Developing and Sustaining a Practice Based Strategy for Reducing Healthcare Associated Infections Programme

Foundation of Nursing Studies in Partnership with NHS London

Evaluation Report

July 2012

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Acknowledgements

Our sincere thanks to NHS London and Trish Morris-Thompson, Chief Nurse for funding and supporting this initiative. We also appreciated the support of Colin Ovington, Guy Young and latterly, Sara Blakey working in the role of NHS London Turn Around Director for Infection Control; thank you for taking an interest in and providing ongoing support to the programme and encouraging participants.

Thanks also to all the Directors of Nursing and managers who supported the projects in their organisations and lastly, and most importantly, all the participants who embraced the programme and the opportunities to improve patient care.
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Abstract

The Foundation of Nursing Studies (FoNS) has a long history of working with nurses and healthcare teams to develop and share innovative ways of improving practice. This FoNS programme in partnership with NHS London aimed to enable clinically based project teams to implement a strategy for developing, changing and evaluating practice to reduce/prevent healthcare associated infections. Using practice development methodology and methods the programme created a desire to change practice by providing opportunities for the clinical teams to explore and therefore develop a greater understanding about their practice, the significant role they had in reducing healthcare associated infections and stimulated ideas for achieving development and change.

16 project teams started the programme, 13 completed the programme/project, and 13 project teams provided a final report (11 reports as some teams combined reporting).

Through the collection of multiple forms of evidence this evaluation found that nine teams reported reductions in healthcare associated infections and/or improvements in practice that would contribute to reducing risks of healthcare associated infections. Of significance in achieving this was the:

- Clinical leadership roles held by project leaders (e.g. ward managers)
- Effective strategic support
- Use of a wide range of practice development methods
- Involvement of the clinical teams

There was less evidence to demonstrate changes to patients’ satisfaction with care. Although many areas planned to gain patient experiences of care, generally the project teams found this challenging and most were not able to achieve this within the timescales of the programme.

Achieving change was not without difficulty and many of the project leaders acknowledged that the process of change had been complex and often slower than desired. However, increased awareness of the barriers to developing practice resulted in recognition of the need to get the workplace culture ‘ready’ for practice development before they could make any significant impact on infection control practice. It was also the case, however, that most of the teams were working in complex organisational contexts and for some, these complexities e.g. ward moves, closures and staffing changes were too significant to overcome within the timescale of the programme.

This report expands on the participants’ experience of the programme, outcome for practice and key learning that has relevance for a wide range of practice areas seeking to develop, change and improve practice.
1. **Introduction**

1.1 **The Foundation of Nursing Studies (FoNS)**
FoNS is a small independent charity that works with nurses and healthcare teams to develop and share innovative ways of improving practice. The ultimate purpose of FoNS is to improve patient care. FoNS aims to achieve this by enabling and supporting nurses and nurse led teams working in any healthcare setting UK-wide to develop themselves and their practice.

1.2 **FoNS values:**
- Working with nurses and all stakeholder groups
- Nursing which is compassionate, safe and person-centred
- Knowledge, recognising that both theoretical and practical knowledge contribute to excellence in patient care
- The patient and wish to see their voice, experience and involvement shape the delivery of nursing practice
- Clinical and academic learning, leadership and ways of working that transform workplace cultures and inspire nurses as a caring profession
- Collaboration and partnership

1.3 **FoNS has expertise in:**
- Enabling collaboration and participation
- Using evidence from a variety of sources to inform developments in practice
- Learning in and from practice through critical reflection
- Working with processes that enable attitude and culture change
- Achieving clinical outcomes
- Sharing the learning and successes of others

2. **The Programme**

2.1 **Background to the programme**
Everyone agrees it is essential that people experience healthcare that is safe and of high quality. One aspect of care, which continues to generate a high level of concern, is the increase in healthcare associated infections (HAI). Whilst the responsibility for continuously improving the quality of care lies with all healthcare professionals, nurses as direct caregivers have a key role in identifying potential problems and leading change. FoNS developed the programme following discussion with the Chief Nurse at NHS London regarding how adopting a practice development approach could help clinical teams address some of the ongoing problems associated with the occurrence of HAIs.

2.2 **The aims of the programme were to:**
1. Explore issues around the responsibility of nursing teams in reducing/preventing healthcare associated infections
2. Identify practice problems related to reducing/preventing healthcare associated infections
3. Develop a proposal for a practice development project/initiative to improve an aspect(s) of practice that will reduce/prevent healthcare associated infections
4. Enable the implementation of a strategy for developing, changing and evaluating practice

2.3 Overview of the programme
The programme ran from April 2009 – December 2011. Table 1 outlines the key activities that were involved in the programme.

<table>
<thead>
<tr>
<th>Date of activity</th>
<th>Outline of activity</th>
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<tbody>
<tr>
<td>April 2009</td>
<td>Recruitment of projects for cohort 1</td>
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<td>April 2009</td>
<td>Cohort 1 Workshop 1</td>
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<tr>
<td>July 2009</td>
<td>Cohort 1 Workshop 2</td>
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<td>October 2009</td>
<td>Cohort 1 Workshop 3</td>
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<td>October 2009</td>
<td>Recruitment of projects for cohort 2</td>
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<tr>
<td>November 2009</td>
<td>Cohort 2 Workshop 1</td>
</tr>
<tr>
<td>February 2010</td>
<td>Cohort 1 Workshop 4</td>
</tr>
<tr>
<td>February 2010</td>
<td>Cohort 2 Workshop 2</td>
</tr>
<tr>
<td>May 2010</td>
<td>Cohort 2 Workshop 3</td>
</tr>
<tr>
<td>June 2010</td>
<td>Cohort 1 Workshop 5</td>
</tr>
<tr>
<td>September 2010</td>
<td>Cohort 2 Workshop 4</td>
</tr>
<tr>
<td>December 2010</td>
<td>Cohort 2 Workshop 5</td>
</tr>
<tr>
<td>January 2011-December 2011</td>
<td>Support with report writing</td>
</tr>
<tr>
<td>April 2009 – April 2011</td>
<td>Site visits by FoNS Practice Development Facilitator</td>
</tr>
</tbody>
</table>

2.4 Recruitment to the programme
The programme was advertised via NHS London and through direct email to all Nurse Executives across London. Nurse-led teams did not need to have a specific project aim, however, within their application they were asked to identify a practice issue in relation to healthcare associated infections and to provide evidence that the clinical team were willing to work together to improve practice. All applications needed to have the support and approval of the Nurse Executive who together with the project leader were required to meet the terms and conditions of taking part in the programme (see Appendix 1).

