INNOVATION IN ELDERLY CARE ORGANIZATIONS

PROCESS AND ATTITUDES

VOLUME TWO OF TWO:

APPENDICES

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VOLUME TWO: APPENDICES

APPENDIX A. INNOVATION HISTORIES FROM THE FIRST 'HOMES FOR THE ELDERLY' STUDY: FULL VERSIONS

A.1. FLEXI-RESPITE CARE (HOME A)

The history of the change from permanent to flexi-respite beds at Home A can be traced back in the Principal's interview to before the Home was opened. She states that when she went to be interviewed for the post, as a result of her past experience as a district nurse she was already sensitive to the need for short term care of the elderly, especially to help carers in the community;

> "And so I've always had it in the back of my mind that there was this need, that I felt the majority of people would support their relatives out there *[ie. in the community]* if they were getting on-going support - and there just wasn't any available."

As well as being influenced by her own past work experience, she had taken the initiative in investigating what provisions for the elderly existed in the neighbourhood of the Home, "...which in fact was zero, 'cos it was a fairly newish estate as you can see, it's not been up that long".

Following her appointment, but still before the Home opened, a third factor influenced her ideas regarding how the beds should be used - the nature of the building itself. The one large lounge was connected via a dividing screen to the community room, and was situated so that all visitors to the Home would have to pass through it; as a result "...there's very little you can do with that lounge to make it a homely type of atmosphere". However, although the design of the Home, the needs of the community and her own past experience influenced the Principal in favour of short term "flexi-respite" care, she was constrained by higher management. The problem was not that the Family and Community Services department was opposed to short term care - in fact they were promoting the idea at the time (as will be seen in the

case history of Home B's short stay wing) - but that Home A had been part-funded by the area health authority, who were pushing for permanent beds to enable people to be moved out of hospital. (The Principal was not told this directly, but gleaned the information from notes and reports regarding the setting-up of Home A). Therefore at the time of its opening, Home A had ten permanent beds and two short stay.

Few of the staff mention in detail the background to flexi-respite care described above, not suprisingly as it all occurred prior to any of them starting at the Home. However, most identify the Principal as the instigator of the idea, although some describe it as a "group decision" from the start. It is clear that there were discussions about alternative ways of using the beds from very early in the Home's history; the Deputy Principal says "...we had talked about it, even way back before the induction period; we'd decided that it was possible to have a more flexible approach". A number of also staff mention how other Homes served as models for what could be done at Home A.

Between the Home opening, with mainly long term beds, and the point at which the change to flexi-respite care began to be implemented, there was a period in which the Home took people in for rehabilitation, to prepare them for a return to their own homes, or a move into sheltered housing. Home A was well placed for the latter option, as it shares a site with sheltered accomodation bungalows (although the Principal does not have sole discretion over admissions into them). The Principal describes re-habilitation as a kind of 'half-way house' between permanent and flexi-respite care; she says,

> "...I thought it would give us a breathing space to carry on trying to change, and get the department to realise that we couldn't do the two *[ie. short term and permanent care]* side by side."

In her interview the Principal does not state why rehabilitation of residents was discontinued; it can be inferred that she saw this as an inevitable result of the change to flexi-respite care. Some staff explain the discontinuation of rehabilitation in terms of a deterioration in the physical and mental state of most residents coming in;

> "We was helping people with strokes to make themselves a cup of tea, things like that...but we don't seem to be doing that now, we seem to be having alot in that can't do alot for themselves".

Several staff express regret at this, as they found rehabilitation work interesting and rewarding.

Opinions conflict over when the decision to change the Home to an all flexi-respite care unit was taken, varying from four months after it opened to "about a year." There are indications that the decision emerged over a period of time as a result of continuing discussions about how best to meet the increasingly apparent need for respite care - the following quotes come from an Assistant Principal and a Care Assistant:

> "...as the months went by we found out we could help more people if we could have a quicker turnover...and it sort of came off the needs of the community";

> "...everybody felt the same, that we ought to move to making a better use of the beds, and I think we gradually decided the best way to use the beds was to have different people in them."

Once it was clear that there was a consensus in favour of changing to all flexi-respite care, the next stage was to gain the necessary permission. The Principal Assistant for the Home's division (ie. the Principal's immediate superior) had been involved in discussions about the innovation from when he was first appointed - four months after the Home opened - and supported the idea. The Principal had more

difficulty persuading the Principals of other Homes in her division and the field social workers in the area, who would be affected by Home A's ten permanent beds no longer being available; eventually she succeeded - helped, as far as the Principals were concerned, by the fact that many of them had just started taking short stay residents, and were aware of the problems created by running the two types of care side-by-side. Final permission to go ahead should have come from the department; her Principal Assistant wrote a report asking for this, but there was disagreement over precisely whose permission was needed, and at the time of this study - two and a half years later "...the actual bit of paper with 'yes I agree' stamped by [Director of Social Services] has yet not been given". Instead of waiting for this, the Principal went ahead, in the knowledge that those affected by the change had agreed to it, and that it was in line with overall departmental policy.

Within the Home, the decision to implement the innovation appears to have been arrived at unanimously, but a few interviewees mention that very early on there was some dissention over details;

> "...when you got into details, when people have got to go out of the building and go from one area to another, and travelling, and Care *[staff]* have got to do cleaning, some went back and said no, they didn't like the idea".

A small number of complaints are made effectively accusing the Principal of being manipulative, though it is also stated that staff are now more aware of this and will stand up against her; "I mean, staff know that [the Principal] knows who to pick on, who won't turn around and say no".

It was agreed from the start that the change to flexi-respite care would be made gradually, with each permanent bed that became empty being converted to short stay. At the time of this study there was still one permanent resident left in the Home. Staff attitudes towards the innovation remain very favourable; people like the fact that they

are able to help a much wider group of clients than they would with permanent beds, and enjoy the variety this kind of care involves - a point stressed by those who had previously worked in traditional Homes. The major problem facing the innovation according to many interviewees is that too many clients are coming in ostensibly for short term care but staying much longer than the standard two week respite period; as a result beds become "blocked", and the fast turnover of short stay clients which the innovation was intended to achieve is prevented. Several people place some of the blame for this on the Principal, for allowing social workers to persuade her to take longer term residents in; "I'm not pulling [the Principal] down, but she doesn't say 'no' very often, you can wind her round your little finger really". (It is interesting to note that this view is rather at odds with the picture of the Principal as manipulative). Not all staff hold the opinion that more effort should be made to keep to something closer to the two week respite period. At least as many - including the Principal and senior staff - stress the importance of flexibility in the length of stay. One Assistant Principal, who arrived a little under two years before this study, sums it up as follows;

> "...when I first started - and it's still around to some degree - [was] the feeling that if people didn't go home after two weeks you'd somehow failed, and that there'd got to be this constant change in people. But I think now, hopefully, people are more flexible so that if somebody does need a longer period we can sort of respond to that as well."

When asked about the future of the innovation, most interviewees see it as continuing much as it is, though some express the hope that there will be fewer longer term residents. Two members of staff suggest that the Principal would like to see Home A become an Elderly Persons Support Unit (EPSU) - a new kind of unit which does not take in residential clients but offers a broader range of support facilities for the community. The Principal herself does not express this intention. For her, the most important development she would like to see is the Home gaining full control over the adjacent sheltered

accomodation bungalows; the Home would then be able to offer a permanent care option, as well as short term and day care.

A.2. ROTATING ROTA (HOME A)

As with the change to flexi-respite care, the Principal was keen to introduce a rotating rota for care staff from the very start of her tenure at Home A. She gives two reasons for this; firstly, and most importantly, she saw it as a way of avoiding conflict between day and night staff, which - from her own experience and from her observations of other Homes she had visited prior to her appointment - appeared to be commonplace;

> "...and there's always, in any kind of setting where you've got two separate staffs, you've got this 'us and them';...there's always this 'oh, they don't know what it's like on days...' and vice versa."

She suggests that a major reason for this is that night staff feel isolated; "...they do work very much by themselves and yet they've got a lot of responsibility." By having a rotating rota, in which all staff work all shifts (mornings, afternoons and nights), she hoped to avoid such a situation. Secondly, she considered that it would enable all the staff to get to know the residents, whereas permanent night staff might have very little personal contact with most residents; "They *[i.e. residents]* might be here two or three years, and yet if they're always in bed night staff haven't a clue what Joe Bloggs is like."

The Principal took up her post four months before the Home opened, and one of the first things she did was to make out rotas, on a rotating basis, with the staff hours she'd been allocated. She presented them to the personnel office, but to her suprise and disappointment was told that she could not run a rotating rota. Their only explanation was that it worked out to be more expensive than a normal rota. The

Principal is quite self-critical about her acceptance of this refusal, as subsequent events indicated that she could of got her way if she'd challenged the decision in the right manner. As it was the Home opened with separate day and night staff, though some staff do say that they were told by the Principal that she hoped to change to a rotating rota.

It was about a year before the rotating rota surfaced again, this time leading to a trial implementation. There is some variation in people's accounts of how this happened, though it is more a case of differences in emphasis than contradictory stories. In the Principal's interview, she describes how she discovered that another Home that had opened around the same time as Home A did have a rotating rota; she discovered that the Principal of this Home - who she notes had opened three other Homes before - had had the rotating rota costed and found it to be slightly cheaper than the normal system. With this example, Home A's Principal was able to push the department into at least letting her have a trial run; "Once I knew *[about the other Home]* I started battling." Other members of staff do mention the fact that the Principal followed the example of this other Home - one describes the course of events in some detail, suggesting that the Principal kept at least some staff informed about what she was doing. Many staff, when asked about the origination of the idea, just say "it came from the Principal", without elaborating further. A third group emphasize more the role of certain members of staff who were involved in drawing up the trial rotas. For instance, the Deputy Principal says; "It was the Principal's *[idea]* in the beginning, but I also feel sure that some staff did suggest it, because they were away on courses in college and had talked to the people that were actually doing this". One member of staff states that the original impetus to try the rotating rota came from her and her partner on nights, supported by some day staff and with the Principal's approval.

There are several areas of disagreement in the accounts of the trial implementation of the innovation. Two members of staff actually denied that any trial had taken place; they said that the idea was abandoned

before this because of staff and higher management opposition. However, both of these individuals were less directly affected by the rota than others - one was an Assistant Principal, whose own work schedule would not have been altered, and the other a member of the night staff who was at the time about to change jobs and become a domestic. All the other staff agree that the rotating rota *was* implemented, and most give a trial period of three or four months (none less than two). Interestingly, some members of staff consider this to have been "quite a long time" for a trial, while others say it was not long enough for people to have a chance to get used to it. The trial was carried out on the basis that at the end of it the innovation would only continue with the agreement of all the care staff involved - in other words, only one member of staff had to oppose it for it to be abandoned. However, before the trial started, two members of the permanent night staff refused to work the new rotating shifts, as they wanted to stay on nights all the time. As one says; "I didn't want it, I didn't come here to do it and I would not have done it". The result of this was that these two night staff, who had worked as partners, were split up so that one of them was on each night, partnered by a staff member on a rotating shift. The rota was organised so that every six weeks each care assistant worked a week of nights, followed by a week off.

Over the outcome of the trial implementation there is no dispute; a meeting was held and it was decided to drop the rotating rota and return to having separate day and night staffs. Everyone also agrees that the problem for those opposed to continuation was having to work nights; reasons given for this are disruption to social and family life and the physical effects of changing from day to night shifts. Where there is disagreement is over how many people voiced opposition at the end of the trial. Some say that "a majority" of the staff were against it, while others that it was only two or three. It is noticeable that those who are most enthusiastic about the rotating rota tend to quote the lowest numbers of people opposed to it. A plausible interpretation of what happened is that while only a small number of people actually voiced opposition at the end of trial

meeting, there was a wider feeling of disatisfaction. This is suggested by one of the permanent night staff who refused to work the rota; "...a lot of them had reservations and didn't voice them in the right place", and by one of the older Day Care Assistants who admits to having spoken up against the innovation;

> "I knew that there were two people who didn't like it - at least - and I didn't like it and I thought if I say that I'm not going to agree to it, it means that nobody else needs to say it, because that was the decision we'd made. When you're young you don't always want to stick out..."

Only four interviewees express regret that the rotating rota was abandoned; the Principal, the two Night Care Assistants who were involved in drawing up the rotas, and one Day Care Assistant. The two Night Care Assistants both say that they would like to see it tried again, as at least one of the people opposed to it has since left the Home - one suggests that next time there should not be a trial period; "If certain people pushed it, we could probably have another trial, but we wouldn't make it a trial, we'd make it a definite 'yes' at the beginning *[laughs]*." The Principal however feels that there is less need for a rotating rota now than there was at the time the Home opened. One reason she gives for this is that "at the moment we've got a good set of night staff and there isn't much hassle here between day and night staff, on the whole". In any case, many of the day staff have spent some time on nights and vice versa, and have seen what each other's jobs are like. Also, the change to flexi-respite care has made the problem of night staff not getting to know residents less important, simply because with most clients coming in for only two weeks, there is little chance for anyone to get to know them well.

A.3. SHORT STAY WING (HOME B)

The conversion of the bottom floor of Home B into a short stay wing happened about two years ago (from the time of this study), after the departure of the previous Principal and the promotion of the current Principal from Deputy. The impetus for the innovation is described by most members of staff interviewed as coming from two sources; the Principal and the Family and Community Services department management. The Principal herself recognises this, when describing how it came to be set up;

> "I was looking at ways of changing - like changing some of the practices at Home B, and changing Home B in itself. And there was alot of sort of talk, and some little bit of pressure from the department about taking in short stay residents".

There is disagreement amongst staff about the role played by the department here - whether it compelled, or merely encouraged, Home B to take short stay residents. Regardless of this, nobody questions the Principal's enthusiasm for the idea, and it was clearly left up to her to determine the details of introducing and running short stay care within the Home. In this, it would appear that her then Deputy (who has since left the Home) played a significant part. One Care Assistant says; "...we got another Deputy and she was keen, into that, and she did alot of work towards that...I'd say she had a big influence on it."

Having decided to take in short stay residents, the first question to address was where these residents would be situated within the Home. In searching for the best solution, the Principal went to look at how other Homes organised short stay beds and she also considered her own experiences in Homes she had worked in previously. Her conclusion was that the only way it could be run was to have one whole wing of Home B given over entirely to short stay beds. She took this idea to her line manager, and together they planned how to do it. Several members of staff mention that at the time there were a number of empty beds on

the lower ground floor, hence its selection as the short stay wing. Only the Principal offers a more detailed - and somewhat different - explanation; that there were "quite a few empty beds all around the building" (not just on the lower ground floor) because of the social workers' strike which had halted admissions, and it was easier to move residents from the lower ground than from other floors as "there'd been a history of the bottom floor being kind of neglected, they [residents] had to be more able to look after themselves". This tendency to allocate more able residents to the bottom floor, and the resultant "neglect", is confirmed by many of the interviewees.

Although some of the residents on the lower ground floor were moved immediately after the decision to turn it into a short stay wing, by no means all of them were. Until a few months ago there were three permanent residents on the floor; two have since died and one is still there. It is taken for granted that her bed will become short stay on her death, thus making it an entire wing of ten short stay beds. The continued presence of permanent residents on the floor is a reflection of the policy of not moving residents against their will; the one remaining permanent resident, for instance, was asked if she'd like to move, but declined to do so. An Assistant Principal points out that;

> "...going back six years, when I came, she'd not have been given any choice...We didn't realise the implications really of moving people about. They were moved from room to room as we saw fit."

An important change that was at least partially a consequence of the introduction of short stay residents was the organization of staff into three floor-based teams. Prior to this, staff were allocated a floor to work on each day. It is not clear whether a team system would have been introduced if the short stay wing had not been set up, but the short stay wing certainly increased the necessity for such a system. As has been mentioned, staff had been able to spend relatively little time on the bottom floor, because the residents elsewhere in the Home generally needed more attention. This could no longer be taken for granted once short stay started, as residents change as

frequently as once a fortnight, and quite often are actually more demanding than many permanent residents.

The policy of not moving residents against their will meant that the change to short stay had to be gradual, happening one bed at a time as residents died or otherwise left the Home. One Care Assistant suggests that the change had to be slow anyway; "...because with the kind of staff group we had it had to be, obviously, gradual". The implication that staff were at first wary of the change is backed up by the Case History Questionnaire findings for this innovation (see chapter six). Comparing initial and current attitudes towards it, six out of ten participants rate their own attitudes as more positive now, and nine out of ten rate attitudes amongst other staff generally as more favourable now. There are no cases of current attitudes (own or others') being rated as less favourable than initial reactions.

The Principal says that she had to spend a great deal of time explaining to staff, especially the older ones, what she was planning to do, and that introducing the short stay wing was "...a Hell of a lot of hard work". She points out that resistance to it wasn't just from Care and Domestic staff, but that some members of the management team at the time also "...didn't either agree or understand".

