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Research and review

Making practice visible: The Workplace Culture Critical Analysis Tool (WCCAT)

Brendan McCormack—Professor of Nursing Research, Institute of Nursing Research/School of Nursing, University of Ulster; Visiting Professor Of Nursing, University of Technology, Sydney, NSW; Adjunct Professor of Nursing, Monash University, Melbourne, Vic, Australia.
Elizabeth Henderson—Director of Nursing, Northern Ireland Cancer Network, UK
Val Wilson—Professor of Nursing Research and Practice Development, University of Technology, Sydney, NSW; Director of Nursing Research & Practice Development, the Children's Hospital at Westmead, NSW, Australia
Jayne Wright—Research Associate, University of Ulster, UK

ABSTRACT

Emancipatory practice development has a key focus on changing the culture of practice to enable more person-centredness to be developed in the care unit (ward, department or clinic). However, getting 'inside' the prevailing practice culture can be challenging and complex and it can be difficult to determine the specific aspects of culture that need to be addressed in a development programme. One way of doing this, and a key process of practice development, is observation of practice. However, many of the tools available for the observation of practice are inconsistent with the philosophy and values underpinning emancipatory practice development, i.e. they tend towards 'judgement' of quality rather than the facilitation of engagement.

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The WCCAT has been developed as an observation tool consistent with the philosophy and values of emancipatory practice development and is a facilitative process. In this paper we set out the framework underpinning the WCCAT, the phases involved in undertaking an observation and examples of how to use the tool in practice. An initial evaluation of the use of the tool by practice development facilitators is also provided. Copyright © 2009 John Wiley & Sons, Ltd.

Key words: Observation, emancipatory practice development, facilitation, culture

Introduction and background

Emancipatory practice development (PD) is a well established methodology that focuses on changing the culture and context of practice in order to develop sustainable person-centred and evidence-based workplaces (Manley and McCormack, 2004). In a concept analysis of PD, Garbett and McCormack (2002) articulated the interconnected and synergistic relationships between the development of knowledge and skills, enablement strategies, facilitation and systematic, rigorous and continuous processes of emancipatory change in order to achieve the ultimate purpose of evidence-based person-centred care. Manley and McCormack (2004) articulate these elements of PD in a model called 'emancipatory PD' (EPD). This recognizes, acknowledges and works to overcome obstacles and generate new understandings about context and culture, and how to overcome barriers within them.

The key elements of EPD are:

- Working with values, beliefs and assumptions, challenging contradictions
- Developing critical intent of individuals and groups
- Developing moral intent
- Focusing on the impact of the context on practice, as well as practice itself
- Using self-reflection and fostering reflection in others
- Enabling others to 'see the possibilities'
- Fostering widening participation and collaboration by all involved
- Changing practices.

Facilitating these processes involves cycles of reflective learning and action, so that clinicians:

- Become aware of how they practise and the things they take for granted
- Develop an awareness of how the system impacts on the way they work
- Identify the contradictions between what they espouse and what they do
- Challenge the system in which they work to create the potential for better patient care
- Actually change how they practice to reflect individual and collective beliefs and values
- Continually refine action in light of new understandings gained through reflecting on practice.

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These facilitated processes help clinicians break down barriers to action and enable cultures of effectiveness to be developed. Key to enabling the development of these cultures is the observation of practice.

Observation methods have their origins in 'ethnographic research' methodology. Ethnography involves the researchers entering the area being researched and thus gaining multiple perspectives in order to identify links with the culture and thoughts and feelings of the people at the centre of the research (Morse, 1991). The essence of ethnography is to understand another way of life from the native point of view and involves learning from people (Ersser, 1997). It enables the observation of taken-for-granted aspects within health care, so that they become visible (Leininger, 1985). In a two-year PD programme with nurses from a range of surgical settings, Boomer et al. (2008) found that helping participants to develop a systematic approach to observing practice in their own and their colleagues' practice settings was a key strategy to informing cultural changes. Analysing the processes and outcomes used in this project, and compared with findings from previous PD programmes of work resulted in the development of the Workplace Culture Critical Analysis Tool (WCCAT).