A total of 16 nurse-led teams were recruited to the programme in two cohorts. Only one project was community based. The first six teams were recruited in April 2009; two of these transferred to cohort two and the remaining four completed in October 2010. A further ten teams were recruited in October 2009 to cohort 2, giving a total of 12. One of these project was only able to take part on an ad hoc basis and therefore withdrew from the programme, two further projects at one site ended after 12 months due to organisational change (the two wards involved in the project were closed and the project leaders changed roles). These projects were all completed by April 2011.

An overview of each team and the focus of their work are outlined in Tables 2 and 3.
Table 2. Cohort One: project titles, teams and locations

<table>
<thead>
<tr>
<th>Project title</th>
<th>Teams and locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Surgical Site Infections</td>
<td>Anne Clearly, Quality and Nurse Development (later replaced by Caroline Foley); Alix Carbon, Ward Manager; Lesley Porteous, Surgical Matron; Chris Lloyd, Tissue Viability Nurse Orthopaedic Ward 7 South, Ealing Hospital, Ealing NHS Trust</td>
</tr>
<tr>
<td>Preventing Infections in an Intermediate Care Setting through Cleaning Patient Equipment</td>
<td>Diana Carne, Matron; Christine Murphy, Infection Control Nurse Denham Unit, Intermediate Care Unit for Older People, Harrow PCT</td>
</tr>
<tr>
<td>Preventing Methicillin-Resistant Staphylococcus Aureus Bacteraemia by Reducing Contamination of Blood Culture Sampling in an Emergency Department</td>
<td>Anna-May Charles, Matron; Rachel Ben Salem, Senior Infection Control Nurse; Robin Khariuk, Practice Development Nurse Emergency Department, Newham University Hospital NHS Trust</td>
</tr>
<tr>
<td>Developing a Culture where Nursing Practice is Consistent with Infection Control Prevention</td>
<td>Tina Jegedy, Matron; Fiona Paterson, Practice Development Nurse Cavell Ward, Jeffrey Kelson Unit, Whittington Hospital NHS Trust</td>
</tr>
</tbody>
</table>

Table 3. Cohort Two: project titles, leaders and locations

<table>
<thead>
<tr>
<th>Project title</th>
<th>Teams and locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Patient Safety through Better Infection Prevention Information to Patients Delivered by Ward Staff (Two projects which ended after 12 months)</td>
<td>Gaby French, Practice Development Nurse; Sheila Howard, Team Manager, Infection Prevention Surgery and Cardiology, Queen Mary’s Hospital Sidcup</td>
</tr>
<tr>
<td>The Reduction of Catheter Associated Urinary Tract Infections through the Implementation of the Short Term Catheter Care Bundle (Two projects)</td>
<td>Debbie Dzik Juraz, Assistant Director of Nursing; Jenny Kirsh, Modern Matron, Infection Control; Jo Prytherch, Head of Nursing, Pre and Post Registration Whipps Cross University Hospital</td>
</tr>
<tr>
<td>Reducing Catheter Associated Urinary Tract Infection</td>
<td>Elaine Glanville, Ward Manager; Selma Mehdi, Infection Control Nurse Heberden Ward, St. George’s NHS Trust</td>
</tr>
<tr>
<td>Developing Practice and Reducing Diarrhoea through Hand Hygiene</td>
<td>Vicky McGauley, Practice Development Nurse; Diana Belshaw, Ward Manager Ward 8 North (Elderly Medicine) Charing Cross Hospital, Imperial College NHS Trust</td>
</tr>
<tr>
<td>Embedding a Consistent Approach in the Care of Central Venous Catheters in Homerton ITU</td>
<td>Tina Stubbs, Practice Development Nurse; Emmaline Sakyi, Senior Staff Nurse General Intensive Therapy Unit (Adults), Homerton University Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Title</td>
<td>Authors</td>
</tr>
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<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Developing and Sustaining a Practice Based Strategy for Reducing Healthcare Associated Infections in Critical Care</td>
<td>Sarah Carter, Senior Sister; Suzanne Daniels, Practice Development Nurse Adult Intensive Care Unit, The Royal London Hospital</td>
</tr>
<tr>
<td>Supporting House Bound Clients to Prevent Healthcare Acquired Infections in their Own Homes</td>
<td>Saw Ean Lee, Infection Control Lead; Karen Gordon, Head of Quality Assurance City and Hackney Teaching PCT (Transferred from cohort one)</td>
</tr>
<tr>
<td>Gaining Patients’ Experiences of Care to Improve Infection Control and Prevention Practice</td>
<td>Toni Lynch, Consultant Nurse; Anne Rush, Matron Elderly Medicine, The Royal London Hospital</td>
</tr>
<tr>
<td>Reducing the Incidence of Surgical Site Infections</td>
<td>Denyse Ghisayawan, Assistant Matron; Adriana Mitchell, Ward Manager; Hannah Georgeson and Mervyn Andiapen, Staff Nurses Leander Ward and Vicary Ward, London Chest Hospital</td>
</tr>
<tr>
<td>Developing Staff Knowledge and Skills in Preventing Healthcare Acquired Infections</td>
<td>Gus Brown, Unit Manager; Loise Muema, Staff Nurse Queen Mary’s House, Camden and Islington Foundation NHS Trust (Transferred from cohort one)</td>
</tr>
</tbody>
</table>

2.5 Role of FoNS practice development facilitator

A FoNS practice development facilitator was responsible for the day-to-day management of the programme. The facilitator provided expert support and facilitation to the project leaders in practice development methods and processes through a programme of five workshops, face-to-face meetings, work based activities and regular email correspondence. Prior to the first workshop the facilitator visited each site to meet the core project team and discuss the programme.

