Challenges of Undertaking an Action Research Project and Lessons Learnt from a Supervised Novice Researcher's Perspectives

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Pub. Date: 2017
Access Date: March 16, 2017
Academic Level: Intermediate Undergraduate, Advanced Undergraduate, Postgraduate
Publishing Company: SAGE Publications, Ltd.
City: London
Online ISBN: 9781473950306
DOI: http://dx.doi.org/10.4135/97814462730501559616 7

Abstract

This case study provides a lived experience of a post-graduate student undertaking an action research project with the assistance of her research supervisor. The rationale behind the choice of research methods and ethical dilemmas from the student's and supervisor's perspectives is addressed. The academic journey took place when I used action research as a theoretical framework, focusing on change and development of clinical practice. The project, part of my MSc in Advanced Practice in Health and Social Care, evaluated the implementation of a Specifically Designed Continence Assessment Pathway Tool in two nursing homes in London. This case study also offers an account of collaborative practice between myself and my supervisor, the design and methods used in the project, including the journey through the project's ethical rejection and eventual approval. The Ethics Committee had suggested that the project could be biased due to my proximity to the participants, as I could have the power to influence the nursing homes' staff. I almost gave up on the project. However, I'm glad that I didn't. Nonetheless, I argue that the closeness of the researcher to the study is an essential part of action research to encourage change and development to practice.

Learning Outcomes

- To appreciate the value of action research in the development of health and social care practice
- To discuss the impact of undertaking a research project on the novice researcher
- To elicit the benefits and barriers of using action research as a practice development strategy
- To raise awareness of the challenges of collaborative engagement between the academic research supervisor and the novice researcher

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Project Overview and Context

After achieving the number of required credits in September 2011, I embarked on an action research project journey for the dissertation part of my master's degree in Advanced Practice in Health and Social Care which focused on the evaluation of the implementation of a specifically designed continence assessment pathway tool (SDCAPT) in two nursing homes in the United Kingdom. Nothing could have prepared me for the challenges that I was about to experience over the following 2 years between September 2011 and September 2013. I designed a Gantt chart (Figure 1) and planned my work for the months ahead as my academic research supervisor had suggested. I made a list of dates for classroom lectures, deadlines for assignments' submission, ethical submission final date and the starting date for the data

collection. I also pencilled the write-up dates for some of the project chapters. Completing a Gantt chart was a faculty requirement for the research protocol assignment and seemed a good idea at the time, so I pinned it on my kitchen wall at home and by my desk at work. I tried to keep to the dates, but it was not long before I had unmet deadlines and had to rewrite the schedule (Figure 2). Balancing full-time work, part-time studies, family commitments and other demands was not always easy.

Figure 1. Gantt Chart (1) 2011–2012.

