COLLABORATIVE CARE RELATIONS: EXAMINING PERSPECTIVES FOR APPLICATION AND CHANGE WITHIN A CANADIAN HOSPITAL

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Abstract

Collaborative care is a philosophy which guides the work of interdisciplinary teams and patients and their families internationally. It has been demonstrated to improve quality of care, safety, and patient and staff satisfaction, yet applying this philosophy still requires much investigation. This thesis describes processes of change directed towards a vision to enhance collaborative care relationships with patients and families within one hospital site of a non-acute academic health science centre in Ontario, Canada. By building focused conversations around existing patient and family centred education and using an initial conceptual framework of customer service, healthcare providers, mid- and senior level leaders shared their perspectives, negotiated meanings and created innovations to enhance collaborative relationships within the organization. Based within the critical paradigm, a critical collaborative ethnography was constructed with the use of sequential and mixed research methodologies. The ethnography evolved over three phases in a step-wise and additive design during the three year period of study. Phase 1 examined the perspectives of healthcare providers in an exploratory case study which contributed to mid-level leaders’ discussions in Phase 2. Cumulative findings from Phases 1 and 2 were brought to discussions with senior leaders in Phase 3. Members of a participative action research team assisted with research design and study processes. Shared meanings and innovative change ideas were developed and captured through the use of semi-structured focus groups and interviews, survey, participant observation and inductive analysis. A conceptual framework of ‘partners-in-care’ emerged and was used to assist participants to make sense of the values and factors important in their work with respect to collaborative relationships. The research processes facilitated the development of many innovations to enhance collaborative practice within the hospital. The organization was described by the research as undergoing directed change to enhance collaborative care as evidenced through participant self-reports, observed initiatives and the ethnographic descriptions.
Co-Authorship

The following manuscripts are in press or review and can be cited as follows:

Manuscript #1 (Chapter 3)

Manuscript #2 (Chapter 4)

Manuscript #3 (Chapter 5)
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>HCP</td>
<td>Healthcare Provider</td>
</tr>
<tr>
<td>MLL</td>
<td>Mid-level Leader</td>
</tr>
<tr>
<td>OTN</td>
<td>Ontario Telemedicine Network</td>
</tr>
<tr>
<td>PFCC</td>
<td>Patient and Family Centred Care</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>SDM</td>
<td>Shared Decision Making</td>
</tr>
<tr>
<td>SL</td>
<td>Senior Leader</td>
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# Glossary of Key Terms

<table>
<thead>
<tr>
<th>Word/Phrase</th>
<th>Operational Definition*</th>
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<tbody>
<tr>
<td>Patient</td>
<td>A person who is formally registered through the provincial health database as receiving hospital services.</td>
</tr>
<tr>
<td>Client</td>
<td>A person using the services of a professional person (Canadian Oxford Dictionary, 2004). Client and patient will be used interchangeably in the thesis.</td>
</tr>
<tr>
<td>Family</td>
<td>Refers to family member(s) or close care-giver(s) defined by the patient as part of his/her care circle.</td>
</tr>
<tr>
<td>Customer</td>
<td>A current or potential buyer or user of products from a store or business (Canadian Oxford Dictionary, 2004). An individual that uses the services or expertise of another, despite whether a product is purchased or not.</td>
</tr>
<tr>
<td>Customer service</td>
<td>Service which when it is satisfactory, is seen to meet or exceed the customer’s expectations (Baird, 2000; Lee, 2004).</td>
</tr>
<tr>
<td>Healthcare provider (HCP)</td>
<td>A person employed by the organization with the mandate to provide healthcare services to patients. It does not refer to a caregiver requested or paid personally by the patient to provide assistance.</td>
</tr>
<tr>
<td>The organization</td>
<td>The healthcare organization where the study occurred.</td>
</tr>
<tr>
<td>Patient and family centred care educational intervention (PFCC)</td>
<td>Facilitated group learning which occurred in the organization. It was composed of weekly two-hour sessions for eight weeks led by two trained and experienced moderators. Participants were engaged to examine traditional practices and ways to enhance patient and family involvement. Curriculum was based on the Registered Nurses Association of Ontario Best Practice Guideline - Client Centred Care (2006) and framework of Identifying Needs, Making Decisions, Caring and Service, Evaluating Outcomes. Discussion occurred on the following topics: ethics, communication, enhanced listening, open-ended questions, issues of safety and risk, vulnerability, power and control. Learners completed five assignment conversations with patients and family, and participated in 7 of 8 sessions to receive certification.</td>
</tr>
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*These are operational definitions for the purpose of the research.
Chapter 1

Introduction

The total cost of healthcare in Canada was close to $192 billion dollars in 2010, representing nearly 12% of the gross domestic product (Canadian Institute for Health Information, 2010). This represented more than a 5% growth over the prior year and a cost of almost $5,700 per person (Canadian Institute for Health Information, 2010). As reflected in Dr. Jeffrey Turnbull’s Sinclair Lecture address at Queen’s University, Canadian healthcare “is one of the biggest companies in North America” (Turnbull, 2012). With anticipated growth and increasing costs of the healthcare industry, a balance between excellent quality of care and efficient business practices is necessary so that it continues to be valued and viable (Drummond, Girioux, Pigott, & Stephenson, 2012).

Patient engagement has been cited as one of six crucial functions to transform the Canadian healthcare system (Denis, Davies, Ferlie, & Fitzgerald, 2011). Patients need to be involved in designing services to meet their needs, participating in good governance and evaluating outcomes. Healthcare professionals and organizations need to adopt new ways of thinking and working, and strategies to enhance communication and mutual learning. Denis, et al. (2011) suggest “in order to realign the system to meet evolving health needs, initiatives that support patient engagement and citizen participation, as well as the use of evidence to inform change are crucial. Both types of levers are potentially powerful instruments to channel organizational and professional strategies toward improvement” (p. i).

There is strong evidence that collaboration in healthcare relationships strengthens health systems and improves health outcomes (World Health Organization, 2010). Collaboration is defined as working in partnership with one or more healthcare team members toward a common
goal for improved health outcomes. It is important to note that the view of the healthcare team has been broadened to include the patient and their identified family and/or support members as essential participants for successful health outcomes (Romanow, 2002). These outcomes are numerous and varied, such as improved patient and provider satisfaction, health promotion and management, system access, to name just a few. As well, many strategies contribute to collaboration in practice and may include interprofessional/interdisciplinary education, an emphasis on components of interpersonal relationships, organizational cultures and structures, and health systems (Curran, 2007). Underlying it all remains the fact that collaboration is a voluntary undertaking. People must want to collaborate with others in order for this to occur.

Customer service, planning, providing and responding for excellence in the consumer experience, is becoming a prime focus in the Canadian public health arena. This is evidenced in legislation (Government of Ontario, 2005; Ontario Ministry of Health and Long-Term Care, 2010), health policy (Closson & Oandasan, 2007; Curran, 2007; Drummond, et al., 2012; Grimes & Tholl, 2010; Romanow, 2002) and in research funding ventures (Health Force Ontario, 2009; The Change Foundation, 2011). Although customer service is used colloquially to represent customer interactions, and in old adages such as, ‘the customer is always right’, what is the meaning of customer service when it involves complex health services and care within a hospital? Do we all have the same ideas of what constitutes excellent customer service? Do healthcare providers identify with this term and is it important to them in their work? Are meanings the same when one assumes different roles of healthcare practitioner, manager, leader or consumer? These are some of the many questions which underpin this study.

1.1 The Research Topic and Rationale

This research project used the conceptual framework of customer service to explore and enhance the culture of collaborative care relationships from the perspectives of healthcare
employees within a hospital organization in Ontario, Canada. Originally, relationships between healthcare staff and patients/families were considered, however, the research evolved to include relationships among staff, based on participant knowledge and contributions.

A critical philosophical stance, drawing from the interpretive paradigm (Higgs, Trede, & Rothwell, 2007), informed the study. The critical paradigm is based on the researcher’s epistemological perspective of concerns for understanding and transforming the influences of power, authority and politics within social structures. I wished to become aware of how thinking was socially and historically constructed in regard to collaborative care relationships, how it was acquired through critical debate and how mental constructs may limit or advantage action within the hospital’s culture. This research stance was related to the concept of ‘knowing for change’ which promotes understanding about strategies to transform current structures and conditions (Higgs, Horsfall, & Grace, 2009). This knowledge comes from observing the culture, by drawing cultural inferences based on what the members of the culture do (behaviours and practices), on what they make (in the case of a hospital, this might be related to work processes and tools), and on what they say (language and shared meanings) (Speziale & Carpenter, 2007). “A significant part of culture is not readily available. This information, called tacit knowledge, consists of the information that members of a culture know, but do not talk about or express directly” (Speziale & Carpenter, 2007, p. 207). For these reasons, it was important to be immersed in the culture for a prolonged time period, in order to understand the explicit and tacit knowledge of the organization.

In addition to understanding members’ perspectives, changes in practices and actions were taken into account to build a cultural picture of a hospital organization undergoing change as it directed its attentions to improved collaborative care relationships. As a participant/observer/researcher throughout the study, I was advantaged in accessing and
collecting additional cultural information from an emic perspective. Cultural knowledge is constructed as the researcher draws inferences and conclusions based on their observations (Krefting, 1989), and an insider’s view facilitated my knowledge and understanding of the culture in its everyday work and activities. Inferences were not only drawn from over 60 hours of interview, meeting and observation time, but also from daily work over the period of the study, a historical context from my prior ten year work history, and a continuing context from my ongoing work within the organization.

1.2 Research Goals and Questions

The primary goal of the research project was to explore, with a view to improve the culture of collaborative care relationships within a non-acute care hospital organization. A secondary goal was to generate innovative ideas for change within the organization. The central research question was:

How can healthcare providers, mid-level and senior level leaders in a hospital advance its organizational culture toward improved collaborative care relationships?

A number of sub-questions were addressed as pertaining to the organization:

- How did healthcare provider, mid and senior level organizational members view the meaning of customer service as it related to patients, families and each other?
- What factors influenced or impeded collaborative care relationships?
- What innovative change ideas were generated to enhance collaboration?
- Which of the change ideas generated were implemented?

These questions were addressed by three phases of research, in which each had associated questions which are defined in the subsequent chapters.
1.3 Location and Boundaries of the Research Project

The focus of this research study has been on learning related to change in collaborative healthcare relationships at the individual, group and organizational levels (Crossan, Lane, & White, 1999; Senge, Kleiner, Roberts, Ross, & Smith, 1994). The literature guided undertakings and interpretations of the study and will be reviewed in subsequent chapters.

The research involved volunteer employee participants from a non-acute academic health science centre which is faith-based, and has a long history of serving communities in Eastern Ontario. This health science centre has three urban sites, over twenty community locations and employs over 1800 staff. The multiple sites have been amalgamated into one corporation and originate from different backgrounds and funding structures. The doctoral research was conducted at one of the hospital sites which has 144 inpatient beds providing complex continuing care, palliative care, physical medicine and rehabilitation and specialized geriatric services. Extensive ambulatory services are also offered at this site in physical medicine and rehabilitation and specialized geriatrics. Study timelines, from September 2008 until December 2010, included a preliminary research phase for completion of a literature review, a grant application and ethics reviews, and data collection in the three subsequent research phases. Analysis occurred throughout this time period and also during the writing of the manuscripts and dissertation which were completed in March 2012.

Participants offered individual perspectives, many of which developed into shared perspectives and meanings related to the research questions, in group settings. Perspectives were sought from a variety of organizational roles and levels within the organization and together formed a view of the culture. Although it was recognized that many different societal influences, for example, prior education and licensing of health disciplines and/or governmental regulatory
and funding mandates, would also affect hospital cultures and relationships, a decision was made that the societal or extra-organizational level was beyond the scope of this study.

1.4 Overview of Methods

Founded within the critical research paradigm, the study design was emergent as the research and questions developed and the study progressed. A mixed methods research methodology was used within the overall tradition of a critical collaborative ethnography.

Ethnography is the deep study of culture which investigates the way that people negotiate and contest meanings in the course of their lives and work. The researcher attempts to see and represent the group, their processes, interactions, and shared understandings, from the perspective of the participants and without the bias of one’s own worldview (Conn, 2010). A critical ethnography is one that is focused on changing inequitable social structures as an outcome of the research process (LeCompte & Schensul, 1999b). This research sought to expose traditional hierarchical structures and authoritarian processes within care relationships by calling attention to them so that opportunities and motivation for change would occur.

Critical collaborative ethnography is an emergent qualitative methodology. It is aligned with participant action research in that it refers to doing research ‘with’ people rather than ‘on’ or ‘about’ people (Bhattacharya, 2008, p. 305). Research is conducted with the participants and can include any or all parts of the research process, from fieldwork to writing, with the common purpose of bringing change, as in the case of this study, to the organizational culture. The focus of the inquiry process is the self-realization of change on the part of the people involved. This process engages innovation and creativity within the research tradition and its credibility can be captured by the term ‘catalytic validity,’ the degree to which the research process leads the participants to gain self-understanding and self-leadership (Bhattacharya, 2008).
As is common in ethnography, a mixed research methodology was used and included an exploratory case study, survey, focus groups, interviews and participant observation. All data collection points were triangulated for analysis along with cultural artefacts such as organizational documents, detailed field notes and the author’s reflective notes gathered throughout the course of the study.

1.5 Organization of the Thesis and Overview of the Manuscripts

This thesis is written using the manuscript style. It begins with an introductory chapter which is followed by a background literature review chapter that summarizes current concepts and factors related to collaboration, participation, partnership and shared decision making in healthcare relationships (Chapter 2). The next three chapters have been written as individual manuscripts and describe the three sequential and linked research phases which constituted the doctoral research project. Within each chapter is a description of the literature, research methods, analysis, findings and discussion pertinent to the research phase. Each manuscript was written with a view for submission to a different and specific peer-reviewed journal. For this reason, journal styles and word limits were observed in writing the individual manuscripts to strengthen their success in being accepted for publication. For example, one journal had a criterion of a maximum of 5,000 words. Therefore, using the manuscript style reduced the number of pages in the thesis as compared to a thesis written in the traditional style. Care was taken in producing the overall thesis to avoid redundancy in information, while also demonstrating that the research phases were linked and evolved over time. All three manuscripts have been submitted to peer-reviewed journals. The second manuscript is in press (Brander, Paterson, & Chan, 2012b) and the first and third manuscripts are currently in review (Brander, Paterson, & Chan, 2012a, 2012c).

Chapter 3 (Manuscript #1) is focused on the first phase of the research project which was directed toward exploring healthcare providers’ perspectives of care relationships. Phase 1 was
funded by a grant from The Ministry of Health and Long Term Care HealthForceOntario-Interprofessional Education Fund 2008/09 in September 2008. Notification of grant approval was received in December 2008 and the research for Phase 1 commenced shortly thereafter. The final grant report was submitted and accepted by HealthForceOntario in October 2010. The final report was used as a foundation for the writing of Manuscript #1 and it is now in review with an international journal with an explicit interprofessional focus.

Chapter 4 (Manuscript #2) represents the second research phase which began with re-analysis of Phase 1 data, with the defined purpose of sharing findings with mid-level leaders who were responsible for clinical care within the organization. Phase 2 used quantitative as well as qualitative methodologies. Mid-level leaders were first surveyed about their opinions on care relationships and customer service. Following the survey, Phase 1 findings were presented at the beginning of a focus group with mid-level leaders to provide an opportunity for deeper investigation and shared construction of ideas related to customer service and care relationships. This manuscript is now in press with The Qualitative Report, an online international journal (Brander, et al., 2012b).

Chapter 5 (Manuscript #3) deepens the cultural exploration by examining within-organization factors related to collaborations and partnerships from the perspective of senior leader participants. Phase 3 was initiated by sharing the triangulated results of the prior two phases with senior leaders/key informants and generated further discourse in individual interviews. This manuscript considers and summarizes all three research phases for the critical ethnography, and takes into account changes which have occurred in the organization over the course of the research. Throughout all study phases innovative change ideas for improved collaborative care relations within the organization were collected as generated by the participants. Key enablers for collaborative care are described in a formative model of
organizational relationships entitled ‘partners-in-care.’ This manuscript has been submitted to an international journal with a research and practice focus on interprofessional care.

Chapter 6 provides a general discussion which integrates all study findings with current health literature. Contributions to existing knowledge are described. Suggestions and applications for improved collaborative care in the organization are discussed. Limitations of the study and recommendations for future research are also presented.

The appendices provide copies of the letters of ethics approval (Appendix A, B, C), details of the research processes used, and related information (Appendices D through T).

1.6 Significance of the Project

This research presents a picture of an organization applying collaborative learning and research practices for improved care relationships amongst healthcare employees, patients, their families and with each other. The organization is a mid-sized non-acute care hospital, one site of a multi-site academic health science centre, in eastern Ontario. A conceptual framework of ‘partners-in care’ was created by shared conversation and debate amongst participants and through the sequential study phases. The underlying components were described for achieving partnership in care relationships within the organization. Innovative change ideas were also created and catalogued for future conversation and directed action. It was recognized that the concept of customer service contributed to these discussions, but was not the representation of choice by all members. Tensions within collaborative practice and the organization were also identified and may be foci for additional consideration and practice development. A collaborative research endeavour was used to develop a conceptual framework of ‘partners-in-care’ through focus groups and interviews within the organization. Collaboration occurred with key informants and an informal participant action research team at key decision points throughout the research and these as described in the subsequent chapters. The research processes were demonstrated to
contribute to the organization’s values for strengthening relationships and enhancing quality of life, by participant self-report, and the generation and implementation of innovative change ideas to enhance collaborations with patients and families. Broad discussion of the research outcomes as they developed, through formal and informal presentations and interactions and with internal and external stakeholders, also contributed to the research processes and analysis. As the ethnography describes a local culture, similarities and differences in contexts must be taken into account before transferring findings to other settings. It is hoped however that the findings presented in this thesis may stimulate conversation in other healthcare venues directed toward enhanced collaborative care relationships for patients, families and healthcare workers.
Chapter 2

Background Literature Review

2.1 Introduction

Collaborative care relationships are of prime concern in today’s healthcare environments. Many articles investigate relationships between healthcare providers and their patients (Conlon, 2007; Gerteis, Edgman-Levitan, Daley, & Delbanco, 1993; Messner, 1993; Young-Mason, 1997) and encompass many countries (Coulter, 1999; Dalton, 2003; Eldh, Ekman, & Ehnfors, 2006; Funk, 2004; MacKean, Thurston, & Scott, 2005). The purpose of this chapter is to review current and relevant literature related to collaborative care relationships and to explore recommendations for related improvements within the healthcare team, including patients and their families.¹

The Commission on the Future of Healthcare in Canada has identified that a team approach to service delivery is one of the key components for primary healthcare service reform (Romanow, 2002). At the 2004 Canada Health Accord, it was agreed that the Canadian government would work together with healthcare professionals to accelerate the development and implementation of new models of primary healthcare delivery and subsequently the Primary Healthcare Transition Fund was created. A series of five synthesis reports was developed with the aid of this fund, one of which was entitled “Collaborative Care” (Curran, 2007), reflecting the prominence placed by federal and provincial partners on new models of collaboration for primary healthcare renewal. In fact, Canadian health policy is increasingly aimed at patient-centred care reform, in an effort to facilitate patients and families as full members of the healthcare team (Curran, 2007; Grimes & Tholl, 2010).

¹ Patient or client is used interchangeably to represent the person registered through the provincial health database as receiving hospital services. Family refers to family member(s) or close caregiver(s) defined by the patient as part of his/her care circle.
Achieving this goal is vital, particularly as clinical options and decisions multiply and become more challenging (Légaré et al., 2008; O’Brien et al., 2008; Street, Makoul, Arora, & Epstein, 2009). At the same time it has been identified that there is a lack of knowledge about the best ways to partner with healthcare customers (Beaver et al., 2007; Dalton, 2003; Gravel, Legare, & Graham, 2006; Légaré, et al., 2008). Although collaboration is globally recognized as desirable and necessary (World Health Organization, 2010), the best methods for its applications are still under investigation. Development and strengthening of inter-collaborative health teams which include patients and families have been strongly recommended for transforming the Canadian healthcare system and will lead to greater safety, consumer and provider satisfaction, and efficiency (Beaver et al., 2009; D’Amour, Ferrada-Videla, San Martin Rodriguez, & Beaulieu, 2005; D’Eon, 2005; Herbert, 2005).

2.2 Examining Concepts: Collaboration, Participation, Partnership and Shared Decision Making

There are different interpretations of the meanings of collaboration, participation and partnership within healthcare teams (Cahill, 1996, 1998; Casey, 2008; Eldh, et al., 2006) and therefore great variation in organizational structures surrounding the application of these concepts (Kim et al., 1993). For the purposes of this discussion, I will set apart the situations where the patient is unable to make decisions, where their family may be unavailable and/or where care decisions must occur quickly in risk or emergent circumstances. These are not the situations addressed by this manuscript, and fortunately, in most interactions, this is not the case.

Differing levels of involvement are evident and it is the responsibility of the health providers working together with the patient and family to satisfy their needs for information and understanding so that they are able to participate to the extent to which they choose (Kiesler & Auerbach, 2006; O’Connor, Drake, et al., 2003). The majority of patients preferred shared decision making (SDM) (78%) over autonomous decision making (< 2%), although some
preferred a passive role (20%), in a survey of outpatients in multiple clinical settings in Ontario (Deber, Kraetschmer, Urowitz, & Sharpe, 2007).

Cahill (1996) conducted a concept analysis of patient participation, compared it to related concepts and developed a model to represent the hierarchical interconnections. Patient involvement was described as the assignment of basic tasks from provider to patient, and did not require intellectual activities such as decision making. Patient collaboration included intellectual involvement of the patient, but not usually physical action. Together these two concepts were foundational for patient participation, which was characterized by a narrowing of the knowledge gap between the clinician and patient, but consensus in decisions was not required. All three, patient involvement, collaboration and participation, were needed to achieve partnership, the pinnacle of the decision making pyramid. She concluded that partnering with patients demanded a working relationship with mutual respect, shared goals, equal control and full sharing of knowledge throughout the care process.

Sahlsten, Larsson, Sjöström, Lindencrona, and Plos (2007) conducted focus groups with nurses in hospitals in Sweden. They found that patient participation was an interactional process and that ‘mutuality in negotiation’ was paramount for success in the nurse-patient relationship. Mutuality of negotiation referred to the process of discussion leading to a shared agreement for a plan of action, with the aim to increase the patient’s influence in planning and implementing care. The relationship was characterized by intimacy, contact, understanding and cooperation between two equal parties (patient and nurse) sharing similar goals. Formal concepts of partnership and shared decision-making were not discussed in the article.

In considering inter-organizational partnerships specific to nursing and midwifery, Kernaghan (1993) classified partnerships based on power. He defined five distinct types of partnerships with collaborative partnerships as being the most sophisticated, where each partner
exercised power in decision making, shared goals, built consensus with balanced power and where mutual dependence was possible. This he distinguished from an operational partnership, typified by work-sharing rather than decision-sharing power, similar to Cahill’s (1996) distinction between involvement and participation. The collaborative partnership, with shared decision making as one defining element, was the ultimate goal of the client/clinician relationship.

D’Armour, Ferrada-Videla, San Martin Rodriguez, and Beaulieu (2005), in seeking the core concepts and theoretical frameworks for interprofessional collaboration, found sharing, partnership, interdependency and power repeatedly mentioned as important components in the literature. Collaboration was described as a complex, voluntary and dynamic process, subject to constant change. Healthcare team collaboration was seen to be challenged by discipline specific and theoretical frameworks and by organizational constraints. A key recommendation was that team collaboration needed to be examined more fully from the perspectives of its determinants, processes and results in healthcare. One drawback noted was the absence of the patient’s perspective in the definitions reviewed for collaboration. Another area requiring more research was how to best integrate patients into the care team.

It has become increasingly evident that one of the most important parts of patient collaboration and participation is that of shared decision making (SDM) (Eldh, et al., 2006; Makoul & Clayman, 2006). There has been much work towards a model of SDM (Towle & Godolphin, 1999). One model that is used widely and captures many players in the process defines SDM as a process that is jointly shared by patients and their healthcare providers by which a quality decision is reached (Briss et al., 2004). However, other players such as the family or caregivers may also need to be included in complex health decisions. Education and information are key determinants for valid SDM and some authors use the term informed decision making or informed and shared decision making to reflect these important preconditions (Towle, Godolphin, Grams, & LaMarre, 2006).
In one systematic review with the goal to gain a clear understanding of the key components of shared decision making, over 681 articles were identified with shared decision making in the title or abstract, from 1980 up to Dec 31, 2003 (Makoul & Clayman, 2006). The authors noted that 418 articles mentioned SDM but did not define the term. They did find 161 articles that included conceptual definitions of SDM in the English language from ‘medically oriented journals.’ From these studies, Makoul and Clayman (2006) then extracted mutually exclusive and exhaustive concepts; using pre-determined coding rules by at least two members of the research team, to compile the most frequently cited definitions of SDM. From this analysis the researchers integrated a complex picture of SDM, including nine essential elements (define/explain problem, present options, discuss pros/cons, patient values/preferences, discuss patient ability/self-efficacy, doctor knowledge/recommendations, check/clarify understanding, make or explicitly defer decision, and arrange follow-up), four ideal elements (unbiased information, define roles, present evidence, and mutual agreement) and ten general qualities on the part of both patients and providers (deliberation/negotiation, flexibility/individualized approach, information exchange, involves at least two people, middle ground, mutual respect, partnership, patient education, patient participation, and process/stages). Makoul and Clayman (2006) concluded that there was no shared definition of SDM, but proposed that the essential elements must be present for patient and providers to engage in SDM, and that the ideal elements may enhance the process, but were not necessary. Characteristics of patients (e.g. age, acute or chronic health condition), healthcare providers (e.g. physicians or allied health professionals) and contexts (e.g. in-patient or out-patient), were not considered. These characteristics may have revealed additional or differing components of SDM.

In another systematic review of the literature from 1990 to 2006, Gravel, et al. (2006) found the three most reported facilitators for SDM to be perceived positive impact on the clinical process, patient outcomes, and provider motivation. The three most reported barriers were lack of
applicability of SDM due to patient characteristics, the clinical situation, and time constraints. The literature reviewed was based on healthcare provider perceptions as opposed to patient perceptions or observed data. Judgements were made by the provider on behalf of clients about who would benefit from SDM and the appropriate clinical situations. This may represent a paternalistic decision making approach, where the healthcare provider knows what is best for the patient (Coulter, 1999). It would be important to determine patient and family views of the barriers and facilitators to decision making.