The resistance, or at least uncertainty, towards the short stay wing can to a considerable extent be understood by looking at the history of the Home prior to the current Principal's arrival. As has been noted she came as Deputy immediately after a six month period of confusion and instability, during which the Home was managed by four different temporary Principals. One member of staff comments, "...they all brought their own way of working and different ideas, and so we went from one change to another...which were pretty bad". Prior to this, the Home was run on "traditional" lines; an inflexible routine for residents, with no room for individual choice, and virtually no contact with the community. As one Assistant Principal says, "...the old type of management was that when those doors were closed that meant the outside world was out and stayed out". Morale was a problem

amongst staff; the Principal talks about a sense of "stigma" about working at Home B which existed when she first arrived. This history of stagnation followed by chaotic changes - and the resultant inadequate standards of care - is mentioned by all the longer-serving members of staff; a long-serving Care Assistant says, "It had a terrible reputation this place at one time, really bad". In such circumstances it is not suprising that many staff were suspicious of new ideas, and in particular one which would radically increase the level of their involvement in the community. The Assistant Principal quoted above sums it up as follows;

> "I mean, it took us a long time really as a unit to get over that, until there was enough trust in more permanent managers' ways, you know; it does take you a long time to adjust to one person from another."

In addition to the historical circumstances, aspects of individual personality may explain some of the initial doubts about the short stay. This is, however, only explicitly stated in two cases (both Care Assistants); interestingly, the grounds they give for not wanting to work on the short stay wing are very different. One accounts for her initial resistance by saying "...personally I'm a bit of a stick-in-the-mud, bit of a routine kind of person"; she asked to go back to one of the upper floors, but was persuaded to try it for a while longer and now is happy to be working there. In the other case, the Care Assistant gives two reasons for disliking the short stay wing; that there was often not enough for her to do, and that being on the short stay wing you were cut off from the rest of the Home; "...I'm a bit nosey you see and I like to know what's going off everywhere." It would be wrong to conclude that because personality characteristics were only mentioned by these two participants, they were unimportant in determining reactions to the innovation - as the findings of the "Experiences of Innovation" study (chapter 4) suggest, people may understate their own anti-innovation characteristics.

The short stay wing is now by all accounts accepted as an integral part of Home B. Those interviewed were unanimous in considering it to be "a good thing", most commonly referring to the way it helps relatives cope with the strain of caring for an elderly person by giving them a break. Some staff point out that not all short stay residents enjoy coming in, and one complains that this can occur because social workers tell old people that everything will be done for them in order to persuade them to come in;

> "I think that some of them [ie. social workers] lie to try and get them in...and then they come in and we say, 'look, we don't do everything for you, you've got to do something for yourself'".

On the other hand, several interviewees talk about how much the residents enjoy the short stay wing - one quotes a recent example of two sisters who asked to be allowed to come back as soon as possible.

A change associated with the short stay wing which has been appreciated by staff is that they are now involved in assessment visits to potential clients. This is cited by some participants as evidence of the increase in the extent to which they are consulted by management and participate in decisions.

The only commonly made complaint about the short stay wing now is that there are insufficient staff to run it as well as it could be run, not because staffing levels have decreased, but because the workload has grown heavier. This is a problem for the whole Home, not just the short stay wing, and is due to the fact that the residents coming in nowadays are generally much more dependent than those admitted in the past. The situation is exacerbated by the high level of staff sickness - itself attributabed to overwork. In some ways the problem is less acute on the bottom floor as there are only ten beds rather than the nineteen or twenty on the other floors, and some short stay residents are highly independent. However, several staff tell of a tendency for many short stay residents to be in a worse condition than most of the

permanent ones. The following two quotes, from different members of staff, sum up the change nicely;

> "When I first came here a long time ago people had to walk, they had to be able to walk over the threshold before they were allowed in, you know, and they had to go down to a little office in the market...and ask if they could come in, to be admitted to a Home."

> "I think the kind of client what's coming in isn't what they were sort of wishing...because we did think they'd be probably more active than they are. And some, I just don't know how people cope when they go home, because some of them are worse than what we have got in permanently."

A.4. KEY WORKER SYSTEM (HOME B)

It was more difficult to reconstruct the history of the key worker system than any of the other innovations. This was largely because it was the least straightforward; although not apparent from the initial questionnaire, it soon became evident in the interviews that there had been a number of different versions of the system. On occasions it was not clear which one interviewees were talking about. In addition, the key worker system had been selected as an example of a discontinued innovation, but on one of the three floors it was still in operation. These complicating factors were compounded by the fact that information about it was less complete than in the other cases - it was discussed by fewer interviewees (nine) but had the longest history.

The first key worker system was introduced about four or five years ago, when Mr.E was Principal of Home B, at the instigation of the Family and Community Services department. Mrs.R., an Assistant Principal who had started work at Home B about six or eight months before this, describes it as something that the Home *had* to introduce.

She and other staff there at the time agree that the department did make an effort to explain the aims of the key worker system - visits by the Principal Assistant for their division and the Chief Assistant are mentioned, as is a memo sent about a year after the system started, giving more details of what was wanted. One Care Assistant describes department's aims as follows;

> "Well, they were saying about getting personal relationships, that's why a key worker was important - having so many residents you could recognise, you know, and they could recognise you".

There were two major factors working against the effective introduction of a key worker system into Home B on this occasion. First, the Principal at the time was not interested in it. This would appear to be a reflection of his management style generally - one member of the night staff describes it as "lacksadaisy" and "too easy going", and he is also criticised for not getting to know or caring about the residents; "...I don't think he could cope with caring about people, you know, 'cos he just didn't". The second, and probably more significant problem was a lack of clarity about exactly what was required and how it was to be implemented. It is described as "...very hit and miss at first, because nobody really knew a great deal about it". Mrs.R. (Assistant Principal), makes a similar comment;

> "...nobody knew what it was, nobody - I don't think even Redvers House *[Family and Community Services headquarters]* really knew, or didn't at that time know, what they wanted from a key worker system".

She describes how, after the initial directive from the department, implementation of the key worker system was left to her and the other Assistant Principal (both of whom were relatively new to the Home);

> "So what we did, the other Assistant Principal and myself, one night we sat down with a list of residents, and we put residents to staff. We tried to keep them on a compatible basis, we tried

to even them out as to workload, you know, were they physically heavy to bath, things like that, and that's how we very first started."

One frequently-mentioned problem with the key worker system as it was first arranged was that staff were allocated residents from anywhere in the Home; they might for instance have one on the bottom floor, two on the upper ground floor, and one on the top. This was clearly inefficient, as it involved them having to constantly move from one floor to another to see to their residents. Another common comment is that staffing levels were not high enough for the system to work properly, and especially to allow cover for those off sick; "...you found that if some people were off sick or wasn't here then their residents were getting left. Some never got bathed or got anything done for them". The issue of staffing will be returned to shortly in connection with the most recent attempt to set up a key worker system. A third complaint about the original version is that staff did not always have any say in which residents were allocated to them; "Sometimes you got a choice, sometimes it was just 'you've got so and so residents'". One interviewee points out that;

"...if one of your residents died and a new resident came in they were automatically yours, so there was no sort of choice, either for you or your resident - I mean, because you could have both had a personality clash and not got on".

What happened to the key worker system between the latter part of Mr.E's tenure as Principal and the appointment of the current Principal is difficult to piece together. Interviewees often are unsure of details and their stories occasionally contradict one another; the conclusions that can be drawn from the transcripts suggests that this confusion largely reflects the state of affairs both in the Home and in the history of the innovation during this period. The story is one of various modifications made to the original key worker system, interspersed with intervals where the system lapsed entirely; staff who joined the Home while Mrs.G was Principal say that

there was no key worker system when they arrived until she started it, similarly other staff credit the current Principal with introducing it. According to one Care Assistant, the chaotic period of different temporary Principals was responsible for the initial breakdown of the system;

> "I'd say it fell down when we had the Principals coming in, because we had different kinds of principals; one would be like a matron type, had to be run like a hospital...and then there was another one; she just said 'you do exactly what you want' sort of thing, you didn't know where you were. So in that time...there wasn't really any kind of system going".

One early modification to the key worker system was to allocate residents to pairs of Care Assistants instead of just one, the idea being that residents would have a key worker on duty for twice as many shifts. This is the system that still operates on the upper ground floor, but several interviewees state that it cannot compensate for inadequate staffing and high levels of sickness; "...if you've got plenty of staff it works that way, but if you haven't then sometimes you don't get time to fit all the work in anyway. We definitely need more staff."

Since the division of the staff into floor-based teams, the history of the key worker system has progressed differently on each floor. On the lower ground floor, the change to short stay care made it impossible to run the original type of system as different residents come in every two weeks or so. One Care Assistant describes a variation on the key worker system that was tried briefly - allocating staff to particular rooms, so that they would be responsible for whoever came into those rooms (bathing, shopping etc). This proved impractical because the workload varies so greatly from week to week. As has been seen, the people coming in for respite care are often in a worse state of health than many of Home B's permanent residents; though some short stay residents are quite self-sufficient, and "...sometimes you've got nobody to bath, nobody came in that week".

The upper ground floor still works a key worker system, based on partners sharing a group of residents. All the interviewees from this floor like this way of working, though all agree that staffing is a problem for running it effectively; "...when we've got the right amount of staff it works well for us; it all depends on the staffing level". One Care Assistant from this floor compares the way its key worker system works to her past experience in a hospital geriatric ward. She says that on the ward "...there were twice the number of staff to start with and there wasn't the same amount of physical nursing...so you were able to spend more time with particular people". That this interviewee found there to be more demand for "physical nursing" in a Home for the Elderly than in a hospital ward is another indicator of the tremendous change that has happened since the days when new residents had to be able "to walk over the threshold".

On the top floor, following the organization of staff into teams, a key worker system was operated for a while but has since been abandoned. Two reasons for this appear in the interviews. One is that there was a higher proportion of confused and incontinent residents on the top floor than elsewhere, making it impractical to leave duties such as bathing to a specific member of staff; "...you couldn't say that you would bath a certain person on a certain day, and a certain person would bath her, because she would probably need a bath nearly every day". It is not clear whether this situation still exists, as some staff claim that the incidence of dementia on the upper ground floor is now practically the same as on the top floor. The second reason for abandoning the key worker system was that the staff on the top floor didn't like being split into pairs within the floor team. The upper ground floor manager, Mrs.R., says that "...they *[ie. top floor staff]* weren't quite happy to split into small groups; you see what they do on here, they work in pairs, and it just didn't appeal to 'em"; a Care Assistant from the top floor says he likes working as a single team because "...the way we're working now we get to know all the residents and we're not split as little units in one unit".

The last comment illustrates an important point; that to some extent the floor teams themselves serve a similar function to the key worker system as they allow care staff to concentrate their attention on a smaller group of residents than the whole population of the Home (as used to be the case). In terms of depth of personal relationships, the difference between two pairs of care staff with ten residents each on the upper ground floor, and four staff with twenty residents between them, is perhaps not that great - especially as for most of the day only one Care Assistant from each floor is on duty at any one time.

Despite the fact that it has been abandoned on two out of three floors, there is general agreement that the key worker system does lead to closer relationships between staff and residents, if there are enough staff to work it properly - which participants feel is not the case in Home B. This support for the idea of the key worker system is shared by the Principal and the Assistant Principal in charge of the top floor. The former says it is currently under review, while the latter comments that she wants to re-introduce it;

> "I'm sort of drawing a plan up. And talking to staff and finding out why it failed, because I think it's important to have a key worker system, in that one person's responsible for a small group; I think it's more effective".

A new phase in the complex history of this innovation therefore seems imminent.

APPENDIX B. CODING MATERIALS FOR IDENTIFYING UNITS OF RELEVANT MEANING: 'HOMES FOR THE ELDERLY' STUDY

B.1. CONTENTS OF THIS APPENDIX

This appendix contains the coding criteria and all supporting materials presented to coders to enable them to identify units of relevant meaning (URMs) concerning influences on the innovation process. The following documents from stage one of the coding are included:

* Introductory instructions for coders
* Background sheet describing the research project
* Background sheets describing the two Homes
* Background sheets describing the innovations
* Details of coding criteria
* Sample interview transcript; unedited and prepared versions

The final document included presents the coding criteria for the second stage of the coding.

B.2.

CODING STAGE 1: INSTRUCTIONS FOR CODER

You will be carrying out coding on two interview transcripts, each one concerning a different innovation example. There are two versions of each transcript. The first is the unedited original, with the interviewer's questions prefaced 'I:' and the member of staff's responses prefaced 'S:'. Before carrying out any coding you should read through the whole of this transcript.

In the second version, the member of staff's responses have been broken down into units (referred to as 'units of general meaning', or 'UGMs'). The interviewer's questions have been placed in brackets. Your task is to decide for each of the research questions stated below, which of these units are relevant (ie. are 'units of relevant meaning', or 'URMs'). To do so, please read and follow the guidelines given below for each research question. In addition you may refer back to the unedited transcript and the background sheets as often as you wish. If necessary you may ask me for any points of clarification. For each transcript, please complete the coding for research question one before proceding to coding for research question two.

B.3.

BACKGROUND SHEET 1: THE RESEARCH PROJECT

This sheet describes the aims of the research project and the way in which the data you will be coding was collected.

The project set out to examine in detail particular cases of innovation in two local authority Homes for the Elderly. There are three main areas of interest: **influences** on the development of each innovation, from conception onwards; **staff attitudes** towards each innovation and the reasons given for these attitudes; the **history** of each innovation, in terms of the key events in its development. The findings in these areas will be used to produce individual "case histories" of the innovations, from which common themes across the study as a whole will be identified.

From each Home two main examples of innovations were selected, guided by responses to a questionnaire sent to all members of staff. In both Homes, the examples comprised one innovation still in use and one that had been abandoned. Members of staff were then interviewed, and the interviews taped. There were three parts to the interview, (though parts one and two were repeated for each innovation example); they are described below.

(i) The member of staff was asked to describe in her or his own words the history of the innovation.

(ii) A short questionnaire was administered verbally, asking about participation in the introduction of the innovation, attitudes towards the innovation and the effects of the innovation. The member of staff was required to indicate her or his response on a five point rating scale. Members of staff were allowed to elaborate on their responses if they so desired, and this was particularly encouraged with regard to their evaluations of the effects of the innovations.

(iii) A longer quantitative questionnaire was administered verbally, including measures of attitudes towards their own jobs, other staff and the Home.

The material you will be coding is from transcripts of part (i). The interviews were carried out between March and May, 1986.

B.4.

BACKGROUND SHEET 2: THE HOMES

Home A is a 12-bedded purpose built unit, which opened in January, 1983. It is a single floor building and stands adjacent to a group of sheltered accomodation bungalows. The bungalows are the responsibility of the Council's Domicilliary Services, but Home A is responsible for providing emergency cover for them. The Home has a total staff of twenty-two; six kitchen and domestic staff, seven day care staff (including three part time), four night care staff, and five senior staff - Principal, Deputy Principal, and three Assistant Principals (including one part time). The current Principal has been in charge since the home opened. Aswell as providing care for its residents, Home A offers a range of services to local elderly people such as luncheon clubs and day care. It also has a community room which is used by groups other than the elderly.

Home B is a 49 bedded purpose built unit, which had been open at the time of the interview for approximately eighteen years. It is on three levels, known as the lower ground, upper ground and top floors. Home B has a staff of eight kitchen and domestic staff, twelve day care staff, five night care staff, and five senior staff - Principal, Deputy Principal, and three Assistant Principals (including one part time). For the first eleven or so years of its history, Home B was run by one Principal. She was replaced by her husband for the next three years and on his departure there ensued a period of about six months where there was no permanent Principal and a series of short-term temporary Principals were brought in from outside. The current Principal arrived, as Deputy Principal, shortly after a new permanent Principal had been installed, and took over as Principal some nine months later, in late 1982. In addition to residential care, Home B provides various services for the community, including a carers' group (for people looking after elderly residents in their own homes), and a blind club.

To preserve anonymity, names have been removed from the transcript. The names of members of staff have been replaced with their transcript code and staff grade ('S12, Care Assistant', etc), with the exception of the current Principals, who are referred to as such - '[current Principal]'. Other individual names have been replaced by initials.

Explanation of terms

Part 3 - Residential care in normal local authority homes (such as Home A and Home B).

E.M.I. Homes - Homes for the Elderly Mentally Ill. Clients will be allocated to E.M.I. Homes if their mental condition and behaviour is such that normal Part 3 homes would not be able to cope with them, for instance if they are violent. E.M.I. Homes have much higher staffing levels than normal Part 3 homes.

Family and Community Services - The council department responsible for residential care of the elderly.

