-practice environment.

▪ For a practitioner engaged in research, IAR bridges the divide between research and practice; it addresses the knotty problem for research to make a difference in terms

of bringing about and embedding actual improvements in practice. As a practitioner-researcher, you can also achieve economies of time by using some parts of the research process as an approach to practice, creating opportunities to gather data, which can inform research.

5. RESEARCH LIMITATIONS

Due to the nature of doctoral research, and in this case, its professional basis as a Doctorate in Business Administration, there is certain research limitations associated with this research model.

- In action research definitive statements are not easy to make in a context where knowledge is personally and socially constructed. This research took place in a specific context (a healthcare organisation) which was undergoing radical transformation under severe financial constraints. This environment influenced the research options open to the practitioner-researcher therefore the conclusions can offer suggested rather than definitive approaches in different contexts. Furthermore, problems of reporting IAR reside in the provisional nature of knowledge.

- As this was a single practitioner-led research project, it had a highly pragmatic orientation. The practitioner-researcher had dual roles in context; the role of practitioner was tempered with the need to design, implement and analyse the research as an IA researcher. Furthermore, as an IA researcher, the 'self' is the research instrument therefore the AR methodology is not 'value free'. It is very much influenced and grounded in the experience, values and worldview of the IA researcher and the co-researchers.

- The knowledge generated in this research was generated by the researcher and the team of auditors as co-researchers through detailed examination of and reflection upon particular experiences and events. In this context, knowledge is personally and socially constructed and is therefore quite different to propositional knowledge which claims generalizability across situations.

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SECTION FOUR:

REFLECTIVE LOG EXTRACTS

1. INTRODUCTION

When reflecting on my IAR experience (Coghlan and Brannick 2010), I sought to confront the challenges of pre-understanding, role duality and organisation politics (Lonergan 1992). In terms of pre-understanding, it is of note that I am a mature woman with considerable experience of working across many areas in healthcare as a clinician and manager and educationalist. My participatory style of management is honed over many years working as an occupational therapist, whose role was to facilitate patients to have voice and be partners in their treatment. I sought to transfer this communal ethos to management and as an IA researcher in adopting a stance of developing and coaching QPSA members to reach their learning and knowledge potential.

In this project and research, I needed to tap into the each member's experience and knowledge to inform the establishment of the audit service, while accepting the limits of my current knowledge as a cost effective way of learning in action. Moreover, as a manager and facilitator I have learned to ask good questions, to prompt debate and to strive to create a favourable voice climate to hear what people have to say. Taking this stance, I now have the confidence to stand back and allow voice, even if the views and opinions expressed are uncomfortable for me and/ or others in the team or indeed, opposing my own views. I am comfortable in seeking conformation and disconfirmation of my sense making (Coghlan and Brannick 2010) both with those who report to me and with colleagues outside of the QPSA team.

I believe I am able to 'speak up', even in adversity, as I am 'as senior as I wish to be' in the studied healthcare organisation. Adapting 'an attitude of inquiry' is therefore a natural stance for me in practice, honed over many years. I am willing to explore purposes (Marshall and Reason 2007) and I am open to renewed insights from those explorations, however provisional. I have learned a great deal from the members of the QPSA team in adapting this stance of encouraging robust feedback from team members. However in adapting this IAR approach, I am aware there is no 'one way', no 'quick fix' and change of this nature requires a great deal of hard work.

2. EXTRACTS

Notably*,* the insights from my reflections on my practice were guided by Lonergans's (1992) presentation for authenticity as characterized by the four imperatives; be intelligent, be attentive, be reasonable and be responsible. I have incorporated extracts from my reflective diary in the form of *vignettes* and observations throughout the thesis to give life to my theoretical exploration. Furthermore, while I loyally maintained this log throughout the IAR project, on reflecting on this tool and its incumbent findings, I include specific extracts below as I consider these as pivot points in the choices I made as a practitioner-researcher during this project and research.

Extract 1: October 2010
The reading for my [DBA] research is to my surprise is informing my practice! Just read the paper 'What academics and practitioners can do together' (Ryne 2007). I also have read a number of papers on the practice area and I now think that I may be able to do this research for my DBA, if I make it part of my work!

Extract 2: November 2010
I bought a copy of 'Doing Research in your own organisation' (Coghlan and Brannick 2010). I now feel that I know how I will research as this feels so comfortable for me. This book I feel will be my companion on what will be a long journey in the strange land of academia.