In a study with a goal to improve inpatient care in Sweden (Sahlsten, Larsson, Lindencrona, & Plos, 2005), nurses perceived the following as hindering patient participation in nursing care: lack of competence (on the part of the nurse to facilitate patient participation), a negative influence of significant others (where the family deterred participation of the patient), and poor organization of the work environment (lack of nurse-patient continuity due to nursing schedules, staffing complements, non-supportive co-workers, task-oriented care plans and physical environments). The authors concluded that it is the responsibility of all professional nurses to find a balance to enhance their patients’ participation by identifying and coping with hindrances:

A nurse, who does not understand that patient participation requires a deliberate approach and way, preserves the paternalistic expert role….A professional nurse must balance the patient’s need of control and self-esteem, promote independence by treating and guiding the patient as an equal partner…Participation presupposes an attitude that it is morally right for patients to make own choices and exercise control. (Sahlsten, Larsson, Plos, & Lindencrona, 2005, p. 227).

There are common features represented in the above studies and reviews. Most studies considered the opinions of healthcare providers only, not those of patients and families, and the majority of the providers were physicians. It was clear that there was very little known about other health professional perceptions of SDM as 89% of the participants were physicians (Gravel, et al., 2006). Clinician subjective judgements were made as to when and if the situation and/or
patient and family warranted a SDM focus (Légaré, et al., 2008). The biomedical approach was strongly perpetuated in the majority of articles reviewed, even though most were published after 1990.

These concepts are sophisticated and take on depths of meanings and attributes according to the individuals and groups who apply them. One must ensure that shared consensus and understanding is built when using meanings to describe core values and beliefs about work practices, especially when the goal is to effect change and to engage teams. Patients and families work with a variety of healthcare providers with diverse skills and educational experiences, each with their own varied personal and educational backgrounds. Healthcare providers, in turn, must be responsive to a variety of patients and families, also with a variety of backgrounds, cultures, individual needs and expectations. Healthcare providers must also work productively with each other. Conceptual frameworks to better understand and evaluate the complex components of collaboration and partnership for successful healthcare team interactions are needed.

2.3 Enabling Collaborative Partnerships

Facilitators and barriers to partnership will be reviewed at the individual, team, organizational and system levels.

2.3.1 Individual level.

A current definition of interprofessional collaboration is that “it is the process of developing and maintaining effective interprofessional working relationships with learners/practitioners, patients/clients/families and communities that enable optimal health outcomes” (The Canadian Interprofessional Health Collaborative, 2010, p. 8). Through an expert curriculum committee, the Canadian Interprofessional Health Collaborative (CIHC) developed and defined six competency domains:
1. Interprofessional communication
2. Patient/client/family/community-centred care
3. Role clarification
4. Team functioning
5. Collaborative leadership
6. Interprofessional conflict resolution

Interprofessional communication and patient/client/family/community-centred care were decided to be the foundational competencies which supported and influenced the remaining four, and were relevant in all interactions. These competencies were defined to enable the learner and/or practitioner to effectively develop their knowledge, skills, attitudes and values which contribute to collaborative practice. An additional goal of the competency framework was to provide a working document from which to compare experiences, language and cultures globally for interprofessional collaborations.

Other intrinsic and extrinsic factors impact outcomes, such as individual experiences and beliefs, culture and diversity in backgrounds, presenting circumstances and implications of decisions (e.g. life-threatening or other), to name only a few (Bissell, May, & Noyce, 2004). Within the CIHC competency framework (2010), it was recognized that the degree of complexity of the situation and the context in which it occurs will influence inter-collaborative experiences. The CIHC framework also states that there is an important relationship between inter-professional collaboration and quality improvement, which is inter-dependent and mutually influential.

Many different transactions of power can exist in clinician-patient interactions and the healthcare expert often controls the interview and/or the outcomes (Canter, 2001). It is not as simple as transferring power from the practitioner to the patient as situations can be difficult for the patient to navigate. In a truly patient-centred healthcare system it would be recognized that the health provider does not hold the sole rights to truth and information, and strategies and
communications would occur with that view in mind. Even with motivated family physicians trained in informed and shared decision making competencies, it was difficult for practitioners to change past habits of relations and communication with patients (Towle, et al., 2006). A major barrier to collaborative practice was concluded as being well-engrained patterns of interacting and communicating with patients (Howe, 2006).

The realities of habitual communication patterns, roles and power structures do not make it easy to provide recommendations that will ensure partnership with patients and families. Patients who actively engaged in communication, were ready with questions and indicated their preferences in care, information and decision making, were shown to promote physician patient-centred behaviours (Griffin et al., 2004; Haesler, Bauer, & Nay, 2007). Informed, activated, participatory patients and families are instrumental to health providers having a better understanding of their needs, but this is also dependent on communicative and patient-centred clinicians (Epstein & Street, 2007). Research has shown that when physicians infer patient preferences for decision making and participation in treatment, physician inferences are often incorrect (Charles, Gafni, & Whelan, 1997). It follows that when the patient shares information directly, fewer errors and miscommunications will result. In an ideal world, patients would air all of their questions and be open and honest with their information, as they are the experts in this regard. They would provide clear feedback as to their treatment choices, decisions and responses (Kiesler & Auerbach, 2006; O'Connor, Stacey, et al., 2003). If we truly want to share decisions, then we must share feedback. However, reality does not always follow the ideal and many variables can intervene.

Healthcare is fraught with difficult decisions and emotions, which take time and resources to work through. The partnership may occur over repeated encounters and even years, so there are often subsequent opportunities to clarify and validate communication. Patients and families should not hesitate to persist, to ask for more assistance or speak to other providers
where needed, but again this is not always easy. The more that patients and families can understand healthcare structures and services, the better they will be able to navigate, investigate and actively participate in decision making, but the responsibility to open the door to their questions remains fully with the clinician.

2.3.2 Team level.

A healthcare team could be as simple as two clinicians working together, and optimally it includes the patient. More frequently now than in the past, the team also includes family members and/or personal friends or caregivers, who along with interdisciplinary clinicians, communicate with each other in directed efforts to accomplish congruent goals (Howe, 2006).

Teams working in complex organizations, such as in hospitals, derive purpose and directions from their work context. For example, rehabilitation teams commonly include a wide variety of health professionals working with the client, whereas emergency room teams may often be composed of patient, nurse and physician. The work drives the team composition, development, and function’ in order to meet the goals at hand. Excellent teamwork, quality care and patient outcomes have been shown to be positively related in current health literature (World Health Organization, 2010); however, their determinants are not yet well understood (Grimes & Tholl, 2010; Leathard, 2003).

Team compositions and functions vary widely within and between organizations and collaborations have often been distinguished by such terms as multi-, inter- or trans-disciplinary teams. However, these teams have not routinely included patients, let alone family, as members. (D'Amour, et al., 2005; D'Eon, 2005). Traditional team processes put forward as involving the patient/family were family conferences or discharge meetings. These were often held to impart provider-to-patient directed information and where equal decision making did not occur. The meeting was chaired by a clinician, (historically the physician); the agenda was set to meet clinician goals (often related to discharge plans and timelines) and an opportunity for additions or
questions from the patient and family was usually included. The patient had marginal, if any, true
decision making power, as decisions had often been decided by the clinical team prior to the
conference. Clinician team members, in their defense, were and continue to be challenged by
organizational resources and standards, such as externally mandated targets for waitlists and
length of stay. The ultimate goal of the collaborative partnership, where there is equality in shared
decisions, may remain elusive and may in fact be unrealistic within today’s funding limitations
and high demands for care.

2.3.3 Organizational level.

Organizational and government mandates greatly impact team efficacy and outcomes
(Miller & Freeman, 2003). Effective teams with positive outcomes for patients have been shown
to be due to organizational factors as well as interpersonal ones. Interpersonal relations between
team members can be greatly affected by fragmented organizational structures, such as
departmental or program models of care, traditional hierarchies in roles, restructuring and similar
resource focused strategies (Miller, Freeman, & Ross, 2001).

Organizational aspects that can either facilitate or impede collaboration may include time
for discussions, staffing levels, geography, language and patient representation (family,
healthcare advocate or community representative) (Eldh, et al., 2006; Gravel, et al., 2006;
Minore, Boone, Katt, Kinch, & Cromarty, 2003). Additional organizational aspects, such as well-
documented mission statements with defined organizational values and a focus on learning and
shared leadership also influence inter-collaborative relations (Bally, 2007; Bart & Hupfer, 2004;

With improved access to electronic information, more organizations are partnering with
their customers to meet defined needs and to provide credible healthcare information to help with
decision making. An excellent example is the Ottawa Health Decision Centre, with online tools
developed with and available for patients (Légaré, Stacey, & Forest, 2007; Ottawa Health Decision Centre, 1996).

2.3.4 System level.

Compounding all of the above is that teams work within and across different health organizations and funding models, in different health funded environments, both public and private sectors, across provinces, territories and the country. Many systemic factors influence the components related to collaborations within health teams.

In Canada, federal and provincial laws mandate processes linked to determinants of collaborative processes. For example, regulated health professionals have a legal obligation to disclose to the patient whatever a reasonable person in a similar situation would want to know about an intervention before making a decision (Goldolphin, 2003). In Ontario, the Consent to Treatment Act requires that patients are informed about the benefits, risks and details of treatment and alternatives (Government of Ontario, 1992). Both legal requirements facilitate the sharing of knowledge and SDM.

Health research funding has been established to facilitate the advancement of shared decision making. Two Canada Research Chairs have been established, one awarded for Healthcare Consumer Decision support to Dr. Annette O’Connor, University of Ottawa and another for Implementation of Shared Decision making in Primary Care to Dr. France Légaré at Université Laval, Montreal (Légaré, et al., 2007). Health Force Ontario, through its Interprofessional Care Education Fund has also awarded grants for studies related to patient and health provider interactions and communications (Health Force Ontario, 2009). This thesis was funded in part by a grant received from this funding agency.
2.4 Summary

Much work is yet to be completed on understanding the dynamics and roles of the patient’s healthcare team and the best means of collaborating together with shared goals for improved health outcomes. Further knowledge about patient and family interactions with varied clinicians, in different health contexts, with a variety of services, disabilities and situations is still required. Studying opportunities to share feedback about the same interventions and team experiences between all team members is important for ongoing evolution in research, in the clinical environment and at health policy and system levels. Until we can speak freely together, and hear each other without fear of repercussions, we will not have equal partnership on the patient’s healthcare team, the imbalance of power will be perpetuated and opportunities for improved safety and outcomes will be lost.
Chapter 3

Customer Service to Partners-in-care: Healthcare Providers’
Perspectives on Care Relationships

3.1 Abstract
Health policy and legislation are directing Canadian healthcare organizations toward higher levels of patient/family engagement and service excellence. Healthcare providers contribute significantly to such outcomes, yet much is still to be learned about best practices for success. Customer service was used as a conceptual framework to uncover healthcare providers’ (HCPs’) views of relationships with patients, families and each other. An exploratory case study examined HCPs’ perspectives of care relationships during semi-structured focus groups/interviews, prior to, immediately after, and six-months after Patient and Family Centred Care educational intervention (PFCC). Five categories (customer, customer service, knowledge, roles, and common vision) and associated themes described the HCPs’ views. Over the longer term, participants recounted many experiences of improved care relationships and attributed these to new practices adopted with PFCC. Important exchanges in healthcare relationships agreed with those previously described, but not all participants identified with ‘customer service’ as representational of care relationships. Participants envisioned a conceptual framework of ‘partners-in-care’ as representative of the care relationships developed in their work with patients, families and each other.

Key Words: Customer service, collaborative practice, partners-in-care, patient and family centred care, cultural change, case study
3.2 Introduction

Interprofessional collaboration has been widely recognized to improve health outcomes (Curran, 2007; Romanow, 2002; World Health Organization, 2010), yet more evidence is needed to guide clinicians in its effective adoption and practice (D’Amour, et al., 2005; Grimes & Tholl, 2010; San Martin-Rodriguez, Beaulieu, D’Amour, & Ferrada-Videla, 2005). The World Health Organization’s collaborative practice definition embraces interactions between all members of health team, including the patient, family and other carers (2010, p. 7) and strategies for this broad involvement are evolving, in improved interpersonal and staff-family communications (Grimes & Tholl, 2010; Haesler, et al., 2007; McGilton, Irwin-Robinson, Boscart, & Spanjevic, 2006; Street, et al., 2009), patient participation in decision making (Beaver, et al., 2007; Gravel, et al., 2006; Légaré, et al., 2007; Légaré et al., 2011; Towle, et al., 2006) and conflict resolution (Brown et al., 2011).

Customer service frameworks focused on meeting and exceeding customer expectations have been commonly applied within private health organizations and in the United States (Lee, 2004; Leebov, 2008; Rangachari, Bhat, & Yoon-Ho, 2011), but an extensive literature review found a limited number of articles which used customer service terminology within the Canadian healthcare sector.¹ Current health policy and legislation target consumer focus, patient engagement and experience (Denis, et al., 2011; 2005; 2010; The Change Foundation, 2011) and customer service is being used as indicative of health services adapting to client-determined needs (The Change Foundation, 2010). The researcher posited that care relationships may be improved by exploring healthcare providers’ (HCPs) views and recommendations for customer service.

Interprofessional education is important to prepare clinicians to learn with, from and about each other to enable collaboration for improved health outcomes (Grimes & Tholl, 2010; The Canadian Interprofessional Health Collaborative, 2010; World Health Organization, 2010).
The Patient and Family Centred Care education intervention (PFCC), already well-established within the organization (Appendix T), aimed to facilitate HCPs in effective collaborative practice with patients and families and provided an opportunity for exploration of their perspectives.

The purpose of this study was to explore in-depth the case of interprofessional HCPs participating in PFCC and though guided discourse, longitudinally reflect their knowledge, attitudes and practices related to collaborative care relationships. The following research questions were developed:

1. How did HCPs enrolled in PFCC view the meaning of customer service as it relates to patients, families and each other?

2. How did their views change immediately after the PFCC educational intervention?

3. How did their views change over time and were they sustained?

Key terms used throughout the paper are defined on page xii.

3.3 Methods

Study Design

The case of interprofessional HCPs participating in an educational intervention (PFCC) and in guided focus groups was explored to better understand perspectives related to collaborative care relationships within the organization. The case was bounded by research granting and scheduled PFCC timelines and research site course registrants.

Study Site and Participants

The study was conducted on one hospital site of a multi-site non-acute academic health science centre in eastern Ontario. The hospital site has 144 inpatient beds providing complex continuing care, palliative care, physical medicine and rehabilitation and specialized geriatric services; and it also offers ambulatory care services. The organization has a long history of serving the community and is faith-based.
The university’s and the organization’s ethics review boards cleared the study.

Volunteers were purposefully recruited from PFCC registrations, Group A (Apr-July 2009) and Group B (September-Nov 2009). Participants were provided with study information and signed informed consent and confidentiality forms. Experienced and consistent course moderators facilitated the established PFCC curriculum. The researcher was not involved with the PFCC education, although she had taken the education previously as part of her own work requirements so understood the content being discussed.

Data Collection Procedures

Data were collected from January 2009 to March 2010 and included participant action research team meetings, focus group/interview transcripts, participant observations, and the researcher’s fieldwork and audit trail notes (Table 3.1). The PFCC moderators and the researcher formed the participant action research team and discussed study design, recruitment, observations, and data confirmation throughout the study.

<table>
<thead>
<tr>
<th>Table 3.1 Data collection procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group</strong></td>
</tr>
<tr>
<td><strong>Participant Action Research team meetings (number)</strong></td>
</tr>
<tr>
<td>Formal</td>
</tr>
<tr>
<td>Informal</td>
</tr>
<tr>
<td><strong>Focus groups (number of participants)</strong></td>
</tr>
<tr>
<td>Pre</td>
</tr>
<tr>
<td>Post</td>
</tr>
<tr>
<td>Long-term post</td>
</tr>
<tr>
<td><strong>Participant observation (approximate hours)</strong></td>
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</tbody>
</table>

* Includes one individual telephone interview
Three focus groups were conducted for each group and scheduled on the same day and prior to the first session (Pre), up to two weeks after (Post), and six months after (Long-term) completion of PFCC. Interviews were scheduled in tandem with focus groups, for those unable to attend the focus groups.

Semi-structured interview guides with open-ended questions evolved as the study progressed and used an appreciative inquiry approach (Mohr & Watkins, 2002; Preskill & Catsambas, 2006). Sample questions were: What is your priority in offering service/care in the hospital? What does the term customer service mean to you? Please describe a time in your work when you were able to offer good customer service. The researcher facilitated the interviews which were of 30-60 minutes duration, audio-recorded and later transcribed verbatim.

Ten volunteers (five from each group) enrolled from thirteen available course registrants. The remaining three registrants did not volunteer for the research and were not asked for their reasons to respect their privacy. All of the ten volunteers participated in focus groups except two individuals who could not be re-scheduled for one of the three focus groups, the Post focus group. One of the participants participated in Post and Long-term interviews via telephone, due to scheduling conflicts. Participant observers completed observational guides for the focus groups and reviewed these with the researcher after each focus group.

Participants represented in- and out-patient settings, the three different clinical programs (complex continuing care, rehabilitation, and geriatrics) and many different roles within two disciplines across the research site. Age range and professional experience were broad (Table 3.2). One person in each group had recent experience as a patient, or with a family member as patient, with the organization within the previous 12 months.
Table 3.2 Participant demographics

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>Group A</th>
<th>Group B</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female/Male</td>
<td>5/0</td>
<td>5/0</td>
<td>10/0</td>
</tr>
<tr>
<td>RN/RPN/Allied</td>
<td>2/2/1</td>
<td>2/3/0</td>
<td>4/5/1</td>
</tr>
<tr>
<td>Age range in years (Mean)</td>
<td>23-54</td>
<td>40-61</td>
<td>23-61</td>
</tr>
<tr>
<td></td>
<td>(45)</td>
<td>(53.8)</td>
<td>(49.4)</td>
</tr>
<tr>
<td>Professional experience in years (Mean)</td>
<td>2-32</td>
<td>5-39</td>
<td>2-39</td>
</tr>
<tr>
<td></td>
<td>(25)</td>
<td>(20.5)</td>
<td>(22.8)</td>
</tr>
<tr>
<td>Educational background</td>
<td>1 Bachelor of Arts &amp; Diploma in Nursing</td>
<td>4 Diplomas in Nursing</td>
<td>1 Bachelor of Arts &amp; Diploma in Nursing</td>
</tr>
<tr>
<td></td>
<td>4 Diplomas in Nursing</td>
<td>1 Bachelor Degree in Nursing</td>
<td>8 Diplomas in Nursing</td>
</tr>
<tr>
<td></td>
<td>1 Bachelor Degree in Nursing</td>
<td></td>
<td>1 Bachelor Degree in Nursing</td>
</tr>
<tr>
<td>Self or family member as a patient in the organization within previous 12 months</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Analytic Procedures

Analysis was completed as described by Stake (1995), using direct and categorical interpretation. Transcripts, observer and field notes were coded to discover key concepts and reviewed iteratively to build conceptual relationships, categories and themes. The researcher and thesis advisors first individually coded transcripts and then discussed these to develop consensus in interpretations. The participant action research team provided member checking through interview review, observational data and feedback. Data was triangulated to seek corroborations and disconfirming evidence. Temporal relationships in HCPs views were examined over the pre-determined time periods of Pre, Post and Long-term Post PFCC (Yin, 2009).
Ensuring Quality

Credibility, dependability, confirmability and transferability were used to establish study trustworthiness (Lincoln & Guba, 1985). Credibility: Research objectives and questions were clearly outlined, and data collection and analytic methods followed well-established sources for case study (Stake, 1995; Yin, 2009). Interview questions evolved in response to participant and research team feedback. The researcher held an emic understanding of the culture as she had worked within the organization for over ten years and was readily accepted as participant/observer/researcher. Findings were presented within the organization as one form of member-checking, and at peer-reviewed conferences (Brander, Paterson, Chan, & Ruffolo, 2010a, 2010b, 2010c). Dependability was strengthened by maintaining a dated detailed log of data collection, decision and reflection points. Interviews were transcribed verbatim, cleaned with audio-recording verification and triangulated with all data sources during analysis.

Confirmability: Co-advisors and the participant action research team were consulted during design and analysis and the researcher reflected on her biases and made every effort to reflect corroborating and disconfirming participant views during interpretation (Krefting, 1991; Yin, 2009). Detailed research activities were provided for external comparison and transferability.

3.4 Findings

Five categories (customer, customer service, knowledge, roles, common vision) representing HCPs’ perspectives of care relationships and associated themes are presented in Table 3.2 and are discussed below. Participant quotes lend support to themes and highlight perspectives over time. Pseudonym and focus group designations follow block quotations, e.g. (Sue/Pre). Changes in perspectives over time are represented by HCP quotations taken from Pre, Post and Long-term Post focus group transcripts and are presented in Appendix R.
Table 3.3 Categories and associated themes

<table>
<thead>
<tr>
<th>Categories</th>
<th>Associated themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer</td>
<td>Rights of the individual</td>
</tr>
<tr>
<td></td>
<td>Freedom of choice</td>
</tr>
<tr>
<td></td>
<td>Exchanges for a service *</td>
</tr>
<tr>
<td>Customer Service</td>
<td>Make everything right</td>
</tr>
<tr>
<td></td>
<td>The power of language</td>
</tr>
<tr>
<td>Knowledge</td>
<td>The power of information</td>
</tr>
<tr>
<td></td>
<td>Patients as knowledge experts</td>
</tr>
<tr>
<td>Roles</td>
<td>Family - From helpers to partners</td>
</tr>
<tr>
<td></td>
<td>Patient as team leader</td>
</tr>
<tr>
<td>Common Vision</td>
<td>Reciprocity of work</td>
</tr>
<tr>
<td></td>
<td>Respect for each other</td>
</tr>
<tr>
<td></td>
<td>Partners-in-care</td>
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</tbody>
</table>

* Sub themes - Communication, Respect, Shared decision making, Accountability

3.4.1 Customer.

Early on participants sought to understand ‘customer’ in a healthcare environment and this seemed a new way of thinking to many of them.

Who is the customer? Is it the patient, family? I need that clarified. (Pearl/Pre)

I think it means patients. Now things have changed. Patients are more aware of their rights. (Elaine/Pre)

But correct me if I’m wrong, a customer is someone who pays for a service. If you don’t like the service, you leave. Patients here can’t leave. (Pearl/Pre)

Themes associated with ‘customer’ were *individual rights, freedom of choice, and exchanges for a service*.

Participants recognized *individual rights* and stated, “the patient needs to be part of the plan, to become a partner and not just a patient” and “the patient knows what’s best.” They relayed difficulties in meeting patient rights in an ever-changing environment. One participant
talked about the difficulties with interruptions and competing needs in trying to help a patient follow a prescription for toileting every two hours, “You start something and then someone else comes to get you.” Understanding patient wishes was another identified challenge, “It is hard when there are communication barriers because then you don’t know what the patient wants.” Promoting patients’ rights was identified as a need after PFCC, “I think for the most part patients are thinking that they really don’t have rights. I think we have a long way to go.” Participants agreed that it was sometimes difficult to meet individual rights and requests due to the nature of work focused on unpredictable human needs and interactions.

*Freedom of choice:* The quote “patients here can’t leave” reflected the reality for some patients who had limited alternatives for care. Providing choice was seen to be constrained by the scarcity of options, “not enough staff” and differences between patient/provider goals.

It is difficult when patients have goals that differ from ours. Some spinal cord patients say, ‘I want to walk out of here.’ We have a body of knowledge that says it’s unlikely but it’s not up to us to say they are never going to walk again. (Elaine/Pre)

Although HCPs wanted to offer choices and assist patients with their goals, they indicated that they were not always able to do so. They recognized that the patient “may be overwhelmed” by circumstances and/or “may not be used to having a voice” and suggested new processes to assist patients, such as attending team meetings.

There needs to be improvements when the team holds goal meetings and the patient isn’t there. I’ve been asked to talk to a patient before the meeting and the patient told me flat out that there is no use as nothing ever happens. I came to that meeting with no goals from the patient. Having the patient there is going to make them more responsible for their goals. (Edna/Post).

Participants described that the spinal cord team now included patients in meetings which resulted in the patient communicating their goals and better understanding of these by the team.

Participants stated that other teams would benefit from this example and would require new processes for this to occur.
Exchanges for a service encompassed exchanges that participants identified as important for successful care relationships. Four exchanges were described: communication, respect, shared decision making, and accountability. Communication was described as a joint responsibility, “Communication has got to be one of the keys, to make yourself understood as well as to be understood by others.” It was recognized that the patient may need assistance, “The patient would be relieved that someone finally listened to what she had to say. It’s really important that we try to connect like that but sometimes it doesn’t work.” One participant indicated that she was now more aware of non-verbal communications and emphasized that this improved her own work satisfaction.

Before this course I wouldn’t have gone the extra distance, to pick up on her body language, stop and get to the bottom of it, to a point where it would ease the patient and satisfy all concerned. It lifted me up for the rest of the shift. (Pearl/Post)

Respect for self was seen as a precursor to sharing respect with others, “If you have self-worth and respect, you are going to share that with others.” Respect for the individual was affirmed, “It is customer service because it is customizing the care to the individual.” Respect for patients’ rights led to discussions about shared decision making, where the patient was involved with the care plan, provided with information and options and assisted with decisions.

Accountability was depicted as an exchange in stories of apologies. Apologies were seen as appropriate and helpful when an error had occurred, however at times errors were described as system-driven and outside the HCP’s control. Providers said they apologized for “lack of time” and “being short-staffed” and felt they were unable to correct these issues. One participant described, “I feel terrible for having to apologize for something that’s not in my control” and another described “being caught in the middle” between patient/family and management expectations. Participants shared concerns for liability and using veiled humor of “finding my name on the front page (of the newspaper).” Participants recognized the need for accountability but found it difficult to be accountable for issues that they felt powerless to correct. They noted
that patients were often aware of these challenges and apologized in turn to the HCPs, “The patients really do not like to bother you because they know we’re so busy. It breaks my heart to think that they are apologizing for bothering us.” The exchanges of accountability and apologizing presented areas of tension for the participants.

3.4.2 Customer service.

In a pre-focus group, it was indicated that ‘customer service’ had corporate overtones, “Customer service feels business-like….We’ve lost something when we’re talking about healthcare customer services. The personal part feels like it’s gone.” A few participants indicated that they felt customer service placed the responsibility on the HCP to “make everything right [so that] the patient walked away happy.” One person stated that relationships with patients and families were built on exchanges of intimate and personal care with vulnerable exchange partners and were often of repeated and long duration. After PFCC, some viewed customer service differently, as represented by this quote:

When I heard about (customer service) in the first focus group, I thought no, that is not what we do. But after going through PFCC, I realized, yes that is what we do. Our patients dictate what they want, what information they need and how they want to be cared for….This is what we need to do. (Bea/Post)

In post-focus groups, HCPs shared their beliefs about the important aspects of customer service in stories from their day-to-day experiences. They talked about “putting themselves in the patient’s shoes” and “it’s just all in the approach.” One story was related to the bedside call bell which links the patient to the nurse through an intercom system. The patient initiates the call, but the response is at the control of the staff person, “I’m thinking of the call bell and you hear the answer, ‘What do you want?’ [Unwelcoming tone] I’m putting myself in a patient’s shoes and thinking, in that case I don’t want anything!” This story represented how power imbalances were perpetuated even in the use of a simple technology.
A few participants did not identify with the phrase customer service throughout all focus groups. One individual emphatically stated: “Don’t use that word…I hate that word, customer service.” When asked why, she said she felt the patient was still “manipulated and forced to comply” and had no other options. This led to a discussion about the use of language and its impact on attitudes and behaviours.