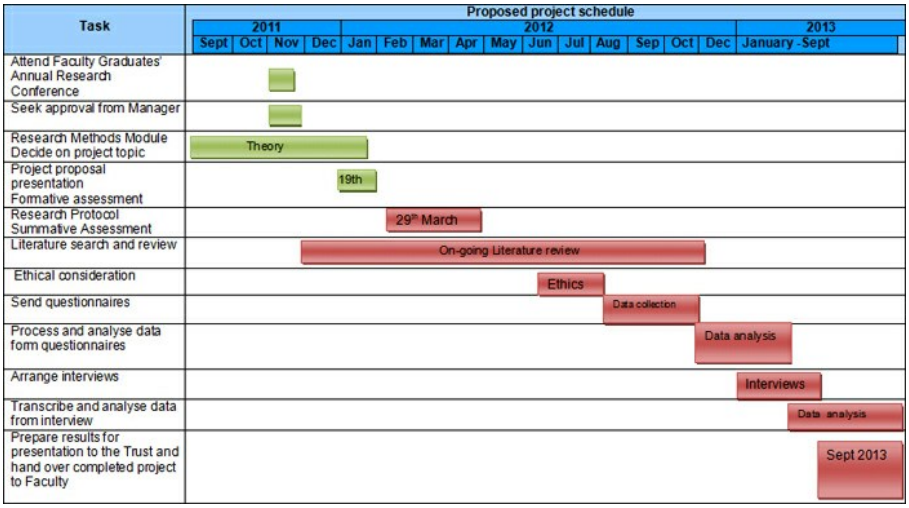
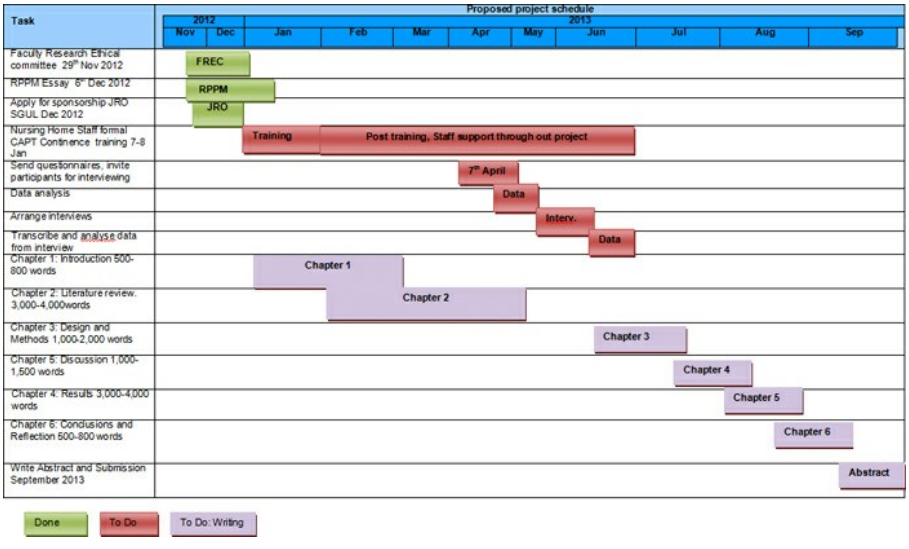


Figure 2. Gantt Chart 2012–2013.



Choosing the Project Topic

The faculty provided several lectures with regards to research methodology. All students were assigned to a research supervisor and I was fortunate to be assigned to Dr Sylvie Marshall-Lucette, who also supervised my BSc research project. Sylvie was familiar with my interest in continence assessments and older people as I was employed full-time as a Continence Nurse

Specialist. After several meetings and discussions on possible research topics, Sylvie said that there was ‘no need to re-invent the wheel’ and I needed to keep my project to something simple, but at the same time something clinically worthwhile that I was interested in and passionate about, as it would be part of my life for the next 2 years. At the time it didn't make much sense, but as I began my research journey through my project, I soon remembered those wise words.

The National Audit of Continence Care in the United Kingdom highlighted the negative impact of bladder and bowel incontinence on older people and revealed that this can affect one in five people, causing ill health and a number of psychosocial problems such as depression, social isolation, low self-esteem and lack of confidence as well as costing the National Health Service (NHS) millions of pounds. The findings pointed out that provision of continence care in the United Kingdom was poor in some areas and adherence to urinary and faecal incontinence guidance was variable across the country. However, my professional observations indicated that continence assessments are normally aimed at containment by the provision of incontinence pads rather than focusing on ascertaining the cause of the symptoms and finding a pathway for treatment. Furthermore, incontinence doesn't appear to be a priority for the government agenda or healthcare professionals. Hence, when I was given the opportunity of choosing a topic for my master's degree dissertation, I thought a project that addressed the identified incontinence problems and could make a difference to patients' quality of life in the area where I work.

Specifically Designed Continence Assessment Pathway Tool

My academic supervisor and I collaborated to develop the Continence Assessment Pathway Tool (CAPT). The following year through collaborative work, we published the findings of the study in a peer-reviewed professional journal (https://www.dropbox.com/s/zvn6d0lvvpqvlra/p34-41%20Divito.pdf?dl=0). Furthermore, CAPT was awarded several recognitions and five awards over the ensuing years, including the best free paper and best abstract at a national conference, the Development in Action Award at the Faculty of Health and Care Sciences and runner-up award for the university Bright Ideas Competition in London.

As a result of the positive reception to the CAPT, in October 2011, we decided that my research project would involve evaluating the implementation of an updated version of CAPT, a specifically designed Continence Assessment Pathway Tool (SDCAPT) in nursing homes using an action research approach as this focuses on collaborative change and development (Bellman, 2012).