Extract 4: January 2011
Dealing with the pressure of keeping [QPSA team] auditors engaged in working, using a procedure from NHS. The need to produce audits, completed while waiting for others to be released leads me naturally to AL. As I have used this before. As a practitioner 'the practice of designing the plane while flying it' (Herr and Anderson 2005, p. 69) is a normal way of working for me. I found the journal 'Action Learning: Research and Practice' really useful here and papers from Rigg, Trehan… of course Revans.

Extract 3: June 2011
Reading Coghlan's (2010) paper 'Interiority as the Cutting Edge between Theory and Practice'. I have re-read it many times as I found it hard to understand. It felt as I am reading, I am shifting back from a reactive manager to a more reflective practitioner

and also appreciating the value of my experience and where it fits into this process. His view "practical knowing works in a descriptive mode and is grounded in experience" (p.297); and his figure 2 of a scissors to illustrate "theory interiority and practical knowing" is useful. "(p.299). I wish I knew how to draw a scissors for my paper. No time now!

Extract 5: April 2012

As the members grow more confident, individuals are speaking up more at meetings, or are using differing methods such as contacting me directly or responding in written form rather than joining in the team debates. At this time, I am challenged in facilitating all voices, even the negative voices to ensure "the quality of the conversation". The papers from Coghlan (2011) and Rigg's (2008, 2011) perspective was useful here.

Extract 6: June 2012

Team meetings are very difficult. I need to maintain the balance between my voice with the [team] vision using AL; need for external courses, the negative voices, which are undermining the confidence of the team in their ability to survive and deliver in the organisation at this time of uncertainty and turmoil. I am feeding back the positive reactions from the Risk committee[20] and the services to the outcome of the audits and the potential benefits to the quality and safety of patients. But always the negative voices, almost as if in competition with me! Reflecting on this I sought direction in the literature and I spoke to my supervisor on the DBA. I need to keep this going and remain positive, I need to find out what is happening, is it the whole team or just the few?

Extract 7: July 2012

Using the performance management process, that I am required to do with senior members of the team, gives me an opportunity to have a formal/ semi-formal 1 hour discussion not just with the senior grades but I included all members of the team using telecom and travelling to different parts of the country to meet people in their offices. I had really good conversations with individual members, around 'what is good for them as a member of the team?', 'what is working well?', 'what do they find difficult?', 'what would help?', 'what would they particularly like to do as part of their

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[20] The Risk committee is a sub-committee of the Board who are concerned with overseeing Quality and Patient safety on behalf of Director General and the Directorate.

development?' and 'what would they wish me to do more of less of?'. Ensuring I had time for an informal exchange of stories, holidays, family, etc. helps me to get to know people and they me. I enjoyed this process and while it took some time it helped us all move forward and I sense that members trust me more. It was encouraging to speak to each auditor individually - they are not all negative; in fact very few are and also I addressed the individual concerns on a one-to-one basis. This exercise was very encouraging. I am ENCOURAGED TO KEEP GOING! Using my critical optimism here! I have to just keep going and working on it.

Extract 8: September 2012

Reading Rigg and Trehan's (2004) paper reminded me that "tensions, contradictions emotions and power dynamics inevitable exist within group". This reminded me of my own experience of working with group in the public services. Really hard work and I think it requires 80% of leaders input for 20% return from group until they get up and running and then it should turn around! I need to balance my own voice here! Am I dominating and not allowing voices? Balance to allow learning and stand back. Allow the voices if you are going to hear the experience and learning from their practice in the present, the knowing through doing. I think the team and I have moved from me doing all the prompting, to them working together and moving what I know to be their own experiences being shared freely.

Extract 9: October 2012

I am working hard to stay with the QPSA team as I am been drawn into other areas of work in the Directorate but I keep taking on extra areas to stay with the team. They are just not ready yet to have me moved on. I had to miss a meeting last week as I had to go to another meeting and the meeting went well without me that was so great to hear it gives me encouragement that soon the team will mature and be able to function well without me!!!

Extract 10: January 2013

Two new members joined one from disability services and a very experienced facilitator from public health (to ensure confidentiality removed details of the person). We engaged a mentoring system here the new auditors joined two audit teams with the lead auditor acting as a mentor. We plan that they will do this for the first year and I would

expect by year two they will be in a position to lead audits. We will monitor this and I will keep in touch with them. They are a valuable addition to the team.