Division - The administrative area into which residential homes are divided by Family and Community Services.

PA - Principal Assistant. Manager responsible for a division. The Principal's immediate superior.

Residents' Charter - A document produced by F & CS, detailing the rights of clients in residential care, especially regarding freedom of choice in lifestyle.

Luncheon Clubs - Groups of elderly people in the community who come into the Home for a meal together on a regular basis.

Day care - Care given to elderly people from the community who come in to the Home during the day on a regular basis, but return to their own homes at the end of it.

Please ask if there are any other terms which you require an explanation of.

B.5.

BACKGROUND SHEET 3: THE INNOVATIONS

Home A

EXAMPLE 1: FLEXI-RESPITE CARE ('FLEXI-BEDS')

"Flexi" and "respite" care are both forms of non-permanent care, and although the terms are often used together or interchangeably, strictly speaking they are not the same. "Respite" care is a form of short stay care whereby elderly people living in the community come in for regular periods of residential care. "Flexi" care refers to the use of beds in a flexible way to meet whatever needs exist for non-permanent residential care. This might include looking after an elderly person whose family are away on holiday; keeping a respite resident in for longer than the normal two weeks because of a deterioration in their own condition or in the situation at home; taking an elderly person in while awaiting a hospital or permanent part three bed, if care can no longer be provided in the community.

EXAMPLE 2: ROTATING ROTA

The rotating (or "three-way") rota is an alternative to the traditional division of care staff between days and nights. Instead of having two separate groups of staff, all care staff rotate between three shifts - mornings, afternoons and nights.

Home B

EXAMPLE 1: SHORT STAY WING

"Short stay" refers to the same kind of non-permanent care provided in Home A; chiefly regular respite care, plus special cases such as holiday relief for relatives etc. In Home B however, only one of the three floors - the lower ground floor - has been given over to short stay residents, rather than the entire Home.

EXAMPLE 2: KEY WORKER SYSTEM

The key worker system is a practice whereby individual Care Assistants are assigned special responsibility for particular residents. This might involve specific tasks such as bathing, shopping, administering medication as well as generally being aware of the individual residents' wants and needs.

B.6.

CODING CRITERIA

Research question one

"What determined or influenced the introduction and progress of the innovation, and its ultimate success or failure?"

A unit will be coded as a unit of relevant meaning for research question one if it describes any factor as determining or having an effect on the introduction, development and/or outcome of the innovation. The influencing factors may be anything within or outside the home; people, events, administrative procedures, policy decisions etc.

A unit does not need to explicitly state that 'X' was an influence for it to be considered relevant to research question one. Every unit should be considered in context; both the immediate context of what was said just before and after it, and the wider context of the transcript as a whole and the background material. Please refer to these as often as you wish. If you have no doubt from the context that the member of staff mentioned something because it was an influence on the innovation, then the unit concerned should be coded as a unit of relevant meaning.

A unit **should not** be coded as a URM for research question one if it describes an attitude or opinion towards the innovation, held by the interviewee or by any other member of staff of the home.

If the unit describes attitudes or opinions held by anyone who is not a member of staff of the home - eg. residents, relatives, council officials etc. - then it may be coded as a URM for research question

one, provided it meets the other criteria given. An example might be *"The head of F & CS residential section was very keen on this idea* [ie. the innovation] *and encouraged us to introduce it".*

When deciding whether or not to code a unit as a URM for research question one, it may be useful to ask yourself the following questions. If you answer "yes" to one or more of them, you should code the unit as a URM for research question one.

(i) "If the event or state of affairs described had not occurred, would the innovation have been introduced?"

For example, the following statement by a domestic discussing how her shifts were changed would be coded as a URM for research question one, because the problems she describes with the previous system led to the introduction of the new shifts:

"But they found out that if,say, I were off they were seven days without a domestic. So we changed that."

(ii) "If the event or state of affairs described had not occurred, would the innovation have developed in a significantly different way?"

For example, a statement such as the following would be included a URM for research question one because it can be assumed that had this state of affairs not existed, the innovation would have progressed less smoothly:

"Management kept us informed throughout when they introduced this innovation, which made it much easier for the staff to operate it."

(iii) "If the event or state of affairs described had not occurred, would the outcome of the innovation have been significantly different?" (ie. would it have been more or less successful, would it have had different effects on people etc.).

The following statement would be coded as a URM for research question one because it describes negative effects of the innovation which led

to its abandonment. The innovation is a change in the way residents' breakfasts are organised:

"...well people [ie. residents] *weren't getting up early and they were all coming in for it about dinner time, and all things were going wrong like that".*

Finally, a unit which refers to someone - be it the interviewee or any third party - as having initiated an innovation should be coded as a URM for research question one. An example would be; *"The idea for the innovation came originally from the Principal".*

Please mark all the units which you consider to be relevant to this research question with a number 1 in the left hand margin, next to the unit.

Research question two

"What were the attitudes of members of staff to the innovation, and what reasons did they give for their own and others' attitudes?"

A unit will be coded as a unit of relevant meaning for research question two if it contains any statement of the member of staff's own attitude towards the innovation, any statement of other member(s) of staff's attitudes towards the innovation, and/or gives any reasons or explanations for the attitude(s). The attitude(s) may be towards any aspect of the innovation: the way it was introduced, the effects it had on the member of staff, on the staff in general, on the residents, the home, the community etc.

The following example illustrates an interviewee (a care assistant), describing her own attitude to an innovation, and her reasons for this attitude (the innovation is a new set of procedures for dispensing medications):

[Interviewer: "Do people like the way it's working now?"]

"Well I feel happier."

[I: "Do you feel better that there's more control or worse about it?"]

"I feel better because you know anything that's wrong will be put right before it's dispensed; you know, you feel more secure."

An example of an interviewee describing other members of staff's attitudes to an innovation comes from a domestic discussing the care staff's reactions to the merging of care and domestic roles:

"I know that alot of the care staff complained about doing domestic."

It is important to note that **not all attitude statements in a transcript will be URMs for research question two.** To code a unit as such you must be satisfied that it refers to the innovation in question, rather than to an unrelated change or to some other aspect of the interviewee's work experience.

Again, as with research question one, units should be considered within their immediate and wider contexts.

Please mark all the units which you consider to be relevant to this research question with a number 2 in the left hand margin, next to the unit.

Before you begin the coding proper, an extract from a fifth transcript will be used for a dummy run, in order that any problems with interpreting the instructions or any other aspect of the coding process may be identified and dealt with.

Thank you for your help.

B.7. SAMPLE INTERVIEW TRANSCRIPT (UNEDITED VERSION)

HOME: B PARTICIPANT: 24 (CARE ASSISTANT)

EXAMPLE 2: KEY WORKER SYSTEM

I: Okay thanks. Right, I also wanted to talk a bit about the key worker system, the system that was tried out here

S: Yes

I: So could you just explain a bit about what that is and when and how it was carried out

S: Well, we started the key worker system about four year ago I should say, and it was very hit and miss at first

I: Yeah

S: Because nobody really knew a great deal about it, [inaudible] management you know, so we just started really with so many residents per person

I: Right. Who was in charge then, was it Mr.E.?

S: Yes I think, yes towards the end of his reign here

I: Yeah

S: And I don't really think he was particularly interested, well he wasn't interested in *[inaudible]*, and S28 and another person we had here sort of started it off, and we each had so many residents and we did pick, er, well we didn't actually pick the people we wanted

I: Yeah

S: But you were sort of given two good ones, two bad ones or perhaps two in a wheelchair or, you know, or one man a piece or something like that; 'til you all got a fair mixed bunch of residents and nobody had too much work to do, *[inaudible]* little group, just started with more or less each resident had a particular person seeing to their clothes, changing their bed of that particular person, which cut down a lot of work. And that's really it; it was quite simple at first, and then when [current Principal] came, she settled on the floor system which took an awful lot of thinking out again, getting staff together at certain times on certain days

I: Did you before that have residents on all floors?

S: Yes

I: Yeah, right

S: You see I'm on this floor and ours works very well actually, 'cos we sort of keep our own residents. I've got five because I'm full time but part timers have less, you do shopping and different things now with your own particular residents

I: Yeah

S: But upstairs they don't seem to have that, they haven't got the same sort of system, you know they just see to anybody

I: Yeah

S: Which doesn't work out really properly

I: Why do you think they're different; is it to do with their supervisor and them or is it to do with the residents they have?

S: I think it is, er, I don't think the type of resident makes any difference really, because thye're really much the same upstairs as

they are down, perhaps some a little bit more confused; apart from that they're more or less the same

I: Yeah so although it was started when Mr.E. was here, you said he wasn't really interested so where was the original impetus from?

S: No, er, I suppose it came from F and C S department really

I: Yeah

S: I think it was Mr.B. that first came up with the idea

I: What was he, was he the P A?

S: He was the Chief Assistant or something like that

I: Right yeah

S: He came from Wakefield and it more or less all sort of started when he came

I: Yeah, yeah; so it was at the same time that the residents' charter was appearing as well?

S: Yes

I: So you said that your floor has kept to the key worker system pretty much since then, or since [current Principal] made it floor systems?

S: Yes

I: You've stuck to that?

S: Yes

I: But the other ones have let it drop

S: They more or less look after everyone you know

I: Yes, but they did try the key worker system at first did they?

S: I couldn't tell you to be honest because I've not really worked up there for any length of time

I: Yeah

S: But I would imagine so, you need a lot of staff for the key worker system, to have a good one anyway

I: Yeah and don't you think there's a high enough staffing here?

S: No definitely not, no

I: Not to work it properly, right; and so your one is still then carrying on and you're doing their shopping and looking after their needs?

S: Doing their shopping, bathing

I: What happens when one of you're off sick or something?

S: Well we work in twos you see, so we have in actual fact we have ten residents each you see, well no not ten residents each sorry ten residents between us, so that those other people when you're off, when the other one's off are your responsibility and if you've got plenty of staff it works that way

I: Yeah

S: But if you haven't then sometimes you don't get time to fit all work in anyway

I: Yeah

S: We definitely need more staff

B.8. SAMPLE INTERVIEW TRANSCRIPT (PREPARED VERSION)

HOME: B PARTICIPANT: 24 (CARE ASSISTANT)

EXAMPLE 2: KEY WORKER SYSTEM

[I: Okay thanks. Right, I also wanted to talk a bit about the key worker system, the system that was tried out here]

1. Yes

[I: So could you just explain a bit about what that is and when and how it was carried out]

2. Well, we started the key worker system about four year ago I should say,

3. and it was very hit and miss at first

4. Because nobody really knew a great deal about it, *[inaudible]* management you know,

5. so we just started really with so many residents per person

[I: Right. Who was in charge then, was it Mr.E.?]

6. Yes I think, yes towards the end of his reign here

7. And I don't really think he was particularly interested,

8. well he wasn't interested in *[inaudible]*,

9. and *S28 [Assistant Principal]* and another person we had here sort of started it off,

10. and we each had so many residents and we did pick, er, well we didn't actually pick the people we wanted

11. But you were sort of given two good ones, two bad ones or perhaps two in a wheelchair or, you know, or one man a piece or something like that; 'til you all got a fair mixed bunch of residents and nobody had too much work to do, *[inaudible]* little group,

12. just started with more or less each resident had a particular person seeing to their clothes, changing their bed of that particular person, which cut down a lot of work.

13. And that's really it; it was quite simple at first,

14. and then when [current Principal] came, she settled on the floor system which took an awful lot of thinking out again, getting staff together at certain times on certain days

[I: Did you before that have residents on all floors?]

15. Yes

16. You see I'm on this floor and ours works very well actually, 'cos we sort of keep our own residents.

17. I've got five because I'm full time but part timers have less, you do shopping and different things now with your own particular residents

18. But upstairs they don't seem to have that, they haven't got the same sort of system, you know they just see to anybody

19. Which doesn't work out really properly

[I: Why do you think they're different; is it to do with their supervisor and them or is it to do with the residents they have?]

20. I think it is, er, I don't think the type of resident makes any difference really,

21. because they're really much the same upstairs as they are down, perhaps some a little bit more confused; apart from that they're more or less the same

[I: Yeah so although it was started when Mr.E. was here, you said he wasn't really interested so where was the original impetus from?]

22. No, er, I suppose it came from F and C S department really

23. I think it was Mr.B. that first came up with the idea

[I: What was he, was he the P A?]

24. He was the Chief Assistant or something like that

25. He came from Wakefield and it more or less all sort of started when he came

[I: Yeah, yeah; so it was at the same time that the residents charter was appearing as well?]

26. Yes

[I: So you said that your floor has kept to the key worker system pretty much since then, or since [current Principal] made it floor systems?]

27. Yes

[I: You've stuck to that?]

28. Yes

[I: But the other ones have let it drop]

29. They more or less look after everyone you know

[I: Yes, but they did try the key worker system at first did they?]

30. I couldn't tell you to be honest because I've not really worked up there for any length of time

31. But I would imagine so,

32. you need a lot of staff for the key worker system, to have a good one anyway

[I: Yeah and don't you think there's a high enough staffing here?]

33. No definitely not, no

[I: Not to work it properly, right; and so your one is still then carrying on and you're doing their shopping and looking after their needs?]

34. Doing their shopping, bathing

[I: What happens when one of you're off sick or something?]

35. Well we work in twos you see, so we have in actual fact we have ten residents each you see; well no, not ten residents each, sorry - ten residents between us, so that those other people when you're off, when the other one's off are your responsibility

36. and if you've got plenty of staff it works that way

37. But if you haven't then sometimes you don't get time to fit all work in anyway

38. We definitely need more staff

B.9.

INDENTIFYING UNITS OF RELEVANT MEANING: CODING STAGE 2

Introduction

The material you will be coding comes from a study of innovation in two Homes for the Elderly. The study focussed on two specific examples of innovations at each Home. Each interview consisted of an open-ended section, during which the history of the first innovation example was described, followed by a structured section in which a short questionnaire about attitudes towards the innovation and its introduction was verbally administered. The whole procedure was then repeated for the second innovation example. All the interviews were taped and transcribed.

To enable a detailed analysis of the interviews to be carried out, all the interviewee statements on each transcript were split into "units of meaning" in a systematic manner. Those units relevant to the research issues with which this study is concerned were then identified - these are referred to as **units of relevant meaning** (or **URMs**).

This stage of the analysis is concerned with identifying where staff attitudes to an innovation influenced its progress or outcome. You will be presented with four interview transcripts on which all the units of relevant meaning relating to staff attitudes to innovations are highlighted. Your task is to apply the set of criteria given on the next page to judge whether or not each of the highlighted URMs should be counted as an influence on the innovation process.

Before proceeding, read through the rest of the instructions carefully

Task Instructions

You will be given full versions of each transcript, and prepared versions, divided up into units of relevant meaning, with those relating to staff attitudes towards innovations highlighted. The first thing you should do is read through each of the full transcripts, at least twice, to familiarise yourself with the contents. Then go though the prepared transcripts one at a time and apply the criteria stated below to decide whether or not each one constitutes an influence on the innovation process.

CODING CRITERIA

The criteria are framed in the negative; that is, they describe the conditions in which a URM *should not* be coded as an influence on the innovation process. Only if *none* of the five criteria apply to an individual URM should you code it as an influence, by placing a large 'I' in the margin next to it on the prepared transcript. Unless stated otherwise (i.e. criteria 4 and 5), the criteria apply both to descriptions of the interviewee's own attitudes - e.g. "I was worried about the innovation" - and descriptions of other staff members' attitudes - e.g. "most people liked the innovation at first".

(see next page for criteria)

1) A URM *should not* be coded as an influence when it describes current attitudes to a past event.

> *e.g. "Looking back, I think the way the innovation was introduced was wrong."*

2) A URM *should not* be coded as an influence when it refers to any current attitude towards a discontinued innovation.

> *e.g. "Some of us were quite sorry we gave up the innovation."*

3) A URM *should not* be coded as an influence when it describes attitudes purely about the future of an innovation.

> *e.g. "I hope we'll be able to make some changes to the innovation quite soon."*
>
> *or "I'd like to see the innovation tried again."*

4) A URM *should not* be coded as an influence when it describes the interviewee's own attitude without any implication that this affected the innovation.

> *e.g. "I didn't like the idea from the start."*
>
> *or "I've enjoyed my job much more since the innovation was introduced."*

(The kind of statement that *would be* coded as an influence by this criterion is: *"I refused to participate in the innovation from the start."*)

5) A URM *should not* be coded as an influence when it describes other member(s) of staff's attitudes to an innovation, and a clear reference is made to these not affecting the innovation.