The number of visits per site by the facilitator ranged from 3-11 over the course of the programme. Each project also received £5000 to support the project. Alongside this, they were given a CD-rom of the RCN Workplace Resources for Practice Development. In addition, the FoNS practice development facilitator had regular contact with the NHS London Turn Around Director for Infection Control.

2.6 Workshops

A workshop programme was developed consisting of five workshop days. These were attended by the core project team (maximum 3 per project) who had responsibility for leading the project. The workshop programme facilitated the teams systematically through a practice development project including project development, implementation, data collection and analysis and report writing. The aim was to introduce practice development theories, methods and approaches and to enable participants to use these to inform their projects back in practice with their teams. To achieve this, a key aspect of the workshops was the development of the project leaders as facilitators and practice developers.
Each workshop had aims and learning outcomes that supported the overall aims of the programme. However, there were core aims that spanned all the workshops which enable the participants to:

- Network and share with the other participants
- Engage in active learning
- Reflect on their own learning and the transfer of learning into and from their own workplace
- Develop knowledge, skills and understanding about practice development with and from others
- Implement and evaluate the development of practice

The workshops were facilitated by the lead practice development facilitator for the programme and other members of the FoNS team.

A more detailed outline of each of the workshops can be found in Appendix 2.

2.7 Practice development approach

The overarching methodology used to inform the programme was emancipatory practice development (Manley et al., 2008). The purpose of emancipatory practice development is to develop person-centred cultures of care by developing people and their practice. Practice development emphasises the importance of practitioners understanding their work based culture and the impact that this has on developing practice. This methodology focuses on developing self awareness and insight into practice, leading to empowerment of those making changes to practice. The methods used within the programme aimed to raise awareness about and to challenge everyday ways of working that had become habitual practice. The development and empowerment of the practitioners is deliberate and focuses on maximising the potential of individuals to grow and develop (McCormack and Titchen, 2007). This was achieved through practitioners engaging in active methods of learning about their practice and reflection.

Whilst a variety of practice development methods and approaches were used by the project teams, there were a number of core approaches that were used by most teams. These included:

- Context Assessment Index – understanding culture and context
- Values clarification exercise working with values ...
- Workplace Culture Critical Analysis Tool
- ‘Snap shot’ observation tool – observing practice
- Clinical Audits
- Capturing patient experiences

Further information about these approaches can be found in Appendix 3.

3. Evaluation of the Programme

It is necessary to undertake a formal evaluation of the programme for both FoNS and NHS London to determine how effective it had been in enabling improvements in infection
control prevention and practice. An evaluation framework for the programme was developed that captured the evaluation aims, processes and means of gathering data (see Appendix 4). This was a challenging process due to the complex nature of healthcare and the wide range of stakeholders involved; however, from the framework it is possible to formulate a number of evaluation questions.

Did the programme enable project teams to:
- Reduce healthcare associated infections?
- Develop a local strategy to reduce healthcare associated infections?
- Develop their knowledge and skills of developing practice?

Did the programme enable project teams to work with staff to:
- Understand the contextual factors that enhance or hinder the implementation of best practice?
- Raise awareness of the individual and the team regarding roles and attitudes towards healthcare associated infections?
- Understand the significance of their practice to patient care?
- Increase staff knowledge and skills in their role to reduce healthcare associated infections?
- Improve patient satisfaction with care?

3.1 Participants
The following people participated in the evaluation:
- Project leaders/facilitators
- Members of the project team who have been involved in the programme
- FoNS practice development facilitators

3.2 Evaluation evidence
The following evidence was reviewed and analysed to answer the evaluation questions:
- Final reports
- Workshop evaluations (see Appendix 5)
- Project leaders’ reflections on becoming a practice developer (see Appendix 6)
- Creative session of the project leaders’ journey through the programme (see Appendix 7)
- Feedback from the project leaders on the role of the FoNS practice development facilitator (see Appendix 8)

An outline of all the evidence is provided below with further information in the appendices. An overview and discussion of the programme outcomes follows in section 4; in this section, the source of the evidence will be identified.