Extract 11: February 2013

As part of our commitment to quality improvement and learning in action, I invited my 'friendly external consultant' to review our report recommendations. He accessed these online. He came and did an interactive workshop with us. Consisting of a brief presentation on the purpose of recommendations, and gave examples of good recommendations. He collated a sample of the recommendations from our reports [see appendices C and D] and we broke into small groups and look at these in line with the guidance he had given us. Each group reworded the recommendations and reported back to the whole group He is so experienced we learned a lot had fun and nobody appeared to have difficulty even if their recommendations were found not to be sharp enough. He also complemented our work. This was a good exercise as he gave the validity to our work that some members were looking for as he has a very high profile in this area in the private sector. This was a very timely exercise at the start of a new year and a look back over the past two years. He also did a short report on his findings which I shared with my manager. This helped to raise our profile and give confidence in our ability to provide assurance. We have achieved a lot over the past two years.

Extract 12: July 2013

[Had] a good 'face-to-face' team meeting. We had lots of robust debate, lots of different opinions. I need to ensure that all opinions are heard and welcomed as informing the debate (some voices are louder than others!). We need to hear all voices as each member has a different perspective. I am careful to ensure that the more recently joined members understand that their opinions are of equal value. As stated by Cassidy et al. (2008) "The focus should be on the quality of the ideas rather than the perceived status of the person voicing them" I also need to manage expectations even though they are heard not all views or opinions [January 2013] can be taken on board and the team need to reach agreement and make decisions. This takes managing to avoid people 'sulking' and withdrawing if some don't get their suggestions accepted. [Pay/ Seniority] grades do play a role here as this culture is so embedded in people. I am surprised as all members report directly to me they still tend to hold back to more senior grades. It will take time to undo - many years of working in a hierarchical organisation.

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APPENDICES

APPENDIX A: NHS PROCEDURES DOCUMENT (EXTRACT)

*** *Copy of Appendix from Paper 2.*

The following extract relates to the HSE procedure[21] of Auditing Practice for Quality Patient Safety audit. This document adopted the NHS Internal Audit Standards[22] as a baseline of inquiry and the studied audit team subsequently developed an adapted version in their application of auditing standards. This adaptation has been refined to the needs of the HSE audit function through six AR cycles over the research-led programme of engagement (2010-2013).

QPSA Service: Procedure for Conducting a Quality and Patient Safety Audit (extract)

Document reference number	QPSA003	Document developed by	Quality and Patient Safety Audit Team
Revision number	6	Document approved by	Director of Quality and Patient Safety Audit
Approval date		Responsibility for implementation	Quality and Patient Safety Audit Team
Revision date	28th May 2013	Responsibility for review	Quality and Patient Safety Audit Team

Policy Statement

The Quality and Patient Safety Audit (QPSA) provides assurance to the National Director Quality and Patient Safety, by auditing the degree to which standards for health and social care activity are met across the system. The audits identify reasons why they are not met and make recommendations to implement change and achieve the required standard/best practice.

Purpose

The purpose of this procedure document is to provide guidance for all auditors on how to successfully complete QPS audits. It provides a standardised methodology which will help facilitate the consistency and reliability of the audits conducted by the QPSA team. All QPSA staff have familiarised themselves with the procedures herein.

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[21] www.hse.ie/go/qpsa
[22] https://www.gov.uk/government/publications/nhs-internal-audit-standards

Scope

This procedure is applicable to the Director QPSA and the QPSA team.

Legislation

This procedure document complies with the following Acts:

➢ Data Protection Act 1988 and 2003

➢ Freedom of Information Act 1997 and Amendment Act 2003

➢ Health Act 2004

Glossary of Terms and Definitions

These include definitions for Assurance, Reasonable Assurance, Audit, Criterion, Guidelines, Policy, Procedure and Protocol.

Roles and Responsibilities

Details relating to the role of Director, Lead Auditor, Auditor, Expert Adviser, Service User are included in the guidelines.

QPSA Audit Procedures

This section consists of the core procedures for undertaking and delivering a QPS audit efficiently and effectively. This document is supported and enhanced by QPSA templates and guidance referenced throughout the text. The section is sub-divided into three key areas:

• Audit Planning

• Audit Fieldwork

• Audit Post-Fieldwork

APPENDIX B: ADJUSTING PRACTICE PROCEDURES BASED ON ANOTHER JURISDICTION

CAL provided a methodology to engage with and modify the QPSA's practice procedures from another jurisdiction (the NHS). This was approached using QPSA sub-teams, building both skills and knowledge in a proactive way. The procedures were modified 'in action' (Rigg 2008) and the data to inform this practice was collected by the team using professional logs (as discussed above) and following the initial investigation, the data was discussed by the team in an intensive two-day meeting lead by two team members. The practice procedures were amended based on this work, providing an ethos of both CAL and continuous improvement within the team (Revans 1998; Reynolds 2011). This process of evaluation was repeated after each of the first six audit cycles, and again repeated at the end of the first year of the QPSA team's existence; based on the collective experience of the team in practice. The procedure document is now developed as a standards of practice (V.6) in which the QPSA auditors must comply. As a document developed in the practice of audit for a new service customised to the Irish health services, it can now form the basis for training for future healthcare auditors.