> *e.g. "Staff weren't keen on the innovation, but nobody said anything to management at the time."*

APPENDIX C. CODING CRITERIA: INNOVATION PROCESS PHASE INFLUENCE SOURCE AND INFLUENCE DIRECTION DIMENSIONS (FIRST 'HOMES FOR THE ELDERLY' STUDY)

C.1. INTRODUCTION

This appendix presents the coding criteria used for categorising Units of Relevant Meaning by innovation process phase, influence source, and influence direction. Note that the independent coders were presented with the three background sheets included in appendix B. These are not repeated here.

C.2. INNOVATION PROCESS PHASE

Coding Instructions: Innovation Phases

INTRODUCTION

The material you will be coding comes from a study of innovation in two Homes for the Elderly. In this study, members of staff were asked to talk about two specific examples of innovations that had been introduced into their Home, which had been identified as important in the recent history of the Home. These interviews were taped and transcribed.

To enable a detailed analysis of the interviews to be carried out, all the interviewee statements on each transcript were split into "units of meaning" in a systematic manner. Those units relevant to the research issues which this study is concerned with were then identified - these are referred to as **units of relevant meaning**, or **URMs**.

Your task is to decide which phase in the innovation process each URM (shown in highlights on the transcript) is related to. You will be coding one interview from each of the four innovation examples. Definitions of the phases and further instructions are given overleaf.

INNOVATION PROCESS PHASES

The two phases of the innovation process which you will be asked to identify are initiation and implemention-absorption. These are defined below, with illustrative examples.

INITATION consists of all the actions, events and conditions leading up to the point at which the organization starts to introduce the innovation. Actions and events could include such things as locating or devising an innovation to use, consultations with higher management, staff or other groups involved, making decisions about how and when to introduce the innovation, and so on. Conditions could include such things as inadequate standards of care, communication problems etc which the innovation in quetsion was brought in to change.

For example, the following statement comes from an interview about flexi-respite care at Home A. It is from an early part of the text and is in response to a question about when the move towards flexi-respite care began: *"... as we became more established and more peole knew we were here and we started with the luncheon clubs, people were coming in to the office, saying 'can you help me? Me husband, me wife...I need a break"*. This would be coded as initiation, because it refers to something that lead to the realisation of the need for flexi-respite care.

IMPLEMENTATION-ABSORPTION is the phase starting with the innovation being introduced and set into operation and concluding with it becoming recognised as a familiar and integral part of the organization's life. This phase may start with a formal trial period, or the innovation may be fully implemented from the beginning. Throughout the phase, modifications to the innovation may occur, in the light of circumstances unforseen at the initiation phase.

The first example of this phase concerns flexi-respite care; it follows a comment about the decision to use the beds in Home A for

short stay residents: *"That meant phasing out the permanent residents we'd got...and such as D., that went into a bungalow, and A. who went into a flat"*. It is coded as implementation-absorption because it is about the way the innovation was introduced.

The second example is from an interview about the short stay wing at Home B. The interviewee is discussing the current situation on the wing: *"I think the kind of client what's coming in isn't what they were sort of wishing ...because we did think they'd probably be more active than they are."* Here, the URM is referring to a problem affecting the innovation now that it is fully established. It thus relates to the implementation-absorption phase, though at a later point in it than the first example. (Please note, however, that **you do not need to be concerned with making any distinctions between different points within the implementation-absorption phase**).

In two of the four innovation examples discussed in the interviews, the innovation was eventually abandoned (at least in part). References to the abandonment of an innovation should be coded according to the stage at which it was abandoned; ie. if it never reached the stage of being implemented, code as INITIATION; if it was implemented, however briefly, code as IMPLEMENTATION-ABSORPTION.

Aswell as these phases, your coding sheet allows you to code a URM as "NON-SPECIFIABLE", that is, not referring to any specific phase. There are two sets of circumstances in which you should make such a classification;

i) When the influencing factor concerned is described in a way that crosses phases - eg. *"Management have always/never listened to what staff have to say."*

ii) When the innovation phase cannot be inferred from the URM itself or its immediate context in the interview. This may occur, for instance, in the case of spontaneous comments or interruptions which are not related to the preceding discussion and are not enlarged upon by the interviewee.

FURTHER INSTRUCTIONS

The following points are to help clarify how to use the phase definitions to code URMs. Read through them carefully; they are presented again in summary form on the CODING PROCEDURE sheet.

When using the phase definitions to code URMs on the transcripts, it is important to recognise that they are not intended to suggest that innovation occurs in a fixed sequence of events, each one clearly distinguishable form the next. In reality, the phases will often overlap - for instance, an innovation may be being implemented in one part of an organization while elsewhere it is only at the initiation stage. Also, there may be a cycling back of the process - an innovation may be fully implemented, but gradually fall into dis-use, only to be re-implemented, or re-initiated in a modified form. Having said this, there can never be implementation and absorption without initiation. The point to remember is that to code URMs according to innovation phase, you must look at <u>what</u> is happening as well as <u>when</u> it happened.

The NON-SPECIFIABLE category should be used as a last resort, when you would feel no confidence in assigning a URM to a particular phase. Avoid the temptation to use it as a "catch-all" for cases where coding is difficult.

Finally, references to the future of the innovation should be coded as IMPLEMENTATION-ABSORPTION; eg. *"Eventually all the beds will be used for short stay"*

CODING PROCEDURE

For each innovation example:

1) Read through the background sheets.

2) Read through the full transcript at least twice - until you are familiar with it.

3) Go through the highlighted URMs on the prepared transcript one at a time and, using the phase definitions and further instructions, decide which phase each one should be allocated to. You should indicate your decisions as follows:

Initiation = IN
Implementation-absorption = I-A
Not specifiable = NS

4) Mark the selected phase for each URM on the coding sheet. If you had particular difficulty deciding, and in all cases where you code NON-SPECIFIABLE, briefly note the problem in the space provided.

5) Refer back to the full transcript as often as you want.

SUMMARY OF FURTHER INSTRUCTIONS

i) Although there can never be implementation and absorption without initiation, the innovation process will not always progress in a neat, clearly defined sequence. Phases may overlap, and the process may cycle back on itself. Remember to look at <u>what</u> is happening as well as <u>when</u> it happened.

ii) The NON-SPECIFIABLE category should be used as a last resort, not as a "catch-all" for difficult cases.

iii) URMs referring to the future of the innovation should be coded as IMPLEMENTATION-ABSORPTION.

C.3. CODING CRITERIA FOR INFLUENCE SOURCE AND DIRECTION

Influences on the innovation process: coding instructions

INTRODUCTION

The material you will be coding comes from a study of innovation in two Homes for the Elderly. In this study, members of staff were asked to talk about two specific examples of innovations that had been introduced into their Home, which had been identified as important in the recent history of the Home. These interviews were taped and transcribed.

To enable a detailed analysis of the interviews to be carried out, all the interviewee statements on each transcript were split into "units of meaning" in a systematic manner. Those units relevant to the research issues which this study is concerned with were then identified - these are referred to as **units of relevant meaning** (or **URMs**).

This stage of the analysis is concerned with antecedents to and influences on the innovation process - that is, factors which contributed to the initiation and/or continuation of the innovation. In particular, it focuses on the **sources of antecedents and influences**. For each URM (shown in highlights on the prepared transcripts) you must first decide whether the source of the antecedent/influence is determinable; if it is, you must then decide what the source is, and allocate it to the appropriate category, as defined overleaf. In addition, you must decide for each URM whether its influence on the innovation was positive or negative (or neither).

Before proceeding, read through the rest of the instructions carefully.

SOURCES OF ANTECEDENTS/INFLUENCES

As mentioned in the introduction, your first task for each URM is to decide whether or not the source of the antecedent/influence is determinable. By source I mean **the individual, group or organization whose actions, demands or needs are primarily responsible for the influence/antecedent.** There are two sets of circumstances in which you should conclude that the antecedent/influence cannot be determined:

(i) When the URM is simply describing a step in the innovation process without refering to any particular antecedent or influence. To take an example from a Care Assistant talking about the key worker system at Home B: *"So we just started really with so many residents per person."*

(ii) When there is insufficient information to identify one particular influence. For example: *"There were lots of reasons why the change didn't work."*

Where a source is determinable, your task is to decide which of the following four categories it belongs to:

(cont'd)

1) CLIENTS: This refers to the people for whom the Home provides a service. Naturally, the main group of clients are the residents themselves, but the category also applies to relatives of residents, elderly people in the community who receive day care or attend luncheon clubs, and any others who use the Home's facilities in any way. For example, the Principal at Home A describes why she decided to change to all flexi-respite beds as follows; *"I could see again just having two short stay and trying to work that along side ten permanent residents was going to create havoc"*.

2) PRINCIPAL/SENIOR STAFF: URMs which refer either individually or as a group to the management staff of the Home - ie. the Principal, Deputy Principal and Assistant Principals. The first of the following statements would be allocated to this category because it refers to the Principal alone, the second because it refers to the entire Home management group: (i) *"...the Principal had decided, she said that she had always wanted a rotating rota"*; (ii) *"Because nobody really knew a great deal about it [key worker system], not even management, you know."* References to higher management in the Department such as the Principal Assistant ('PA'), or to the Homes' staffs as a whole (even if this at least implicitly includes the Principal and Senior staff) should not be put into this category.

3) HOME STAFF: All references to the Homes' full and part-time staff (other than management), as sources of influence - individually, in groups or as a whole. eg. A Care assistant at Home A explaining why the rotating rota was abandoned; *"I think because one or more of us didn't like it the management hadn't got much choice"*.

4) HIGHER MANAGEMENT AND OTHER OUTSIDE AGENCIES: This includes members of the Family and Community Services management ("Redvers House") such as the Principal Assistant (PAs) and Chief Assistant, Medical and Social Work professionals, Principals of other Homes, and any other outside agencies with an influence on the Home. This example is from the Principal of Home B; "There was a lot of talk, and some little bit of pressure from the department about taking short stay residents".

In addition, the category includes aspects of the Home itself determined by higher management or others, such as staffing levels, financial resources, and physical attributes of the building. eg. "You need a lot of staff for the key worker system, to have a good one anyway".

DIRECTION OF INFLUENCE

For each URM, once you have allocated it to a category you must decide what type of antecedent/influence it is; positive, negative or indefinite. To do so, you should consider whether the factor referred to in the URM helped or hindered the progress of the innovation. (Please note, you should code for direction of antecedent/influence **regardless of whether the source was determinable** - ie. for *all* the URMs on the prepared transcripts).

If it is given as a reason for the decision to introduce the innovation, if it made the introduction of the innovation easier or quicker, or if it made the innovation more effective in achieving its goals, the URM should be coded as a positive antecedent/influence (+), eg. (from rotating rota) *"It was just an off-shot from another Home had done it, so let us have a go."* Also, where a URM describes an individual or group as the originator(s) of an innovation, it should be coded as direction positive; eg. *"Mrs.R [assistant principal] and another person we had here at the time started it off [ie. key worker system]".*

If it made the introduction of the innovation slower or more difficult, if it made the innovation less effective in achieving its goals, or if it is given as a reason for the abandonment of the innovation, the URM should be coded as a negative antecedent/influence , eg. (from key worker system) *"But really it goes back to the same problem again, because there weren't enough staff to work it properly."*

If it was neither a help nor a hindance, or a bit of both, or if the direction of influence is unclear, the URM should be coded as indefinite (0), eg. (from flexi-respite care) *"And we'd got some very young staff at the time and so a lot of them didn't know very much about residential care anyway."*

Additionally, where a URM was coded as 'not determinable' for influence source because it was describing a step in the innovation process rather than a specific influence (see above), it should be allocated to the present category (0) for direction. This example comes from a member of Home A's Domestic staff, answering a question about how the change to flexi-respite care was implemented; *"Gradual. As soon as, like, one permanent resident died, it turned into a flexi-bed."*

FURTHER INSTRUCTIONS

The following points are to help clarify how to code URMs by antecedent/influence source and direction. This page deals with issues of concern to both sets of coding, while problems specific to influence source and direction separately are covered overleaf.

(i) You must allocate each URM to one category, and one category only, of influence source and direction. Inevitably this will prove to be more difficult in some cases than in others, as no classification system of this type can be expected to correspond exactly with the interviewees' viewpoints. You should look, therefore, for the best possible fit of URMs to categories, rather than for a perfect fit. In cases where a number of classifications seem possible, try to decide what the essence of the URM is. Consider the following example;

> [Interviewer] Could you tell me why this innovation was introduced?
> [Participant] Well, we all agreed that it was the best way to help the community.

This refers to both the staff ("we all agreed") and the clients ("the best way to help the community"). However, the statement that the staff agreed is really saying no more than that it *was* introduced; the reason *why* it was introduced was to meet the needs of the community. The URM would thus be coded as category one - 'clients' - for source. As it is given as a reason for the introduction of the innovation, it would be coded as 'positive' for direction.

Difficulties may arise for classifying both the source and direction of an antecedent/influence, where a URM refers to influencing factors in negative terms; eg. "Higher management were not involved in the innovation", or "We did not consider the needs of the residents fully". In these cases, the source category should be selected as if the URM was phrased positively - thus the above examples would be in

categories three and one respectively. When deciding on the direction of the influence, it is important not to automatically categorise all 'negative' URMs as negative influences; in many cases they may describe facilitators of innovation. For example, not allowing staff to participate in a decision may actually make it easier to introduce an innovation (whatever one thinks of it as management practice), as may lack of involvement by higher management. You must make your judgement on the basis of the description given by the interviewee, and try to avoid being biased by any preconceptions you might have of what helps or hinders innovation.

The following points offer advice on some particular problems in coding for influence source and direction.

SOURCE

(i) There is a potential confusion between the 'Non-management staff' and 'Higher Management and others' categories where participatants refer to staff shortages as an influence on the innovation process. You should code such instances as 'Higher Management etc' only where the URM *explicitly* mentions staffing levels as the influence; eg. *"and then again it [ie. key worker system] went skew-whiff a bit because of staffing levels."* URMs which refer to such things as staff being off sick leading to increased workload should be coded as category three ('Non-management staff') even if it is apparent that the situation was due to staffing levels. eg. (from the same interview as the last example) *"...say if anybody's off and you have five residents, each of your mates has got to do ten, somebody has to, and that's where it fell down really."*

(ii) At Home B, interviewees quite often refer to the actions of a particular "floor" in relation to the innovation; eg. *"The top floor abandoned the key worker system."* These URMs should be coded as 'Non-management staff', as they are concerned with the staff group on the floor.

DIRECTION

(i) Descriptions illustrating the failure of the innovation process should be coded as negative; eg. *"The rotating rota never really got off the ground."*

Similarly, illustrations of the innovation's success should be coded as positive; eg. *"Short stay has greatly improved the service we can give."*

(ii) References to the future of the innovation should only be coded as positive or negative if some concrete decision or action has been taken to effect it; otherwise, such references should be coded as 'indefinite'. For instance, a URM such as; *"The new floor manager is going to re-introduce the key worker system"* - would be coded direction positive, while *"It's possible we'll try the rotating rota again in the future"* would be coded indefinite (0).

SUMMARY OF FURTHER INSTRUCTIONS

overall

i) For both influence source and direction, allocate each URM to one category only.

ii) Do not expect all URMs to fit unambiguously into a category; some may be quite difficult to classify. Look for the category which fits best, rather than for a perfect fit.

source

i) Explicit references to staffing levels as a source of influence should be coded as 'Higher management etc'; URMs where the influence of staffing levels is implied (however strongly) but not expicitly stated should be allocated to 'Non-management staff' (or whatever other category seems appropriate) - not to 'Higher management etc'.

ii) At Home B, references to the actions, attitudes etc of particular "floors" may be assumed to refer to the staff group on that floor, and should be classified accordingly.

direction

i) Do not assume that negative references in URMs - "Staff were not consulted", "Higher management were not interested" etc - always imply negative antecedents/influences (or that positive references mean positive antecedents/influences); look at the context.

ii) When coding for direction of antecedent/influence, make your decision on the basis of what is presented in the transcript, not on any preconceptions about what helps or hinders innovation.

CODING PROCEDURE

For each innovation example

1) Read through the background sheet.

2) Read through the full transcript at least twice - until you are familiar with it.

3) Go through the highlighted URMs on the prepared transcript one at a time and for each decide:

(i) whether the source of the antecedent/influence can be determined;

YES = Y

NO = N

(ii) what the source is (where the source *is* determinable), from the categories provided - clients, staff, higher management & other outside agencies;

CLIENT = C

PRINCIPAL = P

STAFF = S

NOT APPLICABLE (ie source not determinable) = NA

(iii) what the direction of the antecedent/influence is - positive, negative or neither (nb, all URMs should be coded for direction of influence, whether or not the source was determinable),

POSITIVE = +

NEGATIVE = -

INDEFINITE = 0

4) Mark the selected categories of antecedent/influence source and direction for each URM on the coding sheet. If you had particular difficulty deciding on either classification, briefly note the problem in the space provided.

5) Refer back to the full transcript as often as you want.