3.3 Analysis of project reports
All the project reports were read and re-read by Jayne Wright (JW) and Kate Sanders (KS) and outcomes, challenges, opportunities, learning and evidence of stakeholder involvement have been identified (see Table 4). Where no final report was submitted JW’s knowledge of the projects from working with the teams was used.
<table>
<thead>
<tr>
<th>Project</th>
<th>Outcomes</th>
<th>Produced a report</th>
<th>Learning, opportunities and challenges</th>
<th>Stakeholder engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing Surgical Site Infections Orthopaedic Ward 7 South Ealing Hospital Ealing NHS Trust</td>
<td>There was a decrease in surgical site infections when comparing pre and post project infection rates (8→5) All RNs on the ward have completed wound care competency training RN’s knowledge and skills in wound care, identification of surgical site infections and aseptic technique improved Patient involvement in wound care now encouraged by staff The collection of patient stories is embedded in practice. These are discussed weekly by the nursing team and practice changes agreed e.g. offering analgesia before wound care</td>
<td>Yes</td>
<td>Nursing team learnt about the challenges of gaining patient experiences in a meaningful way and how to use the feedback to implement changes to their practice The nursing team recognised the need for on-going work to improve patient information Other ward areas keen to learn from Ward 7 South’s experiences The project team working alongside staff in practice was an effective way of engaging staff in learning The project lead left near the end of the project</td>
<td>Context Assessment Index completed by Registered Nurses (RNs) and Health Care Support Workers (HCSWs) Values clarification exercise completed by RNs and HCSWs Wound infection audit undertaken by RNs Wound care knowledge questionnaire completed by RNs Patients experiences of wound care collected by RNs and later HCSWs and student nurses Ward team meetings including occupational therapist (OT) and physiotherapist (PT)</td>
</tr>
<tr>
<td>Preventing Infections in an Intermediate Care Setting through Cleaning Patient Equipment Intermediate Care</td>
<td>The cleanliness of the underside of equipment improved as demonstrated by photographic audit Environmental changes were made to reduce infection opportunities e.g. introduction of easy clean light sheets</td>
<td>Yes</td>
<td>The ward manager learnt the value of adopting a facilitative style of leadership, to help staff take ownership of the project and develop practice An external facilitator can</td>
<td>RNs and HCSWs all chose and undertook individual activities to explore current practice e.g. taking photographs of equipment, audit of ward cleanliness, visiting other units, observing practice, reviewing infection control papers</td>
</tr>
<tr>
<td>Preventing Methicillin-Resistant Staphylococcus Aureus Bacteraemia by Reducing Contamination of Blood Culture Sampling in an Emergency Department</td>
<td>Preventable infection rate reduced by 33%</td>
<td>Yes</td>
<td>Values clarification exercise completed by 15 staff from Emergency Department and Medical Assessment Unit</td>
<td></td>
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<tr>
<td>---</td>
<td>Preventable bacteraemias acquired in hospital reduced by 50%</td>
<td>Web-link: <a href="http://www.fons.org/Resources/Documents/Project%20Reports/LSHANewhamJune2011.pdf">http://www.fons.org/Resources/Documents/Project%20Reports/LSHANewhamJune2011.pdf</a></td>
<td>Observation of practice undertaken by ward manager or infection control link nurses</td>
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<tr>
<td>Audit of hand hygiene compliance showed 90+% compliance (90-100%) for 6 months (as compared with 51-82% in previous 6 months) following the introduction of weekly hand hygiene audit</td>
<td>The project leaders learnt the value of role modelling good practice and giving staff feedback</td>
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<tr>
<td>Development and implementation of staff training programme to ensure best practice for taking blood cultures</td>
<td>Observation of practice enabled the need for training and support in challenging poor infection control practice to be identified and addressed</td>
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</tr>
<tr>
<td>Staff training implemented to facilitate challenge of poor infection control practice</td>
<td>The size of the unit made it difficult to include all staff in the project</td>
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<tr>
<td>The project leaders learnt the value of role modelling good practice and giving staff feedback</td>
<td>Values clarification exercise completed by 15 staff from Emergency Department and Medical Assessment Unit</td>
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</tr>
<tr>
<td>Observation of practice enabled the need for training and support in challenging poor infection control practice to be identified and addressed</td>
<td>Weekly hand hygiene audits undertaken by ward manager or infection control link nurses</td>
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<tr>
<td>The size of the unit made it difficult to include all staff in the project</td>
<td>Observations of practice by RNs</td>
<td></td>
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</tr>
<tr>
<td>Developing a Culture where Nursing Practice is Consistent with Infection Control Prevention</td>
<td>Audit results demonstrated significant improvements in patient screening, adherence to MRSA protocol and ward cleanliness over the time of the project. Development of an educational DVD focused on infection prevention. Staff gained skills and confidence in challenging poor infection control practice. Increased staff awareness of their role and responsibilities in relation to infection control and prevention.</td>
<td>Yes</td>
<td>Web-link: <a href="http://www.fons.org/Resources/Documents/Project%20Reports/LSAWHittingtonOct2011.pdf">http://www.fons.org/Resources/Documents/Project%20Reports/LSAWHittingtonOct2011.pdf</a></td>
<td>The project leads learnt the value of facilitation when developing practice and that approaches that enable active participation of staff can lead to ownership of the project by the ward team. Staff learnt the value of challenging poor infection control practice as this can lead to improved patient care. The ward manager was appointed 12 months into the project. One of the project leads changed roles. The context caused difficulty in finding time for staff to meet, reflect on and discuss the project.</td>
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<tr>
<td>Improving Patient Safety through Better Infection Prevention Information to Patients Delivered by Ward Staff</td>
<td>The contextual challenges faced by these projects led to them ending after 12 months. The outcomes therefore focused on the project leader’s learning about practice development processes and methods and thus their development as practice developers.</td>
<td>Yes</td>
<td>Web-link: <a href="http://www.fons.org/Resources/Documents/Project%20Reports/LSHASidcupNov2011.pdf">http://www.fons.org/Resources/Documents/Project%20Reports/LSHASidcupNov2011.pdf</a></td>
<td>Key learning by project leaders was that it was vital to have stability and continuity in the workforce and environment to successfully implement change. Project leaders learnt skills of facilitation.</td>
</tr>
<tr>
<td>Project Title</td>
<td>Description</td>
<td>Completed by</td>
<td>Notes</td>
<td></td>
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<td></td>
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<tr>
<td>Surgery and Cardiology Queen Mary’s Hospital Sidcup (2 project teams)</td>
<td>Major organisational change and service reconfiguration led to staff moves and ward closer Limited opportunity to meet with staff to discuss and reflect on the practice</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The Reduction of Catheter Associated Urinary Tract Infections through the Implementation of the Short Term Catheter Care Bundle Two In-patient Wards Whipps Cross University Hospital</td>
<td>Reduction in catheter acquired urinary tract infections (6%-0%) on the 2 pilot wards Development and implementation of catheter care bundle</td>
<td>Yes</td>
<td>Web-link: <a href="http://www.fons.org/Resources/Documents/Project%20Reports/LSHAWhipsXNov2011.pdf">http://www.fons.org/Resources/Documents/Project%20Reports/LSHAWhipsXNov2011.pdf</a> The importance of the project leaders working closing with the pilot sites was recognised The engagement of ward staff at all levels in the process facilitated the implementation of change The transformational clinical leadership of the ward sisters was essential to the success of the project The need to take time to prepare staff before implementation was acknowledged Opportunities for patient involvement should be increased and patient information developed Working group involving key stakeholders including: microbiologist, project teams, infection control lead and ward based nurses Ward staff involved in an appreciative inquiry approach to enable collaboration and promote successful implementation of CCB Staff involved in evaluation using questionnaires and through participation in workshops</td>
<td></td>
</tr>
<tr>
<td>Reducing Catheter Associated Urinary Tract Infection</td>
<td>Yes</td>
<td>Engaging staff in various practice development activities enabled them to gain knowledge to inform practice changes. The approaches used could be transferred to explore and improve other aspects of care. One of the project leaders was a trust wide infection control nurse which provides an opportunity to share learning.</td>
<td>Context Assessment Index completed by the nursing team (RNs and HCSWs). Values clarification undertaken by RNs and HCSWs. The nursing team engaged in various activities to explore practice such as observations of practice, audit of catheter care. Regular workshops for the nursing team.</td>
<td></td>
</tr>
<tr>
<td>Heberden Ward St. George’s NHS Trust</td>
<td>Reduction in the number of patients who are catheterised (22%→8%) Changes to catheter care practice Improved documentation</td>
<td>Web-link: <a href="http://www.fons.org/Resources/Documents/Project%20Reports/LSHAStGeorgesAug2011.pdf">http://www.fons.org/Resources/Documents/Project%20Reports/LSHAStGeorgesAug2011.pdf</a></td>
<td></td>
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</tr>
</tbody>
</table>