APPENDIX C: QPSA AUDIT PROCESS (FLOWCHART)

AUDIT PROPOSAL WORKING GROUP – SCOPES OUT PROPOSAL IN TERMS OF OBJECTIVES & RATIONALE (LIAISES WITH ANY RELEVANT STAKEHOLDERS)

PROPOSALS SIGNED OFF BY DQPSA/DQPS AND SUBMITTED FOR MANDATE TO RISK COMMITTEE AND DIRECTOR GENERAL

AUDIT ASSIGNED TO TEAM
SCOPING: BACKGROUND WORK & LIAISON WITH NOMINATED LINK/EXPERT

ISSUE AUDIT NOTIFICATIONS (NATIONAL, REGIONAL AND SITE LEVEL)

DEVELOP & AGREE AUDIT PLAN

CONDUCT AUDIT: OFFSITE FIELDWORK (DATA COLLECTION, BASELINE INFORMATION)

ON SITE FIELDWORK – CONDUCTING SITE VISITS (NORMALLY FOUR BUT THE NUMBER OF SITES REQUIRED HAS INCREASED OVER 2013/14)

DRAFT REPORTS: SITE & FINAL

REPORTS SUBMITTED FOR PROOF READ

SITE AND FINAL REPORTS: INITIAL REVIEW BY GENERAL MANAGER & ISSUE FOR FACTUAL ACCURACY AND MANAGEMENT COMMENT

SITE & FINAL REPORTS SIGNED OFF BY DIRECTOR QPSA

ISSUE SITE & FINAL REPORTS AT NATIONAL AND LOCAL LEVEL

POST AUDIT FIELDWORK:
EXIT INTERVIEW; CUSTOMER FEEDBACK

APPENDIX D: QPSA END OF YEAR REPORT 2013 (EXECUTIVE SUMMARY)

1. Introduction

Quality and Patient Safety Audit (QPSA) service, as a key constituent of the HSE Quality and Patient Safety Division provides assurance for clinical and social services as part of the HSE assurance framework. QPSA promotes a system which recognises and applies the values of transparency and accountability. This is achieved through conducting audits, providing supportive analysis to inform key strategic and operational decision-making needs, and making recommendations to achieve required standards. QPSA plays an important role in driving quality improvement and accountability for quality and patient safety. Progress on the implementation[23] of QPSA recommendations is subject to validation and re-audit, and is used as an integral part of performance analysis, trending, and measuring quality improvements.

The year 2013 was one of significant change within the HSE. It marked the establishment of five service divisions (Acute, Health and Wellbeing, Mental Health, Primary Care, and Social Care) and the first hospital groups. As governance arrangements change and new structures are embedded, this level of change can have associated risks for staff and service users. Throughout these changes, QPSA has continued to support services to maintain a focus on quality and patient safety.

During 2013, QPSA auditors commenced 17 new audits and completed 17 audits; six audits are currently in progress and due to be completed in Q1 2014. Audits commenced in 2013 dealt with diverse services and areas including primary care, inpatient and community mental health services, intellectual disability services, acute services, pre-hospital emergency care, and other HSE-funded services. The majority of audits examined services' compliance with standards and recommendations; policies, procedures, processes and guidelines; and report recommendations. Other audits analysed governance structures, patient complaints and referral patterns. Three auditors participated in the year-long Irish National Audit of Dementia Care in Acute Hospitals.

2. Performance Targets 2011 - 2013

QPSA Performance Indicators are linked to HSE Corporate Plan 2011-2013 and the annual National Service Plans.