Nursing homes in the United Kingdom are privately owned establishments, and most of the

homes do not commission continence care or staff training from local continence services. Usually, continence care is provided to residents by the nurses working at the nursing homes. However, continence pads are supplied free by the NHS to all patients who need them in any care setting including nursing homes. My employment is with the local continence community services, and I am in charge of the overview of the cost of pads in all settings including nursing homes. Lack of resources prevented the inclusion of all nursing homes in the local area in the study, so we agreed that the study would be undertaken in one nursing home; this was later changed to two nursing homes to address ethical concerns raised by the Faculty Research Ethical Committee (FREC) at my university (see Ethical Considerations section later in this case study).

The Action Research Journey

In the winter of 2011, the Gantt chart was on my wall, the supervisor assigned, the topic chosen, the assessed research proposal accepted and I was quite happy with the plan so far. The next step was to think about the research design and methods. The faculty lectures had included very little on action research methodologies and the literature available was scarce. However, my supervisor had suggested that I consider action research because of the practice development element of the topic, which involved evaluating the implementation of SDCAPT in nursing homes. I once again trusted her judgement and the more I read about action research, the more it seemed to fit my project ideas.

In the United Kingdom, the action research approach is often used by healthcare professionals to develop practice, and Koshy, Koshy, and Waterman (2011) argue that the importance of this method is to manage change in the NHS. The action research approach was therefore considered an appropriate theoretical framework, as it focused on collaborative change and development aiming to improve practice, thus involving nursing home staff in the process. Williamson and Prosser (2002) described action research as a new paradigm with features of mixed-methods approach, which could complement and confirm the findings of the study. Action research is different from traditional research in terms of ‘what, how and why’ is being studied, in the theory form and in that the researcher is part of the research project. This action research study sought to improve a social and clinical practice situation by evaluating the implementation of SDCAPT. As a Continence Nurse Specialist, I was part of the project and I offered expert continence advice into clinical practice guided by SDCAPT.

McNiff (2002) who has written extensively on action research believes that the principle that underpins this research approach can be illustrated as a cycle. It consists of identifying a problem, formulating a solution, implementing the solution and evaluating the findings. In light

of the evaluation, change to practice will take place. How the cycle was applied to the project is shown in the following:

- *identify the problem or area of practice to be investigated*. Inadequate continence service provision in local nursing homes highlighted the need to take action and make changes.
- *formulate a solution*. Implementation and evaluation of the SDCAPT in local nursing homes was proposed.
- *implement the solution*. Nursing home staff were trained, SDCAPT was implemented and progress was monitored.
- *evaluate the solution*. SDCAPT was evaluated through staff self-report questionnaires and analysis of secondary existing data provided by the home delivery service.
- *change practice*. Practice change proposal was based on study recommendations.