The WCCAT has been informed by a number of theoretical frameworks and development processes (Table 1).

The use of these theoretical perspectives is illustrated in the conceptual model below (Table 2). This model demonstrates the linkages between the different levels of culture (superficial, middle and deep) and how the phases of observation, reflection and feedback that underpin the WCCAT enable a deep understanding of workplace culture to be achieved and developed in a PD action plan.

Process for using the WCCAT

The WCCAT adopts a five-phase process to undertaking an observation study, analysing the data, feeding back to clinical teams and developing action plans. The five phases are:

- Pre-observation
- Observation
- Consciousness raising and problematization
- Reflection and critique
- Participatory analysis and action planning

Phase 1: Pre observation

Step 1: Preparing the clinical area for observation

Preparing a clinical area for observation is an important phase of the process. Staff anticipation of being observed can generate heightened anxiety and concern. It is

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Table 1. Theoretical frameworks and development processes underpinning the WCCAT

Framework	Contribution to the WCCAT
The person-centred nursing framework (McCormack and McCance, 2006)	The person-centred nursing theoretical framework has identified five care processes for patient-centred care and six attributes of the care environment. These care processes and attributes have informed the observation foci.
Critical companionship (Titchen, 2001)	Critical companionship is a framework for developing helping relationships. It describes strategies for enabling enlightenment, empowerment and emancipation. In particular, the strategies of observing, listening and questioning have informed the facilitation strategies in the WCCAT.
Culture (Schein, 2004)	Schein describes a conceptualization of culture that moves from superficial to deeper levels of understanding. The three stages of analysis outlined in the WCCAT are based on this analysis of culture.
Workplace culture (Manley, 2000a, b)	Manley developed a set of staff, patient and workplace indicators that she suggests need to be in place for an effective person-centred and learning culture. These have been integrated into the observation foci.
Essence of care (Department of Health [England], 2001)	Patient-focused benchmarks for clinical governance. Nine fundamental aspects of care derived from what patients consider important. Elements of these benchmarks have been integrated into the observation foci.

therefore important to undertake preparatory work in order to reduce anxiety, clarify processes to be used and engage staff in planning for periods of observation.

In order to reduce anxiety and prepare for the observation study, it is important to:

- Discuss the overarching PD project and the place of cultural analysis in this work.
- Clarify ethical principles underpinning the processes, such as evidence of ethical approval. If you do not require formal ethical approval, you should still have evidence of approval from the management team. Consider also how you will ensure confidentiality, anonymity and non-interference with ward activities. You will need to secure 'process consent' – that is, at each observation period seek verbal consent from patients and staff for the observations being undertaken.
- Explain the processes to be used in observation (e.g. where you will be positioned, number of observers, number of observations to be undertaken, frequency of observations and the types of notes you will maintain). Wherever possible, negotiate these arrangements with staff.

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Table 2. WCCAT conceptual model

	Culture levels (after Schein, 2004)		
	Superficial level – *What is seen?* **Symbol/artefacts** Routines Actions Interactions	**Middle level – *What is lived?*** **Consciousness raising and problematization**	**Deeper level – *What does it mean?*** **Clarifying assumptions through reflection and critique**
Facilitation strategies (after Titchen, 2001)	• *Observing and listening*	• *Questioning* • *Articulation of craft knowledge*	• *Feedback* • *Challenge and support* • *Critical dialogue*
Observation areas For example: • Physical environment • Communication • Privacy and dignity • Patient involvement • Team effectiveness • Risk and safety • Organization of care • Learning culture N.B. These observation areas may change according to the context within which the WCCAT is used	**The observers adopt the attributes, reflexivity and skills of a qualitative researcher, in observing and listening to clinicians at work in their everyday working environment.** Using the WCCAT guidelines and the observation proforma, the observer systematically records aspects of practice relevant to the focus of the observation.	**The purpose here is to check out if what has been observed matches clinicians' experience, and in so doing facilitate consciousness raising and problematization.** Consciousness-raising is a way of enabling practitioners to become more alert with respect to daily practice and to their knowledge embedded in it. The observer poses questions about what has been observed, thus getting clinicians to articulate their craft knowledge. This helps the clinician to surface the tacit understandings that have grown up around repetitive and habitualized practice. Problematization is making problematic that which has previously been assumed to be satisfactory. It may also refer to the observer pointing out or questioning things not being attended to.	**Feedback about what has been observed is offered to clinical teams using strategies of high challenge and high support as a catalyst for learning.** **Observers then engage clinical teams in critical dialogue with respect to this feedback.** Critical dialogue promotes collaborative interpretations, critique and evaluation of data and validates clinicians' judgement (where appropriate). This fosters clinicians' self-awareness, and reflective and critical thinking. Challenging taken-for-granted assumptions, beliefs, values, expectations, perceptions, judgement and actions in a constructive, interested, supportive way helps clinicians to gain new understandings of situations.