| Developing Practice and Reducing Diarrhoea through Hand Hygiene | Yes | Engaging staff in various practice development activities enabled them to understand what aspects of practice needed to change and determine how these changes could be achieved. The team learnt the value of, and developed skills to challenge poor practice. Staff acknowledge that the work is not time limited and developments continue. | The Context Assessment Index completed by the nursing team (RNs and HCSWs). Values clarification exercise undertaken by the nursing team. Observations of practice by RNs. The nursing team gained patients experiences of care. Audit of all members of the multidisciplinary teams (MDT) hand hygiene practice. Regular nursing team workshops and the nursing team undertook. |
| Charing Cross Hospital Imperial College NHS Trust | Reduction in healthcare associated infection rate Improvements in hand hygiene compliance (100%) Raised awareness of the significance of the nurses’ role in reducing HAIs Improved signage of infection prevention on wards aimed at staff and visitors | Web-link: [http://www.fons.org/Resources/Documents/Project%20Reports/LSHAlmperialAug2011.pdf](http://www.fons.org/Resources/Documents/Project%20Reports/LSHAlmperialAug2011.pdf) | |
| Embedding a Consistent Approach in the Care of Central Venous Catheters in Homerton ITU | Reduction in central venous catheter (CVC) infection rates (21 per 1000 catheter days → 6 per 1000 catheter days) | The implementation of High Impact Intervention CVC bundle – audit of compliance 80-100% | New documentation developed and implemented – independently tested and identified as a good example | Yes | The Context Assessment Index and subsequent staff workshops enabled discussion about barriers to developing practice; these are being addressed by ongoing engagement with staff using a number of approaches. The project team learnt that gaining consensus views on changes to documentation was time consuming but led to greater ownership by the team. The project team acknowledge that the ability to facilitate group discussions is a skill that requires practice and reflection. Strong support from management for the project leaders was beneficial. | The Context Assessment Index was completed by the RNs. The nursing team undertook a values clarification exercise. Stakeholder working group including; doctor, microbiologist, matron, infection control nurse and staff nurse. Audit of infection rates. Observations of practice by the RNs. Workshops for all the nursing team. | responsibility for an activity i.e. researching posters, setting up teaching and observing practice |