APPENDIX D. THE CASE HISTORY QUESTIONNAIRE: FIRST 'HOMES FOR THE ELDERLY' STUDY

The items administered verbally to participants at the end of each Case History interview are given below. The response scales were presented to participants on cards, for them to indicate their answers to each question. Where the questions differed for continuing and discontinued innovations, both versions are shown in full.

(1) INVOLVEMENT IN THE INNOVATION

i) To what extent did management explain to the staff why they were introducing [the innovation]? *Responses: "They made a great effort to explain" (5), "They made a reasonable effort to explain" (4), "They made some effort to explain" (3), "They didn't make much effort" (2), "They made little or no effort" (1).*

ii) How much say did the staff have in the decision to introduce [the innovation]? *Responses: "A great deal" (5), "Quite a lot" (4), "A moderate amount" (3), "Not much" (2), "Little or none" (1).*

iii) Once [the innovation] was introduced, how much notice did management take of staff reactions to it? *Responses: "A great deal" (5), "Quite a lot" (4), "A moderate amount" (3), "Not much" (2), "Little or none" (1).*

(2) OVERALL ATTITUDES TOWARDS THE INNOVATION

i) When [the innovation] was first introduced, did you think it was a good idea or a bad idea? *Responses: A very good idea (5), Quite a good idea (4), Wasn't sure (3), Quite a bad idea (2), A very bad idea (1).*

For examples of continuing innovations, the other three questions were;

ii) Now, looking back, do you think it was right to introduce [the innovation]? *Responses: Certainly (5), Probably (4), Not sure (3), Probably not (2), Certainly not-(1).*

iii) Were the other staff in favour of or against [the innovation] when it was first introduced? *Responses: All in favour of it (5), Most in favour of it (4), Roughly equal numbers in favour and against (3), Most against it (2), All against it (1).*

iv) What are their attitudes to it like now? *Responses: All in favour of it (5), Most in favour of it (4), Roughly equal numbers in favour and against (3), Most against it (2), All against it (1).*

For examples of discontinued innovations, the remaining items were;

ii) Now, looking back, do you think it was right to abandon [the innovation]? *Responses: Certainly (5), Probably (4), Not sure (3), Probably not (2), Certainly not-(1).*

iii) Were the other staff in favour of or against [the innovation] when it was first introduced? *Responses: All in favour of it (5), Most in favour of it (4), Roughly equal numbers in favour and against (3), Most against it (2), All against it (1).*

(3) EVALUATIONS OF THE INNOVATION

i) Overall, has [the innovation] been a good thing or a bad thing for:

(a) Your job?

(b) The residents?

(c) The running of the Home?

Responses: Very good (5), Quite good (4), Neither good nor bad (3), Quite bad (2), Very bad (1).

APPENDIX E. THE GENERAL QUESTIONNAIRE: FIRST 'HOMES FOR ELDERLY' STUDY

The General Questionnaire was administered verbally to participants at the end of their two Case History interviews. All the measures included and relevant response scales are presented here. The questionnaire was divided into three sections, entitled **questions about yourself and your job**, **questions about other people in the Home**, and **questions about the Home and Elderly Care.**

E.1. QUESTIONS ABOUT YOURSELF AND YOUR JOB

1) Experience of Change in Your Job

i) Overall, how much has your present job changed in the time you've been doing it?

Responses: "A great deal" (5), "Quite alot" (4), "A moderate amount" (3), "not very much" (2), "hardly at all" (1).

ii) Have the changes been for the better or for the worse?

Responses: "Almost always for the better" (5), "Mostly for the better" (4), "Not sure" (3), "Mostly for the worse" (2), "Almost always for the worse" (1).

2) Job Satisfaction

How satisfied are you with the following features of your job?

i) The physical work conditions.
ii) The freedom to choose your own method of working.
iii) Your fellow workers.
iv) The recognition you get for good work.
v) Your immediate boss.
vi) The amount of responsibility you are given.
vii) Your rate of pay.
viii) Your opportunities to use your abilities.
ix) Relations between management and care/domestic staff.
x) Your chance of promotion.
xi) The way the Home is managed.
xii) The attention paid to suggestions you make.
xiii) Your hours of work.
xiv) The amount of variety in your work.
xv) Your job security.

Responses: "Extremely satisfied" (7), "Very satisfied" (6), "Moderately satisfied" (5), "Not sure" (4), "Moderately dissatisfied" (3), "Very dissatisfied" (2), "Extremely dissatisfied" (1).

3) Anxiety

i) Please indicate on the each of the scales the kind of person you are <u>generally</u> by marking the relevant point with a letter 'G'.

anxious:____:____:____:____:____:non-anxious

relaxed:____:____:____:____:____:tense

nervous:____:____:____:____:____:not nervous

ii) Now indicate the kind of person you are <u>at work</u>, by marking the relevant points with a letter W.

Responses on the same scale as (i)

4) Disposition Towards Change

Which of the following words do you think describe you? (n.b. words read in the order presented).

ACTIVE ADAPTABLE ADVENTUROUS APATHETIC CHANGEABLE
CONSERVATIVE CONTENTED CONVENTIONAL CURIOUS DARING
DISSATISFIED DISTRACTABLE ENTHUSIASTIC FICKLE IMPULSIVE
INDEPENDENT INDIVIDUALISTIC INHIBITED INITIATIVE INTERESTS
NARROW INTERESTS WIDE METHODICAL PERSISTENT PLEASURE-SEEKING
RESTLESS RETIRING RIGID SELF-DENYING SPONTANEOUS STABLE
UNCONVENTIONAL UNSTABLE WITHDRAWN

Responses: "Yes" or "No"

E.2. QUESTIONS ABOUT OTHER PEOPLE IN THE HOME

1) Your Opinion of Your Principal

Do the following descriptions fit your Principal?

i) Lets you know where you stand.
ii) Does a good job.
iii) Interferes too much
iv) Always too busy to see you.
v) Stands up for you.
vi) Quick tempered.
vii) Can discuss problems with her.
viii) Hard to please.

Responses: "Yes", "No", or "Uncertain".

2) Your Opinion of Your Supervisor

Do the following descriptions fit your Supervisor?

i) Lets you know where you stand.
ii) Does a good job.
iii) Interferes too much
iv) Always too busy to see you.
v) Stands up for you.
vi) Quick tempered.
vii) Can discuss problems with her.
viii) Hard to please.

Responses: "Yes", "No", or "Uncertain".

3) Your Opinion of Your Colleagues

Do the following descriptions fit your Colleagues?

i) Easy to make enemies.
ii) Hard working.
iii) Some of them think they run the place.
iv) Know their jobs.
v) Work well as a group.
vi) Stupid.
vii) Unpleasant.
viii) Do their share of the work.

Responses: "Yes", "No", or "Uncertain".

4) Change in Your Opinions of Management

Has your opinion of the present management changed much since you first knew them?

Responses: "I like them a lot more" (5), "I like them somewhat more" (4), "No great change" (3), "I like them somewhat less" (2), "I like them a lot less" (1).

E.3. QUESTIONS ABOUT THE HOME AND CARE OF THE ELDERLY

1) Commitment to the Home

To what extent do you agree with the following statements?

i) I am quite proud to be able to tell people who it is I work for.
ii) I sometimes feel like leaving this employment for good.
iii) I'm not willing to put myself out just to help [name of Home].
iv) I feel myself to be part of [name of Home].
v) In my work I like to feel I am making some effort, not just for myself but for [name of Home] as well.
vi) The offer of a bit more money with another employer would not make me seriously think of changing my job.
vii) I would not recommend a close friend to join our staff.
viii) To know that my work had made a contribution to the good of [name of Home] would please me.

Responses: "Strongly agree" (5), "Agree" (4), "Not sure" (3), "Disagree" (2), "Strongly disagree" (1).

2) Attitudes towards Care of the Elderly

To what extent do you agree with the following statements?

i) The quality of life for residents in an Old Persons' Home depends very much on how well the Home is run.

ii) [Name of Home] plays an important role in the local community

iii) Care of the Elderly should be a top priority in the Health and social services.

iv) There is little that any Home can do to improve the quality of life for its residents.

Responses: "Strongly agree" (5), "Agree" (4), "Not sure" (3), "Disagree" (2), "Strongly disagree" (1).

APPENDIX F. QUESTIONNAIRES FROM THE SECOND 'HOMES FOR THE ELDERLY' STUDY

This appendix includes copies of the three questionnaires distributed to participants in the second 'Homes for the Elderly' study, plus the short version of the third questionnaire, given to those who did not return the full version.

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April 1987

QUESTIONNAIRE 1

INSTRUCTIONS - PLEASE READ CAREFULLY

This questionnaire is the first part of a research project which will be looking at changes that happen in and one other home for the elderly in Sheffield up to September of this year. It includes questions about the home and about yourself.

Please answer all the questions in Sections 1, 2 and 3, but do not spend too long on any one question: first responses are usually the best. Section 4 is for any comments you'd like to make: if you do not have any comments to make, you need not write anything here. Please do not discuss your answers with other people. It is your opinion which matters.

Complete confidentiality is assured for everyone taking part in the study: only I will see the completed questionnaires, and at no point will individual answers be made available to anybody. Do not put your name on the questionnaire: you have been assigned a code number which will be used instead of your name to enable your answers now to be matched with those in the later questionnaires.

When you have completed the questionnaire, seal it in the envelope provided (first removing the name tag on the envelope) and return it to the office. I would be grateful if you could return the questionnaire by Friday 1 May.

Thank you.

Nigel King

Code Number .....

SECTION 1: BIOGRAPHICAL DETAILS

A What is your post? .....

B When did you start working at the Home? ..... Year ..... Month

C 1 Do you have any nursing qualification? Yes / No

2 If 'yes', please write which qualification(s) you have in the space below:

.....

D 1 Have you taken, or are you currently taking, any in-service or other residential social work course(s)? Yes / No

2 If 'yes', please write which course(s) you have taken/are taking in the space below:

.....

E Please indicate your age by ticking the box next to the appropriate category:

16-25	26-35	36-45	46-55	56-65
☐	☐	☐	☐	☐

SECTION 2: MANAGEMENT

A These questions concern the way changes have been introduced since the new principal was appointed. For each, indicate your response by circling the appropriate figure. (Thus, if your answer to A1 was 'a moderate amount' you would put a circle around the '3').

In general, since the new Principal was appointed:

		A great deal	Quite a lot	Moderate amount	Not much	Little or none
1	How much effort has been made to explain to you why changes have been introduced?	5	4	3	2	1
2	How much say have you had in decisions to introduce changes?	5	4	3	2	1
3	How much notice have management taken of your reactions to changes that have been introduced?	5	4	3	2	1

B The following statements are about your Principal. Please indicate whether or not you agree with each statement, or whether you are uncertain about it, by circling the appropriate number following each statement. For example, if you agree that your Principal lets you know where you stand, you would circle the number '3' to indicate 'yes'.

		Yes	Uncertain	No
1	Lets you know where you stand?	3	2	1
2	Does a good job?	3	2	1
3	Interferes too much?	3	2	1
4	Always too busy to see you?	3	2	1
5	Stands up for you?	3	2	1
6	Quick tempered?	3	2	1
7	Can discuss problems with him/her?	3	2	1
8	Hard to please?	3	2	1

SECTION 3: YOURSELF

A A number of statements that people have made about their place of work are listed below.

Please indicate the extent to which you agree with each of them by circling the appropriate figure.

		Strongly agree	Agree	Not sure	Dis-agree	Strongly disagree
1	I am quite proud to be able to tell people who it is I work for	5	4	3	2	1
2	I sometimes feel like leaving this employment for good	5	4	3	2	1
3	I'm not willing to put myself out just to help the Home	5	4	3	2	1
4	I feel myself to be part of the Home	5	4	3	2	1
5	In my work I like to feel I am making some effort, not just for myself but for the Home as well	5	4	3	2	1
6	The offer of a bit more money with another employer would not make me seriously think of changing my job	5	4	3	2	1
7	I would not recommend a close friend to join our staff	5	4	3	2	1
8	To know that my own work had made a contribution to the good of the Home would please me	5	4	3	2	1

B These questions are about how you do your job. Please answer each question by circling the appropriate figure.

Compared to other people in the same job, how often do you:

		Much more often	More often	About average	Less often
1	Think of new ways of doing things at work?	4	3	2	1
2	Attempt to change your own working methods?	4	3	2	1
3	Argue for changes in the Home?	4	3	2	1
4	Look for different ways of doing things at work?	4	3	2	1

C A number of statements which people have used *to describe themselves* are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you generally feel. There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe how you generally feel.

		Almost never	Some-times	Often	Almost always
1	I feel nervous and restless	1	2	3	4
2	I feel satisfied with myself	1	2	3	4
3	I am a steady person	1	2	3	4
4	I wish I could be as happy as others seem to be	1	2	3	4
5	I feel like a failure	1	2	3	4
6	I get in a state of tension and turmoil as I think over my recent concerns and interests	1	2	3	4
7	I feel secure	1	2	3	4
8	I lack self-confidence	1	2	3	4
9	I feel inadequate	1	2	3	4
10	I worry too much over something that really does not matter	1	2	3	4

SECTION 4: COMMENTS

If there are any comments you would like to make about any aspect of the Home, or about yourself, please write them in the space below:

Thank you for your co-operation.

MRC
Medical Research Council

ESRC
ECONOMIC AND SOCIAL RESEARCH COUNCIL

MRC/ESRC Social and Applied
Psychology Unit
Department of Psychology
University of Sheffield
Sheffield S10 2TN

telephone 0742 756600

NK/KAB

July 1987

QUESTIONNAIRE 2

INSTRUCTIONS - PLEASE READ CAREFULLY

This questionnaire is the second part of a *research project which* is looking at changes that happen in and one other home for the elderly in Sheffield up to September of this year. Thank you for completing the first questionnaire.

Section 1 of this questionnaire asks about biographical details; you need only answer questions A and B unless you are new to the home and therefore did not complete the first questionnaire in May. The questions in the second section are about the new supervision arrangements which are being introduced, and the third section contains questions about the management of the home, which you may recognise from the first questionnaire. They are included again to see if people's opinions have changed over the past three months.

Please answer all the questions in Sections 1, 2 and 3, but do not spend too long on any one question: first responses are usually the best. Section 4 is for any comments you'd like to make: if you do not have any comments to make, you need not write anything here. Please do not discuss your answers with other people. It is your opinion which matters.

Complete confidentiality is assured for everyone taking part in the study: only I will see the completed questionnaires, and at no point will individual answers be made available to anybody. Do not put your name on the questionnaire: you have been assigned a code number which will be used instead of your name to enable your answers now to be matched with those in the other questionnaires.

When you have completed the questionnaire, seal it in the envelope provided (first removing the name tag on the envelope) and return it to the office. I would be grateful if you could return the questionnaire by Monday 3 August.

Thank you.

Nigel King

SECTION 1: BIOGRAPHICAL DETAILS Code Number .....

A What is your post? .....

B When did you start working at the Home? ..... Year ..... Month

Only answer questions C, D and E if you did not complete the first questionnaire in May.

C 1 Do you have any nursing qualification? Yes / No

2 If 'yes', please write which qualification(s) you have in the space below:

.....

D 1 Have you taken, or are you currently taking, any in-service or other residential social work course(s)? Yes / No

2 If 'yes', please write which course(s) you have taken/are taking in the space below:

.....

E Please indicate your age by ticking the box next to the appropriate category:

16-25	26-35	36-45	46-55	56-65
____	____	____	____	____
____	____	____	____	____

SECTION 2: THE NEW SUPERVISION ARRANGEMENTS

Supervision was identified as being a priority area in the Home's recent Annual Review, and new arrangements for supervision of all staff have been made. The questions in this section are about these new supervision arrangements.

A These questions concern the way the new supervision arrangements have been introduced. For each, indicate your response by circling the appropriate figure. (Thus, if your answer to A1 was 'a moderate amount' you would put a circle around the number '3'.)

		A great deal	Quite a lot	Moderate amount	Not much	Little or none
1	How much effort has been made to explain to you why the new supervision arrangements have been introduced?	5	(4)	3	2	1
2	How much say have you had in the decision to introduce the new supervision arrangements?	5	(4)	3	2	1
3	How much notice have management taken of your reactions to the new supervision arrangements?	5	(4)	3	2	1

B Overall, do you think the new supervision arrangements are a good thing or a bad thing for ...

		Very good	Quite good	Neither good nor bad	Quite bad	Very bad
1	Your job?	5	(4)	3	2	1
2	The residents?	(5)	4	3	2	1
3	The running of the home?	(5)	4	3	2	1

C 1 Please list three **good** things about the new supervision arrangements in the space below. If you cannot think of three, put down as many as you can.

.....

.....

.....

2 Please list three **bad** things about the new supervision arrangements in the space below. If you cannot think of three, put down as many as you can.