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- Written information about the study and the procedures should be provided.
- Answer all questions openly and honestly.

As well as negotiating and explaining the observation procedures, it is also important to identify staff beliefs and values, as a means of identifying the espoused beliefs and values of the team. Values clarification is a complex and often lengthy process, and in this phase it would be impossible to undertake a values clarification to this extent. However, undertaking a values clarification as a component of step 1 will enable you to understand the team's values at a superficial level and provide a benchmark for considering the data collected during the observations and how this relates to the values that staff want to underpin their practice. In having this awareness, feedback can then be structured (phase 4) in a way that is meaningful and less threatening. If the clinical setting does not have an available set of clarified beliefs and values (such as a stated philosophy of care), then you will need to facilitate a values clarification process with team members about their practice – see Appendix 1 for a suggested values clarification process and also refer to Manley (2000 a), Wilson (2005) or Boomer at al. (2006) for explanations of the process.

Step 2: Preparing yourself to observe

In order to gather detailed and accurate information systematically, you (the observer) need to develop specific skills in observation, including the ability to concentrate in often busy environments, to stand apart from the context you are observing and to defer any judgements you may wish to make about what you are observing. It is also important for you to take into account the role your own subjectivity plays in the observation process (Fawcett, 1996). While practice helps the observer to obtain the necessary skills, a deeper understanding of the intricacies of observation is developed through such things as group discussions, self-directed learning and critical reflection.

The following practical guidelines (Table 3; adapted from Fawcett, 1996) will assist you in preparing and undertaking an observation using the WCCAT. The observation is phase one of the critical analysis and relates to what is seen happening in the clinical setting, including such things as the routines, actions and interactions. The findings are used as a basis for critical discussion with staff about what you have seen and heard, and how this connects to their experience of practice.

Phase 2: Observation

Observation of the workplace culture should be undertaken at the negotiated time by two trained observers using the WCCAT observation proforma. An example of one observation area of the proforma is presented in Appendix 1. Who the observers are may be different in each project in which the WCCAT is being used, and may include different combinations of internal and external observers. Observers should maintain field notes about the experience as a process for reviewing the effectiveness of the observation undertaken.

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Table 3. Preparing and undertaking an observation using the WCCAT

Guideline	Rationale
Preparing for observation	
(1) What is the focus of the observation (e.g. medication administration)?	It is not possible to observe everything within a multi-sensory environment. You need to choose a focus for your observation. You may be required to observe on a number of occasions (at different time periods) to build up a picture of what is happening in a workplace. You need to take into account the environment, verbal and non-verbal communication, actions, events and people.
(2) How will you document your findings?	It is helpful to develop a system for documenting your findings that enables you to capture data during the observation in a timely manner. Consider what abbreviations or codes you may use to document findings. Having large margins allows you to capture your thoughts during and after the observation. You will need to take note of things such as place/date/time (see the example below).
(3) Gaining access to the site	You need to negotiate access to the site, think about how often and for how long you might want to observe practice. You also need to inform staff about the purpose of your observation and obtain consent where appropriate.
(4) Preparing yourself	It is best to observe with a colleague in order to validate your findings and agree on key issues. When choosing a partner for observation, consider the need for an insider/outsider approach (i.e. if you are insider to the setting then perhaps someone from outside the setting would be most appropriate as a partner [and vice versa]). Consider having a 'practice observation' with a colleague; that way you can both observe the same thing and then compare notes about what you observed.
Undertaking an observation	
(1) Positioning yourself (+ other observer if required)	Think where the best advantage point is for you to observe practice. You need to take into consideration such things as how easy it is for you to observe what is happening without being 'in the way' or highly visible.
(2) Time	As you are developing your observation skills, you may find that you can only spend 15–20 minutes observing practice at a time, as a high level of concentration is required. As you become proficient, this time can be increased.
(3) Recording data	Try to capture as many data as possible. Ensure that notes are clear and concise.
After the observation	
(1) Review your notes	Write any additional comments as soon as possible after the observation period, as well as any questions you are posing about what you have observed. Compare notes with the other observer to develop a greater understanding about what was happening.