One of the ways that we change is to change the language. I can see where client is more on the same level, or even perhaps more of a director level, than the person giving the service; as opposed to patient, where we’re up here [Gestures up high] and we have more power than they do. So in that way I can see that client would be the better way to go. It’s a difficult transition for me. I have been in nursing for almost twenty-five years and it’s difficult for me to think in those terms. (Elaine/Post)

In post PFCC groups, there was consensus that this change was desirable and that rethinking language and subsumed power imbalances were important to lead change in this regard.

3.4.3 Knowledge.

Participants spoke about the power of information early on, “I think if we are looking on our patients and their families as customers…we need to empower them with information.” They reflected on their ability to extend their knowledge to patients: “We need enough knowledge ourselves…to understand the ways in which patients learn, the best way to present knowledge to them.” They expressed a desire to “continue with our own education” and to “learn about cultural differences, age differences.” Conversely after PFCC, patients were portrayed as knowledge experts, “A lot of clients are very savvy. They know more and have access to the internet.” One participant expressed a desire to tap into this knowledge, “It would be interesting to see what our clients feel about customer service, what we can do better. It may not be what we think.” One participant noted that they now had a “different way of thinking” in regards to the exchange of knowledge.
There’s been a tradition as professionals of ‘we know what’s best’. I think we are moving away from that. It’s going to be a hard transition for everyone, as we are in a position of power. (Sadie/Post)

3.4.4 Roles.

*Family – From helpers to partners:* In pre focus groups, participants spoke about their views of family roles in care relationships. Families were portrayed as *helpers*, “It makes a difference if you have families that can give you some help.” They were also portrayed as interrupting care, “We have an issue right now with a family…they’re disrupting our care, always around, never leave the room and that’s really hard.”

Post-PFCC, a very different example was described, “The family was there 24/7 as an interpreter… that’s a positive thing that has changed.” In a long-term focus group, a participant talked about her ability to look beyond initial reactions and facilitate a family’s request for a written response to their question.

I was thinking was that this is a bizarre request and I didn’t want to take it on. My name might end up on the front page [of the newspaper]! Where is this person going with this? ... She may just want to reinforce the information…to share it with her brother. I explained that I had never been asked this before….and reviewed all the safety mechanisms that had been put into place….She seemed OK but she still needed the opportunity to talk with the manager. (Ada/Long-term post)

Perspectives of the family’s role appeared to change from one of helpers to *partners*, and from interrupting ‘our care’ to a more inclusive view where the family was now part of the care team.

*Patient as team leader:* Participants said that power imbalances still prevailed and that “there is a big perception out in the public that if you come into a hospital, you do what they say” and that “it has always been this way, the doctor…dwindling right down to the nurse, and below that the patient.” But one HCP added, “Not for me; for me the patient is the team leader.” Post PFCC, a participant identified that by placing the patient in a leadership role, “We are really looking at empowerment of the patient and with them being the director” and that by taking the
cue from the patient and encouraging them to direct their own care where possible, the team would be better focused on the patient goals.

3.4.5 Common vision.

In building a common vision for care relationships, participants discussed *reciprocity of work, respect for co-workers, and partners-in-care.*

Participants initially spoke to concerns about *reciprocity of work,* “depending on the group you can have everything running smoothly or everybody is just out to look after their own patients.” The call bell was again illustrative in that “some answer every bell but others say, ‘It’s not my patient so I don’t answer it and I just let it ring.’ This in turn caused “anxiety and frustration” for the patient and HCP. Post-PFCC, participants expressed that assumptions occurred and expectations for reciprocation may not always be the same: “It wasn’t put out there. ‘If I do your pills we’ll work together’, wasn’t exactly said. So part of the problem was assuming that the other nurse would reciprocate.”

*Respect for co-workers* was also discussed as a basis for developing a common approach to care. It was suggested that valuable lessons could be taken from PFCC, “As a guide perhaps we should be pushing more patient centred care and the ethics and attitudes involved with that, not only as to how we treat patients, but also so we treat each other with more respect.” When asked about seeing co-workers as clients, the response was, “clients of each other, that’s an interesting point. We are working for each other and helping each other…it’s still a bit of a stretch.” Clinical practice was seen largely as an individual responsibility and linked to licensure and liability, “We all have to be autonomous and responsible for our own practice.” Further discussion led to “professional relationships” and the need for “respect for one another.” This revealed a tension related to working collaboratively and yet being accountable for one’s own work concurrently. Accountability for independent practice was described as separate from
collaborative practice. This may demonstrate a need for greater understanding of the applications of collaborative practice in work culture.

**Partners-in-care:** In seeking alternative representations for customer service, it was suggested that “partners-in-care resonates better…It’s more of an equal thing.” Another participant stated, “The word ‘partner’ denotes collaboration, cooperation, mutual goals and aspirations of what’s to be accomplished and what’s not to be accomplished.” Many attributed their new views to PFCC, “For a nurse on a floor, ‘partner’ is something new. It’s never been referred to that way. People are recognizing as they take the course that the patient needs to be part of the plan; to become a partner, not just a patient.” Conversation became focused on egalitarian relationships, “I find sometimes the power that should be with the patient isn’t with the patient. That’s what we are trying to correct. It will take a long time before that gets on board with everybody.”

Overall participants expressed great satisfaction with new practices and said this would lead to improved care relationships in the workplace. Participants stated that PFCC would be instrumental in creating a common vision for care.

I would like to see more staff take PFCC so that everybody is on the same page. It is really important…that we are all working together as a team within the hospital. That right from admission…we start to facilitate what the patient wants…and what they want to accomplish (so that) philosophically we all have the same mindset, where the patient is the director. (Elaine/Post).

### 3.5 Discussion

This exploratory case study illuminated the phenomenon of customer service from the perspective of the HCP participants. Components for successful relationships were identified. Patients, families and HCPs were seen as interdependent knowledge experts and partners after interventions. Participants ascribed improved relationship experiences to their newly adopted practices and for up to six months after interventions.
Many of the themes (communication, respect, shared decision making and knowledge) concur with previously reported determinants for successful collaborations (Orchard, Curran, & Kabene, 2005; San Martin-Rodriguez, et al., 2005; Suter et al., 2009; World Health Organization, 2010) and for patient safety and error reduction (Howe, Billingham, & Walters, 2002).

‘Rights of the individual’ was a repeated theme. Healthcare providers questioned the degree to which patients and families understood their rights and the mechanisms for which rights were enabled and power imbalances equalized. The underlying causes for difficulties in rights enactment, such as those attributed to operational processes, communication challenges and historical norms, need further investigation. It would be useful to consider these causes along with studies which point to loss or denial of human rights in healthcare (Morris, 2011).

Communication, shared-decision making and respect were exchanges seen to aid relationships and the negotiations of power and may present future development areas for enabling human rights within care relationships.

Two areas of tension emerged which relate to the sub theme ‘accountability’ during analysis. Apologizing created tension for the HCPs when used for issues seen as beyond their control and when patients apologized for their need requests. This tension was not found in the reviewed literature. Another tension was evident between accountability for independent practice and that for collaborative practice. Much is still to be learned about conceptualizations, performance and outcomes of effective interprofessional collaborations (Reeves et al., 2011; Suter, et al., 2009). Real-life work experiences and accountabilities related to collaborative practice enactment are areas for future study (Grimes & Tholl, 2010).

An important finding was that not all healthcare providers related to ‘customer service’ as a guide for practice. ‘Partners-in-care’ was a conceptual framework with which participants better identified and represented a balance of power in relationships to them. As the use of thoughtful representations and semantics by members of an organization is important for sharing of
conceptual models and understandings (Crossan, et al., 1999), initiatives to work with staff and others in the care team must reflect language that is meaningful to them. This study mirrored the four phases which Orchard, Curran and Kabene (2005) stated as necessary to create a culture of collaborative practice. Participants questioned their own and each other’s values and debated the use of language and power (sensitization), explored their roles, decisions and practices (exploration), collaborated with others who had received PFCC education (intervention) and shared reflections and new practice implications (evaluation). Peer advocacy and inquiry in a safe environment, with opportunity to implement new ideas and skills have been reported as necessary for effective practice change (Argyris, 1977). These principles align with modeling of effective interprofessional learning opportunities which include exposure, immersion and mastery of processes (Grant, Bainbridge, & Gilbert, 2010). Focused discourse, time for independent reflection and practice in tandem with PFCC, may all have contributed to the successful changes reported by participants.

The study was limited to the available registrant disciplines on the research site. Additional HCP disciplines from a variety of sites would deepen understanding. The researcher’s emic knowledge of the organization aided her comprehension of context and culture but may also have influenced interpretations. Efforts were made to hear and accurately reflect participant views; for example, the thesis advisors assisted with consensus coding in the analysis. This exploratory case study does not generalize directly to other settings but may assist others in considering ways to integrate and engage patients and families into the care team.

Areas for future research include the application of collaborative practice with all integral members of the health team, most particularly patients and families (Grimes & Tholl, 2010). Linking HCP views with those of patients, families, managers and leaders would contribute to knowledge of creating and sustaining patient and family centred healthcare partnerships to optimize health outcomes.
3.6 Conclusions

Partners-in-care was a conceptual framework suggested and seen as meaningful by HCP participants to understand the components for successful care relationships. Nomenclature meaningful to the HCPs was seen as important for practice change and may be an important consideration with health policy and legislation leading cultural change. Further research is still needed toward shared understandings between all stake-holders in promoting key values to advance excellence in care relationships.
Notes

1. Literature review search strategy, designed to capture concepts related to ‘customer service’ in Canadian healthcare, used the following keywords: customer care, customer centred, customer centric, customer excellence, customer focus, customer service, patient satisfaction, consumer satisfaction, ‘with ‘professional-patient relations, nurse-patient relations and physician-patient relations, hospital-patient relations (Mesh heading) and Canada. PubMed, CINAHL and HealthStar were searched on Dec 12, 2011. A manual search of reference lists from relevant retrieved articles was performed. Only English publications were considered. Eleven scholarly articles were retrieved from 1994 through 2011.

2. HealthForceOntario-Interprofessional Care Fund 2008/09 timelines were from December 2008 (acceptance) to September 30, 2010.
Chapter 4

Fostering Change in Organizational Culture Using a Critical
Ethnographic Approach

4.1 Abstract

Healthcare organizations are striving to meet legislated and public expectations to include patients as equal partners in their care, and research is needed to guide successful implementation and outcomes. The current research examined the meaning of customer service as related to the culture of care relationships within a Canadian hospital in southeastern Ontario. The goals were to better understand, develop shared meanings and influence cultural change from the perspectives of the organization’s employees about their interactions with patients, families and work colleagues and to generate ideas and a groundswell for change. An ethnographic approach within the critical research paradigm was used over the course of a three phase study, where direct care healthcare providers (Phase 1), mid-level leaders (Phase 2), and senior leaders (Phase 3) volunteered to explore their values, philosophies and suggestions for change in the organization’s care relationships. This paper describes Phase 2 of the overall research project. A mixed methodology was used where mid-level leaders were individually surveyed and then participated in a focus group and/or interview to discuss these concepts. Mid-level leaders indicated that providing excellent customer service was important in their own work with many customers including staff, patients and their families, students, volunteers, and outside agencies. They believed that this in turn led to improved partnerships for care, health service transitions and linkages, customer satisfaction and health outcomes. The majority stated that the organization’s culture would support change related to customer service relationships and opportunities for this were explored.
Key Words: critical ethnography, customer service, healthcare relationships, culture, mixed methodology, organizational change, patient and family centred care, relationship centred care, shared decision making

4.2 Introduction

Over the past thirty years there has been a socially mediated paradigm shift to relocate the patient from that of a passive recipient of care to that of an active participant in their healthcare journey (Curran, 2007). Writings related to this philosophy permeate clinical (Bissell, et al., 2004; Légaré, et al., 2011), consumer (Atkins, 2010; Conlon, 2007; Gerteis, et al., 1993), and health policy (Denis, et al., 2011; Romanow, 2002) literature, are becoming more evident in recent legislation (2005; 2010) and in current news media (Dan Sherman and the Canadian Press, 2011; Picard, 2011). Conceptual representations of a more customer-oriented healthcare are many, and include collaboration (Curran, 2007; D'Amour, et al., 2005; Dalton, 2003), patient participation (Cahill, 1996, 1998; Eldh, et al., 2006; Martin, 2008), partnership (Casey, 2008; Coulter, 1999; Hinojosa, Sproat, Mankhetwit, & Anderson, 2002; Sahlsten, et al., 2007), shared decision making (Gravel, et al., 2006; Légaré, et al., 2008; O'Connor, Drake, et al., 2003), patient/family centred care (Blickem & Priyadharshini, 2007; Dewing, 2004; Epstein & Street, 2007; Gerteis, et al., 1993) and relationship centred care (Nolan, Davies, Ryan, & Keady, 2008).

These terms are inter-related, and at times are used interchangeably, but they do describe distinctly different concepts. Cahill (1996) conducted a conceptual analysis of patient participation and extended a hierarchical model based on this research. In her model, she represented the inter-related concepts of patient involvement, collaboration, participation, and partnership on a pyramid. Patient involvement and collaboration were placed at the bottom of the pyramid, as foundational actions for patient engagement, but were described as limited to unidirectional, clinician to patient communication. These two concepts acted as precursors to patient
participation, which depicted a two-way relationship with greater equality in power, and was positioned in the centre of the pyramid. Patient participation required a narrowing of the knowledge gap between the clinician and the patient and enlisting the patient in activities that they saw as beneficial to their own care. All three concepts were precursors to the penultimate goal of patient partnership, defined as the productive association directed towards a joint venture and based on mutual trust, respect and equality.

Extending from Cahill’s model (1996), other conceptual frameworks were considered. Shared decision making warranted attention as it has been much examined in recent literature (Gravel, et al., 2006; Légaré, et al., 2007). It is defined as a process whereby patients are supported to become involved in decision making to reach healthcare choices together with their practitioners (Légaré, et al., 2008). Similar to partnership, it includes elements of mutual trust within a relationship where interactions influence each other; however, it is recognized that in practice, decision making is often not equally shared. At best, practitioners will take a lead role based on patient needs, however, clinician-as-expert models of decision making still exist, so it is a goal to work towards (Makoul & Clayman, 2006). Patient and family-centred care has continued to demand much research in such areas as identifying its dimensions (Hobbs, 2009), values (Epstein & Street, 2011), and patient-centred practice attributes (Pelzang, 2010). A recent literature review found the fundamental principles of patient centred care as a patient-provider relationship that promotes patient involvement and the individualization of care (Robinson, Callister, Berry, & Dearing, 2008). Patient centred care is frequently linked with shared decision making in its enactment (Pelzang, 2010). Relationship centred care has been positioned as going beyond patient-centred care in that it focuses on respect for personhood while de-emphasizing autonomy and individualism, as this may not be appropriate in all populations, such as with an elderly population (Nolan, Davies, Brown, Keady, & Nolan, 2004). It emphasizes the view of human beings as belonging to a network of social relationships and recognizes that the quality of
relationships is significant for healthcare (Beach, Insui, & The Relationship-Centered Care Research Network, 2006).

Involving patients in communications and decision making about their own health has been shown to improve outcomes in patient satisfaction (Niedz, 1998), in patient perceived enhanced recovery (Williams & Irurita, 2004), and in patient communication behaviours (Rao, Anderson, Inui, & Frankel, 2007). In one study examining nurse-patient communication in a hospital setting, it was seen that the care providers often demonstrated conversational dominance and missed patient cues, leaving the patients with unanswered questions or issues (Barrere, 2007). Minore, Boone, Katt, Kinch, & Cromart (2003) concluded that improved communication and interpersonal supports on the part of healthcare providers could ameliorate patients’ decreased personal choices and negative healthcare experiences, in research of how client health choices influenced cancer care in Northern Ontario. Chloë Atkins in her auto ethnography entitled My Imaginary Illness (2010) described reactions of disbelief, dismissal and even hostility from her healthcare providers to the point where she felt “vilified by her physicians” (2010, p. xxvi). In addition to a terrible misdiagnosis, her story is one of extreme erosion of communication and trust within healthcare relationships. Others recount the need for improved collaboration and communication (Conlon, 2007; Wente, 2011), with the hopes that their stories will lead to improvements in access, quality and safety of care, and even enhanced healthcare provider morale and reduced burnout (Blickem & Priyadharshini, 2007; Canadian Medical Association, 2008; Curran, 2007). This literature does not address the question as to how care relationships within the healthcare milieu can be improved.

Healthcare managers play an essential role in building and communicating a coherent and compelling vision for organizational change and in linking this vision to hospital operations (Ball, 2009; Kerfoot & LeClair, 1991). They are responsible for leading staff through change processes and routinely meet staff resistance and must plan accordingly (Kotter & Schlesinger, 2008).
Managers must first understand and model the change themselves, anticipate staff reactions, and tailor contingent strategies for individual employee needs, while maintaining positive working relationships and trust (Goh, 2002). Ball (2009) states that healthcare managers and leaders need “to help design functional meaning into the way the delivery of healthcare will operate in the future” with a view to the public interest as well as that of the organization (p.1).

For these reasons, Phase 2 of the research engaged healthcare mid-level leaders at a publicly funded healthcare organization in discourse about the customers they and their staff serve and in defining their values, beliefs and recommendations about improving relationships for care. In Phase 1, healthcare providers providing direct patient care, and in Phase 3, senior leaders from within the organization were similarly consulted about customer service and care relationships. The formal data collection was sequentially undertaken from April 2009 to Dec 2010, each phase building on the findings presented from the previous study phase. This paper discusses Phase 2 methodology and findings.

The central question for the overall research project was: What changes in the organizational culture may lead to improved collaborative care relationships?

There were three sub-questions for Phase 2:

a) What did mid-level healthcare leaders value and believe about customer service and care relationships within the organization?

b) How was the concept of customer service relevant to the mid-level leaders in their work and to what extent?

c) What change ideas did the mid-level leaders identify as likely to lead to improvements in care relationships and as applicable for the organization?
4.2.1 Key concepts.

The following concepts are defined for their use in this paper: patient, patient and family, customer, customer service, healthcare provider, mid-level leader, organization.

‘Patient’ refers to a person who is formally registered through the provincial health database as receiving in/outpatient services. The phrase ‘patient and family’ is used throughout the manuscript, and refers to the patient and his/her choice of family, close friends or personal caregivers, who lent support in the care process.

‘Customer’ often connotes a business transaction. The Canadian Oxford dictionary (2004) defines customer as “a person who buys goods or services from a store or business” and it may connote negative associations as evidenced by the second definition: “a person one has to deal with (one tough customer)” (p. 287). This definition is limited to the situation where a pair of resources is being exchanged, e.g. money for goods, whereas in healthcare provider/patient interactions the exchange is heterogeneous. Products such as empathy, information and hands-on-care from the provider may be exchanged for satisfaction, decreased illness, or improved function on the part of the patient (Hirschman, 1987). It is with this broader understanding of the complexity of the marketing exchange that the term ‘customer’ is used and it is applied to include the many situations where exchanges can occur within the health service continuum, not only that between the patient/family and care provider, but also between co-workers, supervisors, external care partners, and others.

‘Customer service’ is a phrase that is commonly used in marketing and the media and is broadly defined as service which is seen to meet or exceed the customer’s expectations (Baird, 2000; Lee, 2004). It has not been widely associated with the provision of health services in Canadian hospitals. It is however a concept which is commonly used in this regard in the United States (Leebov, 2008). The use of this phrase in healthcare is further explored in this research.
‘Healthcare provider’ refers to the individual who is employed by the organization and has the mandate to provide personal healthcare services. It does not refer to an informal caregiver, for example one requested or paid personally by the patient to provide assistance. ‘Mid-level leader’ describes an individual who holds a role at the director, manager, educator, or similar level within the organization. The healthcare organization will simply be referred to as ‘the organization.’

4.2.2 Author location and reflexivity.

As a direct care physiotherapist for twenty years, mid-level leader for over ten years at the research site, health service consumer, and now as a health researcher, the primary researcher, Rosemary, believed that building positive working relationships with the patient, their family and with co-workers contributes to successful health outcomes. These outcomes might include improvements in patient and staff satisfaction, safer environments and a sense of well-being, even in the face of very difficult circumstances. It occurred to her that mid-level leaders, along with the healthcare providers with whom they work, may have considerable insights into promoting greater equality and balance in care relationships. She thought that by discussing the concept of customer service, shared understandings might be developed between and with individuals and groups and that this in turn may lead to organizational change directed towards fostering positive relationships for care. As she was an employee within the organization and had worked in different manager roles with different groups, she had in-depth knowledge of the organization and was known to most of the participants. This led to her ready acceptance as participant/observer/researcher. This paper contributes in part to Rosemary’s doctoral research while enrolled at Queen’s University. Margo Paterson, Professor in the School of Rehabilitation Therapy, was her research supervisor, and with Yolande Chan, Professor in the School of
Business, advised her on ethical, methodological and writing decision points throughout the process.

4.3 Methods

4.3.1 Research philosophy and approach.

The goal of Phase 2 of the research project was to understand and represent mid-level leaders’ beliefs and values about care relationships and to capture their ideas to effect change for these within the organization. Both qualitative and quantitative methods of inquiry were used in the study. The qualitative inquiry was primarily predicated on the critical research paradigm which is derived from emancipatory interests where social structures and actions are influenced by exploring values, views and practices from socially constructed norms and processes (Higgs, Titchen, Horsfall, & Armstrong, 2007; LeCompte & Schensul, 1999a). The critical paradigm expressed a research philosophy that provided a foundation for acquiring knowledge through discourse and critical debate (Higgs, Titchen, et al., 2007). The authors’ research interests were founded on a desire to understand the meaning and applications of customer service with the goal of improving relationships for care through questions and focused conversations. An overview of the study’s research foundations including paradigm, philosophical tradition and methodologies is presented in Table 4-1.
Table 4.1 Reviewing research foundations including paradigm, philosophical tradition and methodologies*

<table>
<thead>
<tr>
<th>Research Paradigm</th>
<th>Philosophical Stance</th>
<th>Research Goals</th>
<th>Research Approach</th>
<th>Data Sources</th>
<th>Data Analysis</th>
<th>Report Writing</th>
<th>Quality Control and Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>Historical Realism- society and culture shape practice</td>
<td>To describe mid-level leader change ideas for enacting care relationships with individual and shared discourse</td>
<td>Critical ethnography Mixed methodology</td>
<td>Participant researcher and key informant observation, Survey, Focus group, Interview, Critical debate, Field notes, Journaling, Audit trail</td>
<td>Sharing knowledge and experiences individually and amongst participants, Review and reflection of individual, group and organizational actions, Critical debate, Member checking, Presentations and writing internally to the organization and externally to varied national and provincial audiences, Confirmation between authors, Negative and exceptional cases</td>
<td>Contextual, Experiential, Descriptive stories, Reflective, Critique, Thematic with recommendations for change ideas to further organizational growth in collaborative care relationships</td>
<td>Ethicality, Volunteer participation, Participant key informants involved in research design, data collection and analysis, Triangulation of data collection and analysis, Coding confirmed between authors, Detailed outline of research processes, Participants and others see and report change and opportunities for change</td>
</tr>
</tbody>
</table>

*Note: Table structure derived from (Higgs, Titchen, et al., 2007, p. 38)
The ethnographic research tradition is a scientific approach used to identify and solve complex social problems by examining cultural patterns within a community (Schensul, Schensul, & LeCompte, 1999). It is guided by and generates theory, can be used to modify formative theory, is most often conducted and applied locally with focus on a community or culture and frequently uses both quantitative and qualitative research methods, often triangulating methods to enhance findings (Schensul, Schensul, et al., 1999). A critical ethnography is an applied ethnography with the goal to inform and effect change in culture, the results of which can become the basis for development and/or evolution of practice, interventions, policies and models (Creswell, 1998). Thus the critical ethnographic tradition met the central research goal of the current study which was to describe opportunities for growth in culture through shared understandings, norms and practices related to customer service relationships, at individual, group and organizational levels.

4.3.2 Study site and participant sample.

The study was conducted within a mid-sized hospital in eastern Ontario, one site of a multi-site academic health science centre which is faith-based and has a long history with the community. Phase 2 participants comprised a purposeful sample of volunteers, recruited from mid-level leaders at the research site. To guide this process, two internal mid-level leaders were invited to act as key informants throughout the study. Each of these had performed a variety of clinical leadership roles, had a formal research background and had worked in the organization for over 30 years and thus held significant present day and historical organizational knowledge and readily understood the research processes. With their input, inclusion and exclusion criteria were established. Inclusion criteria were that all invited participants held a clinical portfolio as a director, manager, educator or similar middle leadership role and formally reported on the research site. These criteria identified leaders working with the healthcare provider participants in Phase 1 as they were best situated to understand and elaborate further on Phase 1 findings.
Excluded were mid-level leaders with clinical portfolios reporting outside of the research site or any that did not hold clinical portfolios. Recruitment invitations were sent electronically to all mid-level leaders who met the inclusion criteria. The invitation outlined the research goals and methods, and was sent approximately one month in advance of data collection to respect busy schedules and to enhance participation. Those receiving the invitation were familiar with the study as the researcher had formally and informally presented information to them on a number of occasions and within the prior 6 months. An invitation reminder was sent approximately two weeks after the initial invitation and included more detailed information about the study, informed consent, confidentiality, and survey forms.

The university and organization’s ethics review committees approved the research study. Verbal and written information about the study and its intended use were given to the participants, including assurances regarding voluntary enrollment and confidentiality. Participants were asked to sign informed consent and confidentiality agreements before enrolling in the study. All transcripts and demographic questionnaires were identified by numeric codes, and available to the researchers only, to protect anonymity. Identifying numeric codes were stored separately from the collected data and all information was kept in locked or in password-protected electronic files.