Table 1: Targets vs. Performance, 2011-2013

	2011 Target	2011 Outturn	202 Target	2012 Outturn	2013 Target	2013 Outturn
Audits Commenced	20	21 *105%*	24	26 *108%*	24	17 *71%*
Audits Completed	17	17 *100%*	20	23 *115%*	20	17 *85%*

Although the target number of audits commenced and completed fell short of the expected targets in 2013, there are a number of reasons for the shortfall:

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[23] *The implementation of audit recommendations is the responsibility of the senior most accountable person in the area concerned.*

- Since January 2011 the QPSA complement of auditors has had a net decrease of 2.0 WTE (16.4 WTE to 14.4 WTE)
- The overall availability of auditors was less this year as compared to previous years:
    - Three auditors worked on the year-long Irish National Audit of Dementia Care in Acute Hospitals, which reduced their availability for other QPSA audits.
    - A number of audits required larger audit teams due to the complexity and scope of some audit requests i.e. the audit of HSE-funded Crisis Pregnancy Services, thus reducing the number of audits the overall team could undertake.
    - As part of our three year evaluation and ongoing commitment to quality improvement, from October through December 2013 one auditor was allocated to the evaluation and quality assurance of QPSA procedures and reports.

The performance indicators of audits commenced and completed have been reviewed and updated for 2014 service planning, and it was determined that strictly measuring the quantity of audits undertaken was not a quality indicator of the reports published.

3. Audits Progressed 2011 - 2013

Since January 2011, 64 audits have been progressed by QPSA, 23 (37%) of which were commenced in 2013. Table 2 and Figure 1 below show the breakdown of the audits by current status and HSE Division. Almost half (47%) of the audits commenced to date have been in the area of acute hospital services.

Table 2: Division Distribution of Audits Progressed by QPSA in 2013 and 2011-2013

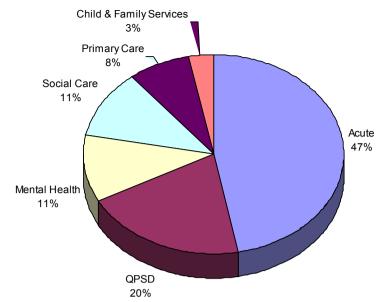| Division	2013				Total Jan 2011 – Dec 2013
	Complete	Closed	Audit In Progress	Pre-Audit Scoping	
Acute	5	2	3	10	30
Primary Care	1	1		2	5
Mental Health	1		1	2	7
Social Care	1		1	2	7
QPSD	4	1	1	6	13
Child & Family Services *	1			1	2
Total	13	4	6	23	64

* now external to the HSE

Figure 1: Divisional Distribution of Audits Progressed, Jan 2011 – December 2013

As depicted in Figure 2, audits progressed in 2011 were weighted towards acute hospital services and QPSD. Whilst demand for audits in these areas did not abate in 2012 and 2013, QPSA made a concerted effort to engage with non-acute services to increase the number of audits undertaken in other areas.
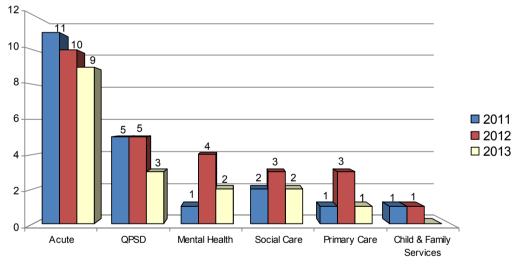
Figure 2: Divisional Distribution of Audits Progressed, 2011 - 2013

4. Audit Duration

From date of audit plan sign-off to date of final report circulation, the length of time to complete an audit averaged 84 business days (median:80.5; range 34-137 days). The average duration of audits has decreased year on year since 2011. This is due to the fact that, as the QPSA service has matured and its Standard Operating Procedure has been refined, audits have progressed at a quicker pace.
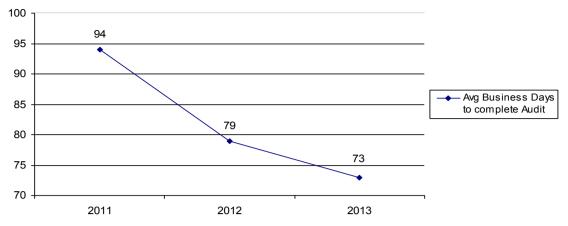
Figure 4: Average Duration of Completed QPSA Audits, 2011 – 2013 by Year

As per Figure 5 below, Divisional analysis of the average length of time to complete an audit revealed that Social Care audits took marginally longer to complete than audits completed in other Divisions.
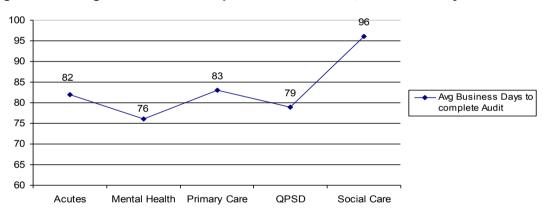
Figure 5: Average Duration of Completed QPSA Audits, 2011 – 2013 by Division

5. Analysis of Closed Audits[24]

A total of 22 audits were closed by QPSA between 2011 and 2013. 2013 saw the lowest number of closed audits per year since QPSA's establishment. This reflects the improving quality and perceived importance of audit requests; as requesters are more familiar with the service, they are increasingly aware of subjects appropriate for QPSA audit.