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Table 3. *Continued*

Guideline	Rationale
(2) Review the process	This can be done as an individual or group activity. What worked well during the observation? What things could you improve upon? What did you learn about observation skills and techniques? What impact did your own value judgements have on what you observed? It may be helpful to capture your answers (and future development opportunities) for your learning portfolio.
(3) Do you require more observation?	Consider whether you (and any other observers) have enough material at this stage to move onto the next phase. If not, you need to consider what the focus of future observations will be, when it will take place and who will undertake the observation.
(4) Preparing notes for the next phase	If you feel you have enough material to undertake phase two (consciousness raising and problematization), you then need to prepare your observations for feedback to staff and to facilitate a discussion in relation to what you observed.

Below is an example of an observation record:

Name of Observer: Jo Smith — ***Unit:*** Ward 4 E

Focus of Observation: Communication during ward rounds — ***Date:*** 5th August 2006

Time	***Observation notes***	***Observer comments/questions***
09.15	Medication round in progress. The nurse approaches AS's bed and checks how the patient's night has been. Inquires about her pain and uses the pain assessment tool to get an accurate indication of the level of pain. Offers analgesia. JRMO approaches nurse as she is getting the medication from the trolley and questions her re another patient. JRMO leaves and the nurse appears flustered. Seems to be unsure what she was doing.	Interruptions of nurses during medicines rounds seems to be a significant issue on this ward. Is there a relationship between these interruptions and drug errors? I wonder how the nurses feel about these interruptions – are they aware of them or are they a 'norm'? This would be useful to explore in the feedback session.
09. 17		

Phase 3: Consciousness raising and Problematization

When the observation is finished, the observers should firstly clarify with individual team members anything they are unsure of. They should also discuss with staff specific aspects of the observation data that they want to further clarify or gain a deeper understanding of. The observers should start by asking open questions relevant to each

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of the eight observation areas in turn, as outlined in the WCCAT proforma. This would help them to gain insight into the practice context and minimize the risk of making false assumptions about what they saw. They should use questions such as 'what is it like to work in this *environment*?' how effective is *communication* here? How is *care organized* here? Tell me about how *learning* takes place here, etc. The observers should make notes/record all responses.

Phase 4: Reflection and critique

Both observers compare their observations and agree a common set of issues to feed back to the ward team. During the feedback session, a critical dialogue is facilitated by the observers with staff. This is done by the observers presenting their 'common issues' as impressions only and putting them up to challenge by staff. Each observation area is discussed in this way and the discussion includes the comparing of the issues raised with the espoused philosophy/values and beliefs/empirical evidence. By the end of the critical dialogue, a common set of issues is agreed between clinical staff and the observers, and these issues form the basis of:

1. Further investigation into specific areas using focused observation instruments, such as nursing handover/mealtimes/privacy and dignity or audit of specific aspects of practice – for example, infection control, care records, etc.
2. Formulation of a PD action plan.
3. Development of a staff development action plan.

Process for engaging in the critical dialogue session

To avoid interruption and to enable the critical discussion to take place, observers/facilitators and members of the clinical team, at an agreed time, should move to an appropriate quiet area. Facilitators should reiterate the purpose of this session, which is collectively to make sense of what has been both observed and articulated, with a view to the clinical team agreeing the areas of practice that need either further exploration or development. Staff may be feeling apprehensive, so it is important to set a positive tone in terms of acknowledging their contribution to the process thus far. It may be helpful at this stage to establish ground rules for the session, to enable dialogue. It is important that facilitators do not appear to be 'sitting in judgement' on the ward team, but rather are offering their observations for critical reflection and discussion to enable insight and learning. The critical companion relationship domain supports the need for facilitators to 'work with' the ward team, demonstrating 'graceful care' in a collaborative spirit of 'giving and receiving'.