4.3.3 Research design.

The overall research project followed three sequential phases (Table 4.2). Phase 2 is discussed in this paper and sought mid-level healthcare leaders’ views about customer service and relationships for care. Phase 1 (Brander, et al., 2012a) and Phase 3 (Brander, et al., 2012c) are discussed elsewhere.
Table 4.2 Study phases illustrating timelines, participants and research processes and cycles

<table>
<thead>
<tr>
<th>Preliminary</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
<td>Healthcare Providers</td>
<td>Mid-level Leaders</td>
<td>Senior Leaders</td>
</tr>
<tr>
<td><strong>Processes and cycles</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepare resources</td>
<td>Plan and Recruit</td>
<td>Analysis</td>
<td>Analysis</td>
</tr>
<tr>
<td>Grant application</td>
<td>Data Collection</td>
<td>Plan and Recruit</td>
<td>Plan and Recruit</td>
</tr>
<tr>
<td>Ethics applications</td>
<td>Analysis</td>
<td>Data Collection</td>
<td>Data Collection</td>
</tr>
<tr>
<td></td>
<td>Write final report for granting agency</td>
<td>Analysis</td>
<td>Analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Begin writing manuscript</td>
<td>Write dissertation and manuscripts</td>
</tr>
<tr>
<td><strong>Data collection</strong></td>
<td>2 groups of 3 semi-structured focus groups, n=10, 5/group</td>
<td>Survey, n=13</td>
<td>3 semi-structured interviews, n=3</td>
</tr>
<tr>
<td></td>
<td>2 semi-structured interviews, n=4, 2/group</td>
<td>1 semi-structured focus group, n=12</td>
<td></td>
</tr>
</tbody>
</table>

Phase 2 began with further analysis of data from Phase 1, with the plan of bringing deeper understanding and representations of care providers’ views to key leaders and decision-makers within the organization for discussion. The researcher met with the Chief Nursing Executive Officer/Vice President of Programs to review Phase 1 findings, options for dissemination and application of results. It was decided to share study findings with mid-level leaders, to seek their views on customer service and relationships for care and to add to the ideas for organizational change generated in Phase 1. In consultation with the two mid-level leader key informants, the data collection strategy was developed which included an individual survey to the mid-level leader participants followed by a group meeting comprised of a presentation of findings from Phase 1 and a focus group discussion.
4.3.4 Survey design and development.

The purpose of the survey was to explore the individual opinions of the mid-level leaders, prior to the focus group. To begin the survey design, the researcher reviewed literature on survey development (Portney & Watkins, 2009) and appreciative inquiry (Preskill & Catsambas, 2006). A survey strategy (Appendix M) was written which outlined the target audience, purpose, guiding questions, format, and analytic methods and a draft survey was developed, directed towards the research goals and questions. The two mid-level leader key informants provided initial feedback on survey planning and later participated in the survey. The draft survey was pilot-tested for readability and application by one other mid-level leader who later participated in its completion, and one outside peer-researcher. The survey took less than 10 minutes to complete. Pilot feedback indicated that four of the questions (1, 4, 10a and 11) were better presented with a Likert-type five-item response choice so that participants were provided with greater latitude to express their opinions beyond the original dichotomous scale. Additional feedback indicated that the survey was very readable, the questions ‘made you think’ and that a take-home survey format would allow more time and consideration of the questions. This led to the decision to electronically send the final survey ahead of the focus group meeting, with the request to complete it and all other forms and bring them to the lunch meeting. The final survey consisted of 16 questions and offered Likert-scale (4), numerical (1) and open-ended (11) response choices (Appendix N).

4.3.5 Focus group design and implementation.

A focus group strategy and semi-structured interview guide (Appendix O) was prepared to complement the preliminary survey. Two mid-level leaders consulted on the design of the focus group and interview questions and acted as participant-observers during the process. The focus group meeting was a relaxed business format, held in an easily accessed and familiar room to the participants with lunch served and lasted one and one half hours. Once the consent, confidentiality, demographic and survey forms were gathered, the researcher presented a 15
minute overview of the Phase 1 research and early findings (Appendix P). The focus group was
guided by discussion of the previous findings and these were projected on a large screen for
reference and to stimulate conversation.

The meeting was audio recorded and the two key informant participant-observers
completed field notes during the meeting. The researcher also completed field notes prior to and
immediately after the meeting.

4.3.6 Analytic methods.

Survey responses to questions 1, 4, 10 (a) and 11 were recorded on a 5-point Likert-type
scale of Disagree, Somewhat Disagree, Neutral, Somewhat Agree and Agree. Responses to
Question 7 were recorded on a five-point Likert-type scale of 0, 1-5, 5-10, 10-15, and greater than
15 times per day. Non-responses were also tabulated. The other eleven questions had open-ended
response choices and were reviewed and coded for similarity and differences in concepts
(LeCompte & Schensul, 1999a).

Focus group data was transcribed from audio-recordings. Transcripts were cleaned while
listening to the audio-tape for accuracy, keeping close reference to the research goals and
questions. Transcription errors were corrected, and pauses, laughter, tone of voice and nature of
the conversations were noted in the transcript margins to add detail and depth to the data.
Ethnographic analysis for survey and focus group text followed the constant comparison and
inductive method as described by LeCompte and Schensul (1999a). They used the metaphor of
assembling a jigsaw puzzle, where the edge pieces are found and linked first (conceptual
analysis), then similar patterns and colours are grouped together (categorical and thematic
analysis) and lastly and over time, by working through the relationships and fit of the pieces, the
complete picture of the puzzle comes into view (cultural analysis). This analogy guided the
analysis, which was initially completed by the researcher. Similar concepts were grouped into
larger categories and themes with a particular focus on the change ideas generated. Exceptional or
surprising cases were noted. Microsoft Word tables were used to collate and compare survey and focus group findings (Microsoft, 2008). Observational field notes were triangulated with the transcript and survey data, with reference to the research questions during the analysis. The researcher maintained and reviewed her audit trail, journal, and reflexivity notes in an effort to separate her own biases from the analysis and to maintain quality. Contradictions and surprising cases were sought and considered in the overall analysis. The thesis advisors also coded transcripts intermittently and coding was discussed collectively to build consensus and confirmation throughout the analysis.

### 4.3.7 Ensuring quality.

The four concepts of trustworthiness as described by Lincoln and Guba (1985) will be reviewed: credibility, dependability, confirmability, and transferability.

Credibility was enhanced by clearly defining research objectives and questions and reviewing these throughout the study. Data collection strategies were conducted according to well-established and published sources (Schensul, LeCompte, Nastasi, & Borgatti, 1999; Schensul, Schensul, et al., 1999). Similarly the analysis was based on detailed reference to documented methods of analysis for ethnography as described by LeCompte and Schensul (1999a). The author’s familiarity with the research site and culture and her acceptance as a participant/observer/researcher, strengthened data collection as participants indicated that they spoke freely in the focus group/interview and she was able to understand the contexts and nuances described based on her emic knowledge. Prolonged engagement with subject matter, analyzing participant verbatim scripts and triangulation of data collection methods such as using an observer during focus groups, audiotapes for transcription, and maintaining field notes and files of relevant data from the research site, were consistent practice. Thick description of the culture was achieved by the variety of sources and great detail accumulated in the data. Research planning and debriefing with participant stakeholders occurred as the study progressed, such as
with mid-level leader participant observers. Reflective and audit trail notes were maintained throughout the study to assist with the evaluation of study design, progress, and analysis. Peer scrutiny of the project occurred longitudinally, as presentations of research plans and findings were provided within the organization, and also at peer-reviewed conferences.

Transferability: The methodological details, participants and the research site have been fully described in order to enable another researcher to evaluate the extent to which results can be applied in another similar context (Krefting, 1991; Streubert & Carpenter, 1999).

Dependability: Documentation of study processes was enhanced by informally presenting summaries and recommendations back to participants (member-checking) and formally presenting findings at scientific conferences for peer review (Lincoln & Guba, 1985; Shenton, 2004).

Confirmability, reducing the effect of investigator bias, (Krefting, 1991; Shenton, 2004) was strengthened by the researcher writing a reflexivity statement at study onset, maintaining a detailed audit trail and reflective research notes which were reviewed throughout and with triangulation of coding and analysis between the researcher and the thesis co-advisors. Every effort was made to be aware of and to set aside biases by the researcher during the data collection and analysis.

4.3.8 Organization of findings.

Results are presented under Demographics, and Survey and Focus Group Findings. As the analysis of the survey and focus group/interview occurred separately and then were re-analyzed conjointly, the findings are presented together. Three main categories of information emerged in response to the three research questions and evidence for these is provided in frequencies of responses and quotations from the text below. An exceptional occurrence is also described.
4.4 Findings

4.4.1 Demographics.

Thirteen mid-level leaders volunteered to participate from a total of 14 mid-level leaders who met two criteria of working with health care providers on the research site. From this purposeful sample, thirteen completed the survey; twelve participated in the focus group and one in an individual interview due to a scheduling conflict with the focus group time (Table 4.3). All participants had considerable relevant experience (17 years or more). The majority had received formal patient and family centred education and only one had had a recent personal experience related to care from the organization.

Table 4.3 Demographics of the mid-level leader participants

<table>
<thead>
<tr>
<th>Independent variable</th>
<th>13/0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of female/male</td>
<td>13/0</td>
</tr>
<tr>
<td>Age range in years (Mean)</td>
<td>42-61  (47.6)</td>
</tr>
<tr>
<td>Professional experience in years (Mean)</td>
<td>17-38  (29.4)</td>
</tr>
<tr>
<td>Highest educational credential</td>
<td>3 College Diploma, 7 Bachelor, 3 Masters</td>
</tr>
<tr>
<td>Received Patient &amp; Family Centred Care education</td>
<td>9</td>
</tr>
<tr>
<td>Self or family member as a patient in organization within previous 12 months</td>
<td>1</td>
</tr>
</tbody>
</table>

4.4.2 Mid-level leader survey results and focus group findings.

There was a high response rate for completed surveys (93%, 13 of 14) and for focus group/interview participation (93%, 12 for focus group plus 1 interview of 14). Three categories of data emerged in response to the research questions: 1. Representation and meanings related to customer service and relationships for care, 2. Relevance of customer service in the mid-level leaders’ work and, 3. Strengths and opportunities for organizational change.
4.4.3 Representations and meanings related to customer service and relationships for care.

A strong majority of the survey responses (85.6%) indicated that customer service is a concept that belongs in healthcare. Strong sentiments validated this in textual responses: “It is the cornerstone of what we do,” “The patient-client is a consumer in the healthcare field,” and “The concept is what I believe should guide all healthcare practices.” Only one respondent indicated that she somewhat disagreed and said “I don’t like the term. It signifies to me if you don’t like the product you can get your money back.” It appeared that the specific terminology was more the issue than the underlying principles as she indicated that “Relationship Centred Care” was a better conceptual framework.

A number of responses indicated that in order for the healthcare employee to clearly understand care delivery needs and goals, patients and families had to be involved in choices and decisions about their own health and care. Aligned with this was a resounding response (92.3%) that declared that providing good customer service was linked with partnering in healthcare. The majority of mid-level leaders said that partnering with clients and having them directly involved in sharing information, planning and setting goals, was directly associated with positive experiences, good outcomes and improved satisfaction. Working together with all stakeholders for smooth transitions across the healthcare continuum was mentioned repeatedly and depicted their belief in the need for partnerships with external as well as internal customers. The mid-level leaders identified a great variety of internal customers: patients, colleagues, staff, family members, volunteers, visitors, students, other departments and administration (managers, senior leadership and Board members), and external customers: partnering organizations, referral sources, third party payers and The College of Nurses.

Some mid-level leaders suggested alternative concepts of healthcare relationships and patient (person or client), and family-centred care was identified most often. Relationship-centred care and therapeutic relationships, as described in the Registered Nursing Association of Ontario (RNAO) Best Practice Guideline (2006), were also proposed. Some mid-level leaders felt it was
important to include newer constructs related to accountabilities for relationships and care provision: that the healthcare provider was part of the “patient’s team” or acted as participants in the “patient’s plan of care.” These represented a movement away from traditional biomedically oriented labels depicting system ownership such as ‘the healthcare team or plan’, ‘the medical record or chart’, ‘the nursing (or other discipline’s) care plan.’

4.4.4 Relevance of customer service in the mid-level leaders’ work.

Customer service was reported as very relevant in the hospital culture by the mid-level leaders. The majority (92.3%) indicated that providing customer service was a large part of their regular work, and estimated that it occurred daily, more than 15 times per day (61.5%), ten to fifteen times per day (15.4 %), and five to ten times per day (15.4 %). One respondent did not respond and may have chosen not to answer, not understood or missed the question. One unsolicited comment was, “It is the only thing that must be present to provide care that meets my standards.”

Mid-level leaders said they were able to provide good customer service when they were responding to patient concerns, compliments or complaints; to staff, other manager or department needs, or to external partners. Many said it was difficult to provide good customer service due to their unmanageable workloads and limited resources, and cited staff absenteeism, conflict, poor performance, poor communication, and outdated practices as contributors. One participant said:

I feel like the patient as director is not yet embedded in our culture, is a telling theme. It’s a multi-faceted approach that is needed....I’m disappointed to see that it is not yet embedded in culture. It shows how enormous, how much work we need to do to realize that cultural change. (MLL focus group)

4.4.5 Strengths and opportunities for organizational change.

Survey data, largely from questions 8, 9 and 12 which asked about facilitators and barriers to customer service and for suggestions to enhance partnership in care, were triangulated with focus group data to garner ideas for change. Key themes that enabled mid-level leaders to
perform well in customer service relationships are listed in Table 4.4 along with examples of change ideas (CI) which are described below.

**Table 4.4 Customer service and care relationships: Mid-level leader themes with example change ideas**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Example Change Idea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being present</td>
<td>1. The patient/family would be present at the multidisciplinary conference when his/her information is being discussed.</td>
</tr>
<tr>
<td>Communicating well</td>
<td>2. Healthcare workers would become more comfortable in talking with patients and families about what we can and cannot do, for example, when discussing goals or expectations.</td>
</tr>
<tr>
<td>Taking action</td>
<td>3. Nurture flexibility and individualism while maintaining consistent and excellent quality of care.</td>
</tr>
<tr>
<td>Having and recognizing each other’s expertise and know how</td>
<td>4. Build partnerships by recognizing and seeking each other’s expertise, e.g. with patient and families and their role in the care process</td>
</tr>
</tbody>
</table>
| Collaborating                                   | 5 a. All key committees would have patient/family participation  
5 b. Develop awareness of traditional biomedical models, which depict hierarchical and authoritative leadership and decision making.                            |
| Ownership and accountability                    | 6. Encourage ownership and accountability for both staff and patients/families. Ask “What happened because I did this or didn’t?”                                                                                     |

**Being present** on the part of the mid-level leader was characterized by “walking the hallways”; “listening and addressing concerns”, being available “in my office and via phone or computer”, and by “completing work for others in a timely manner.” Being present on the part of the patient and family was also seen as important area for change, with suggestions for this to occur more routinely at team meetings and at hospital committees where decisions are made.

The patient (would) come to the multidisciplinary conference. The conversation (would happen) with the patient, not always about the patient. I think the timeliness and outcomes (of the meetings) would improve so much. (MLL focus group, CI #1)
**Communicating well** was frequently noted and described in different situations: communicating regularly and in a straight-forward way; informing a staff member in crisis of important resources, e.g. of the Employee’s Assistance Program; listening to and addressing concerns. One example noted difficult conversations with patients and families about goals and expectations:

> I think we can improve on where we are not meeting the patient’s goals or expectations; it is how we communicate with the patient about that. Sometimes we feel there is a failure on our end or we don’t have the resources and then we don’t communicate about it. We just don’t go there… We need to become more comfortable talking to people about what we can do and what we may not be able to do. (MLL focus group, CI #2)

**Taking action** was evident in the verbs used throughout the examples: Respond, ensure, inform, work with, promote, facilitate, investigate, complete work, and provide. There were many concrete examples and the past tense was often used which indicated that these actions were occurring in the organization.

> I provided data within very tight timelines to support a service review. (MLL survey)

> It was so impressive when the group got together, talked about each individual patient, met with the patient, and the patient had a piece of the conversation and work on resetting expectations. (MLL focus group)

> Another story was a sign-post for the complexity inherent in changing culture and the reactions and consequences related to these.

> We had a lot of discussion on one floor where a nurse did something extra for a patient because that patient was very needy and was criticized by her coworkers pretty severely for doing that. It was done out of compassion for that patient’s needs on that particular day. So I think she was providing good customer service. I understand that everyone needs to be on the same page but the page needs to include what happens on that day. (MLL focus group, CI #3)

> This story reflected the view that consideration of individual needs and situations must be part of decision making when planning and maintaining quality care standards.

A theme of **having and recognizing each other’s expertise and know-how** was evident in examples such as when clinical mid-level leaders provided “opinions to Finance” and “new
information to staff about delirium and a new screening tool.” A partnership in recognizing each other’s expertise was recommended:

Most of our patients don’t know what the possibilities [for care] are. That’s what we can bring to the table, the expertise and knowledge so that we can help our patients bring all the pieces, what’s important to them, the context of their life and how that will fit in. We have a partnership. (MLL focus group, CI #4.)

There was also strong evidence depicting the importance of **collaborating with patients, family and with staff** that appeared to be embedded within the culture. One phrase repeatedly used by the mid-level leaders was “working with” individuals, staff and teams. A suggestion for augmenting collaboration was provided:

My vision of a patient centred organization would be that on all key committees, or at key decision making times, there would be an opportunity for the patient or family to comment. Procedures or policies would not be set in place without asking, “What does that do for me as a patient or family?” (MLL focus group, CI #5 a.)

Somewhat incongruent were phrases depicting permission or an imbalance of power, as in “allowing teams to make decisions”; “giving more knowledge”, and “allowing students to be paired.” Vestiges of biomedical models of care within the culture were reflected in the conversations, but were recognized and corrected at times: “Giving information… not just giving information, helping the person to understand.” Although authoritative phrases such as these appeared infrequently in the data, they provided evidence of expert models remaining somewhat embedded in the workplace, as well as a desire to reconsider these old models in efforts to change norms (CI #5 b.).

**Ownership and accountability** was another theme that arose when discussing productive care relationships and an opportunity for change. It was stated that accountability needed to be shown on the part of all involved in the care relationship:
I think one element that tends to get lost, both on the side of the patient and staff is ownership. We own what we do. We own the responsibility. The patient takes ownership for their health….Unless the patient understands, participates and builds (the plan of care) he/she may feel that it is being done to them….rather than with them. That repeats itself time and time again. How do we foster that kind of ownership? Secondly….there are areas where we have things such as unmet expectations….where people are throwing up their hands and saying, “Well it’s out of my control” or “It’s not what I do.” They put up barriers and don’t take ownership for their actions instead of asking, “What happened because I did this or didn’t?” I don’t know how we foster that in the culture but I believe that we have the strength. (MLL focus group, CI # 6.)

4.4.6 Unexpected occurrence.

After the focus group, five interested individuals spontaneously stayed and continued with discussion and feedback. This impromptu occurrence was also audio-recorded, with their permission, and provided additional data for transcription and review. The conversation focused on the ways and means of continuing the patient and family centred care education which had been stopped in the organization due to staffing changes and in order to re-evaluate its format and worth. This information further demonstrated the motivation and interest that many held in advancing the organizational culture towards strong patient and family centred relationships. If this small group had demonstrated views vastly different from the larger group of participants, it might have had significant impact on the findings; however, this was not the case and it was an extension and in consensus with the prior focus group conversation.

4.5 Discussion

Phase 2 revealed one component of the organization’s culture: that of a motivated group of mid-level leaders, eager to volunteer their time and thoughts toward exploring ways to seek greater engagement of healthcare customers for improved care relationships. This motivation was evident both at the individual level, by the high survey response rate and focus group participation for individuals and the group respectively and, by the in-depth participant contributions. The mid-level leaders clearly stated that customer service was very important in their own day to day work and believed that this contributed to positive outcomes, citing
improved partnership with patients and staff, service satisfaction and transitions between health services.

In their award-winning article, Crossan, Lane and White (1999) described a framework for organizational learning, first mediated at individual and group levels by intuiting and interpreting the phenomenon of interest, which later becomes embedded at group and organizational levels by integrating and developing shared understandings, coordinated actions and institutionalizing routines in systems and strategies. This was a dynamic process which fed forward and backward as changes were adopted and interactions occurred between all levels. This research exemplified the Crossan et al. (1999) framework of organizational learning by first engaging individuals and then a group of mid-level leaders in discussion and development of shared knowledge and meanings about healthcare relationships. Real members of the organization generated possible actions for organizational change by sharing creativity and enthusiasm towards these opportunities and envisioning applications for further growth.

Mid-level leaders play a unique role in the organization as they work with and transfer information between multiple groups. Great leadership is built on effective relationships and collaboration which inspires others to be effective (Goleman & Boyatzis, 2008). In the current study managers reported that their focus on customers and service, including staff as well as patients and families in their definitions of customers, was important in their work. This underlying motivation to build relationships and attend to those around them leads to the development of socially intelligent leaders who can act as role models to others in the organization (Goleman & Boyatzis, 2008).

Another important motivation is the willingness of leaders to share information broadly with others in the organization (Goh, 2002). This contributes to an open culture that is ready for innovation, the creation of new ideas and a win-win mindset to improve the work (Ball, 2009; Youngblood, 1997). In reflecting and contributing to the change ideas generated by the healthcare providers within the organization, mid-level managers were able to reflect on this knowledge and
add additional practical ideas. A future plan would be to hold conversations together with a great variety of individuals from all levels of the organization to spread ideas and generate greater innovation.

The author, in her role as participant/observer/researcher and with her emic knowledge of the organization, may have influenced the analysis and been a limitation to the study. Every effort was made to represent the participant voices, with the use of key informants for consultation and participant observation, presentations as member-checking within the organization to participants and to outside to peer-audiences. Co-advisors independently analyzed transcripts and then reviewed analyses together to build consensus coding to decrease bias in interpretation. The inclusion of additional mid-level leaders with non-clinical portfolios and across organizational sites would have allowed for deeper cultural representations, but this was not part of the original research plan due to time and resource limitations.

The ethnography described the culture of a non-acute hospital organization, the findings are specific to the identified local community and may not be generalizable to other settings (LeCompte & Schensul, 1999a). The cultural themes and change ideas derived from the mid-level leader participants may well be useful in other hospitals; however, settings would need to be compared before applying the results to other contexts.

A critical ethnographic approach was used to explore the meaning of customer service and relationships for care for mid-level leaders working together in a mid-sized hospital organization. Important cultural themes were found to enable further discussions and debate was directed towards identifying concrete strategies for change. These change strategies were again used in the third phase of the research, which involved senior leaders and key informants within the organization, with anticipation that future integration and adoption would advance customer service relationships within the organization.
Acknowledgement

The researchers gratefully acknowledge the time and contributions extended by all study participants, key informants and financial and resource support from HealthForceOntario, The Monieson Centre and The School of Rehabilitation Therapy at Queen’s University.
Chapter 5

Using a Common Vision of ‘Partners-in-care’ to Enhance Hospital Relationships

5.1 Abstract

Hospital organizations must create and cultivate environments to meet present-day customer, policy and legislative mandates for improved collaborative care. A critical ethnographic research study on collaborative care relationships was conducted at a mid-sized non-acute hospital in Ontario. Interdisciplinary staff groups and individuals were engaged across the organization to inform cultural change focused on concepts related to customer service and care relationships, with the long term goal to improve the quality of care. The relationships initially discussed were staff /patient and family relationships and these became extended to include relationships among staff. This paper reviews Phase 3 of a three phase study, which engaged senior leaders in interviews to contemplate customer service relationships and to reflect on prior study findings from healthcare providers (Phase 1) and mid-level leaders (Phase 2). Overall findings from the project formed a description of the organization’s culture (self-awareness, congruency, and health), explicated five organizational tensions, and generated many questions and innovative change ideas to advance organizational growth toward a vision for ‘partners-in-care.’ The findings are considered while drawing on documented frameworks of organizational culture, learning, and leadership.

**Key words:** organizational learning, cultural change, interprofessional practice, critical ethnography, relationship centred care, shared leadership, transcendent leadership
5.2 Introduction

How do contemporary healthcare philosophies, such as client centred care or relationship centred care, among others, become embedded in an organization’s culture so that new knowledge is internalized, behaviours and norms change, and new actions become second nature? Much work is being accomplished in efforts to include and be more responsive to healthcare customers. This is evident in such areas as patient and family centred care (Conlon, 2007; MacKean, et al., 2005), shared decision making (Légaré, et al., 2008; Légaré, et al., 2011; O’Connor, Drake, et al., 2003; Weston, 2001), collaboration and partnership (Brown, White, & Leibbrandt, 2006; Hinojosa, et al., 2002), and interprofessional practice (Schroder et al., 2011). Understanding how individuals and groups learn together within an organization, so that new and vibrant cultures develop, is a prevalent topic for discussion and for ongoing study (Crossan, et al., 1999; Orchard, et al., 2005; Reeves, 2010a).

This paper summarizes results from Phase 3 of a three phase study, where senior leaders (SLs) were interviewed regarding their perspectives on customer service and care relationships and about prior study results with healthcare providers (Phase 1) and mid-level leaders (Phase 2). Phase 3 results therefore represent a cumulative summary of all phases used to build understanding of the culture of customer service and relationships for care (Table 5.1).
Table 5.1 Study phases illustrating timelines, participants, research processes and cycles

<table>
<thead>
<tr>
<th>Phase</th>
<th>Preliminary</th>
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<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timelines</strong></td>
<td>Sep 2008 –</td>
<td>Apr 2009 –</td>
<td>Sep 2010 –</td>
<td>Oct 2010 –</td>
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<tr>
<td></td>
<td>Mar 2009</td>
<td>Sep 2010</td>
<td>Oct 2010</td>
<td>Dec 2010</td>
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<tr>
<td><strong>Participants</strong></td>
<td>Researcher(s)</td>
<td>Healthcare</td>
<td>Mid-level</td>
<td>Senior Leaders</td>
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<tr>
<td>(n)</td>
<td>(3)</td>
<td>Providers</td>
<td>Leaders</td>
<td>(3)</td>
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<td>(10)</td>
<td>(13)</td>
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<tr>
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<td>Literature review,</td>
<td>Semi-structured</td>
<td>Survey,</td>
<td>Semi-structured</td>
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<tr>
<td>and data</td>
<td>Grant</td>
<td>focus groups/</td>
<td>focus</td>
<td>interviews,</td>
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<td>collection</td>
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<td>group/interview,</td>
<td>Observational</td>
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<td>Ethics</td>
<td>Participant</td>
<td>Participant</td>
<td>notes,</td>
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<td>applications</td>
<td>observation,</td>
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<td>Field notes</td>
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Phase 1 engaged healthcare providers (HCPs) in discussions about their beliefs and practices regarding customer service relationships (Brander, et al., 2012a). Their perspectives were documented and many of these were seen to change over time as related to the existing patient and family centred care educational intervention (PFCC) and the focus group discussions. Healthcare providers reported that they had developed new perspectives and had adopted new practices which resulted in improved care relationships, immediately after, and up to six months following the interventions. Changes in their perspectives included an increased recognition of patients as knowledge experts being fully involved and leading their care whenever able. They also discussed viewing interdisciplinary colleagues as resource experts and as possible customers. Self-reported practice changes included improved communication strategies, such as enhanced listening and the increased use of open-ended questions, and recognizing and acting on non-verbal cues. Secondary analysis of the Phase 1 data generated themes and change ideas for the organization which were taken to mid-level leaders for further discussion (Phase 2) (Brander, et al., 2012b). Following a triangulated analysis of findings from Phase 1 and 2, a summary was brought to senior leaders (Phase 3) to build a deeper understanding of the organizational factors.
that aided or hindered care relationships with the goal to identify opportunities for quality care.