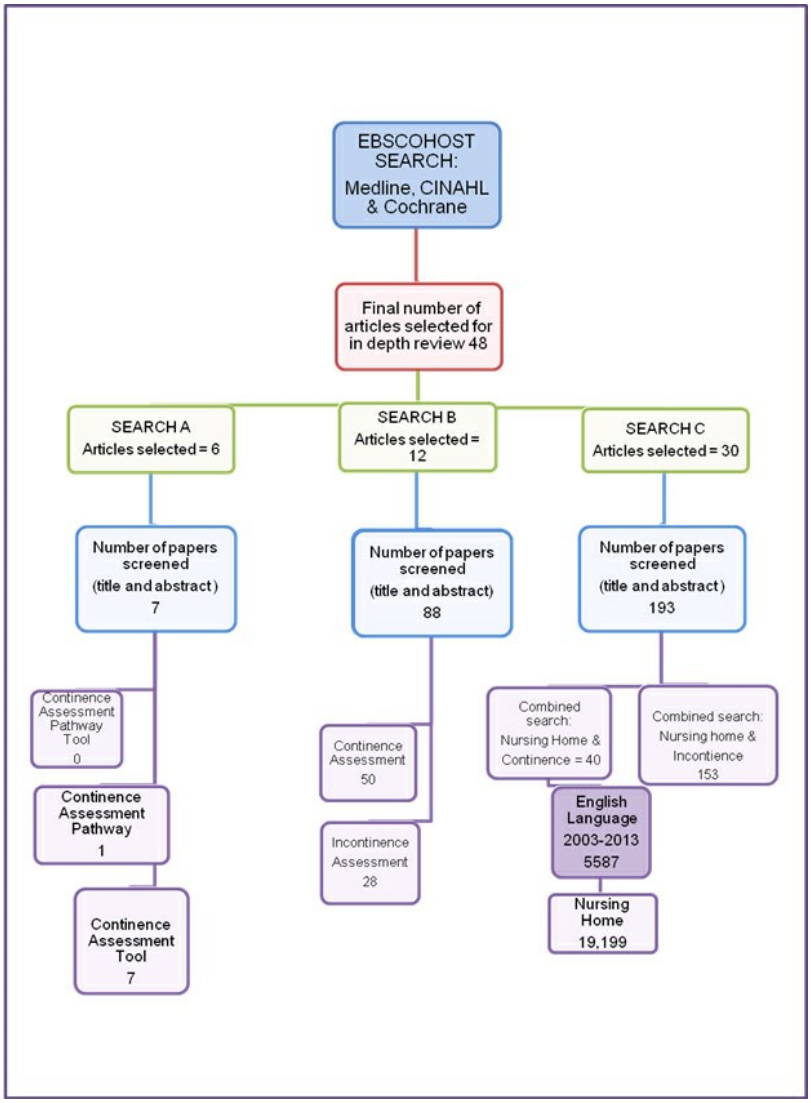
Access and Sampling

A non-probability purposive sampling method was chosen because it allows the researcher to select the most appropriate participants who are considered capable of answering the research questions, within a set of inclusion and exclusion criteria. As such, my professional experience of the target population helped me with the selection process. A letter was sent to the nursing home managers to inform them of the project's aim and plans to provide support training and implementation of the new assessment documentation during the implementation phase, which included SDCAPT. All Registered Nurses and Healthcare Assistants working at both nursing homes were invited to participate.

The Project

The action research study commenced in September 2011. The first year was mainly used to write essays, plan the project and write the first chapters of the dissertation such as the project introduction and literature review. Searching for up-to-date literature and selecting articles for reading was time consuming, so I organised the task by creating a graph (see Figure 3). Most of the summer months of 2012 were used to develop the SDCAPT. By September that year, I was considering ethical issues which were mainly concerned with approval from the organisation that I work for and the nursing homes manager. Unfortunately, this was not as straightforward as I thought because faculty approval from the research committee was also needed. The forms were submitted, then rejected in December 2012 but later approved in February 2013.

Figure 3. Search strategy.



The practical side of the project took place from February 2013 with the implementation of SDCAPT, during 2 days of training to healthcare staff at the two nursing homes. At the end of the training sessions and during the implementation period of 3 months, posters with an illustration of SDCAPT were displayed in the nursing homes and all the attendees were provided with a SDCAPT booklet to support information given during the training. Providing written information from lectures to students is an important aspect of teaching and learning as information can empower people. It was unfortunate that only 42% (n = 46) healthcare professionals attended the free bespoke training. The next step was sending the questionnaires to ascertain the staff views on SDCAPT

Methods of Data Collection

Following training on the implementation of SDCAPT in February 2013 to all qualified nurses

and healthcare workers involved in patients' incontinence management, self-report questionnaires were sent through a postal service in May 2013, 3 months later to allow the participants time to use the tool and ascertain its effectiveness. Advantages and disadvantages of using questionnaires to obtain data were considered, and a table with easy to read information was designed for the research study based on Oppenheim (2000) suggestions (Table 1). After hours of searching online and at the faculty library, I was unable to find a validated questionnaire that would have been applicable to the project. Therefore, I specifically designed a questionnaire to answer the research questions that addressed the study aim and objectives. Following the distribution of the questionnaires, only two completed questionnaires from one nursing home were returned. This was very upsetting to me, as I had put so much effort into delivering the training and designing the forms and the training booklet. I was told that the staff had been too busy to complete the questionnaires. I guess this activity was very low on the staff priority list. My manager at the continence service had allowed me to use hours from my regular working time for this project. I stayed late at work and also spent many weekends at home reviewing, researching and updating the project. I wanted the project to be worth all the extra effort I put in. I was therefore very disappointed with such low response. I telephoned the homes to ask whether they were aware of the closing date for returning the forms and found that the questionnaires had been placed in the incoming post tray of the lead nurses. The nurses had been either on holiday or too busy to distribute them. The manager of the homes agreed that I could send the questionnaires again. This time I addressed each envelope with the participant's name to invite them to take part. Furthermore, I visited each home and delivered the questionnaires myself. I took this opportunity to speak to the nurses to encourage participation. The extra hours and the extra trips to the homes were worthwhile, as the final response was very satisfactory with 90% (n = 19) questionnaires collected from Home A and 72% (n = 18) from Home B by June 2013.