One method of feeding back may be to offer some general feedback first (using the 'praise sandwich' technique – positive first, then the less positive and finishing with positive again), then actively engage with staff by focusing on a number of specific areas for more in-depth exploration. In this exercise, observers/facilitators are attempting to challenge practice by drawing attention to the differences between values espoused and

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those observed in practice, in order to enable staff to see things from a different perspective. For example:

'Your philosophy states you aim to provide patient-centred care, yet in practice we have observed that getting the task done seems to be more important than stopping to listen to patients; what might be going on here? How does that observation make you feel? What is being valued here? Why is that? What is that saying about the culture you work in? What would person-centredness look like? What might be hindering the team from being able to undertake that? What would help the team to provide care in that way?'

Processes used, for example, in action learning sets should be employed, such as attending and active listening, one person speaking at a time, open questioning, probing, reflecting back, non-confrontational challenging and using positive affirmation to give support. To achieve closure, it may be helpful to evaluate the critical dialogue session in terms of what staff found most useful, least useful and one thing they are taking away that they have learnt.

Phase 5: Participatory analysis and action planning

Once the observers have the information from phases 2–5, the next stage is to make some sense of it and try to understand what it is saying about the ward/department/unit culture. The process for doing this is to theme the data.

The data analysis phase should be undertaken as a participatory analysis with the ward staff. As many of the ward staff as possible, or a representative sample of staff, should participate in the analysis of the data (it is essential that the ward sister/charge nurse/nursing unit manager are included). Themes for action planning are arrived at by going back and forth between the different data sets and identifying similarities and differences. Participants in the data analysis are asked to identify impressions, feelings, metaphors, key words and images that reflect the data. This process helps to develop an intimate knowledge of the data and an 'embodiment' of it – that is, how the data feels. Initial impressions are noted and a list of tentative themes and common issues are noted. The themes are then revised and refined and narrative or examples of what was observed are selected to link the themes. Theme statements are then written based on common characteristics. All findings are compared for patterns, commonalities, differences and unique happenings. A six-step process adapted from McCormack (2002) is set out below. Participants in the data analysis process should undertake steps 1–5 independently of each other, and step 6 should be undertaken together:

1. Look at all the information you have and read it though a few times. A few things may stick out in your mind, such as something that happened more then once or something that you thought was really good or concerned you.
2. Devise an 'image' (this could be a collage, poem, collection of metaphors, movements, etc.) that captures the 'essence' of the data *overall* for you. Each

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participant does this and shares their image with other participants. This stage helps to ground the holistic nature of the data and provides a tangible representation of the whole data set before the next stages occur, and during which the data will be segmented.

2. Return to the data; as you are reading through the data, think about how they are linked – for example, you may have noted that a person was given choice about when they wanted to get up and that the nurse took time to listen and follow the person's wishes. Another time, a nurse asked a person where they would like to sit in the lounge and gave the person time to make their decision. You could theme this as 'patient choice' or 'respect for the individual'. Another example may be that screening was inappropriate around a person's bed and that it was noted by the observer that they could see behind the curtains while the patient was having personal care. Another time, a nurse walked behind the curtain without asking. These can be themed as 'lack of privacy' or 'lack of respect for the individual'.
3. Go through all the data developing the themes, keeping in mind your 'image', which is a representation of the essences of the whole data set. Consider the linkages between the themes you are developing and the image. Do the themes help to add detail to the whole image? Is there a relationship between the image and the individual themes? Are some themes stronger than others?
4. Refine the themes. Each participant in the workshop shares their initial themes and any explanations that might help to make sense of the themes for others. Do not worry if you have lots of themes at first; by reading and reviewing the themes, the number will become reduced. The themes are then synthesized/reduced by using Post-it Notes. Firstly, the themes are written on flipchart paper. Each person, using Post-it Notes, suggests where there are overlaps, shared meanings and areas of commonality. It is easy to think that some things are obvious and do not need including, but remember that it is this everyday taken-for-granted information/data that is important.
5. Once you have some tentative shared themes, discuss them in the group and agree that these are shared themes. Identify the individual data sources that are linked to these themes and note them.