| Developing and Sustaining a Practice Based Strategy for Reducing Healthcare Associated Infections in Critical Care | Audit of mouth care and cuff pressures used to inform the development of new policy. Infection rates static but with higher patient turnover. | Yes | All staff more actively engaged in auditing to enable understanding about practice. The practice development approaches enabled staff to | Context Assessment Index with all staff including doctors and physiotherapists. Values clarification exercise also included all the MDT. |
| Adult Intensive Care Unit  
The Royal London Hospital | Reduction in ITU acinetobacter isolates following implementation of ICU infection control action plan (down from average of 9.75 per month to 1.5 per month)  
All patients seen daily on a microbiological ward round  
Infection control issues discussed daily | reports/LSHABartsNov2011.pdf | gain a greater awareness of the enablers and inhibitors of practice change  
Changes supported by parallel service transformation work streams and Trust wide initiatives  
The Trust went through reorganisation which caused uncertainty over jobs  
As part of the reorganisation the unit manager left and a new leader appointed | Observations of practice using the Workplace Culture Critical Assessment Tool by the RNs |
|---|---|---|---|---|
| Supporting House Bound Clients to Prevent Healthcare Acquired Infections in their Own Homes  
City and Hackney Teaching PCT | Gained evidence directly from patients about the information that would be of value in a patient infection control and prevention information leaflet  
Gained an understanding of patients knowledge of infection control and prevention  
Infection control link nurses had a clearer understanding of their role and responsibilities, and had raised the profile of the nurse’s role in infection prevention within the patients’ own home  
Project team gained confidence in | Yes  
Web-link: [http://www.fons.org/Contents/Project%20Reports/LHSAHackneyNov2011.pdf](http://www.fons.org/Contents/Project%20Reports/LHSAHackneyNov2011.pdf) | The project team learnt about the complexity of developing a questionnaire and interviewing patients to gain meaningful information  
Large geographical area that was covered by the nurses presented challenges to the project  
The project leader left near to the end of the project | Patient survey carried out by the infection control nurses  
Patient interviews carried out by the infection control nurses  
Action learning/reflective nurse group for the infection control nurses  
Values clarification exercise with the infection control nurses |
<table>
<thead>
<tr>
<th>Project Description</th>
<th>Observations/Findings</th>
<th>Challenges</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaining Patients’ Experiences of Care to Improve Infection Control and Prevention Practice</td>
<td>Gained insight into the patients’ experience of being in a side ward. This led to the introduction of ‘intentional rounding’ and better explanation to patients of why they were in a side room.</td>
<td>No</td>
<td>Developed practice from the information gained through listening to patients' experiences. One of the project leaders left during the project. Limited time for staff reflection and project leaders to spend on the project. Did not complete a project report.</td>
</tr>
<tr>
<td>Reducing the Incidence of Surgical Site Infections</td>
<td>Reduced incidence of surgical wound infections</td>
<td>No</td>
<td>The project team did not engage with the FoNS programme and therefore information about their progress is limited.</td>
</tr>
</tbody>
</table>
| Developing Staff Knowledge and Skills in Preventing Healthcare Acquired Infections | Improved hand hygiene practice  
Increased the team’s awareness of infection control and prevention | No | The team learnt that infection control and prevention is importance to non acute areas  
The complex context limited the opportunity for the team to engage in the project  
The ward manager left part way through the project | Context Assessment Index completed by all the nursing team  
Hand hygiene audits carried out by the project team  
Nursing team meetings introduced |
3.4 Outline of evaluation activities undertaken during workshops
At the end of the workshops, participants were asked to complete evaluation activities. The purpose of these activities was to inform future workshops and the support provided by the FoNS practice development facilitator to the project teams in practice; and to evaluate the learning and development of the project leaders as facilitators of local practice change. Only data relating to this final purpose will be included in this report. The data collected was analysed by JW and key themes identified.

An outline of these activities along with the key themes is provided in Table 5 and further details about each can be found in Appendices 5-7.
### Table 5. Outline of workshop evaluation activities and key themes

<table>
<thead>
<tr>
<th>Workshop (1-5)</th>
<th>Evaluation activity</th>
<th>Key themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-5</td>
<td>Participants asked to identify: • What they liked most about the workshop • What they liked least about the workshop • What key learning/action there were taking away (See Appendix 5 for more details of findings)</td>
<td>• Sharing with and learning from others • Value of facilitation • Time to focus and reflect • Learning about practice development • Practical issues • Unanswered questions • Evaluation • Using creativity • Implementing learning • Practice development tools • Ability to make a difference • Engaging staff • Focus and structure to project • Ending/continuing</td>
</tr>
<tr>
<td>2-5</td>
<td>Participants were asked to complete a reflective critique of learning relating to their involvement in the programme based on Mezirow’s (1991) transformational model of reflection (See Appendix 6 for more details of findings)</td>
<td>• Positive but challenging • Gaining insight and confidence • Recognising assumptions • Self as facilitator of practice development • Opportunities to influence the development of practice • Engaging with stakeholders • Collaboration, inclusion and participation • Listening to others • Using evidence to support decisions • Applying concepts of practice development to practice</td>
</tr>
</tbody>
</table>
Participants were invited to create a ‘picture’ of their journey through the programme. Key themes were captured by the FoNS practice development facilitator during the process (See Appendix 7 for more details of findings)

The start of the journey:
- Ups and downs
- Help!
- Confused
- Opps, what’s this all about?
- Steep uphill
- Engaging and challenging
- Taking off point

Middle of the journey:
- Like a rollercoaster
- Swimming against the tide
- Fuzzy felt
- Walking through treacle
- Questions
- Pulling ideas together
- Networking/partnership
- Ideas/tools
- Clarifying goals
- Coming out of a dark tunnel

The end of the project:
- Achievements
- Celebrate success
- Feeling good about me
- Enlightened
- Enhanced knowledge
- Roller coaster
- Continuous
- Empowerment of others
3.5 Feedback from the project leaders on the role of the FoNS practice development facilitator

The project teams were asked to complete a questionnaire to evaluate their experience of working with the FoNS practice development facilitator. Sixteen questionnaires were distributed and five were returned. The responses were analysed by JW and key themes identified. A summary of responses is provided in Appendix 8.

4. Programme Outcomes

A summary of the outcomes for all the projects is provided in Table 4.

The aims of each of the projects varied and reflected the development needs of the clinical area. Some of the aims were identified at Trust level following poor infection control results such as, Newham Trust A&E Department which focused on reducing blood culture contaminates as local audits had shown the number from this A&E were higher than the national average. Other project aims were developed by the nursing teams as the project progressed, for example, the elderly medicine ward at Charing Cross Hospital applied to the programme because they reported higher than average numbers of C. difficile infections, but developed a focus on hand hygiene following a workshop involving the ward nursing team. Other teams started with an aim at the beginning of the project however, as they began to develop greater understanding about practice development, these changed. This is reported by the project team at Whittington Hospital which started by looking at reducing bacteraemias but as these rates were dropping due to Trust-wide measures, the project changed to focus on creating a culture where there was a sustained reduction in infections. In line with the philosophy and principles underpinning practice development, it was important that each nursing team focused on an aim that was relevant to their clinical area; this was part of the process of creating ownership of the project.

Because of the varied foci, the project outcomes were inevitably different; however, the majority of projects reported reductions in healthcare associated infections. The following sections will therefore firstly outline the key outcomes relating to reducing healthcare associated infections and related improvements in practice before considering the wider outcomes from the programme; including understanding patients’ experiences of care, creating cultures and contexts conducive to change, and the development of people.