Table 1. Advantages and disadvantages of postal questionnaires (Oppenheim, 2000).

Advantages	Relevant to study	Disadvantages	Relevant to study
Low cost	YES	Response may be low	YES
Anonymity protected	YES	No opportunity to clarify questions	YES
Bias avoidance form interviewing	YES	Cannot ensure that questions are answered in groups or passed to others	YES
Easy to use	YES	Relies on literacy skills	YES
Familiar to respondents	YES	Questionnaires may have saturate the population	Possibility
Can be used for large studies	NO	Reponses maybe guided by the perception of the topic	Possibility
Easy to answer and analyse	YES	Reponses may be influence by the quality of the design	YES

Secondary Data

I also collected quantitative retrospective secondary data from the local home delivery service, including the number of nursing home patients in the service, pads usage and cost of patient-per-pad-use per day. The data collected from the two selected homes gathered coincided with the implementation and evaluation of SDCAPT. Jolley (2010) argues that there are fewer ethical issues when using data that have been collected and analysed by a secondary source; however, having access to the data, storage and publication may present a problem. I acknowledged these issues and did not anticipate any complications.

Data Analysis

The analysis of this action research project aimed to explore the deviations in data, compare findings between the two participating homes and the relationship of the data provided by Registered Nurses versus Healthcare Assistants, as well as establishing the efficacy of CAPT. The questionnaires were coded and all data entered into statistical software, Statistical Package for Social Sciences (SPSS) version 20. All responses were included as missing data were insignificant.

Secondary data used were acquired through the home delivery database. As part of my employment as a Continence Nurse Specialist, I manage the patient database which contains information on demographics and pad use, pad cost and deliveries. In addition, quarterly reports are produced by the home delivery service. I analysed the data using Microsoft Excel and presented the data in tables and bar charts.

Ethical Considerations

The results of the project proposal assignment came through by March 2012 with good comments from the two examiners who marked my research proposal independently and then moderated the work to agree on a mark and grade. Our faculty examination regulations stipulate that one of these examiners be my research supervisor and the other one must be a lecturer from the Research Methods teaching team; the moderated work is further assessed by an external examiner from a different university, appointed on a 4-yearly rotational basis, by the Course Director. This rigorous approach is in place to add to the quality control element of our post-graduate dissertations and theses assessments process. Subsequently, all I needed was to keep to my Gantt chart of activities and cross the boxes off as the activities were completed. I worked diligently for long hours and developed the SDCAPT booklet throughout the summer of 2012. This booklet was to be provided to the project participants to complement the pathway chart during the continence training to the nursing home staff (https://www.dropbox.com/sh/zysgmqwej3sh7ic/AABXWBECttLqTS9rOluJ3Np8a?dl=0).

My understanding from the faculty lectures and the student handbook was that I did not need ethical approval because there were no patients involved in my project. However, the manager of the continence service that I work for needed to agree to the project and I also needed to complete a health and safety risk assessment which I did. Unfortunately, this information was inaccurate at the time because there had been some amendments to ethical approval guidelines for students' research studies. Two months later, I was told that my project would need to be approved by the university's FREC because data were to be collected from non-NHS staff. I didn't think that this would be complicated. In comparison with fellow students who had to summit for full ethical approval, it seemed like I was the lucky one since I needed only to fill out a relatively short form with the study details. However, when I sat down to fill out the form, I realised the complexity of the task. I had an idea and a proposal of the project, but the final details had not been decided at that point in time and details were requested by the FREC. The committee wanted to know all, even the small, details and also needed to see the booklet that was to be used for training. I had almost completed the writing of the booklet but needed to demonstrate that I had copyright clearance from the companies allowing me to use their images and illustrations in the booklet. Finding the right person from the companies with the authority to grant the copyright clearance of their images was challenging. Finally, the form was submitted in early December 2012 and I happily set off for an early Christmas shopping day.