You now have your list of themes, and can go on to develop the action plan.

Process for devising action plans

When a finalized list of themes has been achieved, an action-planning workshop should be organized with the ward sister/charge nurse/nursing unit manager and the staff of the ward (as many as possible should attend, or a representative sample of staff, but it is essential that the ward sister/charge nurse/nursing unit manager is included) to develop an action plan.

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Each theme should be considered as an area for action. However, some themes may be combined and actions developed to address the combined themes. Alternatively, it may be found that an identified action(s) may address a number of themes. Whatever way it is structured, the action plan should include:

1. Focus of the action (the theme).
2. The *specific* actions being taken (i.e. state 'set up weekly team meetings' as opposed to 'establish better communication in the team').
3. Consider any policies in the organization that need to be considered/implemented/adhered to.
4. Identify the person(s) responsible for taking the action.
5. Agree achievement dates.
6. Agree review dates.
7. Have the action plan approved by the relevant line manager.

Experiences of using the WCCAT in practice

The WCCAT has been used in a number of PD programmes in Northern Ireland, England, Scotland, the Republic of Ireland and Australia. Lead facilitators (n = 10) of those PD programmes were asked for their views on using the WCCAT from four perspectives: the contribution of the WCCAT to the PD work; the benefits of using the WCCAT; challenges associated with using the WCCAT; and lessons learned from using the WCCAT. Four lead facilitators returned completed responses.

The contribution of the WCCAT to the PD work

For all participants, having a framework that was focused on the everydayness of practice and encapsulating issues that resonated with clinicians was a key feature of the WCCAT.

'The WCCAT gave us a framework to develop and utilize existing work around patient care and assessment using practice development principles'.

The structure of the framework was valued by the facilitators, as it '*enhanced experiential learning*' and gave a '*sense of ownership over the practice development process*'. It '*made practice development "real" to clinicians at a ward level*'. The framework provided multiple approaches to data collection and assisted in developing PD and facilitation skills across the organization:

'The WCCT offered a structure for aiding the practitioners' observations of practice, and I was able to promote and engage in reflective conversations around key issues. After the observations, the practitioners met with me to note key learning about their practice and come up with key themes'.

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While many viewed the framework to be challenging to use, overall, respondents felt that it provided an opportunity for they and clinicians to '*"live the experience" using the senses and to reflect on the culture and the context in which care is being delivered*'. Living the experience included the opportunity to observe team behaviours, experience customs and routines and see the '*way of life*' in a clinical setting as it is experienced. The involvement of clinicians and other stakeholders in the process was considered to be valuable and it made espoused emancipatory ways of working real in practice: '*the framework involves those at the heart of practice in both the processes of observation and the evaluation of outcomes*' . . . '*Raising consciousness – leading to challenging the status quo/shortfalls in both practices and the culture of the organization*' through a structured approach to the giving and receiving of feedback and the action-planning process.

The benefits of using the WCCAT

Respondents identified the following benefits of using the WCCAT:

- Involves ward staff in PD work.
- Gives ownership of initiatives to ward staff.
- Allows issues to be prioritized and actioned according to what is important to the ward staff.
- Enables development of better patient care at a ward level.
- Provides a comprehensive picture of what is really happening on the ward.
- Gives evidence to anecdotal issues and concerns.
- Develops self awareness and deeper understanding about self and one's own values and beliefs.
- 'Present moment living' – using the senses to 'tune into' the culture in which care is being provided.
- An opportunity to reflect on events and experiences.
- Information generated adds to a body of knowledge about culture and practices already documented.
- Prompts in the tool are useful to guide one in the collection of data/evidence.
- Provides a structure for critical dialogue when giving feedback.
- New way of learning and questioning the culture of the organization/practice – the importance of being able to process and learn from experience.
- Challenges the taken-for-granted assumptions in practice.
- Outcomes/changes can be achieved and made sustainable.