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[24] *"Complete" vs. "closed audit": A complete audit is one that follows the audit plan to completion. A closed audit is terminated ahead of completion. The decision to close an audit must be agreed with the audit requester and the Director QPSA. An audit report is written for all closed audits as a record of work to date and the reason for closure. A closed audit may be deferred to a later date.*

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Table 4: Audits Complete vs. Audits Closed, 2011- 2013

	2011	2012	2013
TOTAL	17	24	17
Audits Complete	10 59%	13 54%	13 76%
Audits Closed	7 41%	11 46%	4 24%

The most frequent reason for audit closure was the withdrawal of the audit request by the requester. The second most frequent reason was timing issues i.e. audit of a policy that was not sufficiently implemented.

Table 5: 2011- 2013 Closed Audits, Reasons for Closure

Reason for Closure	No of closed audits
Requester withdrawal	6
Timing issues	5
Issues with requestor/request	3
Governance/implementation issues	2
Insufficient information / absence of key staff	2
Restructuring issues	2
Deferred for emergency audit	1
Being pursued by internal audit	1
TOTAL	**22**

Audits closed in 2012 and 2013[25] were analysed to ascertain the length of time audits were scoped before closure i.e. the date of audit assignment until the publication of the closed audit report. For the 15 audits closed in that time, scoping took an average 35 business days (median: 29). Broken down by year, in 2012 the average was 38 days, whereas in 2013 the average was 26 days; this represents a reduction of 12 days scoping until an audit was closed.

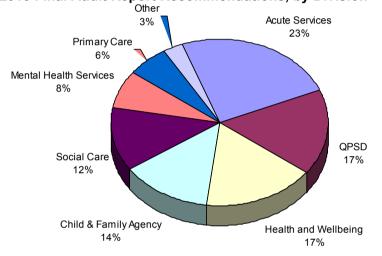# 6. Analysis of Audit Recommendations (2013)

Audit recommendations are issued as part of each final audit report with the objective of improving HSE services and increasing quality and patient safety. In the 13 final audit reports issued in 2013, 66 recommendations were made. Below, recommendations are grouped according to the service division which has governance for implementation.

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[25] *This data was not collected in 2011.*

Table 6: 2013 QPSA Final Audit Recommendations, by HSE Division

HSE Division	Report Recommendations
Acute Services	16
Quality & Patient Safety	11
Health and Wellbeing	11
Child & Family Agency	9
Social Care	8
Mental Health Services	5
Primary Care	4
Other[26]	2
TOTAL	**66**

Figure 3: 2013 Final Audit Report Recommendations, by Division

The 66 recommendations were coded to identify common themes. For example, a recommendation to revise a policy was coded as "policies, procedures, protocols and guidelines" whilst a recommendation that a service must clarify accountability structures in leadership teams was coded as "governance." The number and percentage of recommendations pertaining to each theme are outlined below:

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[26] The 2 recommendations categorised as "other" fall under the governance of the RDPI West for integrated HSE services.

Table 7: 2013 Final Audit Report Recommendations, by Theme

Theme	Sample Recommendation	2013 Recommendations No.	2013 Recommendations %
Policies, Procedures, Protocols & Guidelines (PPPGs)	Where relevant, voluntary hospitals should amend polices on the management of complaints to include the actions stipulated under Regulation 16(1) and 16(2) of the Health Act 2004 (Complaints) Regulations 2006.	15	23%
Communication	Approved centres should ensure that the HSE's Office of Mental Health Services is formally notified of incidents of sudden, unexplained death. This should include incidents of sudden, unexplained death that occur in the approved centre along with incidents that occur while patients are on leave (but not discharged) from the approved centre.	11	17%
Governance	Management and staff at all hospital sites must take responsibility and ensure accountability for implementing Standard 3 of the HSE Standards and Recommended Practices for Healthcare Records Management (V3).	11	17%
Documentation & Records Management	Regional child and family services should ensure that documentation in respect of home visits follows a structured approach, to include topics and recommendations outlined in the RCCC Inquiry i.e. stating the purpose of home visits.	11	17%
Human Resources	Agency staff attends induction training which covers areas such as disability awareness, attitudes, moving and handling, behaviour support and child and adult protection.	10	15%
Performance Monitoring	Hospitals must monitor and report information to the SDU on the number and the reason categories of delayed discharges, according to the SDU instruction of April 2013.	8	12%

Implementation of Recommendations and Quality Improvements

Feedback on the implementation of the recommendations is ongoing and forms part of the QPSA work programme for 2014. Progress on the implementation is periodically reported to QPSA, and can be subject to validation and re-audit.