.....

.....

.....

D If there are any comments you wish like to make about the new supervision arrangements, please write them in the space below:

SECTION 3: MANAGEMENT

A These questions concern the way changes have been introduced since the new principal was appointed, or, if you have joined the home since May, since you have been working here. For each, indicate your response by circling the appropriate figure. (Thus, if your answer to A1 was 'a moderate amount' you would put a circle around the '3').

In general, since the new Principal was appointed:

		A great deal	Quite a lot	Moderate amount	Not much	Little or none
1	How much effort has been made to explain to you why changes have been introduced?	5	(4)	3	2	1
2	How much say have you had in decisions to introduce changes?	(5)	4	3	2	1
3	How much notice have management taken of your reactions to changes that have been introduced?	5	(4)	3	2	1

B The following statements are about your Principal. Please indicate whether or not you agree with each statement, or whether you are uncertain about it, by circling the appropriate number following each statement. For example, if you agree that your Principal lets you know where you stand, you would circle the number '3' to indicate 'yes'.

		Yes	Uncertain	No
1	Lets you know where you stand?	(3)	2	1
2	Does a good job?	(3)	2	1
3	Interferes too much?	3	(2)	1
4	Always too busy to see you?	3	2	(1)
5	Stands up for you?	3	(2)	1
6	Quick tempered?	3	2	(1)
7	Can discuss problems with him/her?	3	2	(1)
8	Hard to please?	3	(2)	1

SECTION 4: COMMENTS

If there are any comments you would like to make about any aspect of the Home, or about yourself, please write them in the space below:

Thank you for your co-operation.

Medical Research Council

MRC/ESRC Social and Applied Psychology Unit
Department of Psychology
University of Sheffield
Sheffield S10 2TN

telephone 0742 756600

NK/KAB

December 1987

QUESTIONNAIRE 3

INSTRUCTIONS - PLEASE READ CAREFULLY

This questionnaire is the final part of a research project which is looking at changes which have taken place at and one other home for the elderly in Sheffield since the beginning of the year. The project has focused on one particular change: the introduction of new arrangements for supervision in the homes. This questionnaire is mostly concerned with what you think about these arrangements. If you receive this questionnaire before you have had your first individual supervision with your group leader, please wait until afterwards to complete it.

Section 1 asks about biographical details; if you are new to the home and therefore have not completed the earlier questionnaires, please answer all the questions in this section. If you have completed one or both of the previous questionnaires, you need only answer questions A and B. The questions in the second section are about what you think of the new supervision arrangements, and the third section asks about other changes in the home. Please answer all these questions. Do not discuss your answers with other people: it is what you think that matters.

Complete confidentiality is assured for everyone taking part in the study: only I will see the completed questionnaires, and at no point will individual answers be made available to anybody. Do not put your name on the questionnaire: you have been assigned a code number which will be used instead of your name to enable your answers now to be matched with those in the other questionnaires.

When you have completed the questionnaire, seal it in the envelope provided (first removing the name tag on the envelope) and return it to the office or send it directly to me. You do not need a stamp.

Thank you for your participation in this study. A report of the findings will be sent to you as soon as possible after all the questionnaires have been returned.

Nigel King

Code Number ..... Date .....

SECTION 1: BIOGRAPHICAL DETAILS

A What is your post? .....

B When did you start working at the Home? ..... Year ..... Month

Only answer questions C, D and E if you have joined the home since this study began and have therefore not answered them on a previous questionnaire.

C 1 Do you have any nursing qualification? Yes / No

2 If Yes please write which qualification(s) you have in the space below:

.....

D 1 Have you taken, or are you currently taking, any in-service or other residential social work course(s)? Yes / No

2 If 'yes', please write which course(s) you have taken/are taking in the space below:

.....

E Please indicate your age by ticking the box next to the appropriate category:

16-25	26-35	36-45	46-55	56-65
☐	☐	☐	☐	☐

SECTION 2: THE NEW SUPERVISION ARRANGEMENTS

Supervision was identified as being a priority area in the Home's last Annual Review, and new arrangements for supervision of all staff have been introduced. The questions in this section are about what you think of these new supervision arrangements.

A When did you have your first individual supervision session with your group leader? (if you can't give the exact date, an approximation will do, e.g. "late October").

....

B These questions concern the way the new supervision arrangements have been introduced. For each, indicate your response by circling the appropriate figure. (Thus, if your answer to A1 was 'a moderate amount' you would put a circle around the number '3'.)

		A great deal	Quite a lot	Moderate amount	Not much	Little or none
1	How much effort has been made to explain to you why the new supervision arrangements have been introduced?	5	4	3	2	1
2	How much say have you had in the decision to introduce the new supervision arrangements?	5	4	3	2	1
3	How much notice have management taken of your reactions to the new supervision arrangements?	5	4	3	2	1

C If you have any comments you would like to make about the way the new supervision arrangements were introduced, write them in the space below.

.....

.....

.....

D Overall, do you think the new supervision arrangements are a good thing or a bad thing for ...

		Very good	Quite good	Neither good nor bad	Quite bad	Very bad
1	Your job?	5	4	3	2	1
2	The residents?	5	4	3	2	1
3	The running of the home?	5	4	3	2	1

E 1 Please list three good things about the new supervision arrangements in the space below. If you cannot think of three, put down as many as you can.

.....

.....

.....

2 Please list three bad things about the new supervision arrangements in the space below. If you cannot think of three, put down as many as you can.

.....

.....

.....

F Please describe briefly in the space below any improvements you would like to see made to supervision at Ravenscroft:

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SECTION 3: OTHER CHANGES

A In what ways, if any, has . . improved since became Principal?

... .

. . . . . .

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B In what ways, if any, has . .. become worse since became Principal?

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.....

Thank you for your co-operation.

Code Number ... .

The following questions are about the new supervision arrangements, introduced last year.

1 When did you have your first individual supervision with your group leader?

(the month will do) . .....

2 When was your most recent individual supervision with your group leader?

(the month will do) .....

3 Overall, do you think the new supervision arrangements are a good thing or a bad thing for each of the following? Indicate your response by circling the appropriate figure. So, if your answer to (a) was "neither good nor bad" you would put a circle around the number 3.

		Very good	Quite good	Neither good nor bad	Quite bad	Very bad
(a)	Your job?	5	4	3	2	1
(b)	The residents?	5	4	3	2	1
(c)	The running of the home?	5	4	3	2	1

4 If there are any comments you would like to make about the new supervision arrangements, please do so in the space below.

.....

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Thank you for your cooperation.

APPENDIX G. INNOVATION CASE HISTORIES FROM THE PSYCHO-GERIATRIC WARD STUDY

Cases Histories of all seventeen innovations observed during the psycho-geriatric ward study (chapter eight) are presented here. At the end a guide to the abbreviations used is presented (G.18).

G.1. NEW TEAMS AND PATIENT ALLOCATION

Description

Members of staff are divided into teams, each headed by a Staff Nurse. A particular group of patients is allocated to each team and it is the responsibility of the team members to ensure that the needs of these patients are met (especially with regard to such things as bathing, keeping track of patients' belongings etc), and to write up the daily and weekly reports on each patient's behaviour and progress. A member of each team attends ward rounds to read notes relating to their patients and generally to give the nursing point of view.

History

Prior to the introduction of the new team/patient allocation system, there did not seem to be any such system functioning. However, something of the kind did exist previously on the ward, when the Charge Nurse had worked there before. It seems to have decayed into non-use under his predecessor. The Charge Nurse mentioned 'team-work' in a general sense as one of the things which he expected to have to do something about, in an interview prior to his taking up the appointment on ward G. It was first discussed formally on the ward at the first ward meeting under the Charge Nurse, where he had put the proposal on the agenda. No one present resisted the change, and a 'rival' proposition of a 'task allocation' system (G.15.) was dismissed in the absence of its proposer without argument ('task allocation' means allocating particular tasks to particular staff each shift). As there was no opposition the Charge Nurse said he would go

ahead and draw up teams tomorrow, though he agreed (at the suggestion of a staff nurse) to change from having three teams to having four teams, as there were now four Staff Nurses. The creation of teams was however delayed twice, first because the Charge Nurse learnt that the ward would be getting a fifth charge nurse and he decided to wait until then, and then because he decided to wait until the new card-indexes for patients' records were introduced. He settled on two teams, each composed of two sub-teams headed by a Staff Nurse; one sub-team would thus have two Staff Nurses. The composition of each team was announced in the ward meeting at the end of July, but they could not start functioning immediately because patients' records were still being transferred from the old card-indexes to the new. The system eventually started operating in early August. At the ward meeting at the end of August the Charge Nurse said he was very pleased with the way the teams were working; Nursing Assistants had already started representing their teams at ward rounds, and that would continue. It was agreed that the names of staff and patients in each team should be put on a board in the office so everyone can see who's in which team. Subsequently a list of patients in each team was put up, though it only names team leaders.

The team sytem on Ward G was praised by one of the Consultants for its helpfulness to him in ward rounds. Team members continued attending ward rounds; when the Charge Nurse was on a shift, he made sure that this happened. There seemed to be considerable variation in how much contribution individual members of staff made in ward rounds, and while those members of staff expressing an opinion were all very much in favour of attending ward rounds, some of the nursing assistants did express anxiety about doing so. At the end of observation period two, the Charge Nurse was still pleased with the way the teams were developing, though he said that some were working better than others. From comments made by some of Nursing Assistants this would appear to be a matter of personalities; criticisms of the Staff Nurses (and to a lesser extent SENs) were largely because the Nursing Assistants feel that some have too much of an 'us-and-them' attitude.

G.2. NEW CARD-INDEXES

Description

The new card-indexes contain standard-format sheets for each patient's nursing records, comprising admission sheet, referral/discharge sheet, assessment details/continuing review, care planning sheet and progress notes. These have been introduced throughout the Sheffield Health Authority Mental Illness Unit; they are part of a series of changes associated with the professionalisation of nursing, and the move towards phasing out the S.E.N. grade. *(See also 'drug rounds' case history).* Previously different localities/specialities used their own record systems.

History

The first observed reference to the new card-indexes was in the June ward meeting, where the Charge Nurse reported that he had decided to delay working out the new teams until they (ie new card-indexes) had been introduced.

The Charge Nurse explained how the new card-indexes will work at the July ward meeting; one important change is that Nursing Assistants will have to have their entries countersigned by a Staff Nurse; SENs can write their own reports but can't countersign Nursing Assistants'reports. The Charge Nurse said that he wanted to see more discussion about each patient when writing up notes at the end of each shift.

The new card-indexes came into use in early August. During the second observation period, staff did on the whole seem to make more of an effort to gain detailed information about each patient's behaviour than they had done during the first observation period, though this did vary considerably from shift to shift. Staff did not seem to have many practical problems with using the new card-indexes - the most frequent was a shortage of continuation sheets for the shift-by-shift records.

In an interview at the end of the second observation period the Charge Nurse said he felt that the new card-indexes had started well, but then people began to get bogged down in recording repetitive details. A meeting was planned to modify them to fit the ward's needs more closely.

G.3. TEA-POT TABLES

Description

Those patients who are physically and mentally most able are encouraged to sit at the two bottom tables in the dining room, where they are provided with tea-pots, milk and sugar in order to allow them to pour tea for themselves. This is part of a policy of encouraging greater independence amongst patients.

History

The ward had used tea-pot tables when the Charge Nurse had worked there before, but this lapsed after he left. At the first ward meeting, the Charge Nurse suggested allowing some patients to pour their own tea, putting it in the context of encouraging patients' independence. Three days after the ward meeting (the next shift observed), someone had put up in the dining room a list of which patients should sit where, but staff did not stick to this. Over the following three shifts observed, adherence to the places on the list fluctuated, seemingly according to which staff were on. By the next shift observed, the list had been taken down and the Charge Nurse told the researcher (privately) that he had not been responsible for putting the list up and had removed it. He had not meant to be rigid about insisting that patients always sat in particular places.

At the ward meeting at the end of June, the question of tea-pot tables was reviewed; there had been problems, eg. some patients who are not considered suitable/capable sometimes sit at the designated tables before those who should be there and won't move. It was decided that they should continue with tea-pot tables, but that there was a need

for staff to take a more supervisory role, sitting at tables - this would also allow more accurate monitoring of patients' food intake, table manners etc. By the start of the second observation period, the practise of using the bottom two tables for patients able to pour own tea seemed to have become established. During this period it was apparent that there was some disagreement amongst staff about which patients were suitable for sitting on them. Staff spent more time sitting with patients during the second observation period than they did during the first period.

G.4. WAITING LIST ASSESSMENTS

Description

To alleviate the backlog of people awaiting places on the Ward from Dr.C's waiting list, would-be patients are assessed in their homes by ward staff in order to prioritise them. Assessments are carried out by six qualified nursing staff in two teams, under the Social Worker and the Community Link Sister. This is an entirely new practice.

History

The innovation came about as a result of an impromptu meeting between the Charge Nurse, Community Link Sister, Social Worker and Dr.C (consultant), which aimed to try and find a way of alleviating the problems caused by the very long waiting list (e.g. that patients have deteriorated considerably by the time a place is available for them). The meeting was described as "dynamic". The Charge Nurse complained shortly afterwards that other people having heard about it wanted to "get in on it" and add their own ideas.

The assessments were carried out, but that alone could not solve the problem, as it couldn't affect the availability of beds, only who got them once they became free; and very few were becoming free. This in turn was largely because long-stay places for the patients already on Ward G were not available; the Charge Nurse said that the only way the

backlog would clear would be if the death rate in long stay or on the waiting list increased - it had been unusually low.

G.5. COMMUNICATION FOLDERS

Description

Each nursing team has a communications folder included in its patients' files, for passing on messages about patients (or other matters) from one shift to the next.

History

Before the introduction of the folders, there was a single "communications book" for all staff, but although it was felt to be a good idea, it was seldom used. After the introduction of the new nursing teams for patient allocation (G.1.), it was decided that each team would have a folder in its files for passing on messages etc from one shift to the next. The folders were duly introduced, but were still not used as often as had been hoped; in particular, Nursing Assistants complained about some Staff Nurses not looking in the folders, and therefore not knowing about things which had happened or needed doing.

G.6. DRUG ROUNDS - DRUGS TO BE ADMINISTERED BY QUALIFIED STAFF ONLY

Description

Drug rounds - previously carried out by any Nursing Staff - can now only be carried out by qualified nurses (i.e. Enrolled and Registered Nurses). Like the new index cards for patient records (q.v.) this innovation was associated with moves towards increased professionalisation of nursing.

History

A directive from higher management, in line with Health Authority policy, insisted that drugs only be administered by qualified staff.

Previously Nursing Assistants could administer drugs. The Charge Nurse felt that although this new system was functioning adequately, it was taking a long time to get the drug rounds finished, and he wanted to see them started during meal times instead of afterwards. This started to happen towards the end of the research period.

This change, along with associated changes in such things as changing dressings, was not liked by some Nursing Assistants, who saw it as part of a process whereby they were being left with less and less responsibility beyond the most menial tasks.

G.7. NURSES ACCOMPANYING DISCHARGED PATIENTS ON FIRST DAY AT PART 3 HOME

Description

Patients moving into Local Authority Homes for the Elderly ("Part 3" care) are accompanied by a member of the ward's nursing staff to help them settle in. This has not been done before.

History

The decision to introduce this innovation had been taken before the study began; though some details remained to be fixed. At the multi-disciplinary meeting for Ward G, shortly after arrival of new Charge Nurse, the first case of a nurse going with a discharged patient to the part 3 Home was about to occur. The plan was for her to spend five shifts there; there was general agreement that this would be too long, though the Community Link Sister stresses that she feels something along these lines must happen. After prolonged discussion of possible options it was decided that on this occasion the nurse would go for two shifts, which duly happens.

The two-shift norm remained the policy after this, as far as was possible given staffing levels. In fact very few patients were capable enough to go to Part three care after discharge, and no more cases were observed by the researcher, although some may have happened

during the interval between the two participant observation periods. In the latter period, releasing staff for this purpose would have been difficult as there was no longer the large number of student nurses that there had been during the first period.

G.8. COMBINED MULTI-DISCIPLINARY MEETINGS FOR WARDS G, H & I

Description

The multi-disciplinary meeting is a meeting of representatives of all the professions involved in the work of the ward; medical, paramedical and nursing. Instead of each of the three E.M.I. wards at the hospital having a separate multi-disciplinary meeting, a single meeting is held for all three, once a month.

History

In the past, each of the E.M.I. wards held a separate multi-disciplinary meeting every other month. It was decided to combine the meetings for Ward G and the other two wards at its hospital, in response to the N.H.S. re-organisation which placed the E.M.I. wards in the Sheffield Area into administrative units based on where they were situated ("localities") instead of in a single E.M.I unit. Combing the meetings was felt to be a way of making the three wards into more of a unit with its own identity, and a better use of resources as many of the same people attended all three separate meetings. The only resistance came from one Consultant who was worried that different wards might have different needs. It was decided to try the combined meetings for six months, but to have them monthly instead bi-monthly as was previously the case.