Each phase, in a step-wise approach, contributed to the ethnography by using focus groups and interviews, survey, and participant observation.

The research questions which guided Phase 3 were:

1. How did the senior leaders view customer service and care relationships?
2. What work was occurring to enhance care relationships in the organization?
3. What factors advanced or hindered the organization’s care relationships?
4. Which of the change ideas generated in Phase 1 and 2 may be of best use in the future and are there others?

Figure 5.1 provides an overview of the research questions as they developed throughout the study phases.
Figure 5.1 Study phases and research questions
5.3 Methods

5.3.1 Study site.

The study site for all phases was a non-acute hospital within a multi-site academic health science centre in eastern Ontario. The hospital site has 144 inpatient beds providing complex continuing care, palliative care, physical medicine and rehabilitation and specialized geriatric services, and it also offers ambulatory care services. The organization has a long history of serving the community and is faith-based. The university and organization cleared the study via ethics review. Voluntary participants received study information, and signed informed consent and confidentiality agreements before enrolling.

5.3.2 Phase 3: Senior leader participants and interviews.

Senior leaders (SLs) were invited to participate from those who met the criteria of having formal responsibility for staff involved in clinical care and working at the research site. These criteria best identified the SLs whose work was directly related to that of the prior study participants. It would be these SLs, along with their teams, who would choose and apply research findings and recommendations for future use. It was recognized, however, that the senior leaders, due to the nature of their roles, also had information related to multiple sites and the broader workings of the organization. Invitations were extended to four leaders and three agreed to participate and formed a purposeful sample. Individual interviews occurred at their convenience in a private office. Early research findings, including themes and organizational change ideas derived from prior study phases, were presented at the beginning of each interview by the researcher (Appendix P). Following the presentation, the researcher used a semi-structured interview guide (Appendix Q) to facilitate the interviews which were audio-taped and of 1 to 1.5 hours duration. An observational guide (Appendix L) was also completed prior to and immediately following the interviews by the researcher.
Transcripts were cleaned by the researcher while referencing audio-files for accuracy. Additional information, such as laughter, pauses, etc., was captured in memos. Analysis followed the method outlined by LeCompte and Schensul (1999a). Relevant concepts were highlighted, with particular note to those that would link, inform, and build on prior concepts and themes. New and different concepts were also identified. The concepts with the greatest frequency of occurrence when coding the transcripts led to the development of three initial categories: changes evident, new ideas, and additional questions. These initial categories were used to populate a working table for additional interpretation and comparison across the data. Emerging themes were noted as the data was re-coded using this taxonomy. As the data were further analyzed new categories were developed which better captured all of the resonating themes. The final categories used in the analysis were culture, tensions, and possibilities as related to the organization.

5.4 Findings

Phase 3 findings reflected an overall synthesis of the first two phases based on the senior leader perspectives. The associated themes will be discussed in the three categories of culture, tensions and possibilities as related to the organization (Table 5.2) and are described below.

Table 5.2 Categories and associated themes

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
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<tbody>
<tr>
<td>Culture</td>
<td>Organizational Self-Awareness</td>
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<td>Organizational Congruency</td>
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<td>Organizational Health</td>
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<td>Tensions</td>
<td>Uniformity and Pluralism</td>
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<td>Corporatization and Care</td>
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<td>Liability and Accountability</td>
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<td>Power and Leadership</td>
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<td>Energy and Relationships</td>
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<td>Possibilities</td>
<td>An Inquiring Organization</td>
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<td></td>
<td>An Innovating Organization</td>
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<td></td>
<td>Partners-in-Care</td>
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5.4.1 Culture

Organizational self-awareness

A collective organizational self-awareness was described. Individuals and groups at all levels of the organization were seen as reflecting on the critical values and actions related to their work.

[The research study] gives you a good window on the internal values of the organization. The embodiment of what people think is really important and their awareness of that within an organization. In some ways it is almost like the organization’s self-awareness. (Senior leader)

The focus group conversations, for which staff had readily volunteered in the prior research phases, were seen as constructive processes by all senior leader participants. These discussions were used to inspire and challenge people in their efforts to understand and internalize new concepts, to adopt new belief systems and to identify preferred practice strategies for themselves, their teams and for the organization. In reference to the study, one leader indicated:

What you are doing, provoking the conversation… asking the questions and not presuming the answers, is really crucial – and it’s the heart of these change ideas. These are great ideas…We have enough [knowledge] that we can easily come back to the things we do really well and build on those, to do the next thing. I think the organization is strategically brilliant that way. … That is what you’re doing, trying to help people negotiate…what it is they do, who they are, to articulate their own sense of [purpose] and galvanize that into practical actions. (Senior leader)

Stories which demonstrated high levels of organizational awareness were recounted. One story illustrated the way in which the organization acknowledged staff needs with groups that had been recently repatriated to other organizations. Careful efforts had been made to understand what this change meant for staff, not only from an operational perspective, but also in considering staff past experiences, organizational loyalty and identity, and their needs to process and understand the change, before the move occurred. Additional time was negotiated so that the staff successfully prepared for the change, despite pressures to move quickly. This enabled staff to participate in the planning of the change process, by being part of planning meetings and sharing
their feedback, and culminated in a staff led celebration. At this celebration the staff thanked the leaders and the organization for their considerable work on their behalf.

Another senior leader cited both emic and etic notoriety of the organization as being a collaborator, as opposed to a competitor, within the regional healthcare continuum.

I think there’s a great spirit in the organization to move collaboration into the foreground. Our partners tell us we’re really good at collaboration...We recognize that in order to pursue the interest of our clients, to help them get where they want to go and have a right to go, that we [need to collaborate]. (Senior leader)

Organizational congruency

Organizational congruency was defined by one participant as the match between employee perspectives and organizational actions. The comment was made in relation to theme of ‘common vision’ and a shared model of care derived in the earlier study phases.

The staff needs to feel like they belong in an organization where their perspective of how things should be, is the perspective of how things would be. The closer the congruency between that and what is perceived by them, the more comfortable they will feel. (Senior leader)

All senior leader participants spoke about the difficulties in attempting to align different parts of the organization on one distinct and labeled model of care and indicated that this would not be a useful enterprise, and in fact it may undermine the goals for doing so. It was indicated that valuable models of care were already established within the organization. In fact, at least six similar models had been identified. The feedback was that labeling one standard model for all was not as important as identifying the underlying values and principles that motivated their creation. A uniform label for the shared model of care was deemed as not important. What was seen as important was the essence of the shared values across the articulated models and to have conversations about these.
There’s a huge desire to come to some sort of shared model of care…You can look at the models and take the simplest elements, the criteria consistent with our values and beliefs. We probably need to have more dialogue to get past the labels. If you talk to the mental health people, they’re going to talk to you about the Recovery [model], and if you really dig into that it’s not a whole lot different than what we are doing [with the Patient and Family Centred Care model]. We need to not use convenient labels as a way to obstruct others….We need to understand what it is about the kind of care that we deliver that makes us who we are. What is it that we do that we can agree on? We all do it. It’s at the heart of how we are able to do things with our clients; what we are able to do. Ask about the essence of what’s behind the model. Choose the one that seems to fit most comfortably, that doesn’t promote division, as models can be used as much to promote divisions within our organization as to heal them. (Senior leader)

The sense was that organizational congruency came from identifying and embracing shared values and beliefs about the work, as opposed to standardization in labels. One suggestion to represent that which was meaningful for people was ‘enhancing quality of life.’

I’m reformulating the whole thing….How do we get together in a modern day sisterhood—a community of vision? Could we use a line from our mission statement around enhancing quality of life? That would be over-arching. (Senior leader)

**Organizational health**

The health of the organization was raised and differences between areas within the organization were noted. One senior leader said “My brain is always thinking, what are we doing across the two sites?…I was happy last week as we had a joint nursing practice council between the two sites using the OTN [Ontario Telemedicine Network]…and now we are starting to show that this initiative has been changed as a result of the nursing practice council.”

With the view to build relationships across organizational sites, the senior leader further reflected about the use of simultaneous webcast telecommunication with the joint nursing practice council and OTN (2012).

I think the use of the OTN between the two sites was powerful [during the joint nursing practice council meeting]. I was at the one site and couldn’t get to the other one, but we shared. We went online and educators and community nurses [shared across sites], but no frontline nurses were there. We’ve got to get frontline nurses there. (Senior leader)
Organizational health was linked back to a need for a high degree of organizational self-awareness and congruency, with the underlying foundation for these cited as shared relationships.

To be able to share freely and engage others… how can one live ‘relationship’ within [the organization]? …This [research study] gives us a bit of a window of the self-awareness that one site has about itself. I think on many levels, wow, that talks about a really healthy organization…If we are looking at the nature of an organization, the way it relates to the world… and its inner self workings….The fact that people are thinking and talking about these kind of things, isn’t that great? (Senior leader)

Relationship development across all sites of the organization was a strong subtheme in all senior leader interviews. Discussions touched on all sites and services across the organization and included in-patient, out-patient, and community staff groups, and introspection about what could be shared, learned and achieved using the wealth and knowledge among the groups.

5.4.2 Tensions.

The senior leader interviews led to the realization of organizational tensions, areas in which there may be contradictions or paradoxes in the work of the organization. These were not binary concepts but rather continuums of beliefs and opinions which can assist or hamper decisions with respect to strategic change. The five tensions which emerged were: uniformity and pluralism, corporatization and care, liability and accountability, power and leadership, and energy and relationships.

Uniformity and pluralism

Standardization is a common fixture within western healthcare. Results from such standard metrics as blood work, wait times, and bed utilization lead to many important decisions about diagnoses, prognoses, patient transfer within and across institutions, and funding. It was signaled that there may be a need to re-situate this emphasis to include interpretive philosophies and methodologies to better collaborate across disciplines, sectors, and diverse cultures in the people-centred business of healthcare.
There’s the preoccupation with standardization…but of course as soon as we standardize, it’s not patient centred, it’s standard-centred. So there are these tensions that we live, within our society, which want to encourage and honour a more pluralistic approach to things or a standardization approach to things. Both are necessary but we have to live in the tension of both. And I think it’s the tension of both that gets people a little unsettled. (Senior leader)

An example of provincial hospital benchmarks was compared on an international level.

In Ontario, the Ontario Quality Health Council has set the benchmark for treatment in emergency room as within eight hours. Now you see these ads on TV [about USA hospitals]. They are talking about the ‘29 minute guarantee.’ If you’re not seen and treated in 29 minutes, it’s free. And here across the border, we’re talking about eight hours as the benchmark. What are we thinking? (Senior leader)

Although the hospital was not involved in emergency care services, this story revealed the fact that the senior leader believed that a numeric standard in itself may not always lead the way to the desired change. In fact it may be misleading and may be less than ideal when compared to other settings. Standardization and metrics without further explanation with respect to contexts, consideration of quality of care and of individual circumstances may misdirect or confuse the public and organizations toward less desirable goals in extremely complex healthcare environments.

**Corporatization and care**

A continuum of tension between the allocation of resources (corporatization) and the provision of care was revealed. This tension was noted by healthcare providers in earlier study phases, often with the view that the two poles of the continuum were mutually exclusive. The senior leader data displayed their increased efforts to involve healthcare providers in setting corporate targets for care. One example given was the dialogue that occurred with the Quality Teams around hand hygiene compliance. The Quality Teams are composed of a majority of healthcare provider and mid-level leader members, and they report directly to the corporate committee of Quality, Safety and Risk within the hospital.
For our hand-washing compliance the ultimate goal is 100 percent. When we started we were at 56 percent and our last quarter was 80 percent. Now where do we go with the target? So we took the conversation to the Quality Teams, as to where does the [next] target get set? And having that conversation is part of how that goal will change. We wouldn’t have done that, two years ago. (Senior leader)

The indication was that the organization had changed. It was now involving those closest to the work, those providing the care, to establish reasonable target metrics and goals.

Another example was given where the allocation of resources and provision of care were not well synchronized, and identified as requiring change.

There’s been a program that’s been sidelined for at least a year which helps people to learn how to cook for themselves. We are trying to discharge long-term clients and they don’t know how to cook anything for themselves. Nobody seems particularly worried that the only facility they have to learn this in has been out of commission for a year. That’s just crazy. (Senior leader)

In this example, a provision of care issue, discharge, is not being well supported due to the fact that the facilities which allow for adequate preparation for discharge were not available. Details regarding the delay were not explained, but somehow the resources were not available to meet the discharge goal.

**Liability and accountability**

A third tension was that between the concern for liability and open accountability. The example provided was about the freedom of access to the patient record, ‘the chart.’ Legally the chart is the patient’s information and the patient has the right to access it, but this is not so easily translated into practice. Patients typically do not lift the chart off the shelf at the nursing station and open it up and read it whenever they so wish. Sophisticated access procedures include formal requests to Patient Records departments, permissions from the admitting physician(s), and/or an employee observer required to be present while the patient’s record is being accessed by the patient. One senior leader contrasted these typical in-patient record practices with those used in community service areas within the organization.
For about 3,000 of our clients, the chart is on the fridge. When I hear people talking about patient confidentiality, I think to myself, well excuse me, but the chart is on the fridge. [Said with emphasis.] It’s kind of laughable when you realize that that’s how we communicate with many [of our community partners]. (Senior leader)

The above example clearly reveals differences in access to patient record information in inpatient versus community patient areas. The question arises as to why the concern for liability and open accountability are different in these two areas?

One of the change ideas presented in a prior study phase was to ‘chart as though the patient will read the chart.’ Concerns about liability were conflicted with a desire for openness and improved communication with patients. The chart exemplifies this conflict. The complexity of this issue was reflected in one senior leader’s suggestion: “We should do a study to have patients read the file to see what impression they get”, and yet another with respect to “We should give patients access to the file on a regular basis, say every Thursday is read your chart day.” Studies and external rules were seen as needed as the traditional norms were anticipated to act as constraints. Complexity was also reflected in comments about patient fear for staff repercussions, and staff fear about patient complaints, when a patient asks to read the chart. Layered on top of these complexities were embedded views and confusion about legal and other constraining processes. For example, it was not clear if the organization was required to ‘maintain privacy of third party information’ (i.e. other hospital information) by removing that information from the chart before extending it for patient access. The question was raised, “If patients read their files on a regular basis would we be as fearful or would we actually change our charting practices?” Anticipated outcomes were improved documentation and decreased fear and stigma. Perhaps this tension represents an opportunity for improved communication and accountability and a focus away from liability?

**Power and leadership**

Attention to the language used by the participants provided insight into the organizational culture with respect to power relationships. One senior leader noted the use of the verb “allow” in
the change idea “allow teams enough time for strategies to come forward” and again in “allowing
the patient to read the chart.” A senior leader asked the question, “What is the use of authority?”
This flagged a common tension between power and leadership. Similar verbs which implied
permission or the conferring of power from one deemed as having power to another with lesser
power, were seen throughout all study phases.

One of the senior leaders spoke about the importance of the manager as a positive role
model when discussing the change idea “create a culture of peer-to-peer mentorship.” Those with
power were traditionally seen to be those in positions of authority; managers with respect to staff,
or physicians and healthcare providers with respect to patients.

I believe that the role of the manager is really crucial in being a person to bring [power
imbalances] forward in conversations ...when you get together as a group [the manager]
sets the tone and how you interact one-on-one with people sets the tone. (Senior leader)

Within this tension there existed an underlying theme regarding the value of mentorships.
A question was asked about the extent to which leaders play a role in productive mentorships, and
one senior leader responded:

People who were powerful mentors for me were not chosen by an organization, or by a
particular system of selection-except my own. I knew it. You just know it in yourself-this
is a person that I could learn a lot from….Mentoring happens. It’s not formal. (Senior
leader)

Practice Councils had been developed within the organization in the previous five years
to assist with community-of-practice decision making. Practice councils are composed of like-
discipline clinical staff members with a goal to support clinical best practice, assist members and
the organization in understanding and enacting these for quality patient care. The recent
formation of the Joint Nursing Practice Council, a new venture of practice councils working
together between two organizational sites, furnished evidence of excellent staff leadership.
Last week we had a Joint Nursing Practice Council meeting….One group was amazing. The frontline nurses articulated how they were having an impact on the practice through the practice council. Information comes from the nurse on the unit and to Council and they’re now starting to advertise examples of ‘this initiative has been changed as a result of Nursing Practice Council’….I had an epiphany which I shared later with the group. I said to them, ‘Anything that comes from Nursing Practice Council, I never get my back up.’ I say, ‘Okay tell me what’s going on, tell me what you’re thinking. How did you come to this? Who was consulted? How do we move on this?’...When it comes to this group…I pay full attention. (Senior leader)

Excellence in practice was seen to be the Council’s prime motive and this shared focus between the members and the senior leaders engendered opportunities for shared leadership and a balance of power with respect to leadership within the organization.

**Energy and relationships**

The balance between negativity and positivity in the environment was characterized as energy flow by a senior leader participant. It was stated that there were often persons in an organization who brought a negative perspective in their comments and contributions. It was recognized that it was difficult for leaders to know how much time to invest in addressing these negative perspectives.

If someone is really negative and you engage them, they draw that energy from you, so you are actually feeding it. Whereas if you just acknowledge them and not be available for them to take your energy, after a while they burn themselves out….We are generally a pathology-preoccupied culture and so we see that as being the problem and we put all sort of energies on it. But are we actually feeding it? Energies that could have gone to other people who are just a bit anemic but still healthy [are used]; let’s put our energies there. (Senior leader)

A focus on the quality of relationships organization-wide, with attention to that which already exists that is healthy and positive, was felt to lead to an improved environment.

The more we open our relationships to patients and families the more we will be patient and family centred in our care…. To me it’s from dimensions of human existence that connect from our heart, from empathy or some kind of greater connectivity, or the quality of the relationship [that we will reach this goal]. (Senior leader)

Building on the perspectives of the healthcare providers and mid-level leaders in turn, gave strength to the shared organizational values related to patient centred care. The senior
leaders’ vision was expressed to include a broader view for relationship centred care, to depict mutuality and equality and an awareness of self that is necessary for relationships.

I think it is great to move towards patient-centred care because that’s a big step over some of the previous paradigms. But I think relationship centred care is even more important as then one must be aware of oneself within the relationships…rather than what I’m going to do to, or for, or at, the patient—which can be an unconscious outcome of the patient-centred care (model). I don’t think that is the intent; however, there is that possibility. (Senior leader)

This senior leader’s view concurred with findings drawn in previous study phases. Participants had indicated that their relationships with colleagues would affect their relationships and work with patients. In considering relationships and models of care one senior leader echoed these findings:

How we work together actually improves our level of care for patients. How we communicate with each other, report time or change of shifts, hand off all of those things that we are working on, impacts our whole experience of working with our patients and their families. (Senior leader)

5.4.3 Possibilities.

An inquiring organization

Senior leader participants asked a combined total of over 70 questions during three and one half hours of interviews. These questions were related to the organization, the work and the staff and the patients and families which it serves. A sample of the questions is presented aligned with the previously defined cultural themes of organizational self-awareness, congruency and health (Table 5.3). These questions are representative of the degree to which the senior leaders are reflecting on and contributing to a culture of inquiry and openness to new ideas within the organization.
Table 5.3 Questions aligned with organizational self-awareness, congruency and health

<table>
<thead>
<tr>
<th>Cultural themes</th>
<th>Sample questions</th>
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<tbody>
<tr>
<td>Organizational Self</td>
<td>How can we live relationships in [the organization]?</td>
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<tr>
<td>Awareness</td>
<td>How do we communicate that our relationships with each other impact our work with our patients and families?</td>
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<td></td>
<td>How do we pay attention to the things that aren’t working?</td>
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<td></td>
<td>How do we improve the quality of what we have, without doing that in a way that operates as a critique?</td>
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<tr>
<td>Organizational</td>
<td>What are the consistencies across the models [of care] already in place across the organization?</td>
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<td>Congruency</td>
<td>How do we capitalize on the value of what we have as an organization and bring that together [across sites and groups]?</td>
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<td>How do we put the question in a way that will help people come together?</td>
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<td>How does it get internalized to our day-to-day lives?</td>
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<td>Organizational Health</td>
<td>What are we thinking when we’re talking about benchmarks? Where do we set the target e.g. hand-washing compliance?</td>
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<td>What does the information from the quality teams really mean? What is that telling us about our clients?</td>
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<td>We have excellent patient satisfaction results. How do we make sure that our staff are feeling the same way?</td>
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<td>What are the questions that we want to ask [in satisfaction questionnaires]?</td>
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<td>Which questionnaires and validated questions should we use? How do we improve the quality and validity of the questions?</td>
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<td></td>
<td>How do we use the information? What have we done with it year after year?</td>
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<td>Some policies and procedures look great but do they work?</td>
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<td>What is the object of the process?</td>
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<td>When is it that people are indoctrinated early on in the Western model as to what success is or means?</td>
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<td>When does the preoccupation with measurement actually push us past the threshold of that which is helpful?</td>
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An innovating organization

Many innovative change ideas evolved as the participants explored similar questions, shared their knowledge, opinions and experiences, and constructed mental models. Some of these change ideas have been shared previously (Brander, et al., 2012b) and will be used to stimulate further discourse, debate and action within the hospital.

Phase 1 resulted in the identification of five categories from the healthcare providers’ perspectives related to the patient and family centred education and focus group interventions over time. These were: customer, customer service, knowledge, roles, and common vision (Brander, et al., 2012a). Phase 2 revealed additional themes based on mid-level leaders’ perspectives of customer service and care relationships within the organization and in response to a summary of Phase 1 findings. These were: being present, communicating well, taking action, having and recognizing each other’s expertise, and collaborating. Six overall themes emerged as important for the development and achievement of collaborative care relationships within the organization from the triangulation of all three study phases. The first three of these had been identified in Phase 2, but the verb tense was changed for brevity, with no intent to change the meaning. These were: be present, communicate well, and collaborate. The three new themes added were: model the way, be open to new ways, and make sufficient time. The new themes are discussed below and details of the first three themes have been discussed previously (Brander, et al., 2012b, in press).

Model the way is composed of two subthemes of leadership and mentoring. These subthemes were evident across all study phases but were strongly represented in the senior leader conversations. Senior leaders recognized the significant contributions of mid-level leaders in providing leadership in formal work relationships with their teams. Self-selected mentorship and learning were suggested as important in contributing to the organizational culture.
Some cultures say, ‘when I’m ready to learn, the teacher appears.’ That’s important for us. When we think of how professional development of healthcare staff is supported and enabled, it’s through relationships. People who were powerful mentors for me were not chosen by an organization or by a particular system of selection—except my own. (Senior leader)

The fifth theme, be open to new ways, includes subthemes of acknowledgement and the need to be aware of old ways. Acknowledgment was the descriptor suggested by a staff member to encompass concepts of ownership and accountability during one presentation of Phase 3 results to a staff group. The term ‘acknowledgement’ appealed to the group of staff attending the presentation as it connected the reasons for taking ownership and being accountable while acknowledging the importance of these skills to build mutual trust in relationships. One senior leader underscored the importance of acknowledgement, ownership and accountability:

I think you need to be willing to have the patient look you in the eye and say, ‘Are you really saying that about me?’ So I think, ‘chart as if the patient will read the chart’ is great accountability. (Senior leader)

An awareness of old ways was reflected as important by one senior leader “because we are always looking for something new and we may already have something that works well.” On the other hand, an awareness of old ways was expressed as necessary to direct the organization to new perspectives for care. The example was given of the organization’s role of providing a home and care for long term patients, some for over 25 years.

There was no opportunity to think about any [other form of care]. So now we’re trying to learn lessons about how one can [isolate] someone by taking great care of them, protect them from the world so that they have no opportunity to participate. (Senior leader)

By understanding history and old ways, new understandings and ideas may evolve.

It seems no study of culture, particularly healthcare culture, can exclude the concept of time. Make sufficient time was portrayed as essential for the development of relationships and the sixth theme. This theme was prevalent throughout all study phases and was seen as a significant facilitator for relationships in a human-centred organization, as stated by one senior leader:
There is this element of time that engages complexity to engage the person. If we are dealing with complex situations and not allowing the team to move to the dimension of personal space and team space to engage complexity, they are always simplistic [conversations]. It never gets us anywhere and continues to build the moral distress that people feel. (Senior leader)

Time was also discussed from the perspectives of improving service for the patient and family. An example of making time on their behalf was the reduction of waiting time for a first appointment from 12 to less than 3 weeks; a 60 percent reduction was achieved by examining the existing intake process and identifying opportunities for change. Details of the project were not related in the interview but there was a focus on not wasting the patient’s or family’s time. The senior leader related another change initiative which had resulted in a faster admission time for a patient.

We believe there are plenty of opportunities to [make better use of time]. Why did it take us three weeks to take a referral? We recently had one from a rural area. The doctor went up there and looked at the patient. He came back and re-admitted the patient. Period. Because he knew when he saw this patient that this was a tertiary care patient [who required admission]. In terms of process, that’s pretty efficient. I think this is an enormously helpful notion: How do we understand what we need to do with this client and family right away? How do we not waste their time? (Senior leader)

**Partners-in-Care**

Senior leaders portrayed a ready understanding of the application of customer service in the workplace, as had the mid-level leaders in Phase 2. One senior leader anticipated the tensions related to the use of customer service terminology, in reference to corporatization and care.

‘Customers’ comes from the language of business and business interaction and ensuring you give the customer what they want to consume. As a customer, I’m going to get what I want, which is very unique to me….It touches on a real tension within healthcare in Canada right now around corporatization, the move to healthcare that is more [based on] consumption and run by a business mentality. There is a real tension between those who have a different worldview around care as opposed to consumption. (Senior leader)

The recurrent themes, carried through all study phases, were used to create the formative conceptual model in Figure 5.2. A strong thriving plant was chosen by the author in discussions with the graphic artist to represent the dynamic and complex hospital organization, supple and malleable and responsive to its environment. In the top centre of the figure is labeled ‘Partners-in-
Care,’ the shared vision that was identified as building consensus for collaborative care relationships. At the bottom of the figure are the roots which represent values portrayed within the organization’s mission statement, ‘Strengthening our Relationships’, ‘Enhancing Quality of Life’, and ‘Compassion’. Extending toward and away from the centre of the plant are strong leaves which symbolize the six themes which incorporate the components necessary for success in care relationships: be present, communicate well, collaborate, model the way, be open to new ways and make sufficient time.
Figure 5.2 Conceptual model for collaborative care relationships within the organization
5.5 Discussion

The final research phase helped to situate the previous study findings into a broader understanding of the culture of care relationships and the interplay between individuals and groups working at different levels within the organization. Through focused discussions, healthcare provider participants developed a shared vision and generated ‘change ideas’ which in turn were explored by mid-level leaders and lastly, by senior leaders. The resulting picture was that of a dynamic organization responding to change at all levels to meet both internal and external mandates for increased collaboration with patients and families. Through the research, participants recognized that enhanced relationships with co-workers would also contribute to the goal of enhanced relationships with patients and families. The organizational culture will be discussed from the perspectives of values, learning, leadership, and innovation.