In March 2014, a review will commence of audits completed in 2013 to ascertain the status of implementation of final report recommendations. The review will examine the implementation of recommendations across a number of strata, for example: recommendations made to a specific service (i.e. Mental Health), or recommendations pertaining to a particular theme (i.e. PPPGs). Learning from reviews such as this provides valuable information which will contribute to health intelligence, including quality health profiles, performance analysis, trending, and measuring quality improvements.

7. Service User Involvement

QPSD is committed to improving engagement with service users. Service users have a central role in determining what constitutes high quality, and contributing ideas for service improvement. Patients and clinicians make different choices about the various elements of care which are reflected in standards and which are measured by an audit. Patients' direct experience of care gives them a different point of view about ways to improve the quality of a service. Involving patients in the design, data collection, and/or delivery of an audit can result in recommendations which are responsive to patient needs.

Between 2011 and 2013, five QPSA audits were conducted with input from service users. In all five audits, engagement took place at the data collection stage of the audit. The following table outlines the method of engagement.

Table 8: Service User Involvement in QPSA Audits 2011 - 2013

Audit	Method of engagement
QPSA018/2011: Assessment of compliance by assessment officers and assessors with HIQA adopted Standards for Assessment of Need under the Disability Act, 2005	The aim of involving service users was to ascertain their views in relation to the Assessment of Need process. The audit team was given parents' details by each regional office, and participants were randomly selected. The team wrote to parents individually and, if parents consented to participate, interviews were conducted via telephone. The response was poor and only a small number of parents consented to participate.
QPSA013/2012: Admission & discharge communication regarding MRSA between acute hospitals and residential facilities for older persons	The audit team contacted the HSE Advocacy unit to obtain information relating to MRSA in long-term care facilities for older persons, and were told there were no issues identified on the subject; this was also confirmed on site visits. The team then contacted "MRSA and Families", a support group which was developed after the MRSA outbreak some years ago, and they agreed to have one of their members meet the team for interview. The service user was engaged in a face-to-face by interview, separate from the site visits.
QPSA016/2012: Provision of Primary Care Team (PCT) services for older persons	The audit team included service users (advocates) in the data collection stage to elicit their views on access to Primary Care Team services by older persons living in long-term residential units. The team contacted the Patient Advisory Service Development Officer, who provided the team with a list of patient advocates for specific residential units. The audit team selected twelve sites (20 advocates) and contacted the advocates to request them to complete a short survey; ten advocates agreed to participate. The response rate from the sample of advocates was poor; three of the ten advocates returned written questionnaire responses (30%).
QPSA027/2012: Audit of SPIRASI (Non HSE agency with SLA through Social Inclusion Care Group)	The audit team interviewed SPIRASI service users so as to ascertain the service's compliance with specific tenets of its SLA with the HSE. The team used a service user panel and requested participation by service users. Service users were engaged in brief face-to-face interviews while the audit team was on site. The team also contacted the advocacy unit to query if SPIRASI service users had made formal complaints to the HSE, but such no complaints were on record.
QPSA014/2013: Audit of action plan developed by the HSE to respond to areas of immediate concern as identified in the Wolfe Report.	The audit team's goal was to clarify if parents and guardians were aware of the Action Plan that had been developed to manage a crisis in the service. Face-to-face interviews (individual and group interviews) were conducted with two groups on the day of the site visit: 1) Four services users who had been trained in advocacy and 2) Parents and guardians of service users who were part of a local parent/guardian group. The audit team contacted the parent/guardian group chairperson pre-site visit to clarify expectations. The audit team engaged with both groups post-site visit to thank them and inform them when the final report was distributed.

8. QPSA Audit Programme 2014

QPSA has proposed a robust work plan for 2014, with audits spanning a wide breadth and depth of services across the HSE and funded services. A number of priority areas for audit have been identified by the QPSA service:

1. Governance: In 2014, a number of QPSD audits will focus on governance structures, focusing on accountability, responsibility and authority for quality and patient safety. The subject is a priority for QPSA as it has been highlighted as a concern in recent QPSA audits, as well as internal and external reports.