4.1 Reducing healthcare associated infections

Of those project teams that produced a final report (n=11, 13 project teams), nine project teams reported reductions in healthcare associated infections and/or improvements in practice that would contribute to reducing risks of healthcare associated infections. These are summarised below and can be seen in further detail in Table 4.

Demonstrable reductions in healthcare associated infections were reported in seven clinical areas.

These included reductions in:

- Wound infections
- Infection rates per catheter days
- Preventable infection rates
- Preventable bacteraemias acquired in hospital
- Catheter acquired urinary tract infections (n=2)
- ITU acinetobacter isolates

Similarly, demonstrable improvements in practice that would contribute to reducing risks of healthcare associated infections were reported in seven clinical areas. These included:

- Improved performance in patient screening audits and adherence to MRSA protocol
- Improved ward cleanliness
- Reduction in the number of patients with urinary catheters
- Increased compliance with hand hygiene (n=2)
- Improved cleanliness of the underside of equipment
- Improved compliance with High Impact Intervention CVC bundle

Of the other four project teams that reported, one developed a better understanding of the information needs of patients in the community with regards to infection control, which will be used to inform service developments. Another introduced intentional rounding after developing a greater understanding of patient’s experiences of being cared for in a side ward. The other two (both included in one report) were unable to report any outcomes due to complex contextual issues and the project teams had to withdraw from the programme after 12 months before any changes could be implemented or evaluated.

Of the three projects that did not report, the FoNS practice development facilitator was aware of reduced surgical wound infections on one of these wards and improved hand hygiene practices on another.

In some cases, it is difficult to determine if reported reductions in healthcare associated infections could be completely attributed to the project. For example, the project team in the ICU at the Royal London Hospital, experienced considerable organisational development and change during the lifetime of the project some of which, could have been disruptive e.g. the recruitment of forty new members of staff, whereas others it could be suggested were supportive e.g. infection status reports are now sent to the nurse in charge of ICU on a daily basis so that issues can be dealt with immediately. However, for many, Trust-wide activity was welcomed and seen as supportive for the projects. For example, a number of initiatives were introduced across St Georges Hospital to reduce the number of catheter acquired urinary infections at the time of the project. These initiatives undoubtedly impacted upon the reduction in the number of patients with catheters, however, on the project ward, the number of patients with catheters reduced to 8% as compared to 16% on other wards across the hospital.

Two other key outcomes relating to improving infection control practice, highlighted by several of the projects were:

- An increased understanding amongst the nursing teams about their role and responsibility in relation to infection control
- Recognition of the need to develop skills in challenging poor infection control practice

These issues will be discussed in more detail in the following sections.
4.2 Understanding patients’ experiences of care

Understanding the patients’ experience of care was the main focus for three of the projects, all of which were in very different healthcare settings (community care, older peoples care and orthopaedics). These project teams adapted the Experienced Based Design (NHS Institute for Innovation and Improvement, 2009) tools to gather patients’ experiences of care and from this feedback made changes to their practice.

One area first undertook a survey to find out about patients’ experiences and then focused on more in-depth interviews with a selection of patients (Hackney and City PCT). The other two projects collected patient stories.

Gaining the experience of care from patients was a challenge for the teams and proved to be more difficult than they first thought. For example, having collected a few stories from patients, the project team at Ealing Hospital realised that they had reduced the tool for gaining patient’s experiences to a list of questions to which the patients could answer ‘yes’ or ‘no’ and as such was of little value. The project leaders reviewed this information and worked with the team to develop skills in asking open questions. The initial focus was to establish patients’ experience of wound care; however, it was found that wider issues around care emerged. These were discussed in ward meetings and actions identified and implemented to resolve them e.g. ensuring patients are offered analgesia before wound care. The process of listening to patients’ experiences is now embedded into everyday ward practice to enable team learning and has led to practice changes, however getting to this stage was a long journey.

The project team at Charing Cross Hospital found that staff needed support from one of the project leaders to enable them to collect patient stories as they did not feel confident to do this alone. In particular, the project leaders found that the nurses had difficulty being objective when the patients were talking. For example, if a patient said anything negative the nurses would explain the actions of the other team member rather than listening to and recording what the patient was saying. However, reading about what patients thought of their care undoubtedly provided a learning opportunity for staff. For example, staff were shocked about how patients with an infection felt about their experience of being in a side ward. Some of the patients’ comments are illustrated below:

‘I felt embarrassed and dirty’
‘I felt lonely and isolated’
‘Like being in a prison’
‘I don’t know why I’m here’

From this information the ward team were able to make practice changes and implemented ‘intentional rounding’. This ensured that patients in side wards were visited by their named nurse at least every two hours to engage in conversation and to check that they could reach their drink and call bell for example. Staff also committed to providing a better explanation of why patients were in a side ward.

Most project teams had planned to collect patient experiences as part of their project; however a limited number actually achieved this. None of the teams were able to gain the
experiences of patients at the end of the project to see if their perception of care had changed. The main reason that patient experiences did not play a more major part in the projects was the time needed to develop the staff skills and understanding in how to gain meaningful patient experiences of care. As the team at Charing Cross Hospital identified, staff were ‘out of their comfort zone’ and whilst they were comfortable talking to patients about care, interviewing them for their opinions on infection control and prevention on the ward was harder and seen as a new challenge. The second obstacle was the time to set up the process such as consent forms, workshops with staff, time to be with patients and transcribing the information gained etc. In future projects, to ensure that patients’ experiences make a greater contribution to the development of practice, the difficulties experienced by these project teams need to be taken into consideration.

Due to the limited number of projects that engaged in exploring the patients’ experiences of care, the programme only partly met the aim of increased patient satisfaction as there was not enough evidence from patients to support that this aim was fully met.