Challenges associated with using the WCCAT

The lead facilitators identified a number of challenges associated with using the WCCATT, including:

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- The challenge of making time to take time out to stop and think what is going on in the context of caring.
- Stepping back objectively and observing the culture in which care is being provided – to be critical/open minded about what is being observed.
- Reflecting on what has been observed.
- Staying 'neutral'
- Dealing with feelings and emotions when issues arise.
- The findings can lead to challenging, examining and changing established practices which may provoke some anxiety.
- Requires well-developed facilitation skills, particularly in relation to helping ward staff work through the issues and see it as beneficial to them, rather than another way of pointing out what they are doing wrong.
- Ward staff availability and time for facilitated discussions and action planning sessions are difficult.
- Staff change from one session to another owing to shift work, making continuity of discussions and action planning difficult.
- The process is fairly time consuming for observers and facilitators.
- Finding enough observers, particularly external observers, is difficult.

Lessons learned from using the WCCAT

The lead facilitators suggested that having a high degree of 'self-awareness' was important as an observer, as undertaking the observations provoked emotional responses that sometimes challenged one's own values and beliefs. One facilitator suggested that observers need to have '*intentional presence, as it is not just a paper exercise*'. This was reinforced by another facilitator, who suggested that:

'. . . it can be an "unpredictable venture" – there is some personal involvement and some risk taking that may cause "discomfort". There maybe a need to "debrief" with the support of others from the team if this situation arises – in other words, the sharing stays within in the group and the learning goes out'.

Preparation of observers, staff, patients and their families in the clinical units is essential, and facilitators reinforced the importance of spending time on this and not rushing into observation. In addition, the need to have the schedule of events, from observation through to feedback and action planning, was seen as critical, so that staff could feel included in the planning of the observation process and take ownership of it. All respondents agreed that 'longer observation sessions' were better:

'The challenge is how long to observe for . . . in the end, 2 hours seemed just right, as we could discuss as we went along and enough happened, and I left it to them which areas of the WCCT they focused on. Some stuck with a few observation areas, while others, like me, flicked through all the observation areas'.

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Finally, the view that the facilitators/observers need to do an overall evaluation of the process needs to be undertaken once the action plans are in place.

Summary

The WCCAT is a new tool that is being increasingly used in a range of PD programmes internationally. The framework underpinning the tool enables a systematic approach to the observation of practices to be realized. The tool relies on expert facilitators working with clinical teams to develop a programme of observation, data analysis, action planning and implementation that is collaborative, inclusive and participative. Without these principles, the WCCAT is in danger of being used as a 'management device', rather than a framework for empowerment. The observation areas are flexible and can be adapted to suit particular practice contexts. Further use of the WCCAT and evaluation of its effectiveness as a tool for PD is ongoing and will result in continuous development of the tool.

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Address correspondence to Professor Brendan McCormack, Institute of Nursing Research/School of Nursing, University of Ulster, Shore Road, Newtownabbey, Co Antrim, UK. Tel: +44 (0)28 9036 8187. E-mail: bg.mccormack@ulster.ac.uk

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Appendix 1. Example of WCCAT observation proforma

Observation area 3: Privacy and dignity

Observer prompts	Observation notes	Questions Arising
• Is patient privacy respected during specific procedures? • How is the valuing of diversity demonstrated *(including attitudes and behaviour towards minority groups – e.g. black and minority ethnic communities)?* • Are individuals' needs and choices ascertained and continuously reviewed? • How is the acceptability of personal contact (touch) identified with individual patients/clients? • How are the patients'/clients' personal boundaries identified and respected and communicated to others? • How is clinical risk handled in relation to complete privacy? • Note how privacy is effectively *maintained – e.g. curtains, screens, walls, rooms, use of blankets, appropriate clothing, appropriate positioning of patient, etc.* • Note how privacy is achieved at times when the presence of others is required • Note how modesty is achieved for those in transit to differing care environments • How are patients'/clients' views and needs ascertained and recorded? • Is information adapted to meet the needs of individual patients?		

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