5.5.1 Culture and values.

Although the senior leader participants readily identified with the term customer service, Phase 1 demonstrated that this was not the preferred vision on which to build work relationships with all stakeholders. Preferred representations included ‘partners-in-care,’ ‘patient (and family) centred care,’ and ‘relationship centred care’, as presented previously (Brander, et al., 2012b). Differences in patient groups, histories and structures had led to the use of a variety of models of care. The senior leader participants recognized that it was most important to emphasize the common values and principles of these models in order to build positive relationships with and among all stakeholders, rather than to identify one specific model as fitting all sites and groups. This agrees with a growing body of research which indicates that the purpose, vision, and values communicated within a hospital mission statement are positively related to organizational performance (Bart & Hupfer, 2004; Youngblood, 1997) and through shared values and beliefs, people are empowered to act in accord with the organizational directions.
Values function as the mortar of organizational life by cementing the foundation of vision and purpose. Values also become magnets, attracting and building loyalty among individuals who share and honor the same ethos. Belonging to a group with high-minded values, employees know that they are working with splendid purpose for a hospital with greatness in its sights (Bart & Hupfer, 2004, p. 101).

5.5.2 Culture and learning.

An interdisciplinary education initiative, similar to the educational intervention used in this study in that it was based on the best practice guideline for Client Centred Care (Registered Nursing Association of Ontario (RNAO), 2006), was shown to influence the spread of values related to client centred practice within another hospital organization (Ford, Rolfe, & Kirkpatrick, 2011). In the Ford, et al. study, consensus and support for the client centred care best practice guideline were the key goals of the project and this was successfully reflected in a number of hospital-wide initiatives. During my research I also tracked new organizational initiatives which embodied the values of the Patient and Family Centred Care education and provide some examples of these here. Senior leaders cited reported improved relationships with and attention to community of practice groups, such as that noted with the Joint Nursing Practice Council. Improved communications across the organization were evident with increased frequency of use of electronic newsletters which showcased staff-contributed success stories and celebrations. The Patient and Family Centred education had been discontinued but was re-initiated after a 1.5 year hiatus, in part due to feedback and findings from the participants within this study.

Highly innovative and adaptive organizations close the gaps between espoused organizational values and actual practice (Brown & Duguid, 1991). Practice is created and enacted within communities-of-practice by employees who learn and problem-solve together in order to succeed in their work. Organizations that close this gap possess leadership which promotes working, learning, and innovating as inter-related, compatible, and necessary. The willingness of individuals and groups within an organization to cooperate and share knowledge is a critical dimension for knowledge transfer (Goh, 2002). This study portrayed participants
learning ‘from, with and about’ each other, defined as foundational for inter-professional education and practice, individually and in groups and across organizational levels (Centre for the Advancement of Interprofessional Education, 2002). It has demonstrated that learning, steeped in the values and vision of the organization, can have influence beyond what was initially planned.

5.5.3 Culture and leadership.

Ideal leaders play a strong influence on organizational culture by building trust, modeling excellent relationship skills and enabling knowledge transfer and collaboration. Two theories of leadership are discussed as related to the study: shared-leadership and transcendent leadership.

Shared-leadership is conceptualized as leadership which is distributed among members within an organization (Pearce & Congre, 2003). It is defined as “the ongoing, mutual influence process through which leadership is rotated to the person with the key knowledge, skills and abilities for the particular issues facing the team” and is inherently part of the organizational system (Crossan, Vera, & Nanjad, 2008, p. 573). Depending on situational needs, leaders come forward and then step back when no longer needed. Shared leadership intuitively links to communities of practice engaged in problem-solving and in making sense of their environment to improve their work. Leaders may be formally designated within teams, but they also can be members who may step up to facilitate team and administrative processes. This form of leadership banks on the unique strengths of individuals as a resource for the organization.

Providing learning opportunities, such as Patient and Family Centred Care education, and collaborative research opportunities, such as those demonstrated in this study, developed unique skills within individuals and groups aligned with the strategic directions of the organization. These learning and research models encouraged leadership to be distributed among many members of the team. In future it is hoped that the organization will continue to mentor and facilitate new opportunities for leadership which includes non-traditional leaders and roles, such
as the patient and family, educators and researchers, working in tandem toward the organization’s goals.

A shared leadership model links with the theme ‘collaborate’ found in this study. It incorporates the value of mutual respect and acknowledges the need for a variety of knowledge areas and expertise to meet and lead in a variety of situations. Collaboration facilitates models of shared leadership as it allows for differentiation of roles and influence so that informal leaders may emerge.

Crossan, Vera and Nanjad (2008) propose transcendent leadership as a framework which represents the responsibilities necessary for strategic leaders to be successful in rapidly changing environments, such as in hospitals (Kernick & Mitchell, 2010). This framework requires the leader to lead self, others, and the organization and indicates that all three components are interdependent and necessary for optimum organizational performance. Within individual, group and organizational levels a learning perspective must thrive in order to be responsive to the rapidly changing environment. “The strategic leader’s responsibility is to provide the infrastructure that enables learning to flow throughout the organization” and to help to create and sustain value-based visions for the organization which are grounded in principles for high capabilities and not in rigidities (Crossan, et al., 2008, p. 572). The focus is on what is to be accomplished and less on the details of how it is done. Management is oriented towards entrepreneurship and coaching to build environments of trust and purpose and less focused on controlling and implementing.

One can readily envision an organization in which uses of these two types of leadership are interdependent. The transcendent leader models and enables the vision and directions for the organization, while encouraging shared leadership amongst others who are engaged at the interface of the work, such as those engaged in patient care in a hospital. Crossan et al. (2008) indicated that diffusion of leadership throughout the organization enabled a balance of freedom and structure which encouraged exploration and innovation.
5.5.4 Culture and innovation.

Many of the components of the partners-in care conceptual model coincide with those described as necessary for complex evolving and responsive organizations which adapt and thrive on change (Youngblood, 1997). Youngblood described three necessary components as shared vision, personal leadership, and free flow of information, all of which are described in this study. Many of the innovative change ideas echoed the themes outlined by Youngblood and others.

These components lead to innovation, in part where an organization actively constructs a conceptual framework, imposes it on the environment and reflects on the resulting interactions and outcomes (Brown & Duguid, 1991). By adopting new learning models with PFCC and by encouraging staff participation, active reflection, and opportunities for practice, the organization has built and strengthened its collaborative care relationships.

It seems to come back to the idea that in a human-centred business the foundational building block for the complex growth of interconnections and interactions is living relationships. Without common understandings and internalization of such qualities as respect, equality, mutual and shared learning, acknowledgement and the knowledge of ways to undertake these in each and every encounter, the organization will be unable to meet the challenges of a dynamic complex environment. Defining and sharing its values, developing and implementing methods for their diffusion and practice, and shared and transcendent leadership models, are needed in hospitals. The organization was engaged in strategies to work toward improved collaboration at all levels. Perhaps a relationship-centred shared governance model, where it is clearly recognized that we are each other’s customers, would further enhance quality as we strive to be ‘partners-in-care’ with our patients, families and colleagues.

5.5.5 Limitations.

This study phase was limited to the senior leaders who met the criteria and volunteered for the study; however, not all senior leader roles were represented. For example, it would have
been useful to have had a physician senior leader participate. As well, the information presented to the senior leaders from the prior two phases reflected the self-reported knowledge from volunteer healthcare providers and mid-level leaders from the one research site. A greater variety of disciplines, across all organizational sites would have provided more varied data, but this was not within the scope of the study. Additional participant observation would also have enriched the data, but this is not always easy in healthcare environments due to such limitations as space and privacy. There remains the challenge of shifting perspectives as culture evolves in a complex hospital organization and it is necessary to reflect on those whose voices may not have been heard (Higgs, Titchen, et al., 2007). The step-wise progression of the study allowed for consultation of participants representing different roles and within levels but in future it would be of interest to consult with groups across organizational levels to build greater consensus and understandings.

5.5.6 Future.

The study adds to foundational knowledge of a hospital organization undergoing innovation as it works toward collaborative care relationships with staff, patients and family. Patient and family centred care education, along with guided conversations in focus groups, interviews, and meetings revealed a variety of opinions and created a shared vision for care. The critical ethnography presented an interpretation of the findings which contributed to the conceptual model of partners-in-care, and to many innovative change ideas suggested by the participants across all organizational levels. This interpretation is being used for further organizational development; for example, it is currently being used in PFCC education sessions to stimulate and nurture the conversations. Next steps will be to consult with groups and leaders about the innovative change ideas, some of which have already been implemented within the organization. Further research will help to identify which of the innovations have improved collaborations across teams which include the patient and family.
5.6 Conclusions

The critical ethnography depicts a healthcare organization undergoing renewal. Cultural themes emphasize existing strengths of an inquiring organization as it develops a community of vision for collaborative care with a view to a relationship-centred governance model at individual, group and institutional levels. Organizational questions, tensions and possibilities were explicated for future shared conversations and debate in directing the organization toward its goals for enhanced quality of life for its customers, patients, family and staff.
Chapter 6

Discussion

This thesis contributed to knowledge and understanding of the complex processes of change regarding collaborative care relationships within a hospital organization in Ontario. The changes described were based on participants’ reported social constructions (attitudes), value identifications, and concept constructions (knowledge), and individual, group and organizational outcomes (practices). New knowledge was built through a critical ethnography which utilized a mixed methods research approach. By interacting first with healthcare provider participants, and then successively with mid-level and senior-level leaders, conceptual models and shared visions for organizational relationships were considered and diffused amongst multiple employee roles and organizational levels. Innovative ideas for change were generated through the use of discourse and narratives that were shared amongst participants, and at venues both within and outside the organization. A shared conceptual model of ‘partners-in-care’ was created. This model was placed in context with current organizational strategic directions for ‘enhancing quality of life’ and ‘strengthening our relationships’ and was used to form a graphic representation to assist with future discussions and ideas to enact collaboration. Compassion was also part of the roots of the conceptual model as it is one of the deepest engrained historical values of the organization. Six themes were developed through ethnographic analysis of the participants’ views of the important aspects of collaborative care relationships and completed the graphic representation (see Figure 5.2).

A beginning point for this research was a concept of customer service, defined as the level of service which is deemed to meet or exceed customer expectations (Bowen, 2012; Lee, 2004). Customer service, involving the patient and family as essential participants in their care experience, is becoming more evident in Canadian and Ontarian health policy (Curran, 2007; Drummond, et al., 2012; Romanow, 2002) and legislation (Government of Ontario, 2005; Ontario...
Ministry of Health and Long-Term Care, 2010). These public statements are directing hospitals and other organizations toward greater responsibility in patient and family involvement and satisfaction with their experiences in quality care. To assist organizations in responding to these directions, it is helpful to understand existing cultures and structures which influence service quality. This thesis is perhaps the first critical ethnography which describes the cultural changes occurring within a Canadian hospital as it strives to meet mandates for improved collaborative care relationships with patients and family.

Another significant contribution to organizational change science was the method of linking the research with the existing Patient and Family Centred Care education (PFCC). This partnership opened the door to study with motivated course moderators and employees engaged in learning about healthcare relationships and willing to spend their own time on related conversations. Not only was it an avenue for recruitment, it augmented the change processes by providing people time and space to openly discuss and reflect on new ideas with peers in a safe environment and to practice new skills in real work environments.

This learning-oriented strategy aimed to produce sustained change by changing the way staff interpreted their interactions with patients and families. Building profound and sustained change is dependent on changing the way people think.

In profound change there is learning. The organization doesn’t just do something new, it builds capacity for doing things in a new way - for ongoing change. It is not enough to change strategies, structures and systems, unless the thinking that produced those strategies, structure and systems also changes. (Senge et al., 1999, p. 15)

As the discussions evolved in PFCC and focus group discussions, staff identified that the relationships they shared with their co-workers also contributed to workplace satisfaction and ultimately to their interactions with patients and families.
Discussion of specific findings and summary

The ethnography described individual and groups of employees within a Canadian hospital advancing its work towards improved collaborative care relationships in a number of ways. The stepwise development of the research findings is depicted in Figure 6.1 and will be reviewed below.
Figure 6.1 Stepwise development of study phases and research findings
Phase 1 healthcare providers (HCPs) engaged in discussions about care relationships over an eight month period: immediately before they were introduced to the Patient and Family Centred Care educational intervention, upon its completion two months later, and finally six months after its completion. Two tensions related to accountability in practice were revealed. The first of these was represented in the use of apologies for situations that the HCPs described as outside their control. This tension contributes to existing knowledge as it was not noted in the reviewed literature. The second tension was evident in the HCPs questions about individual versus collaborative accountabilities in practice. The latter tension emphasizes the point made by others that it is important to evaluate new frameworks for learning and working, such as collaborative practice and interprofessional practice, so that we may better understand their true advantages (Jones & Jones, 2011; Reeves, 2010b). Collaboration and interprofessional practice have quickly become accepted entities, normalized into healthcare theory, writing and teachings, but there remain many complexities and outstanding questions regarding methods of implementation and use in the workplace.

In Phase 1, five categories representing HCPs’ perspectives of care relationships emerged (customer, customer service, knowledge, roles, common vision). Included within these categories were themes which discussed individual rights, the power of information, reciprocity of work, respect for co-workers and partners-in-care. These themes were comparable with previously documented enablers and competencies for collaborative relationships, which included role clarification and valuing (respect, sharing and trusting of knowledge and power sharing) (Orchard, et al., 2005) and understanding roles and communication (Suter, et al., 2009). Although many HCP participants identified with ‘customer service’ as a guiding principle for healthcare relationships, some did not. An important finding was that the use of ‘customer service’ connoted an emphasis on corporatization and/or servitude in the relationship which was unpalatable to some of the participant HCPs and whose opinions did not change over the course of Phase 1. This
finding was not previously reported in the reviewed literature. As HCPs together discussed concepts of customer service, a shared mental model of ‘partners-in-care’ emerged as representative of collaborative relationships with patients, families and work colleagues within the organization.

Phase 2 first engaged individual mid-level leaders in a survey, to reflect on their own ideas on customer service and care relationships. Next, they jointly discussed HCPs perspectives from Phase 1 in a focus group. The key themes that enabled the mid-level leaders to perform well in customer service relationships were: being present, communicating well, taking action, having and recognizing each other’s expertise and know how, collaborating, and encouraging ownership and accountability. Many of the themes are similar to those reported in the literature. In nursing leadership, Bally (2007) identified attentiveness, open communication, feedback, credibility and treating others with respect, as characteristics that built trust and an organizational culture that was seen as safe and that enhanced collaboration. Leadership was envisioned as a collective professional responsibility, shared by all in the organization (Bally, 2007). Tellis-Nayak (2007) stated that managers play crucial roles in the commitment, satisfaction and retention of their staff. Middle managers construct a “person-centred workplace that deepens staff engagement” with the reciprocal result of staff promoting the well-being of the patients (Tellis-Nayak, 2007, p. 46). It has been contended that great leaders have a strong social intelligence epitomized in many interpersonal competencies that inspire others (Goleman & Boyatzis, 2008). These competencies act as the foundation for building the trust necessary for success in manager/staff/patient relationships. This literature supports the study findings where HCP participants said that positive co-worker relationships (including those with managers and others) promoted positive work satisfaction and improved relationships with patients. They also stated that the converse was true; negative relationships with fellow employees contributed to poor workplace satisfaction which
may in turn contribute to less positive relationships with patients and clients. It is reinforcing to read, deep within Romanow’s influential report:

Healthcare managers are frequently overlooked in the healthcare system, yet their work is vitally important to the overall organization, planning and funding of healthcare systems across the country. Often working behind the scenes, healthcare managers are responsible for threading the pieces together, organizing services, and trying to get the best value for the health resources available – in terms of both people and dollars. Health managers are responsible for implementing difficult decisions and managing complex and evolving organizations. (Romanow, 2002, p. 103)

In Phase 2, the mid-level leaders saw customer service as important in their own work. They reflected on and added to the change interventions suggested by the HCPs. They understood that not all healthcare stakeholders identified with customer service and they presented alternative representations, including patient-centred care, relationship-centred care and also identified with ‘partners-in-care.’ The use of metaphors, analogies and shared stories has been shown to coordinate thinking about and vision for the work to be done (Amabile & Khaire, 2008; Brown & Duguid, 1991). Collaboration drives innovation and creativity. As not all of the innovative change ideas that were generated in the study were presented in previous chapters due to peer-reviewed journal space limitations, a summary list is presented in Table 6.1. These change ideas are captured here in the hope that they will assist in future developments and collaborations within the organization. The words in the first column of the table echo the participants’ words as closely as possible, in an effort to be true to their intent. Some of the innovations are broad initial ideas, others are more detailed. The second column provides additional description and explanation to the original concepts. The third column provides an indication as to which of these innovations have been implemented and are already leading change with respect to collaborative care across the organization.
<table>
<thead>
<tr>
<th>#</th>
<th>Change idea (Participants’ words)</th>
<th>Further detail</th>
<th>Some examples in progress</th>
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<tbody>
<tr>
<td>1.</td>
<td>Articulate the principles of the shared vision for the organization (at the staff/work interface).</td>
<td>A shared vision was said to be needed specifically at the direct care or ‘unit’ level to engage everyone in similar goals and focus to best accomplish the work at hand.</td>
<td>Quality Improvement (QI) Plan 2011-12 developed with staff and leader consultations on Quality Teams.</td>
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<td>2.</td>
<td>The minute a patient steps into the door we have a team meeting with them.</td>
<td>Meet to discuss anticipated admission course, patient goals, discharge plans and end of life care as early as possible. Meetings currently occur 3-4 weeks after admission.</td>
<td>Occurs in some areas of the organization, but not routine in others.</td>
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<tr>
<td>3.</td>
<td>Chart as though the patient is going to read the chart.</td>
<td>Change attitudes with a view for greater openness and transparency in the patient record. Creative suggestions included “Patients read their chart every Thursday” so that this would become the norm and routinely accepted.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Seek more ideas from patients and families for better patient and family centred care (PFCC).</td>
<td>Recognition that patients and families are knowledge experts in this area and other ideas could be generated. Speaks to the desire to engage with our customers.</td>
<td>Specialized Geriatrics has chosen patient autonomy for quality improvement initiatives 2011-12</td>
</tr>
<tr>
<td>5.</td>
<td>All key committees would invite patient and family engagement.</td>
<td>Create opportunities for regular feedback and equal membership on advisory committees, for example.</td>
<td>Community and long-term-care sites currently have patient and family members as advisors.</td>
</tr>
<tr>
<td>6.</td>
<td>A one hour PFCC education session available for all staff.</td>
<td>This recommendation was made when PFCC education had been discontinued.</td>
<td>“Enhancing our Relationships - PFCC education” was re-launched January 2012. Registration is open to all staff and physicians.</td>
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<tr>
<td>#</td>
<td>Change idea (Participants’ words)</td>
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<tr>
<td>7.</td>
<td>Ensure patient satisfaction feedback is being used for real improvement.</td>
<td>Patient satisfaction information is regularly collected. Participants identified their desire and their need to learn from regular feedback.</td>
<td>Patient satisfaction results have been published and discussed at staff forums. Higher rates of feedback are targeted in QI Plan 2011-212</td>
</tr>
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<td>8.</td>
<td>Real sentences/real videos to generate discussion as to how the patient’s experience could be better and to celebrate successes.</td>
<td>An openness to receive more direct feedback was discussed.</td>
<td>Some patient video feedback is available on the organizational website.</td>
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<tr>
<td>9.</td>
<td>Drama productions to invite and inspire and model the way.</td>
<td>This was suggested as a creative way to engage staff and others at emotional and empathetic levels.</td>
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<tr>
<td>10.</td>
<td>Allow teams enough time for strategies to come forward.</td>
<td>Statement that time was needed to engage the complexities of the work for teams to resolve and lead for solutions.</td>
<td>Team retreats, including physicians, have occurred for strategic program planning.</td>
</tr>
<tr>
<td>11.</td>
<td>Aim high and deep.</td>
<td>Engage teams to set relevant targets - they will often engage depths and perspectives that might otherwise be missed.</td>
<td>Teams were engaged to set own hand-washing targets.</td>
</tr>
<tr>
<td>12.</td>
<td>We talk about concrete things. The spiritual things need to be considered.</td>
<td>References the complexity of healthcare issues and work.</td>
<td></td>
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<td>14.</td>
<td>Create a culture of peer-to-peer mentorship that reflects the values of the organization. Re-engage staff by asking them to be a mentor.</td>
<td></td>
<td>A mentorship program was introduced in 2011.</td>
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<td>#</td>
<td>Change idea (Participants’ words)</td>
<td>Further detail</td>
<td>Some examples in progress</td>
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<tr>
<td>15</td>
<td>Assist our patients to understand.</td>
<td>Understand the patient’s information and perspectives so that knowledge is shared reciprocally and better understanding is achieved for all involved.</td>
<td>Spinal Cord team routinely invites patients and families as part of multidisciplinary rounds and discussions.</td>
</tr>
<tr>
<td>16</td>
<td>Assist staff in taking and enacting new learnings to teams after the education is completed.</td>
<td>Staff indicated that there may be a backlash in bringing new learnings back to teams.</td>
<td>PFCC now has a new format with registration open to all disciplines and from any of the organization’s sites.</td>
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</table>
In Phase 3, senior leader volunteers were asked to contemplate the results of the prior phases and to give their views on enhanced collaborative care relationships. The results from this phase were triangulated with those from Phases 1 and 2 in order to build a broad picture of the organization from the perspective of its culture (organizational self-awareness, congruency and health); organizational tensions (uniformity/pluralism, corporatization/care, liability/accountability, power/leadership, energy/relationships) and possibilities for growth. Change ideas generated from Phases 1 and 2 were shared with the senior leaders and their suggestions were also added to Table 6.1. Some of the change ideas have been developed and implemented in the work of the organization and will be discussed below.

6.1 General Discussion of Findings and Overview of Change Processes

This applied research studied people in the organization engaged in the process of changing their thinking and their work culture. Cultural change requires profound change in values, beliefs and practices at the individual and group levels within a community (Applebaum et al., 2008; Atkinson, Delamont, & Housley, 2008). Senge et al. (1999) outlined many challenges that oppose profound change, the deep change that requires learning, so that inner shifts in people’s values and behaviours occur and result in outward shifts in processes, practices, and systems. He separates these challenges into three areas related to initiating, sustaining, and redesigning/rewriting the processes for profound change. The change processes associated with the research are reviewed from the perspective of the three areas identified by Senge et al. (1999) to highlight the iterative and complex processes required for profound cultural change.

6.1.1 Initiating Change

An important first step was to ensure that the organization saw the research project as potentially useful so as to gain sponsorship. The Vice President of Patient Care/Chief Nursing Officer was approached and engaged in the study and she readily agreed to act as sponsor. The next step was to follow-up on an identified opportunity for a HealthForceOntario-
Interprofessional Care Education Fund 2008/09 grant submission. As a novice researcher and PhD student, the sponsorship and guidance of my research supervisor, Dr. Margo Paterson was invaluable in this regard. The grant also required sponsorship from the organization’s chief executive and financial officers. I wrote a one page executive summary, which was taken to the organization’s board of directors and support for the project was achieved. I also presented ideas for the project informally to healthcare providers and managers with whom I worked and sought their suggestions and support. Their many contributions and those from other co-workers within the organization helped to focus research questions and to gain momentum for and diffusion of information about the project. People were talking about it. These steps set the groundwork for the study in that it had been widely communicated, shared and shaped by many people within the organization from its inception.

It seemed a fitting opportunity to link with the Patient and Family Centred Care (PFCC) education occurring within the organization, as course registrants were potential study participants who had committed to participate in learning about enhanced interactions with patients and family. To this end, I approached the PFCC course moderators, three advance practice nurses with many years of clinical and leadership experience within and outside of the hospital. This was a second key enabling point for the study. The PFCC was new in the organization (about two years) and was gaining recognition for changing ideation toward increased collaboration with patients and family. Even with maximum capacity and scheduling, only 6% of the staff had received course certification at the beginning of the research project. It was imperative to plan the research with the moderators so that it contributed, and was not seen to compete, with the PFCC initiative. It was also important to communicate that the goal was not to evaluate PFCC; (they were already evaluating their own efforts); rather it was to consider the culture of care relationships and customer service from the vantage points of the individual most involved with relationships with patients and families, the HCPs. Educational time is precious in
a hospital. There are daily challenges with emerging patient needs, staff scheduling and replacement, student supervision, and the list seems endless. Fortunately, the course moderators readily supported the project and offered to share information and recruitment flyers with those registered. A charge nurse and ward aide were consulted regarding recruitment flyers and they advised me to keep it simple and to hold focus groups rather than interviews, as staff would be more likely to attend a group. Over 75% of the registrants volunteered three lunch hours of their own time to participate. This was thought to demonstrate interest in the topic, a comfort level with the project and with me as the researcher. I strived to demonstrate maximum flexibility and respect for participants and their time, offered face to face, telephone and email contact, and provided alternative interview formats (small group, individual, telephone). These options encouraged maximum participation and were provided in deliberate efforts to model excellent customer service for all involved.

The PFCC course moderators and I met throughout the 18 months as the two courses rolled out and data collection was completed in Phase 1. During that time period, organizational changes occurred in the Vice President of Patient Care position. Fortunately, the new Vice President of Patient Care was well-informed about the project, knew my work, and readily took on the role of sponsor and supported subsequent study phases with mid-level and senior-level leaders. A high rate of participation in Phases 2 and 3 was evident, (93% for mid-level leaders) and (75% for senior leaders) respectively, and the remaining data collection was completed quickly over a four month period.

Throughout the study, I presented the study with its early results and received valuable feedback at internal meetings and at peer-reviewed provincial and national forums (Appendix S). This feedback helped to shape subsequent interview guides and analysis. For example, one repeated question was if there had been any physicians participating in the study. Unfortunately the answer was no, and although I was powerless to change the mix of available participants, I
was able to present this as a finding and as evidence for the need for a wider variety of healthcare disciplines involved in the PFCC education.

6.1.2 Sustaining Change

Over the several years of conducting this research I have noted many organizational changes contributing to enhanced relationships within the organization. The corporation’s formal mission statement was revised in 2009 and key strategic directions now emphasize collaborative care relationships, for example, strategic direction #1, *Enhancing Quality of Life*, includes the pursuit of “holistic and collaborative approach to care” and strategic direction #4, *Strengthening our Relationships*, includes “consistent and meaningful conversations between clients, staff, physicians and management.” There have been improved avenues in communication; for example, the organization’s intranet is now available and staff regularly contributes articles and information to a new weekly electronic newsletter. In the summer of 2011, a call for great stories was extended to individuals and teams across the organization with results that many celebrated in print which has increased opportunities to learn from, with, and about each other. The development of a mentorship program (Sep 2011) and an introduction to the values of the organization are now key parts of new staff orientation (Jan 2012). New leadership training and ongoing leadership mentorship are two other initiatives that have been developed and strengthened.