Two weeks before Christmas, my application was rejected because the FREC had ethical concerns and required clarifications before my application could be fully considered. The FREC

strongly advised me to work closely with my supervisor to address these concerns. Among a list of other issues, the FREC had suggested that there was

> an opportunity for significant bias to be introduced, a concern for a possible conflict of interest, a coercive power relationship and that due to potentially small participant numbers, care must be taken to ensure that identification by implication does not occur.

It was also unclear to the committee what additional information would be gained from the interviews that I initially planned to undertake, and it was suggested that the questionnaire alone should be used as ‘this would have an additional effect of removing some of the power and bias concerns’. The committee suggested that should the interviews be required, the involvement of an independent interviewer ‘might be worth considering’. The latter suggestion, to me, was out of the question because I wanted to learn about research interviews and collect all the data myself under the guidance of my research supervisor, and I lacked the resources to delegate this task.

In response to the FREC recommendations, as recommended by Bellman (2012), I reviewed my position, acknowledged the ethical issues and my potential coercive power relationship within the action research project. Coghlan and Brannick (2012) have suggested that action research studies may be influenced by the researcher's ‘bias’ due to the proximity to participants, in particular for those working in their own organisation. As I work for the local continence service and overview the provision and spend of continence products supply to nursing homes, it could be perceived that I had the power to influence the nursing home's staff. On the other hand, Waterman et al. (2007) argue that the investigator's closeness to the study is an essential part of action research to encourage change to practice. Furthermore, as Williamson and Prosser (2002) suggest, this could be strength with ethical weakness. The main changes that my supervisor and I made were to remove any potential coercive relationship and bias by removing the interviews, thus relying on the questionnaires and secondary data for data, as well we included a second nursing home to maximise participation and responses.

Consequently, I became very distressed and almost gave up on the research project and felt that my ‘whole world of action research’ had crumbled. I spent the next few weeks trying to make the changes and chasing people, negotiating and almost begging for help. Additionally, a member of the continence team left the organisation. This doubled up my workload, and I had to lead the service with little experience in some of the clinical practice areas. I called my academic supervisor and told her that I was thinking of giving up at this point so that I could enjoy Christmas with my family. At the university, lecturers often talk about the need for *work–*

play life balance, but I felt that in my life at the time there was no balance and that I was missing so much of my family time and no matter how late I stayed at work, I could not see ‘the light at the end of the tunnel’. However, my academic supervisor helped and supported me, and I am sure that she has also missed a few Christmas dinners herself, but hard work and determination led to the resubmission of the project in January.

Specifically Designed Continence Assessment Pathway Tool Booklet Ethical Considerations

I had been working towards this project for a number of years, and finally, it was taking place. I had developed the SDCAPT booklet and my supervisor overviewed the academic content in preparation for printing. I had taken for granted that the work would flow as planned in the Gantt chart, in an orderly manner. However, the schedule was not working as planned but far from it, as the project had come to a halt. I did not have ethical approval for the project, and I suddenly realised that I also had to consider the ownership of the SDCAPT booklet and copyright. Questions were raised: Who did the booklet belong to? Was it the organisation that I worked for? The nursing homes? The faculty? I couldn't think clear and I felt it was unfair that other people could potentially claim ownership of my booklet; hadn't I written it? I felt unsure whether I had taken on a project that was too complex and becoming unmanageable. I had the clinical and practical nursing knowledge but lacked the business awareness and negotiation skills to see the project through. I thought about not using the booklet. But, I was able to discuss my concerns with my research supervisor, and it became clear that the booklet would make the project robust and it was worth considering.

A discussion with my manager clarified that I owned the booklet. My manager agreed that I could approach the company who manufactures the continence products that we provide for patients to request funding for the printing of the SDCAPT booklet and wall charts. The Code of Practice for the Pharmaceutical Industry states that gifts or advantages must not be offered to healthcare professionals as inducement to prescribe or recommend any medicines. Furthermore, the Nursing and Midwifery Council requests that nurses are not to be influenced by commercial considerations. A pertinent point to make is that the organisation that I work for spends 98% of the overall expenditure on continence products provision on this particular company due to the high quality and effectiveness of their products. The incontinence product manufacture generously provides my employer with a regular yearly educational fund, and therefore, the company agreed to cover the cost of the booklet printing. Coghlan and Brannick (2012) suggest that in action research, engagement in the organisational political system, including budgeting, is a requirement for maintaining credibility as an effective project driver. The key point to note is that I was able to reflect and I learnt from the experience, became more confident and moved forward.