The six month trial period extended beyond the end of this study. It was noticeable that the last meeting observed was much less well attended than the ones before it, and that there was less enthusiasm amongst those present there had been - in part because of the problems which the multi-disciplinary document was running in to (G.13.).

However, there was no discussion about altering the format or the frequency of the meetings.

G.9. OBJECTIVE PATIENT ASSESSMENTS

Description

The proposed assessment scale would be an instrument which could be used to assess patients' mental and physical abilities more systematically and objectively than is possible when relying only on the daily and weekly nursing notes in the card-indexes. It would present some kind of check-list of abilities that could be tested by staff for each patient.

History

The Charge Nurse mentioned the need for an objective assessment method in an interview prior to taking up the appointment on Ward G. During the first observation period, he asked two of the Staff Nurses to try to design an assessment scale; at first they did alot of work on it, but they seemed to lose motivation as time went on, and then one of them left the ward. At the September ward meeting two other Staff Nurses volunteered to take over responsibility for designing the scale. One of them reported at the next ward meeting that they were both working on ideas and that he's been trying to design something based on Maslow's Need Hierachy, but hasn't got very far yet.

In an interview with the Charge Nurse after the end of the second observation period, he reported that again the two Staff Nurses had got 'bogged down' and hadn't made much progress. He now thought that perhaps it could only be done if they had a research worker to develop it.

G.10. WARD G GARDEN PROJECT

Description

It is proposed that improvements be made to the Ward G garden, to allow patients to get more use out of it. The proposal focuses on the purchase of a greenhouse to be erected in the garden.

History

In the past there had been a committee of Ward G staff to discuss possible improvements to the garden, but nothing had got done and it had effectively dissolved.

At the June ward meeting, improvements to the garden in a general sense were proposed as one of the possible uses for resources, following a request for such suggestions from the administration. Nothing further happened on this issue until the August M.D.M., at which the Art Therapist announced that he had already made some horticultural improvements to the garden at no cost (using cuttings from other Hospital gardens), and he made a number of suggestions for more substantial developments, including a greenhouse. People at the meeting said they liked his ideas, but that proper costing would have to be done before any of them could be acted upon.

The Art Therapist brought information about the cost of different types of greenhouse to the next (September) M.D.M. and it was decided that the League of Friends would be approached for funding. At the October M.D.M. the Art Therapist produced more information about greenhouses, and it was decided that the decision about which design to chose should be left to him. (There was some degree of impatience apparent about the time that this issue had been taking up at M.D.M.s.) The League of Friends had been contacted but no decision would come from them until after their next meeting. This is the stage which the proposal had reached at the end of observation period two.

G.11. "DEDICATED" AMBULANCE SERVICE FOR WARD G DAY HOSPITAL

Description

It is proposed that the day hospital at Ward G should have an ambulance service for the sole use of its patients and those of Ward I's day hosital - referred to as a "dedicated" service.

History

The arrangements for Ward G day hospital patients during the research period were that they shared an ambulance service with other day patients for the hospital. This was discussed at a multi-disciplinary meeting and widely held to be inadequate - patients arrived late and were often kept waiting at the end of the day which could lead to feelings of anxiety that undermined what staff had achieved with them during the day. The day hospital Staff Nurse called it "a disgrace". The Senior Nurse for the three wards mentioned that the possibility of acquiring a mini-bus for the E.M.I. wards had been raised, but it seemed unlikely that funds for staff to act as drivers and escorts would not be available. It was decided that the mini-bus was desirable in its own right, and fund-raising should go ahead, but it wasn't suitable to be used for transport of patients.

At the next multi-disciplinary meeting, the Senior Nurse stated that he'd spoken to the person in charge of planning ambulance services who had shown him computer print-outs "proving" that a "dedicated" service for the Elderly would not be more efficient. The two Consultants said they'd heard the same but weren't convinced. N.W. encouraged them to press for a dedicated service, and it ws decided that one Consultant would write formally to her to request it. This was the point reached at the end of the research period.

G.12. PHLEBOTOMY SERVICE FOR THE E.M.I. WARDS

Description

It is proposed that the three E.M.I. wards have a regular phlebotomy service, rather than having to use the general hospital service which was heavily in demand. (Phlebotomy is the collection of blood for tests etc).

History

At a multi-disciplinary meeting one Consultant raised the point that repeated requests for this service had been ignored in the past. He felt that the elderly received low priority *within the hospital* and wider health service. The other consultant suggested writing to N.W.; this was agreed, but with considerable pessimism expressed.

N.W. attended the next multi-disciplinary meeting, and reported that the adminisration were trying to arrange the service. At the meeting after that no final decision had been given, and the discussion focussed on the number of days cover that would be needed.

G.13. MULTI-DISCIPLINARY DOCUMENT

Description

The proposed document would contain the views and recommendations of each discipline involved in the multi-disciplinary meetings for EMI wards G, H, and I, to be presented to the head of the Psychiatric Unit at the Hospital, and other relevant persons in the administration, prior to further reorganization of EMI services next year. Such a document appears never to have been produced before.

History

The document was proposed by the Charge Nurse of ward X at the September M.D.M., in response to organizational changes in the psychiatric services, and after some discussion it was decided to proceed with it. However, the head of the Community Psychiatric Nurse

service refused to allow her subordinates to be involved with it when she heard about it, and reported to the head of the Psychiatric Unit, who saw the proposal as some kind of "revolt".

An extraordinary M.D.M. was called to clear up the misunderstandings and the document was then given the go-ahead. At the next scheduled M.D.M. (October) some confusion and disagreement about the purpose of the document and the contribution particular individuals should make was still evident. At the end of the second observation period the decision to proceed still stood, though with a later deadline. However, it was unclear what action was being taken, and at least some members were sceptical about the document and thought it likely that the future of EMI services would lie in the hands of the head of the Psychiatric Unit who would make his own decisions, regardless of their opinions.

G.14. TEA/COFFEE SCHEME FOR VISITORS

Description

A scheme to provide tea/coffee for visitors to the ward, with proceeds going towards improving facilities for patients, is proposed.

History

It was suggested by the ward-based Social Worker, at the first multi-disciplinary meeting observed, that a tea/coffee scheme for visitors be introduced, with the aims of providing a service for visitors and raising funds for the wards. It was pointed out by the Assistant Director of Nursing Services that a recent district directive had said that drinks for visitors should be free. A bigger obstacle was the problem of where to keep the money raised, as there were strict and very low limits (i.e. £10) as to how much money could be kept on the ward. It is generally the case that anything to do with money on the wards becomes very complex because of fears of mis-use (or accusations of mis-use). The meeting therefore decided not to proceed with the

idea, although a commitment was made to explore other fund-raising possibilities in future.

G.15. TASK ALLOCATION SYSTEM

Description

Task allocation is a system whereby each member of nursing staff is allocated particular tasks to do on each shift; e.g. bathing patients, changing dressings etc.

History

Some nursing staff had encountered task allocation before, though not it seems on Ward G. The idea to introduce it was added to the agenda for a ward meeting by one of the Nursing Assistants; however, she wasn't working that day and so didn't attend the meeting. It was put there as an alternative to the patient allocation system that was to be organised on the basis of the new nursing teams (see G.1). The Charge Nurse asked if anyone had anything to say on the subject of task allocation, and as no one did he moved on straight to patient allocation.

On a shift in the following week, the Nursing Assistant who proposed it asked the researcher what had happened to her suggestion about task allocation. She said she was not willing to come in unpaid in her own time for a ward meeting. She raised the issue again at the next ward meeting and was told that it hadn't been discussed as she wasn't there and that they had decided on patient allocation. It was suggested that in future if people had items for the agenda but wouldn't be able to be present , they should ensure that someone who was going was able to explain their point for them.

. 16. PATIENTS' NAMES - USE OF SURNAMES

Description

One Nursing Assistant suggests that patients should be addressed by their surnames - Mr or Mrs Bloggs etc - at least at first, because the current practise of using first names is disrespectful and encourages favouritism by staff.

History

The suggestion was made at the ward meeting in September, and raised again at the next ward meeting, roughly a month later. On both occasions it received no support, and at the end of the second of these meetings the Charge Nurse put an end to the discussion by stressing that changes *couldn't* be made on one person's whim when everyone else disagreed with it. Nevertheless, it became apparent that after the suggestion was made, though first names were generally used, staff addressed *patients* by their surnames more often than they had previously.

G.17. NEW DRUG RECORD CARDS

Description

A new type of record card for details of patients medication histories and requirements is proposed.

History

A sample of the new-style drug record card was sent to the ward by one of its Consultants. The card enables records of patients medication histories to be kept over a long period of time - something which the Charge Nurse admits is badly needed for psycho-geriatric patients - but the Consultant failed to provide sufficient information about how to use the new cards; they were not similar enough to existing cards for this to be self-evident. It was agreed at a ward meeting that the sample should be returned, with a request for further information. The cards had been implemented, seemingly successfully, elsewhere. There

was some disagreement about whether the present record cards were adequate, though the Charge Nurse was insistent that they were not.

G.18. ABBREVIATIONS

ChN = Charge Nurse

SN = Staff Nurse

SEN = State Enrolled Nurse

NA = Nursing Assistant

TNA = Temporary Nursing Assistant

CPN = Community Psychiatric Nurse

CLS = Communtiy Link Sister

SW = Social Worker

OT = Occupational Therapist

E.S., J.B., N.W. = Members of administration (in ascending order of seniority)

EMI = Elderly Mentally Infirm

M.D.M. = Multi-Disciplinary Meeting

Pt.3 (part 3) = Local Authority Homes for the Elderly

APPENDIX H. CODING INSTRUCTIONS FOR CATEGORIZING INNOVATIONS BY TYPE: THE PSYCHO-GERIATRIC WARD STUDY (CHAPTER 8)

H.1. INTRODUCTION

The coding instructions and associated materials presented to coders for categorizing innovations by type are included here. Note that coders were also given the full set of Case Histories from the psycho-geriatric ward study (chapter eight) and the list of abbreviations (both included in Appendix G).

H.2. BACKGROUND MATERIALS

Classifying Innovations by Type: Background and Coding Instructions

THE STUDY

The data which you will be coding comes from a study of innovation in a hospital psychogeriatric ward (referred to as Ward G). Innovation is defined as;

"The intentional introduction within a role, group or organization of new and different ideas, processes, products or procedures, designed to significantly benefit role performance, the group, the organization or the wider society."

The aim of the study was to observe innovations introduced into the ward over a six-month period following the appointment of a new Charge Nurse (the Charge Nurse is the most senior nurse on the ward). To do this I spent two one month periods working on the ward - in May/June and November/December 1986 - and observed the progress of all the changes brought in. Between these two periods I attended the monthly ward meetings and Multi-Disciplinary Meetings (M.D.Ms). The latter are

meetings involving representatives of all the disciplines involved in the work of the ward: Nursing and Medical staff, Occupational Therapists, Physiotherapists, Social Workers etc. (During the first observation period it was decided that a common M.D.M. should be held for the three psycho-geriatric wards at the hospital - the other two will be referred to as Ward H and Ward I.)

From the notes taken during shifts and meetings, I was able to construct short 'Case-Histories' of seventeen innovations. These are the materials which you will be coding. Before explaining your task, I will present some background information about the ward.

DESCRIPTION OF THE WARD.

Ward G is a 25-bedded psycho-geriatric assessment ward in a large Sheffield General Hospital. Its function is to take patients referred from other institutions or from the community and assess their mental and physical abilities, in order to determine the type and level of care they will require in future. Patients normally stay on the ward for a minimum of six weeks.

There is a Day Hospital based on the ward, providing therapeutic and recreational facilities for elderly people from the community. Some of the more mentally able patients from the ward generally join in the activities. The Day Hospital is run by a Staff Nurse helped by a Nursing Assistant, and has a large degree of autonomy from the main ward.

During the first period of research the day-time staffing level on the ward was as follows; one Charge Nurse, four Staff Nurses, three Enrolled Nurses (S.E.N.s), and ten Nursing Assistants (three on temporary contracts). The following specialist staff were based on the ward: a Social Worker, a Community Link Sister and an Occupational Therapist. A trainee Social Worker and a trainee Occupational Therapist were on placements here during this period (the O.T. not

starting until June), and two Physiotherapists included Ward G amongst their responsibilities. There were Student Nurses working on the ward throughout this period

Over the course of the research there were a considerable number of staff changes. The net result of these was an increase in the number of staff nurses by one, and an increase in the number of Nursing Assistants by one. Also, in June the group of Student Nurses finished their time on the ward, and from then on there was never more than one student nurse assigned to the ward at any one time.

RECENT HISTORY OF THE WARD

The new Charge Nurse mentioned above had worked on the ward previously, about three years before the start of this study, sharing authority with the then Sister (who is now the ward's Community Link Sister). He left to take responsibility for another psycho-geriatric ward, and another Charge Nurse took his place. The ward experienced a number of problems which reduced its effectiveness; this was attributed by members of the administration largely to the management abilities of the new Charge Nurse. He was therefore transfered to a different post, and the current Charge Nurse brought back. During the first observation period of this study, changes in the organization os Sheffield psychiatric services took place. Previously, Ward G was administered as part of an EMI speciality, including psycho-geriatric wards at a number of Sheffield hospitals. Now the service is organized in 'localities', so Ward G is included with the other two psycho-geriatric wards ('H' and 'I') at the same hospital under the direct authority of the hospital's psychiatric unit. The whole period of this study was one of continuing significant change for all the psychiatric services.

H.3. TASK INSTRUCTIONS

YOUR TASK

You are asked to read through the seventeen case-histories, and categorise each of the innovations described using a four dimensional typology. The dimensions are; **programmed - non-programmed, instrumental - ultimate, technical - administrative** and **radicalness.** These are defined below.

Dimension 1: programmed or non-programmed?

A **programmed innovation** is one which is scheduled in advance; it is not a surprise to the organisation (though it could be to some members, because of lack of communication etc.) and the way it is introduced is expected to follow well-defined routines and procedures. In many cases it is recognised as the inevitable consequence of a preceding change; for instance, the introduction of a training course for a new form of treatment, following the actual invention of the treatment. It is likely that in most cases (but not all) it will be introduced "from above"; i.e. by the order of higher management outside the ward.

A **non-programmed innovation** is one which is not scheduled in advance. If you determine that an innovation does not meet the criteria for programmed innovations (above), you must decide which of the following three sub-types of non-programmed innovation it is.

a) **Slack innovation:** "slack" is defined as the difference between available resources (financial, human etc.) and the resources necessary to maintain the organisation's daily functions. A slack innovation is therefore one which was introduced in order to utilise available slack resources. Clearly for you to place an innovation in this category, evidence of the availability of organisational slack must be apparent.

b) **Distress innovation**: these are innovations which are initiated in response to pressing problems affecting the organisation. For an innovation to be typed as "distress", the requirement from the case-history is that (i) there was a recognised problem of at least a moderate degree of urgency, and (ii) the innovation was initiated specifically to deal with it (though it may have had other subsidiary aims).

c) **Pro-active innovation**: the third sub-type consists of those innovations which attempted to draw the organisation's attention to an area where the need for change was not previously recognised, or was not considered to be of any real urgency. In addition to meeting this criterion, the innovation must not be motivated by the desire to use up slack resources - as it would then belong in sub-type (a).

In some cases, the distinction between pro-active and distress innovation may be difficult to make. To decide, you should consider the situation which the innovation was introduced to change. If it was one where it was recognised that something had to be done about a problem fairly quickly, the innovation is of the distress type. If, on the other hand, the innovation was introduced in response to a situation which, while to some degree problematic, could have been left unchanged indefinately, it should be considered pro-active.

Dimension 2: instrumental or ultimate?

An **instrumental innovation** is one which is brought in with the sole or main aim of making the introduction of further changes possible or easier. The further changes might be particular innovations - e.g. a new drug, or more general - e.g. improvements to paramedical cover.

An **ultimate** innovation is one which is an ends in itself - it was not brought in to be instrumental in subsequent changes. Please note, however, that further innovations/changes may occur in response to an ultimate innovation if they were not planned as such when the first

innovation was introduced; e.g. a new physiotherapy technique to aid patient mobility might necessitate the introduction of a new training programme, but it could not be said that the aim of the technique was to facilitate introduction of the programme, so it would be categorised as an ultimate innovation.

Dimension 3: technical or administrative?

A **technical innovation** is one which is concerned with the primary work activity of the organisation. For Ward G, the primary work activity is the physical, mental and emotional care and assessment of patients. Technical innovations in this case therefore could include new care or assessment practices or new ways of carrying out existing practices, new medical or psychiatric techniques or equipment, and so on.