2. Re-audit and Repeat Audits: In 2014, QPSA audits completed and closed to date will be reviewed. This will be done with the aim of progressing either re-audits (conducting audits again, in the same sites as the original audit) or repeat audits (using the same methodology and data analysis as a previous audit, but at different audit sites). Repeat audits and re-audits measure if quality improvement changes have been implemented by those accountable. The QPSD have set a target that at least four re-audits or repeat audits are to be undertaken in 2014.

3. Implementation of Recommendations: The HSE Risk Committee has identified the implementation of report recommendations as an area of high priority for assurance. This will involve seeking assurance from services that recommendations from internal and external reports, investigations, and guidance have been implemented.

4. Patient and Staff Experience: To support the role and importance of involving both staff and service users in the design and delivery of our health services, QPSA will undertake audits which analyse staff and patient involvement. Audit recommendations will assist services in enhancing engagement with those who deliver and receive health services, in line with guidance and policies on same.

9. Quality Patient Safety Audit: Director's Summary

As part of the HSE assurance framework, QPSA continued to provide assurance for clinical and social services in 2013. QPSA audit reports provided a valuable source of information based on evidence to inform senior managers on assurance requirements for quality improvement plans and decision making for a safe and high-quality service.

In 2013, QPSA competently continued to manage challenges facing the service, including the reduced availability of auditors and also difficulties associated with a transforming organisation and governance changes. QPSA participated in new ventures as well, for example three auditors participated in the year long 'Irish National Audit of Dementia Care in Acute Hospitals'. This was a worthwhile project as it raised the profile of QPSA as a second level of assurance, and also increased auditors' experience and capacity. Moreover, our involvement added validity and expertise to the national audit.

Whilst acute care audits continued to dominate (47%) we did strive to engage more with social care (11%), mental health (11%), and primary care (8%) *(p.2).* QPSA will focus more on these areas in 2014.

It is of note that we had a significant decrease in closed audits in 2013 *(p.4)* which may suggest that, as QPSA is now in existence for three years, the HSE has a more mature understanding of the need and benefits for the level of assurance that QPSA audits provide.

QPSA auditors continue to be well received across the organisation, and for the most part evidence is returned to the auditors in a timely manner. Increasingly, there is a better understanding of what constitutes "evidence," and this is encouraging. Audit team members assist audit sites with identifying and sourcing evidence within the timelines required by the audit; this also assists services prepare for external audits and inspections. We welcome and respond positively, insofar as our audit independence allowed, to requests for advice by services concerning assurance.

QPSA audit recommendations are made to inform both local and national quality improvement plans (QIPs). It is of concern that between 2011 and 2013, there were recurring recommendations concerning Policies Procedures Protocols (PPPGs)(23%), Communication (17%), Documentation and Records Management (17%) and Governance (17%) *(p.4,5).* As we endeavour to close the quality loop, QPSA continues to track implementation of recommendations, and these may be the subject of future audits to evidence implementation and quality improvement.

QPSA is committed to openness and transparency, to promoting a culture of accountability for quality and safety, and to informing learning and sharing across the system. To this end, executive summaries of final audit reports are available on the QPSA section of the HSE website at http://www.hse.ie/go/qpsa. In addition, QPSA is committed to seeking engagement and input from services users, and in 2014 we will continue to creatively seek service users input at all stages of the audit procedure.

QPSA has a strong commitment to quality improvement concerning its own structure and work processes, and acting early on the intelligence provided. This process includes input and feedback from the NDQPS, the chair of the Risk Committee, and senior management; it also includes an online customer experience survey. We carry out regular internal reviews of the QPSA Procedures to formalise and document a best-practice approach to conducting audits. In 2013, a senior QPSA auditor undertook an internal evaluation of QPSA procedures and reports, and findings are being fed back directly back into practice. We are committed to "a system which recognises and applies the values of transparency, honesty and candour."

Finally, the audit programme for 2014 will be available to view on our website. It represents internal analysis of areas requiring QPSA audit, as well as requests from DQPSA, NDQPSD, ND's, and the Risk Committee, and is endorsed by the Director General. In particular, in 2014 we will focus a number of audits on implementation of external and internal recommendations from key reports/ investigations. QPSA makes allowances for emergency audits on that programme; if such an audit is required it should be submitted to the Director of QPSA and, with agreement of the NDQPS, these audits will be prioritised.

We would like to thank all services for their continued cooperation with QPSA auditors and I welcome your comments, suggestions and feedback.

Edwina Dunne, Director, Quality Patient Safety Audit Services