Of particular note is the fact that PFCC has been re-initiated in January 2012 after 1.5 year discontinuance, with new energy, a new format and focussed on, but not limited to, a different organizational site. This recommendation was made by the VP of Patient Care based on feedback from former attendees, and in part from information shared from this study, and was approved by the senior leaders within the organization. The course has been re-launched as “Enhancing Our Relationships – Patient and Family Centred Care.” In speaking with course moderators, I learned the title was changed to emphasize that collegial collaborations and
relationships contribute toward enhanced interactions with patient and families, a conclusion that study participants had also made. As well, registration is no longer oriented to one staff group and a wide variety of staff from different organizational sites are now attending. This enhances collaboration across staff disciplines, programs and organizational sites.

I was invited to share the research project and findings with the new course participants within the new ‘Enhancing our Relationships-PFCC’ curriculum in January 2012 and on an ongoing basis. Initially I was asked to speak in the fourth session of the course, but this was changed to the opening session of subsequent courses, as the moderator told me that the experiences and findings shared from the study were needed “right up front” to set the stage for the course. As of March 2012, I have been privileged to engage in six sessions, sharing some of the research results with staff, and hearing their feedback. Four additional sessions are planned in the spring of 2012. As more staff have the opportunity to consider relationships for care and converse together, it is hoped that new norms and practices will continue to develop, be implemented, and spread for improved collaborations across the organization.

In rewriting and re-evaluating my presentation and interactions with the new PFCC attendees, I am forced to reflect on my own learning and influence within this initiative. Advanced Change Theory is a model of change proposed to achieve real adaptive and deep change by “mobilizing people to make painful adjustments in their attitudes, work habits, and lives” (Quinn, Spreitzer, & Brown, 2000, p. 147). The underlying premise of the model is that emergent leaders for change lead from a deep personal vision for the common good, and during the process become aware of their own self-deceptions and vulnerabilities. The inner tensions of the change agent, due to the processes of clarifying and aligning their own values and behaviours, involve risk and “operating at the edge of chaos” (Quinn, et al., 2000, p. 160). The change agents must surrender their inaccurate assumptions and biases in the middle of ongoing action. Their behaviours, engagement of risk in a quest for the vision, and their true concern and appreciation
for others’ worth and contributions, are necessary to engage the collective community in the change.

Customer service seemed a good vantage point from which to begin the study as it awarded a possible and novel means to engage others in thinking about improved care relationships with patients and families. To me it represented a tool to engage patients and families as equal partners, by demonstrating common courtesy and respect and recognition of their significant worth to the process. This seemed a logical and meaningful framework, one which would rally the troops in renewed vigour toward a shared-vision. After all, scholarly literature, disability writings, health policy, and legislation supported this view. Instead, it was a false assumption that this would have the same meaning and motivation for all. I quickly learned through the study that some of my respected colleagues had a very different understanding and reaction to ‘customer service.’ To some, it represented that they were the ‘servers’ and thus responsible for “making everything right,” and that their voices were disempowered and authority de-legitimatized in their professional roles. To others, it represented the ‘dreaded’ corporatization of healthcare, with a focus on cost over care. Pursuing a strong customer service orientation may have stopped the conversation before it got started. I began to drop references to customer and customer service in the interview questions, although because the concept still appealed to me, I would still inch it forward, often in conjunction with other more palatable frameworks, such as ‘patient-centred’ and ‘partners-in-care.’ Even after the eighteen month period, from start to end of Phase 1 data collection, I was told resoundingly by a participant: “Don’t use that word. I hate that word, customer.”

The shared vision emerged as “partners-in care.” Other suggestions arose, but by and large, people told me that they identified with a vision where the patient and family were the leaders in their own care journeys. Many innovative suggestions about how this could evolve within the organization were generated. Perhaps not surprisingly, mid- and senior-level leaders
more readily identified with a customer service framework, but many also understood why some members in the community might not. The result was that I focused on the vision of ‘partners-in-care,’ one which was more likely to build internal commitment to the change at all levels.

Further reflection, reading, and writing the thesis has taught me much about collaboration and change. The more I engage in thinking about these processes, the more I wish to seek participation from all partners, organizational levels, and through all parts of the growth and diffusion processes for changes in collaborative care and in future research.

6.1.3 Redesigning and Rethinking Change

A challenge that HCPs voiced during the study was an anticipation of “backlash” from teammates upon returning to their work areas. Participants considered this enough of a threat that some described maintaining silence about the course, sharing their new beliefs and practices less directly by role modelling, or by sharing a success story. They did not necessarily reveal their success as stemming from their PFCC experience. This represents an opportunity for re-thinking and re-designing support for staff as they adopt new attitudes, knowledge, and beliefs into practice environments, especially with teammates steeped in old traditions and norms and able to wield much power in staff relationships.

A related challenge was the concern for liability in distinguishing between accountability in individual and collaborative practice. Healthcare providers talked about their fear of liability - a concern for legal and non-legal ramifications if and when not all treatments were applied. A common example of this is the need to establish the patient’s end-of-life wishes early in the admission process and to clearly communicate his or her wishes with the team including the family. Unless this information is deliberately sought, shared, and documented, a HCP may feel obliged to carry out a treatment such as cardio pulmonary resuscitation (CPR) in a critical event. Best practice directs the HCP to discuss end-of-life choices with the patient and family well
before an event, whenever possible. This will develop a shared plan of care that can be understood, communicated, and documented for all team members. Actions will follow the patient’s wishes and the identified best plan of care, and not occur due to a fear of liability on the part of an individual HCP.

There are many less tragic situations that mirror this concern. How can the organization help all to develop a healthy balance in practice decisions, so that members feel supported and nurtured in both their individual and collaborative work? Effective teamwork has been internationally recognized as critical for delivering high quality and safe patient care (Suter, et al., 2009; World Health Organization, 2010) but understanding the components of successful collaborative practice is still in its infancy (Grimes & Tholl, 2010). Identified collegial trust, team meetings, shared objectives in conflict management, and individual professional autonomy within the team were components which have been identified as important for effective teamwork (Jones & Jones, 2011) and may offer other opportunities to continue to move the organization towards collaborative care innovations.

6.2 Limitations and Strengths

Traditionally, ethnographic methods included prolonged periods of formal observation resulting in what was most commonly an outsider’s account of the people observed. One possible limitation of the study may be considered to be a lack of extensive formal observation of the healthcare employees while completing their daily work. However, post-modern ethnographers speak to the concerns of non-participation and question the validity of etic interpretations (Erickson, 2011). Prolonged informal observation time was accumulated in my role as participant/observer/researcher from within the organization for over three years (September 2008 –March 2012). My emic knowledge as a current employee with a ten year history within the organization contributed to my understanding of the culture. This information augmented the months of formal data collection in the field. Immersion in the culture itself does not create the
ethnography, rather the researcher’s perspective must be alerted and oriented to the research questions at hand and the researcher must actively attend to the actions, language, opinions, and meanings extended by its members (Altheide, Coyle, DeVriese, & Schneider, 2008).

The study was limited in its number of participants, due to the small numbers of available PFCC registrants in Phase 1, and of mid-level leaders and senior leaders who met the inclusion criteria in Phases 2 and 3. Participation rates from those who met inclusion criteria were high, 77%, 93% and 75%, respectively. This demonstrated that there was a high level of motivation of those contacted to be involved in the research. The reasons why a few declined to participate are not known, and may have shed additional insight into the culture. It would have been an advantage to have had input from more employees of different backgrounds and disciplines and from physicians, across all sites of the organization, but the recruitment strategies, research grant and study timeframes did not allow for this. Most importantly it will be important to engage patients, families and other partners in discussions about partnerships and collaborations for the organization. As the study was largely qualitative, the researcher attempted to offset this limitation by thick description of the richness and depth of the data to enhance the trustworthiness of the findings.

The contrasting side of emic knowledge of the culture is that it may bias the researcher. The use of a participatory orientation by involving others in the research processes served to ‘keep me honest’ with respect to my own biases as participant/researcher. An example of this was ‘setting aside’ my initial conceptual frame of customer service in preference to the one extended by the participants, ‘partners-in-care.’ I also recognized that part way through the study, my position had changed from that of Program Manager, responsible for direct care clinical staff, to a formal research position within the organization. Due to this change, I was no longer as close to clinical and staff relationships as I had been previously and knew that my perspective and knowledge were not as current as those of the study participants.
The fact that methodological choices evolved while I was learning about them may have been a limitation in that not all methodological considerations were anticipated in advance. For example, upon submission of manuscript #1 (chapter 3), the reviewers recommended ‘an exploratory case study” design, over that of a critical ethnography. Giving full attention to this new methodology, after all three study phases had occurred, proved to be a useful, although at times challenging, experience. It required me to step away from the overall study and reconsider the first phase, which in retrospect was only one portion of the ethnography in order to fit the description of a case study design. It may have been preferable to orient data collection and analysis to a case study design from the inception of Phase 1, yet this was only realized in hindsight. In addition, some of the data in Phase 1, including a detailed description of changes in participant views over time, could only be discussed very succinctly due to the journal’s space limitations. Although this may not be seen as a methodological limitation, it did limit the ethnographic description of observed changes over time.

The mixed methodological approach proved effective in building the critical ethnography. The study is largely qualitative with a small quantitative component, which included participant demographics and the use of a survey in Phase 2. The focus on the interpretive paradigm was deliberate, in part to gain a deep and thorough understanding of participant views of care relationships. In addition, it provided methodology which enabled participants to learn about each other’s’ perspectives and to develop shared views about collaborative care relationships within the organization. This latter point was aligned with the critical theory and collaborative foci of the research, and could not have been addressed adequately using quantitative methodologies.

At the time of data collection, no published survey was found related to customer service experiences in healthcare and which met the research needs. Due to this a survey was developed in Phase 2. As its parametric qualities had not been established the validity of the results may be
questioned. The findings from the survey were triangulated with the qualitative findings to enhance credibility. Validated surveys regarding collaborative practice and their use in clinical practice have been published subsequently (Grymonpre et al., 2010; Schroder, et al., 2011) and may be valuable in future work.

It is not known if the use of electronic qualitative analysis would have assisted or strengthened the findings. Early in the study it was decided that qualitative software was not required, after investigation and in consultation with expert users and advisors. I often wondered, as I was hand-searching transcription texts and self-developed tables, if efficiency and graphic design may have been improved with an electronic application. However, I developed a hands-on understanding of the processes of data reduction, interpretation and analysis for the study, which I may not have achieved otherwise.

The extent to which the project itself has effected organizational change is not clear, nor was it the main goal. Rather, a greater understanding of the processes of change with respect to collaborative care relationships in a hospital has been rendered. Cultural change within a dynamic and complex hospital organization is most likely due to contributions from many areas. Innovations with a focus to improve collaborative care relationships are now active within the organization. It is clear that the hospital is undergoing rapid change towards this goal, and the results indicate that the research project has contributed to this process.

As with any ethnography, and interpretive research in general, the findings describe the local culture during a specific time and place, and cannot be generalized directly to others (LeCompte & Schensul, 1999a). I encourage any who wish to use the elements shared in this research to carefully consider contexts and details, with the hope that some of the findings may prove useful in other similar environments.
6.3 Contributions and Directions for Future Research

This research is perhaps the first critical ethnography of a Canadian hospital as it works toward enhanced collaboration with patients, their families and staff. The study emphasized a collaborative research approach by engaging participants in reflecting on and creating their own work cultures and environments. By applying the principles of collaboration, the research in itself has modelled concepts of service and partnership. The research engaged participants within a Canadian hospital to reflect upon and envision innovations to optimize care relationships with patients and families. A related theme for success in collaborative relationships with co-workers emerged as necessary to the whole process.

Phase 1 demonstrated HCPs negotiating meanings in the development of a conceptual model of partners-in-care, through the use of the PFCC educational intervention and focused conversations over a nine month period. Participants reported changes in their perspectives and practices which led to improved relationships with patients, families, and each other in the workplace. They attributed these changes to the educational intervention, discussions and opportunities to practice new skills within the real work environment. Many of the HCP participants identified with a customer service framework for relationships with patients and family. Some initially did not identify with customer service but changed their views after the PFCC education. A few remaining HCPs still did not identify with concept of customer service even six months after the educational intervention as it seemed more representative of the corporate world and devalued the therapeutic relationship required in professional clinical care interactions. Consensus was built around a model that would represent collaborative care relationships and this was ‘partners-in-care.’

Both mid-level and senior leaders indicated that providing excellent customer service was important in their work. It may be that the type of work in which healthcare leaders engage is more customer-centric, such as in responding to concerns and complaints, interacting with outside
partners and service agencies. It does not include the provision of hands on care that is entered into by the HCPs. The differences in views of relationships beg further investigations and may contribute to greater understandings amongst different positions and levels of healthcare workers. Understanding each other’s perspectives and roles in the workplace has been shown as contributing to collaboration (Orchard, et al., 2005; Suter, et al., 2009).

The research draws attention to the importance of the development of shared conceptual models among those advancing organizational culture for profound change. It is through shared values and beliefs that people are empowered to act in accord with directions for change. The use of convenient labels, preconceived or unilateral ideas may actually obstruct the development of negotiated meanings and ultimately the desired change. Continued emphasis on ‘customer service’ may have interfered with the change processes, as some of the members did not identify with it. The shared model of partners-in-care built consensus in discussions and assisted in the generation of change ideas for enhanced collaboration amongst all team members that included the patient and family.

A number of practice and organizational tensions surfaced in the research. Two practice tensions, the need to apologize for issues that HCPs saw as outside their control, and individual versus team accountabilities with regards to practice decisions and actions, highlight areas for further study for successful applications of collaborative care. Five organizational tensions (uniformity and pluralism, corporatization and care, liability and accountability, power and leadership, and energy and relationships) offer insight into the organization’s culture. These tensions may offer areas for consideration to the organization as it works to meet strategic goals for collaborative care.

The innovative change ideas offer many strategies which can be developed and applied to advance collaborative care relations. Some of these may be considered novel and even ’way out
there’ but these may serve to push the tight envelope of old normative practices and lead the way to change. Inviting the patient to read his/her chart and creating opportunities for regular feedback, such as on committees, are timely examples (Table 6.1).

Research findings have been shared within the organization and at peer-reviewed and non-peer reviewed venues outside the organization, informally and formally and in conversations, presentations and publications (Appendix S). Three manuscripts have been submitted to peer-reviewed journals: Manuscript #2 (Chapter 4) is in press with *The Qualitative Report* and Manuscripts #1 and 3 (Chapters 3 and 5) are in review.

In considering the future use of the research, I read about new emergent qualitative methods, and specifically about critical collaborative ethnography (Bhattacharya, 2008). Collaborative research speaks to doing research ‘with’ people as opposed to ‘about’ or ‘on’ them, and may include any or all part(s) of the research process, from fieldwork to the writing up (Altheide, et al., 2008). The philosophical underpinnings of the critical collaborative ethnography are that culture is co-performed by the researcher and participants as part of the research undertaking. One measure of its credibility is its ‘catalytic validity,’ the degree to which the research process leads participants toward self-understanding and direction (Bhattacharya, 2008, p. 310). This study demonstrated a high degree of catalytic validity in that the HCP participants shared many stories regarding their changed beliefs and practices which resulted in improved collaborations. Many of the innovations have been implemented to advance collaborative care within the organization such as new mandates for staff orientation and leadership training. Perhaps some of the strongest evidence of critical change was the re-institution of the PFCC education in a new format in part due to feedback from this research.

An opportunity exists to further engage the participants in writing and presenting about their collaborative experiences as another means to shape the organization’s culture. I plan to
invite participants to act as co-authors/presenters for an overall summary of the project. The conceptual model for ‘partners-in-care’ (Figure 5.1) might act as a basis for conversation and be updated or changed, if necessary, according to their feedback. Collated questions from participants, for example, those from the senior leaders (Table 5.3) could be used to stimulate discussion and ideas. The innovations for collaborative care (Table 6.1) could also be shared, and more detail derived with respect to implementation and future plans. One participant already offered to assist in this regard. A celebratory ‘summing-up’ could serve to engage all participants, including myself, as co-performers and creators of our culture. This would assist in overcoming challenges related to diffusion and growth of profound cultural change (Senge, et al., 1999).

Other opportunities for conversation and diffusion have begun within the new patient and family-centred care education, ‘Enhancing our Relationships.’ Study results have been discussed with over 40 staff registrants and three new course moderators, from January through March 2012, and additional sessions are planned. Registration is now encouraged from all interdisciplinary staff including physicians, and from all organizational sites. This presents new openings to interact with staff with a wide variety of roles, disciplines, and perspectives.

It is with this mission in mind, I close this chapter, and with a deeper understanding of the potential and the importance of applied research in contributing to complex and profound change in a dynamic hospital organization and of the potential represented in collaborating with others.
References


Centre for the Advancement of Interprofessional Education. (2002), from http://www.caipe.org.uk/about-us/defining-ipe/


Appendix A

Queen’s University Research Ethics Board Approval Letter

QUEEN’S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

January 26, 2009

Ms. Marcy Saxe-Bradtiva
Vice President of Programs
Providence Care – St. Mary’s of the Lake Hospital Site
340 Union Street
Kingston, ON K7L 5A2

Dear Ms. Saxe-Bradtiva,

Study Title: Changing the culture of customer service for patients, families and health caregivers: A learning process

Co-Investigators: Dr. M. Paterson, Dr. Y. Chan, Ms. R. Brander

I am writing to acknowledge receipt of your recent ethics submission. We have examined the protocol and consent form for your project (as stated above) and consider it to be ethically acceptable. This approval is valid for one year from the date of the Chair’s signature below. This approval will be reported to the Research Ethics Board. Please adhere carefully to the following list of ethics requirements you must fulfill over the course of your study:

➤ Reporting of Amendments: If there are any changes to your study (e.g., consent, protocol, study procedures, etc.), you must submit an amendment to the Research Ethics Board for approval. (see http://www.queensu.ca/vpr/reb.htm).

➤ Reporting of Serious Adverse Events: Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other serious adverse events must be reported within 15 days after becoming aware of the information.

➤ Reporting of Complaints: Any complaints made by participants or persons acting on behalf of participants must be reported to the Research Ethics Board within 7 days of becoming aware of the complaint. Note: All documents supplied to participants must have the contact information for the Research Ethics Board.

➤ Annual Renewal: Prior to the expiration of your approval (which is one year from the date of the Chair’s signature below), you will be reminded to submit your renewal form along with any new changes or amendments you wish to make to your study. If there have been no major changes to your protocol, your approval may be renewed for another year.

Yours sincerely,

Albert Clark
Chair, Research Ethics Board

Study Code: REH-440-09

Investigators please note that if your trial is registered by the sponsor, you must take responsibility to ensure that the registration information is accurate and complete.
APPENDIX A Continued

QUEEN’S UNIVERSITY HEALTH SCIENCES & AFFILIATED TEACHING HOSPITALS RESEARCH ETHICS BOARD

The membership of this Research Ethics Board complies with the membership requirements for Research Ethics Boards as defined by the Tri-Council Policy Statement Part C Division 5 of the Food and Drug Regulations, OHRP, and U.S. DHHS Code of Federal Regulations Title 45, Part 46 and carries out its functions in a manner consistent with Good Clinical Practices.

Federalwide Assurance Number: #FWA00004184
#IRB0001173

Current 2008 membership of the Queen’s University Health Sciences & Affiliated Teaching Hospitals Research Ethics Board

Dr. A.F. Clark Emeritus Professor, Department of Biochemistry, Faculty of Health Sciences, Queen’s University (Chair)

Dr. H. Abdullah Professor, Department of Medicine, Queen’s University

Dr. C. Cline Assistant Professor, Department of Medicine Director, Office of Bioethics, Queen’s University Clinical Ethicist, Kingston General Hospital

Rev. T. Delaine Community Member

Dr. M. Evans Community Member

Dr. S. Irving Psychologist, Providence Care, St. Mary’s of the Lake Hospital Site

Prof. L. Keepin-Burke Assistant Professor, School of Nursing, Queen’s University

Mrs. J. Kotecha Research & Programs Manager, Centre for Studies in Primary Care, Department of Family Medicine, Queen’s University

Dr. J. Low Emeritus Professor, Department of Obstetrics and Gynaecology, Queen’s University and Kingston General Hospital

Dr. W. Racz Emeritus Professor, Department of Pharmacology & Toxicology, Queen’s University

Dr. B. Simelison Assistant Professor, Department of Anesthesiology, Queen’s University

Dr. A.N. Singh WHO Professor in Psychosomatic Medicine and Psychopharmacology Professor of Psychiatry and Pharmacology Chair and Head, Division of Psychopharmacology, Queen’s University Director & Chief of Psychiatry, Academic Unit, Quinte Health Care, Belleville General Hospital

Dr. E. Tsak Associate Professor, Department of Paediatrics and Office of Bioethics, Queen’s University

Rev. J. Warren Community Member

Ms. K. Weissbaum LL.B. and Adjunct Instructor, Department of Family Medicine (Bioethics)

Dr. S. Wood Director, Office of Research Services (Ex-Officio)
Appendix B

Queen’s University Research Ethics Board Renewal Letter

Queen’s University, in accordance with the “Tri-Council Policy Statement, 1998” prepared by the Medical Research Council, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada requires that research projects involving human subjects be reviewed annually to determine their acceptability on ethical grounds.

A Research Ethics Board composed of:

Emeritus Professor, Department of Biochemistry, Faculty of Health Sciences, Queen’s University (Chair)

Dr. A.E. Clark

Professor, Department of Medicine, Queen’s University

Dr. H. Abdallah

Community Member

Rev. T. Delisle

Community Member

Dr. M. Evans

Psychologist, Providence Care, St. Mary’s of the Lake Hospital Site

Dr. S. Irving

Assistant Professor, School of Nursing, Queen’s University

Prof. L. Keeping-Barke

Research & Programs Manager, Centre for Studies in Primary Care, Department of Family Medicine, Queen’s University

Mrs. J. Kotecha

Emeritus Professor, Department of Obstetrics and Gynaecology, Queen’s University and Kingston General Hospital

Dr. J. Low

Emeritus Professor, Department of Pharmacology & Toxicology, Queen’s University

Dr. W. Racz

Assistant Professor, Department of Anaesthesiology, Queen’s University

Dr. B. Simelbon

WHO Professor in Psychosomatic Medicine and Psychopharmacology

Dr. A.N. Singh

Professor of Psychiatry and Pharmacology

Chair and Head, Division of Psychopharmacology, Queen’s University

Chair and Head, Division of Psychopharmacology, Queen’s University

Belleville General Hospital

Dr. E. Tsai

Associate Professor, Department of Paediatrics and Office of Bioethics, Queen’s University

Rev. J. Warren

Community Member

Ms. K. Weisbaum

L.I.B. and Adjunct Instructor, Department of Family Medicine (Bioethics)

Dr. S. Wood

Director, Office of Research Services (Ex Officio)

I have reviewed the request for renewal of Research Ethics Board approval for the project “Changing the Culture of Customer Service for Patients, Families and Health Caregivers: A Learning Process” as proposed by Ms. Marcy S. B. Proc. Providence Care – St. Mary’s of the Lake Hospital Site. The approval is renewed for one year, effective January 27, 2019. If there are any further amendments or changes to the protocol affecting the subjects in this study, it is the responsibility of the principal investigator to notify the Research Ethics Board. Any unexpected serious adverse event occurring locally must be reported within 2 working days or earlier if required by the study sponsor. All other adverse events must be reported within 15 days after becoming aware of the information.

Chair, Research Ethics Board

[Signature]

January 25, 2019
Appendix C
Providence Care Research Review Committee Approval Letter

April 3, 2009

Rosemary Brander
Research Assistant and Doctoral Candidate
c/o Specialized Geriatric Services
St. Mary’s of the Lake Hospital

Re: Changing the Culture of Customer Service for Patients Families and Health Caregivers: A learning process

Dear Rosemary

Thank you for your letter of March 13, 2009, responding to the recommendations of the Providence Care Research Review Committee and for supplying a sample of the confidentiality agreement, the revised consent form and demographic questionnaire.

This information was shared with the Research Review Committee members.

I am pleased to confirm that with these amendments, the committee was comfortable with the project proceeding.

Yours sincerely,

John Puusty, M.B., Ch.B., FRCPC
Chair, Providence Care, Research Review Committee

/gl

c: Madeline Halladay, Director, Patient Records and Registration
     Maurio Ruffolo, Acting VP Programs and CNO
     Susan Wood, Director, Office of Research Studies, Queen’s University
Are you interested in

**Customer Service in Health Care?**

Are you a Staff Member interested in patient and family centred care?

Can you help us to determine *what is most important* about *Customer Service* and our *Relationships* with our patients, their families and close friends?

We are conducting a study that will involve 2 to 3, one-hour focus groups, before and after participating in the Patient and Family Centred Care groups.

If you have any questions or would like to participate, please contact:

Rosemary Brander, Research Assistant
[Contact information was provided here.]
Appendix E
Letter of Information and Consent

Informed Consent Form

Consent to participate in the research project: “Changing the culture of customer service for patients, families and health caregivers: A learning experience”

You are being invited to participate in a research study conducted by Dr. Margo Paterson, Associate Professor, Queen’s University, Dr. Yolande Chan, Professor, Queen’s School of Business and Rosemary Brander, Research Assistant, [the organization].

This research project is designed to investigate how best to include patients and families in Patient and Family Centred Care education for health caregivers at [the organization]. The information will also help to inform [the organization] and the broader healthcare community about customer service in the delivery of healthcare in a teaching hospital.

What is involved?
You are being asked to participate in 2 to 4 focus group/interview sessions of about one hour each and Patient and Family Centred Care education sessions. Patient and family participants will be asked to come to a maximum of two education sessions, for about one hour each. Healthcare providers will be asked to attend all of the education sessions as per the usual course schedule (typically 6 to 8 sessions, 2 to 3 hours each). You are asked to sign this consent form if you volunteer to participate. You may withdraw from the study for any reason at any time.

Will my information be confidential?
Personal health information is not required, nor will your personal health information be accessed through any of your medical records. All participants will agree to keep any information that may come up in discussion as confidential and will sign a confidentiality agreement before enrolling in the study. Data collection may include electronic and hard copy notes, video and audio recordings. Electronic information will be password protected and hard copy information will be stored in a locked file. Raw data will be destroyed once data analysis is complete. Only the study investigators will have access to the collected data.
Appendix E Continued

Risks and Benefits
Confidentiality will be requested within focus groups and confidentiality agreements will be signed by all participants, however, there may be a risk of disclosure of personal/confidential information that you verbally share within these groups. Focus groups, interviews and education sessions will occur at [the organization]. Parking costs will be reimbursed and refreshments provided at the educational sessions. Your participation will benefit the investigators in completing the research and will provide valuable information about ideal customer service and patient and family interactions for healthcare planning at [the organization] and to the wider healthcare community.