Conclusion

The literature on continence that I reviewed highlighted the negative impact incontinence has on people's life and the public perception that it is part of ageing extends to healthcare professionals. Incontinence is a treatable and often curable embarrassing condition that is often managed by the provision of incontinence products rather than by identifying the problem and treating the underlying cause. Several authors have identified poor continence assessment documentation, inequality of service delivery, lack of knowledge and lack of resources. Many had made recommendations for practice change; unfortunately, the changes are few and slow in the United Kingdom.

The main reason for my research project study was to ascertain nursing home healthcare professionals' views of SDCAPT for continence management. The results provided evidence that SDCAPT is easy to use and participants agreed that all steps of SDCAPT should be included in a continence assessment. The analysis demonstrated no statistically significant difference in the responses provided by the two homes with regard to the healthcare professionals grade or to gender. Secondary data demonstrated a reduction in the cost of pads used across both nursing homes. SDCAPT avoids the use of unnecessary incontinence pads as correlated by three quarters of the participants. The significant savings when pads are used appropriately could be used to engage commissioners to implement SDCAPT in other local nursing homes, therefore extending the benefits to a wider community.

The journey through my research was at times challenging and difficult. Identifying a problem in clinical practice and finding a solution led to the implementation and evaluation of SDCAPT in two local nursing homes. Doing research is complicated because it needs to be well thought out and precise. Receiving a request for a resubmission of ethical approval was demoralising at the time. At the time of the events, in my opinion, FREC had felt that my project within the framework of action research had the potential of being biased. I felt that the committee failed to recognise my enthusiasm of trying to prove that incontinence can be cured and pads are not the only way of managing incontinence. However, when reflecting on the situation and analysing the FREC decision, it became clear that the Ethics Committee acted on one of their key responsibilities of protecting the study's participants and I can now acknowledge that the FREC probably recognised my enthusiasm for the project but had a responsibility to consider the participants.

Nonetheless, I felt so despondent about the whole situation that I almost gave up this long and hard research journey. Furthermore, the designing of the SDCAPT booklet to enhance learning

during the training took hours of writing and development, and negotiating funding to pay for the booklet printing was challenging. However, encouragement and fantastic supervision from my academic supervisor to ‘soldier on’ and her belief that my project was worthwhile in the advancement of clinical practice and subsequent approval from the FREC made my action research project possible.

The nursing home staffs' poor attendance to my bespoke free training suggests that due to lack of resources in nursing homes, nurses have to prioritise their daily clinical work, and although the staff do provide basic continence care, carrying out continence assessments is not on their list of urgent priorities and is often postponed or ignored. At the time this led me to question the value of my efforts to develop practice. However, while writing the last few sentences of my research project, I felt that I had adequately demonstrated that SDCAPT was easy to use by healthcare professionals in nursing homes to improve the quality of life of patients who are incontinent and that appropriate assessments are cost effective, which in turn can save the NHS money. Overall, my research journey provided me with the opportunity to advance an important aspect of my clinical practice through action research and the literature notes that this is an ideal framework to bring about change and development in clinical practice, but change requires commitment, determination and resilience. As my academic supervisor would say, ‘it's the little things that make a big difference’ and I am happy I took small step in the world of continence.

Exercises and Discussion Questions

1. In the study, I described myself as a novice researcher. Think of an example where you may be a novice and an example where you may be an expert. Describe your experiences as both novice and expert.
2. Assessment tools are widely used in nursing practice for a variety of conditions; what types of assessment tools have you used? Please describe them. Discuss whether you feel that tools aid the assessment process, whether they were easy to use and why.
3. In my action research project, I did not receive ethical approval on the first attempt. How would you prepare for the ethical approval process to avoid a rejection?
4. In this case study, I discuss my work–life balance between academic work and personal life. What do you suggest you can do for maintaining focus and motivation in your research project while still making time for a personal or private life?

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