An **administrative innovation** is an innovation in the social system of the organisation; i.e. concerned with relationships and communications between organisational members, and the rules, roles, procedures and structures governing or influencing these. Note, however, that in the context of a psycho-geriatric ward, staff relationships with patients must be considered to be part of their primary work activity, and so innovations relating to these would be considered technical.

Dimension 4: radicalness

Unlike the previous three dimensions, radicalness does not consist of discrete categories, but rather is continuous; i.e. you are not asked to decide whether an innovation is radical or not, but *how radical* it is. Radicalness consists of two elements - **novelty** and **risk**. You are to rate each innovation on these two separately, as "high" (3), "medium" (2) or "low" (1), utilising the following guidelines;

Novelty

You should code an innovation as **low novelty** (score of 1) in *any* of the following circumstances: if it was introduced onto the ward from elsewhere in the hospital or Sheffield district health authority without any notable modification *and* was already familiar to at least

a significant minority of staff; if it was only a minor modification of an existing (or previously existing) technique, procedure etc.; if it was the extension, without significant modification, of an existing technique or service into a new area.

You should code an innovation as **medium novelty** (score of 2) in *any* of the following circumstances: if it was introduced from elsewhere in the hospital or Sheffield district health authority with significant modification(s), or without modification but was completely unfamiliar to all or nearly all staff; if it was a major modification of an existing technique, procedure etc; if it was the extension, significantly modified, of an existing technique or service into a new area.

You should code an innovation as **high novelty** (score of 3) in *any* of the folowing circumstances: if it was introduced from outside the hospital or Sheffield district health authority *and* was unfamiliar to all or nearly all staff; if it was an entirely new way of carrying out an existing function or task (from whatever source); if it was an entirely new technique or service invented for the ward (i.e. not imported from outside).

Risk

You should code an innovation as **low risk** (score of 1) in the following circumstances: if it was unlikely to fail, *and* its failure would not have endangered the well-being of patients or staff, *or* harmed the reputation(s) of those responsible for its introduction, *or* seriously inconvenienced the ward in any way.

(An innovation may be considered to have "failed" if it was rejected before it could be implemented, or if it was introduced but clearly did not achieve its aims. Situations where you should consider that failure was likely include those where there were doubts about the availability of resources and/or support from higher management, or about the competence and/or commitment to the innovation of staff. Please remember though that you should try as far as possible to **make**

this assessment on the basis of the information that was available to decision-makers at the time the innovation was first initiated).

You should code an innovation as **medium risk** (score of 2) in the following circumstances: if it was unlikely to fail, but its failure would have endangered the well-being of patients or staff, *or* harmed the reputation(s) of those responsible for its introduction, *or* seriously inconvenienced the ward in some way; *or* if it was likely to fail, but its failure would not have endangered the well-being of patients or staff, *or* harmed the reputation(s) of those responsible for its introduction, *or* seriously inconvenienced the ward in any way.

You should code an innovation as **high risk** (score of 3) in the following circumstances; if it was likely to fail, *and* its failure would have endangered the well-being of patients or staff, *or* harmed the reputation(s) of those responsible for its introduction, *or* seriously inconvenienced the ward in some way.

NOTE.
For several of the case-histories, you might find that it is difficult to employ the criteria for one or more of the dimensions because the information available about the innovation(s) is not sufficient; in such instances you must allocate the innovation to whichever category seems most likely to fit it on the basis of what you do know about it. Please feel free to ask me for clarifications, and do consult the background materials as often as you require. Lastly, if information in one case-history appears to be of help in explaining some detail of another, please use it. For this reason you should *read through all the case-histories once before you attempt to code any of them.*

H.4.

Coding guide: classifying innovations by type

1) Read through all the instructions and background material. Ask me about anything you do not understand.

2) Read through all the case-histories before you start any coding.

3) Write your codings on the sheets provided, as follows:

DIMENSION 1	Programmed = PR
	Non-programmed: slack = S
	" " distress = D
	" " pro-active = P-A
DIMENSION 2	Instrumental = I
	Ultimate = U
DIMENSION 3	Technical = T
	Administrative = AD
DIMENSION 4	Novelty + Risk: score 1-3 on each

Thank you for your help

INNOVATION	DIMENSION 1 programmed - non-progr.	DIMENSION 2 instrumental - ultimate	DIMENSION 3 technical - administrative	DIMENSION 4 radicalness: novelty	risk
1) New nursing teams					
2) New card-indexes					
3) Tea-pot tables					
4) Waiting list assessments					
5) Team communication folders					
6) Drug rounds - qualified staff only					
7) Nurses to go with pateints to part 3 Homes					
8) Combined multi--disciplinary meetings					
9) Objective patient assessment					

INNOVATION	DIMENSION 1 programmed - non-progr.	DIMENSION 2 instrumental - ultimate	DIMENSION 3 technical - administrative	DIMENSION 4 radicalness; novelty	risk
10) Garden project					
11) Ambulance service for Day Hospital					
12) Phlebotomy service for E.M.I. wards					
13) Multi-disciplinary document					
14) Tea/coffee scheme for visitors					
15) Task allocation system					
16) Use of patients' surnames					
17) New drug record cards					

APPENDIX I. CLASSIFICATION OF INNOVATIONS BY PROCESS ELEMENTS: PSYCHO-GERIATRIC WARD STUDY.

I.1. INTRODUCTION

The seventeen observed innovations from the psychogeriatric ward study (chapter eight) were all classified on six process elements (section 4.2.1.). The full set of categorizations is shown below. For the sake of brevity, innovations are referred to by number. The numbering corresponds to the order of the innovations in table 8.2, and in Appendix G.

1. = New nursing teams
2. = New card-indexes
3. = Tea-pot tables
4. = Waiting list assessments
5. = Communications folders
6. = Drug rounds (*qualified staff only*)
7. = Nurses accompanying patients to Part 3 Homes
8. = Combined multi-disciplinary meetings
9. = Objective patient assessment schedule
10. = Garden project
11. = Day Hospital ambulance service
12. = Phlebotomy service
13. = Multi-disciplinary team document
14. = Tea/coffee scheme
15. = Task allocation system
16. = Use of patients' surnames
17. = New drug record cards

I.2. WHO THE INNOVATION WAS INITIATED BY

There were two broad categories, each divided into two sub-categories: **ward staff**, divided into **Charge Nurse** and **others**; and **non-ward staff**, divided into **higher management** and **others**. The innovations were classified as follows.

1) Ward Staff
i) **Charge Nurse**: (1), (3), (5), (9), (13)
ii) **Others**: (4), (7), (11), (14), (15), (16)

2) Non-Ward Staff
i) **Higher Management**: (2), (6)
ii) **Others**: (8), (10), (12), (17)

I.3. WHERE THE INNOVATION WAS INITIATED

Three categories were used; **on the ward**, **at multi-disciplinary meetings**, and **elsewhere**.

1) **On the Ward**: (1), (3), (4), (5), (9), (15), (16)
2) **At Multi-Disciplinary Meetings**: (7), (8), (10), (11), (12), (13), (14)
3) **Elsewhere**: (2), (6), (17)

I.4. SOURCES OF RESISTANCE TO THE INNOVATION

Three sources of resistance were identified upon which to classify innovations; **within the ward**, **higher management**, and **medical staff**.

1) **Within the Ward**: (3), (14), (15), (16), (17)
2) **Higher Management**: (11), (13), (14)
3) **Medical Staff**: (8)

I.5. RESOURCE PROBLEMS FOR INNOVATIONS

There were three categories of types of resource problem; **financial**, **human**, and **material**.

1) **Financial**: (10), (11)
2) **Human**: (7), (9)
3) **Material**: (2), (4), (11)

I.6. COMMUNICATIONS PROBLEMS

Communications problems created major obstacles to the development of the following innovations: (3), (13), (15), (17)

I.7. OUTCOMES

Four categories of innovation outcome were defined; **rejection**, **major problms**, **minor problems**, and **no significant problems**.

1) **Rejection**: (14), (15), (16), (17)
2) **Major Problems**: (7), (9), (11), (13)
3) **Minor Problems**: (2), (3), (5), (10)
4) **No Significant Problems**: (1), (4), (6), (8), (13)

APPENDIX J. COMPONENTS OF THE TWO INNOVATION PROCESS MODELS COMPARED IN THE PSYCHO-GERIATRIC WARD STUDY, AND CODING INSTRUCTIONS

J.1. INTRODUCTION

This appendix includes the stages/observations from the two process models compared in chapter eight, section 5 (Zaltman et al, 1973; Schroeder et al, 1986). Note that when given to coders these were not numbered, nor were they identified as belonging to a particular model. Instructions were given verbally; the text used is presented below, as is a copy of the coding sheet. Coders were also given the backgound materials to the study and the ward (see appendix H), the list of abbreviations and the relevant transcripts (appendix G).

J.2. TASK INSTRUCTIONS

You will be given, in random order, twelve observations concerning the innovation process, and the Case Histories (plus supporting research notes) of seven innovations observed over the course of seven months in a psycho-geriatric ward. Your task is to decide for each Case History whether there is evidence supporting each observation. There are four possible decisions in every instance:

"Yes" - when there is clear evidence to support an observation
"Maybe" - when there is some evidence to support an observation, but you do not feel it to be conclusive
"No" - when there is no evidence to support an observation
"Not applicable" - when you feel that an observation is not relevant to a particular Case History for any reason, for instance because the innovation has not yet reached the point described.

Mark your decisions for each Case History on the coding sheets provided. If you have especial difficulties over any coding decision, make a note of what they are on the separate "Coding Problems" sheet.

Before you begin, read carefully through the background material provided.

J.3. ZALTMAN ET AL'S MODEL: PROCESS OBSERVATIONS

Observation 1: The innovation process has two distinct stages; 'initiation' and 'implementation'.

'Initiation' consists of information processing and decision-making, leading up to the point where the idea is legitimated by powerholders in the organization. 'Implementation' consists of the actual mechanics of managing the changes that occur following the decision to introduce the innovation.

Observation 2: The crucial first step in the innovation process is knowledge or awareness of the innovation.

Before any innovation can take place, potential adopters must be aware that the innovation exists and that there is an opportunity to use the innovation in the organization. In some cases, the organization may see the need to adopt the innovation as a result of becoming aware of its existence; in other cases, a particular need within the organization will lead it to search for ways of meeting the need, and it will become aware of the innovation through this searching.

Observation 3: Members of the organization form attitudes towards the proposed innovation.

Once a potential innovation has been identified and there is some motivation to change, the attitudes that organizational members have toward the innovation are important in determining whether innovation proceeds (though not to the exclusion of all other variables).

Observation 4: Information concerning the potential innovation is evaluated, and a decision about whether or not to implement it is made.

The innovation is likely to be implemented when organizational decision-makers are highly motivated and/or have favourable attitudes regarding the innovation. At this point in the process, the organization needs to process a good deal of information.

Observation 5: The organization makes a first attempt to utilize the innovation.

At this point, some sort of trial of the potential innovation occurs.

Observation 6: The organization continues to use the innovation.

If the initial implementation has been successful in that organizational members understand it, have information about implementation, and experienced few significant problems, there is a greater likelihood that the innovation will continue to be implemented.

J.4. SCHROEDER ET AL'S MODEL: PROCESS OBSERVATIONS

Observation 1: Innovation is stimulated by shocks, either internal or external to the organization.

Some form of shock is necessary before an organization comes up with new ideas or acts upon new ideas already in existence. 'Shock' is defined very widely and is not viewed as necessarily a negative event like a financial crisis; it could be a change in leadership or an unexpected offer of cooperation from another organization.

Observation 2: An initial idea tends to proliferate into several ideas during the innovation process.

The initial idea which starts the innovation process proliferates into an increasing number of alternative paths. Also in most cases the innovation cannot be said to consist of a single new procedure, product or device. Proliferation makes management of the innovation increasingly complex, as more and more people are involved in it or affected by it.

Observation 3: In managing an innovation effort, unpredictable setbacks and suprises are inevitable. Learning occurs whenever the innovation continues to develop.

It is impossible to predict all the factors which will affect the innovation process, or the effects the innovation will have. Learning from setbacks and surprises is thus very important.

Observation 4: As an innovation develops, the old and the new exist concurrently, and over time they are linked together.

When an innovation enters an organization, it initially exists alongside the established order. Implementation may be obstructed or delayed if there are not sufficient links between the old ways and the new.

Observation 5: Restructuring of the organization often occurs during the innovation process.

Managers often attempt to deal with innovation characteristics such as proliferation and the co-existance of the old and the new by some form of restructuring of the organization. This may be formal or informal, permanent or temporary, and includes such things as creating new teams, committees or departments, and changing peoples' responsibilities within the organization.

Observation 6: Hands-on top management involvement occurs during innovation. One or two levels of management removed from the innovation itself are directly involved in all major decisions.

During the innovation process, a considerable degree of active involvement by top management is found. This tends to be most apparent early in the innovation process, diminishing as it progresses.

J.5.

COMMENTS SHEET

If you had any difficulties with particular observations on this example, please briefly describe them on this sheet. Please comment, for instance, if you felt that an observation was difficult to apply in this case, or that the evidence for it was particularly ambiguous, or if you had any other problem. For any observation where you responded "Can't Say", please try to explain why. Use the other side and extra sheets as necessary. There is no need to comment on every observation; where you had no real problem in deciding on a response there is no need to write anything on this sheet.

EXAMPLE:

OBSERVATION COMMENT

J.6. CODING SHEET

EXAMPLE:

OBSERVATION

A	YES	PARTLY	NO	CAN'T SAY
B	YES	PARTLY	NO	CAN'T SAY
C	YES	PARTLY	NO	CAN'T SAY
D	YES	PARTLY	NO	CAN'T SAY
E	YES	PARTLY	NO	CAN'T SAY
F	YES	PARTLY	NO	CAN'T SAY
G	YES	PARTLY	NO	CAN'T SAY
H	YES	PARTLY	NO	CAN'T SAY
I	YES	PARTLY	NO	CAN'T SAY
J	YES	PARTLY	NO	CAN'T SAY
K	YES	PARTLY	NO	CAN'T SAY
L	YES	PARTLY	NO	CAN'T SAY

APPENDIX K. CODING INSTRUCTIONS FOR SEQUENTIAL ACCURACY OF THE ZALTMAN, DUNCAN AND HOLBEK (1973) MODEL: PSYCHO-GERIATRIC WARD STUDY

K.1. INTRODUCTION

Instructions for coding the sequential accuracy of Zaltman et al (1973) innovation process model are included in this appendix, along with an example of coding and the five observations relating to the five sub-stages of the model (n.b. the latter were presented to the coder in random order). The coder was also given the background materials (see Appendix H), copies of the two Case Histories involved, along with the list of abbreviations (Appendix G), and descriptions of the stages from Zaltman et al's model in random order (Appendix J).

K.2. TASK INSRUCTIONS

You will be given case histories of two innovations observed during the study (the **new nursing teams** and the **tea-pot tables**); these consist of a description of each innovation, and a narrative of its history. Appended are all the relevant extracts from my research notes, upon which the case histories are based. You will also be given five general observations about the innovation process, mounted on card. Your task is to take each observation and go through the case histories to find any evidence supporting it. At every point where you feel that some aspect of the history supports an observation, mark the section in pencil and note the code letter of the observation (you will be shown an example of what I mean). If you think that one section of a case history supports more than one observation, mark it as such - this is entirely permissible. Do not feel obliged to find some support for every observation from both histories.

K.3. EXAMPLE OF CODING

WARD G GARDEN PROJECT

Description

It is proposed that improvements be made to the ward X garden, to allow patients to get more use out of it. The proposal focuses on the purchase of a greenhouse to be erected in the garden.

History

In the past there had been a committee of Ward G staff to discuss possible improvements to the garden, but nothing had got done and it had effectively disolved.

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At the June ward meeting, improvements to the garden in a general sense were proposed as one of the possible uses for resources, following a request for such suggestions from the administration. Nothing further happened on this issue until the August M.D.M., at which the Art Therapist announced that he had already made some horticultural improvements to the garden at no cost (using cuttings from other Hospital gardens), and he made a number of suggestions for more substantial developments, including a greenhouse. People at the meeting said they liked his ideas, but that proper costing would have to be done before any of them could be acted upon.

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The Art Therapist brought information about the cost of different types of greenhouse to the next (September) M.D.M. and it was decided that the League of Friends would be approached for funding. At the October M.D.M. the Art Therapist produced more information about greenhouses, and it was decided that the decision about which design to choose should be left to him. (There was some degree of impatience apparent about the time that this issue had been taking up at M.D.M.s.) The League of Friends had been contacted but no decision would come from them until after their next meeting. This is the stage which the proposal had reached at the end of observation period two.

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