Payment
Parking costs will be reimbursed and refreshments provided at the educational sessions. You will receive a thank you in the form of a $30 book gift certificate for completion of the education and data collection.

Voluntary nature of the study/Freedom to withdraw or participate
Your participation in the study is voluntary. You may withdraw from this activity at any time without any adverse effects.

Informed consent
I have read and understand this consent form. I have had the purposes, procedures and technical language of this research activity explained to me. I have been given sufficient time to consider the above information and to seek advice if I choose to do so. I have had the opportunity to ask questions which have been answered to my satisfaction. I am voluntarily signing this form. I will receive a copy of this consent form for my information.
Appendix E Continued

If at any time I have further questions, problems or adverse events, I can contact:

Rosemary Brander
Research Assistant
School of Rehabilitation Therapy, Queens University
613-548-7222, extension 2414
rosemary.brander@queensu.ca

Dr. Margo Paterson
Associate Professor and Chair
Occupational Therapy Program
Queen’s University
613-533-6094
margo.paterson@queensu.ca

Dr. Yolande Chan,
Professor,
Queen’s School of Business
Queen’s University
613-533-2364
ychan@business.queensu.ca

If I have any concerns about this study I can contact:

Dr. Elsie Culham, Professor and Director, School of Rehabilitation Therapy, Associate
Dean (Health Sciences), Queen’s University
613-533-6727
elsie.culham@queensu.ca

If I have any concerns about my rights as a research subject, I can contact:

Dr. Albert Clark, Chair of Research Ethics Board, Queen’s University
613-533-6081
Appendix E Continued

**Informed Consent Form**

Consent to participate in the research project: “Changing the culture of customer service for patients, families and health caregivers: A learning experience”

By signing this consent form, I am indicating that I agree to participate. I am also indicating that I understand that I may contact any of the names listed above if I have any questions about the study.

_________________________  ______________________
Signature of participant     Date

_________________________  ______________________
Signature of witness        Date
Appendix F
Statement of Confidentiality

Re: Research study: “Changing the culture of customer service for patients, families and health caregivers: A learning process.”

I understand that in my association with [the organization] as a voluntary participant in the study indicated above, I will have access to information shared by other participants in the focus groups.

I recognize that the information shared in the focus groups is confidential. I will respect this and ensure confidentiality by not sharing it with others outside of the focus groups that I am attending.

________________________________________________________________
Participant’s Name                Signature                Date

________________________________________________________________
Witness’ Name                    Signature                Date
Appendix G
Demographics Questionnaire

Please answer the following questions to the best of your ability.
If you have any questions, please ask the Research Assistant for assistance.

1. Are you: Female     Male

2. What is your age: ___________ years

3. a) Are you a former patient of the hospital?  Yes     No

   If yes, approximately how long ago did you receive services? _______________________

   b) Are you a family member/close friend of a patient who received services from the hospital
   in the past 12 months?  Yes     No

   If yes, please describe your relationship (e.g. Spouse, daughter, friend etc.)
   _______________________________________________________________

   c.) Are you a healthcare professional who works at the hospital?  Yes     No

   If yes, please indicate your role (e.g. Nurse, Recreation Therapist, etc.)
   _______________________________________________________________

   If yes, please describe your educational qualifications
   _______________________________________________________________

   If yes, please indicate your length of professional experience ________________ years
Appendix H

Sample Focus Group Script, Healthcare Provider Focus Groups

Welcome:
Please help yourself to lunch and have a seat. Once everyone arrives, we’ll make formal introductions and I’ll tell you a bit more about the study.

Once all here:
Is everyone comfortable? Please take a seat and we’ll start.
First off, there are two consents to sign, if everyone could check them off as they hand these in, so that we have them all completed, much appreciated. Are there any questions? Does anyone need more time?

Start recorders: At this time with your permission I would like to start the recorders. Is everyone ready?

Introductions: Myself, my role, the observer and ask participants to introduce themselves.

Thank you for agreeing to participate. During today’s focus group we will discuss the value and meaning that customer service has to you at the hospital and how it impacts your work. The value of a focus group is that we can learn from each other and integrate ideas as we converse together. This data will be part of my doctoral research study, which, I hope to complete and to publish.

Timelines and norms: We have the next 55 minutes booked for our discussion and we will wind up at 12:55 pm, so that you have time to get ready for the patient and family centred care education Please be comfortable, ask questions.
Just to review some group norms, I ask everyone to encourage all to contribute to our discussion, to listen respectfully and wait until someone is finished talking before joining in, and to allow others time to speak. It is OK to have different opinions, to disagree or be controversial. This will lead to better understanding and I am here to learn from you, so you are the experts!

All results are confidential and I remind everyone, in respect for all, to do the same and not take the information discussed outside of the room.

Are there any questions?

Let’s get started chatting about customer service in healthcare.

(Move to focus group guide, see Appendix I).
Appendix I
Focus Group Guide, Pre-intervention

1. Describe a time when you offered good service in the hospital?
   What was that like for you?
   What was the outcome?
   Other examples?

2. Describe a time when you were unable to offer good service?
   What was that like?
   What was the outcome?
   Other examples?

3. What does the term customer service mean to you?
   How do you feel about the term “customer service” being used in Healthcare?
   Are there other or better terms?

4. What is a priority in offering service/care in a hospital to patients?
   To families?

5. How do/could healthcare providers help to improve (customer service or other term) in the hospital?

6. Is there anything else to add?

THANK YOU!! How did it go? Any suggestions?
Appendix J
Focus Group Guide, Post-intervention

1. What would your vision be for patient and family involvement at the hospital?

2. How would you set it up to be successful?

3. How do you think centering care on our patients and families links with customer service? (Tell me more…..)

4. What does the phrase ‘partners-in-care’ mean to you?

5. How is the patients’ perspective heard in the care team? How are we doing?

6. Next questions might be a bit provocative: Whose team is it anyway?

7. Who is the best evaluator of success of care/customer service?

8. What do you think your workday would be like focusing more on patient and family centred care/customer service?

9. In your role at work, whom do you see as your customers?

10. What do you think are the important questions to bring patient family centred care and customer service forward?

11. What would be your vision as to excellent quality of care?

12. Is ‘compassionate care’ the same as customer service? Is it a luxury or a necessity?

13. What impact does the individual situation have on the overall outcome?

14. a) Do we need to consider differences in working with people from different cultures?
    b) Different genders?

15. What will be important to ask in 3 months?

16. THANK YOU!! Is there anything else? Any suggestions? How did it go?
Appendix K
Focus Group Guide, Long Term Post-intervention

Part 1. It has been almost six months since the end of the patient and Family Centered Care course and you’ve had a time to apply the things that you learned and to reflect on some of the conversations and discussions. Is there anything recently in your word that was a positive experience that made you think, “Oh, wasn’t that good that I knew that, or that I applied it this way?” Or is there an experience that wasn’t so positive that you would like to share?

Part 2. Do you remember receiving this information along with your pay check about the Accessibility for Ontarians with Disabilities Act (AODA) (Government of Ontario, 2005)? (Rosemary displays orange information flyer regarding the AODA and gives a short overview of and ‘The Customer Service Standard’ which is the first enacted standard of the AODA in 2007.)

a) Does it surprise you that there is a standard called customer service?

b) Are there other ways in the hospital that we can help to meet this standard?

c) Are there things that have already changed in the hospital to help with compliance to the act?

d) Are there other examples that you have thought about?

Thank you! Is there anything else? Anything missed?
Appendix L
Observation Guide

Observer: _____________________________  Date: ____________

Research Question: (Research questions pertaining to study phase were displayed here.)

Notes prior to observational experience:

Notes During experience:

Setting:

Time of Day:

Environment:

Participants:

Internal Interactions:

External interactions:

Unusual occurrences:

Reaction to facilitator:

Other:

Notes following observational experience:
Appendix M

Survey Evaluation Strategy, Mid-level Leaders

Target Audience
Mid-level Managers/Leaders within the organization at the current research site

Guiding Survey Questions
The guiding questions for the manager/leader survey were defined as follows:

1. How important is customer service in your work?
2. What suggestions do you have to enhance customer service?
3. Which of these would offer the greatest value in reinforcing and enhancing principles of collaborative care?
4. Are there other change ideas that are important to consider?

Survey Question Format
Open ended-questions and Likert-type response scales will be used.

Analysis
Surveys will be manually counted and analyzed, as the number will be small (approximately 15). Responses will not be identified by individuals and all data will be compiled to further the understanding of culture related to customer service.

Findings
All data will be reported in aggregate form to protect anonymity. Results will be used to build recommendations for discussion with key informants and senior leaders within the organization and towards the doctoral research.
Appendix N
Survey for Mid-level Leaders

Thank you for your time and consideration of the following questions. Your responses will help to inform recommendations regarding customer service for the organization and research study. There is no right or wrong answer. Responses are anonymous and will be aggregated for data analysis.

Please circle, write or choose the most appropriate response where appropriate:

1. Customer service is a concept that belongs with the delivery of health care.

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
</tr>
</thead>
</table>

2. Please describe why or why not:


3. Is there a phrase(s) or term(s) that better represents customer relations in health care and if so, what would it be?


4. Providing good customer service is linked with partnering in care, in health care.

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Somewhat Disagree</th>
<th>Neutral</th>
<th>Somewhat Agree</th>
<th>Agree</th>
</tr>
</thead>
</table>

5. Please describe why or why not:


6. Who do you identify as your customers at work? (e.g. patients, etc.)

7. How many times during your workday do you provide customer service?

| 0 | 1-5 | 6-10 | 11-15 | greater than 15 |
Appendix N Continued

8. Please provide 2-3 examples of when you were able to provide good customer service at work:

____________________________________________________________________________________

____________________________________________________________________________________

9. Please provide 2-3 examples when it was difficult to provide good customer service at work:

____________________________________________________________________________________

____________________________________________________________________________________

10. a) The hospital’s culture would support organizational change related to customer service.

   Disagree  Somewhat Disagree  Neutral  Somewhat Agree  Agree

   b) Please briefly describe why or why not?

   ______________________________________________________________________________________

   ______________________________________________________________________________________

11. Customer service is important in my work.

   Disagree  Somewhat Disagree  Neutral  Somewhat Agree  Agree

12. List 3 (or more) suggestions to enhance partnership in care at the hospital:

   ______________________________________________________________________________________

   ______________________________________________________________________________________

   ______________________________________________________________________________________

13. Which suggestions could be easily implemented?

   ______________________________________________________________________________________

   ______________________________________________________________________________________

   ______________________________________________________________________________________
Appendix N Continued

14. What would contribute to their successful implementation?

15. Are there suggestions that might be more difficult to implement but which would still be important to consider?

16. Please provide any other ideas or comments that might have been missed:

Thank you for your help!
Appendix O

Focus Group Strategy and Interview Guide, Mid-level Leaders

Opening Script:

- Welcome. Please help yourself to lunch
- Please place your completed forms on the table in the labeled boxes
- Is everyone here? Is everyone comfortable?
- Does everyone know each other? Introduce participant-observers taking ‘field notes.’
- Is it OK to start the recorders? (Started recorders)
- Thank you for bringing your expertise and creativity to our second focus group.
- Next 1.5 hours are booked for our discussion. We will wind up at 1:25 pm, if not before.
- Be comfortable, move around, and ask questions as needed.
- Please bring your imaginations and forthrightness to the discussion

Just to review some group norms:

- Please feel free to openly contribute to our discussion, listen respectfully and allow one to finish talking before joining in, giving time for all to speak.
- It’s great if you share different opinions or are controversial, so please bring any and all of your ideas forward. You hold unique positions within the organization to speak to customer service and relationships for care, so I’m very fortunate to have your time.
- Participation is voluntary, details of our conversations are confidential and everyone has indicated that they will respect confidentiality. I will remove any and all identifying features from the transcripts and no one sees them but me. Results are all rolled up together for analysis and presentation purposes.
Appendix O Continued

Are there any questions so far? Let’s get started chatting about customer service in healthcare.

Presentation of Early Findings

- First author presented a fifteen minute overview of the study, the progress to date and Phase 1 findings, including cultural themes and innovative change ideas. The latter was presented on a large screen throughout the focus group for reference and to stimulate discussion.

Guiding Focus Group Questions

1. Which of the internal organizational change ideas stood out?

2. Which could be applied easily and provide positive impact on care relationships?

3. Are there other change ideas that are important to consider?

4. Which of these are priorities?

5. In what new ways could the learning be introduced and sustained?

6. How could we move forward?
Appendix P

Presentation of Early Findings to Mid-level Leaders and Senior Leaders

Customer Service & Care Relationships: Early Findings

Presented for
1) Mid-level Leaders (Oct 21, 2010)
2) Senior Leaders (Nov/Dec, 2010)

By Rosemary Brander

Customer Service & Care Relationships study: Data Collection Outline (Phase 1)

Week 1
Pre FG #1

Week 1-8
Patient & Family Centred Care Education

Week 9
Immediate Post FG #2

6 months
Long-term Post FG #3
Appendix P Continued

Health Care Provider Views (Phase 1)

4 Cultural Categories

- Healthcare Providers
- Patient and Family/Caregivers
- Internal to Organization
- External to Organization

8 Preliminary Themes:
1. **Common Vision/Goal** ➔ Everyone needs to be on the same page; to share the same vision
2. **Patient as Director** ➔ Philosophy of patient as director/leader not yet embedded in culture
3. **Expectations** ➔ Not meeting these, leads to frustration for all
4. **Feedback opportunities** ➔ Need more options and information for all
5. **Modeling the way** ➔ Importance of setting the tone for new staff; experienced staff as well
6. **Reciprocity of work** ➔ Need to recognize that we are each other’s customers and build strong teams
7. **Backlash** ➔ Can be a minority backlash within staff
8. **Each others’ strengths** ➔ Awareness of each others’ strategies & strengths

Health Care Providers’ and Mid-level Leaders’ Innovative Change Ideas (Phase 1 & 2)

1. Need a **shared model of care** that’s articulated for the organization.
2. The minute a patient **steps into the door** we have a team meeting with them.
3. **Chart** as though the patient is going to read the chart.
4. More ideas we get from patients and families, the better patient-centred the care.
5. All key **committees** would (invite) patient and family comments: ‘What’s that do for me as a patient or family?’
6. A one hour PFCC education session, **continuously going** for staff.
7. **Real sentences or real videos** to generate discussion as to how that patient’s experience could be better or to celebrate successes.
8. Drama productions to **invite and inspire** and model the way.
9. Re-engage some of staff by asking them to be a **mentor**.
10. Allow teams enough time for strategies to come forward.
11. **Aim high**.
12. We often talk about concrete things. The **spiritual things** need to be considered.
13. Provide information about ‘**relationship centred-care**’ in new staff orientation.
14. Create a culture of **real peer-to-peer mentorship** that reflects the values of the organization.
15. Ensure patient satisfaction feedback is being used for **real improvement**.
16. **Empower** our patients to understand.
Appendix Q

Interview Guide for Senior Leaders

Welcome. Please complete consent forms.

Thank you for meeting with me today.

Timelines and norms

- 45 minutes or so booked for our discussion
- Be comfortable, move around, and ask questions as needed.
- Participation is voluntary. All details of our conversations are confidential.
- I will remove any and all identifying features from the transcripts. No one sees them but the investigating researchers. Results are all rolled up together for analysis and presentation purposes.
- Your imagination and creativity is welcomed.

Are there any questions so far?

Ok, well let’s get started chatting about customer service in healthcare.

Is it alright with you if I turn the tape recorder on? START RECORDERs

Move to presentation (A brief presentation of the findings from Phases 1 & 2 was shared.)

Purpose of today’s meeting:

To capture your views on what change ideas from the healthcare provider feedback, and from your own knowledge, would be helpful and could be implemented to enhance partnering in care/customer relationships at the hospital.

Focus Group Questions:

1. Which of the change ideas stood out to you?
   Can you tell me more?
2. What are the possibilities?
3. How could we move forward?

Some other questions that came up from the mid-level leader focus group:

5. In what ways could patients and families become real active participants, in ways that we couldn’t even envision?
6. How can we bring the conversations forward with staff, about dignity, respect…the difficult conversations with people?

We cannot do everything…what are the right things?
## Appendix R

### Healthcare Providers’ Perspectives Over Time Aligned with Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Pre</th>
<th>Post</th>
<th>Long-term Post</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Customer</strong></td>
<td>“Who exactly is the customer? Is it the patient, family? I need that clarified.” (B/Pearl/p1)</td>
<td>“I think because there is no money changing hands we forget that we are being paid to provide people with a service.” (A/Edna/p2)</td>
<td>“Customer service has lost meaning over time...if you go back and look at what it meant at your local hardware store, they cared about the person, the individual....” (A/Edna/p10)</td>
</tr>
<tr>
<td></td>
<td>“If they are the customers, then we are the servers.” (A/Jenny/p1)</td>
<td>“Client is starting to fit better. I can see after going through this course that you are really looking at language and the empowerment of the patient or of the client and with them being the director.” (B/Elaine/p7)</td>
<td>“The comment [from the patient] is that they don’t see me as a person. It’s like a robotic routine of care—the same everyday with every person.” (A/Connie/p9)</td>
</tr>
<tr>
<td></td>
<td>“That’s why I am here. I wonder what I can do, what I can say without sounding badly. You have to be tactful.” (B/Pearl/p7)</td>
<td>“A customer to me - I visualize passing over money and you are going to receive this amount of care. It almost seems like an American thing…<strong>putting a price on what we do as nurses</strong> A lot of what we do comes from our compassion. Do you put a price on that?” (B/Elaine/p8)</td>
<td></td>
</tr>
<tr>
<td><strong>Customer Service</strong></td>
<td>“Customer service feels business-like. It’s pulling it away from the personal aspect; it takes away from that [which we were trained with]. <strong>It feels like we’ve lost something.</strong>” (A/Connie/p11)</td>
<td>“We forget that these are our customers. <strong>We should be looking more to what they want instead of the way we have always done things.</strong>” (A/Edna/p2)</td>
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</tr>
<tr>
<td></td>
<td>“How do my patients perceive what I am saying to them?” (A/Sadie/p3)</td>
<td>“I think it’s all in the approach, choosing your words in a friendly open manner and not shutting someone down.” (B/Pearl/p15)</td>
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</table>

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165
<table>
<thead>
<tr>
<th>Category</th>
<th>Pre</th>
<th>Post</th>
<th>Long-term Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer Service (continued)</td>
<td>“I think it’s customizing the care to the individual.” (B/Elaine/p12)</td>
<td>“We should be pushing more of PFCC and the ethics and attitudes involved in that so that we are more consistent and <strong>not only do we treat patients with more respect, we treat each other with more respect.</strong> (P8 B p)</td>
<td>“I had a patient and I could tell there was something on her mind just by her body language. She’d been stewing with a concern that wasn’t being addressed. I took the time to listen to her concern because she’s important. She opened up and I was so happy that she did. <strong>Before I had this course I wouldn’t have gone the extra distance, to pick up on her body language, stop and get to the bottom of it where it would ease the patient and satisfy everybody concerned.</strong> It lifted me up for the rest of the shift.” (B/Pearl/p1-3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I’ve found that with this course, I’m stopping myself ahead of going in and making a blunder because it is programmed into us since day one. <strong>This course has opened my eyes to the possibilities. When you talk to people and ask them their ideas, goals, and aspirations, it might open up a whole new aspect and perspective for you in how to help them achieve their goal.</strong>” (P7Bp9-10)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>“One of the basic things that we learnt in this course was learning how to communicate in a positive way. <strong>The power of language…the words that we use can really influence how you respond with the patient, how you interact and the intimacy that you can achieve.</strong>” (Bp2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Some of these open ended questions…put the ball back into their court. Putting it back to the client, if what we are doing isn’t right and you’re not happy with it and asking them about it, puts the ball back into their court. <strong>Before you were trying to fix the equation and sometimes that would make things escalate.</strong>” (A2p3)</td>
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<td>Category</td>
<td>Pre</td>
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<td>Long-term Post</td>
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</tr>
<tr>
<td>Knowledge</td>
<td>“To have enough knowledge ourselves so that we can give them knowledge and understand the ways in which they learn; the best way to present knowledge to them.” (B/Elaine/p8)</td>
<td>“When you are in the profession you feel that you are the expert and know better [than the patient]. [Now] it’s a different way of thinking. You can still let the client know that you have this knowledge but it has to come from them as to what they need to know. They are self-directing as to what they need to know that is best for them.” (A/Ada/p2)</td>
<td>“One thing I learned in PFCC is how to ask questions more efficiently to get more information. For example, if somebody said, I didn’t get a good sleep last night, I ask, ‘Why do you think you didn’t sleep well?’… I ask leading questions more than I used to…more open-ended questions.” (B/Hazel/p15)</td>
</tr>
<tr>
<td></td>
<td>“Traditionally it has been, ‘We know what’s best.’ I think we may be moving a bit away from that. I think that’s going to be a really hard transition for everyone.” (B/Elaine/p10)</td>
<td>“I have a hard time speaking up. I’m a minority amongst a sea of people who have much more experience.” (B/Pearl/p3)</td>
<td>“It’s an automatic thing with me now [patient-centred care]. I don’t go back to the old way. I’ve become more and more familiar to this patient-centred care approach and I’m getting a lot of positive results with it.” (B/Pearl/p16)</td>
</tr>
<tr>
<td></td>
<td>“Experience is one thing but having common decency and respect is something else.” (B/Elaine/p3)</td>
<td>“Before I took the course, I didn’t realize. I found that after taking the course, I can communicate better. I’m more conscious of what I’m saying to the patient.” (A/Sadie/p2)</td>
<td></td>
</tr>
<tr>
<td>Roles</td>
<td>“We have an issue right now with a family. They’re interrupting our care…always around…never leave.” (A/Sadie/p9)</td>
<td>“Family is huge. They tell us different words they use or routines, basic non-verbal communication.” (A/Sadie/p6)</td>
<td>“We have a patient who does not speak English and the family is there 24/7…I think it’s a big acceptance on our part to allow this 24/7. Before we would say, ‘You wait, he’s just going to physiotherapy’….or we would ask the family to step out [of the room]. Now they don’t have to; they can see the progress; what’s going on. I think it’s a positive thing.” (B/Pearl/p11)</td>
</tr>
<tr>
<td>Category</td>
<td>Pre</td>
<td>Post</td>
<td>Long-term Post</td>
</tr>
<tr>
<td>--------------</td>
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<td>----------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Common Vision</td>
<td>“You offer to help another nurse and she may decline your assistance and then go and get someone else.” (A)</td>
<td>“Partner is a new word in nursing and health care. People are recognizing as they take the course that the patient needs to be part of the plan, to become a partner, not just a patient. I think it is a new term for many nurses who have been here.” (A/Ada/p5)</td>
<td>“We all have different ways of seeing things, so you might develop a plan and if people don’t recognize the ends or reasons to the plan, they don’t always follow through.” (A/Edna/p6)</td>
</tr>
<tr>
<td></td>
<td>“We should focus on what the goal is and the patient care, regardless of whose patient it is.” (Bp8)</td>
<td>“Partner denotes collaboration, cooperation, mutual goals and aspirations of what’s to be accomplished or not.” (B/Pearl/p8)</td>
<td>“It wasn’t put out there, ‘If I do your pills, we’ll work together’, wasn’t exactly said. So part of the problem was assuming that the other nurse would reciprocate.” (A/Ruth/p6-7)</td>
</tr>
<tr>
<td></td>
<td>“I think it’s really important that we are all on the same page.” (Bp1PRE)</td>
<td>“It’s for everybody to be on board with the philosophy taught in this course, with the use of language, how to listen and how to really put the client first. I really think we are at the beginning.” (B/Elaine/p10)</td>
<td>“A couple of weeks ago there was a patient with a bit of verbal aggression…We did not let the emotion of the situation get in the way. We talked more on what we could do for the patient and how we were going to make it work for everybody.” (A/Connie/p3)</td>
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<td>“I think if the patient was the driver of the team, they would be at multidisciplinary conferences, and they’re not.” (B/Mary/p12)</td>
<td>“You can really tell those that have taken the course and those that haven’t. Sometimes there’s a lot less labeling that goes on with people who have taken the course; more treating people as individuals. And with those that haven’t, you can see that there’s more blaming… more blaming on the patient.” (B/Elaine/p.5)</td>
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<td>“When people feel respected, it’s easier for them to respect others. So I think if you’re respecting your co-workers and they feel respected, it’s easier for them to respect the patients….It’s like a domino effect.” (B/Elaine/p.7)</td>
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**Notes:** Bold font indicates author’s emphasis. Square brackets surround author’s additions to quote for clarification. Reference in round brackets after quote indicates the PFCC group A or B/pseudonym for the HCP participant/page number reference in transcript.
Appendix S

Publications and Presentations Related to My Research

Publications (Peer reviewed)


Abstracts in refereed conference proceedings

Brander, R., Paterson, M., Chan, Y (2012). Collaborative care: Examining perspectives for application and change within a Canadian Hospital. All Together Better Health 6th annual conference Kobe, Japan. October 5-8, Abstract #10031.


Appendix S Continued

Abstracts in refereed conference proceedings (Continued)


Presentations (Non peer reviewed)


Appendix S Continued

Presentations (Non peer reviewed) (Continued)


Articles (Non peer-reviewed)

Queen’s University, School of Business, The Monieson Centre News, Queen’s School of Business, Spring / Summer 2010

Appendix T

Sample Patient and Family Centred Care Flyer

PATIENT & FAMILY CENTERED CARE (PFCC)
Learning Sessions

Weekly on Tuesdays 1300–1500    September 21 – November 23, 2009

Please Note: This meets the reflective practice requirements of most regulatory colleges.

Some comments from past participants:

- “It was excellent, changed how I communicate with patients and coworkers.”
- “I learned how to really listen to my patients.”
- “The sessions were a very positive learning environment.”
- “Everyone needs to take the course.”
- “Helped reconnect me to why I want to work in healthcare.”

Description: The sessions are learner-focused and are an opportunity to examine the traditional model of healthcare and what enhances Patient and Family involvement. The Best Practice Guideline for Client Centered Care is the foundation and includes the framework of four core processes of: 1) Identifying Needs/Concerns, 2) Making Decisions, 3) Caring & Service and 4) Evaluating Outcomes. (RNAO, 2006)

There are 8 sessions held once a week over 2 hours, for a total of 16 hours. The sessions are reflective and interactive. Discussion is guided by the challenges brought forward in day-to-day practices and on selected readings from the literature.

Content:
- Discuss ethical dilemmas by exploring values and beliefs
- Examine blocks to communication
- Develop enhanced listening skills
- Learn how to ask open-ended questions
- Discuss issues related to safety and risk
- Understand vulnerability, power and control issues

Requirements:
- Participants will be expected to read 2-3 short articles for each session.
- Assignments will consist of five conversations with a patient or family
Participants must attend a **minimum of 13 hours** to receive a certificate of completion.