4.3 Creating cultures and contexts of care conducive to change

When developing healthcare practices, some changes will take place, but the success and sustainability of these changes will be dependent on the strengths and weaknesses of the local and organisational culture and context. The literature on practice development supports the importance of understanding the context of a clinical area prior to commencing change (McCormack et al., 2009). Similarly, recent publications have highlighted the significance and impact of culture on the workplace and how individuals provide care (Francis, 2010; Patterson, 2011). Context is defined by McCormack et al. (2002, p 96) as an ‘environment or setting in which people receive health care services’. The environment in healthcare is rarely straightforward but can be seen as constantly changing and with many diverse cultures operating at different levels in the organisation. Context within this programme utilised the definition created by the Promoting Action on Research Implementation in Health Services (PARIHS) framework (Rycroft-Malone et al., 2002) such that the successful implementation of evidence into practice is influenced by three contextual characteristics; culture, leadership and evaluation of effectiveness (McCormack et al., 2002).

To achieve an understanding of the practice context, 10 of the 16 projects completed the Context Assessment Index (CAI) (McCormack et al., 2008) (see Appendix 3) with their teams at the start of their projects. Seven of the projects repeated the CAI at the end of the project to assess if the team’s perspective of their context had changed during the course of the project. Three projects were not able to repeat the CAI; this was because two projects ended after 12 months and the third project ran out of time and made a decision not to repeat the CAI.

Three projects made a conscious decision not to explore their practice context using the CAI. One stated that they knew the clinical setting well and that the culture was one that embraced change (Whipps Cross Hospital). Another decided not to explore the context as at the time they did not see this process as relevant (CTU at The Royal London Hospital). Both these projects could be described as taking a more traditional approach to service improvement. Another was a community based project and covered a very large area. The
project team felt that exploring the context would be too challenging for the scale of the project; however they plan to do this in the near future.

When reflecting on their role in the project, some of the project leaders stated that they felt exploring the context was not relevant as they did not fully understand the significance to the project. This delayed them engaging in using the CAI. For example, one person stated:

‘It took me and X some time to get my head around it, then the team longer. It was a real awakening using it. We had to think about things that we had not thought of before, the bigger picture’

The CAI has a scoring system that provides an overall or team context score (0-100%) indicating a strong (receptive to change) or a weak (not receptive to change) context. Those that did provide scores illustrated that the staff perceived the context to be above average (i.e. tending towards being a strong context) at the start of the projects. For those projects that repeated the CAI, the perception of the staff was that the context was stronger by the end of the project or the same. Instead of focusing on the overall scores, some areas focused on the individual questions that scored low and worked at incorporating these into the project and providing evidence of how they had made changes in these areas. For example, the team at St. Georges Hospital identified the following weakness in their context from the CAI results:

- Culture – 14/29 staff members believed that staff did not receive feedback on the outcomes of complaints
- Evaluation – 14/29 staff members did not believe that the organisation was non-hierarchical
- Leadership – 11/29 staff members did not believe that HCPs in the MDT had equal authority in decision making

An interesting outcome relating to the CAI was that all the projects that repeated the CAI reported a greater return rate for the repeat CAI compared with the initial CAI. The project teams reported that this was due to the staff having greater understanding and insight into the purpose and significance of the CAI. This was supported by the project leaders also being more confident in explaining its purpose.

Whilst the CAI is a tool that provides teams with information on their perception of the context, more can be gained from its use if there is an opportunity for teams to discuss the outcomes of the CAI and what these mean to practice. These discussions were the first time that the teams had had an opportunity to discuss the culture of the clinical setting and as such for some proved to be a catalyst for the project. This is reflected by one project leader:

‘To be honest it seemed an odd thing to do, I mean what had it got to do with infection control. I thought I’d give it a go and it proved to be of value in opening up the team to how things were on the ward and how they felt. It got us started. I think on reflection I was under confident using it and better in the repeat CAI. It’s something we will do again as it really opened staff up’
Most of the project teams were able to create the opportunity for staff to meet and discuss the CAI as demonstrated by the above statement. However some of the project teams had difficulty creating this reflective space. As such, for a couple of teams, the CAI was seen as a tool separate from other aspects of the project and the teams did not see its relevance to their practice (Queen Mary’s Hospital). It became a ‘paper exercise’ and was not effective in enabling the teams to explore and understand the context of the clinical setting and how this may impact on care. In some of the project reports, it is evident that the discussion of the CAI is seen as an ‘add on’ to the project rather than an integral part.

4.4 Developing people – learning in and from practice

The focus of practice development extends beyond the implementation of a specific change in practice to the transformation of individuals and teams enabling the development of person-centred cultures, this requires facilitators who can help to create the conditions in which teams can question current practice and develop new understanding that stimulates action (Dewing, 2008; McCormack and McCance, 2010). Learning in and from practice is a key component of practice development; learning arises from the development of self awareness through critical reflection about the impact of our actions or inactions on others within the context of our workplace (Manley et al., 2008).

Informed by a practice development methodology, the programme aimed to enable project teams to raise awareness about and to challenge everyday ways of working that had become habitual practice. The project teams engaged in a number of activities with their clinical teams to facilitate the development of greater insight and understanding about their current practice. These included activities to:

- Understand the culture and context of care (n=10)
- Work with values and beliefs (n=11)
- Observe practice (n=8)
- Gain patients’ experiences (n=6)
- Audit clinical practice (n=12)

Other activities included project leaders role modelling in practice and working alongside staff in practice and workshops.

The ways in which the completion of the CAI impacted upon the project teams has already been discussed. The ways in which the other activities enabled the learning and development of individuals and teams will be outlined below.

4.4.1 Working with values and beliefs

Working with values and beliefs is an important part of practice development work because our values and beliefs influence our behaviour. Values clarification i.e. making explicit our values and beliefs, is the starting point for cultural change in the workplace as this enables individuals and teams to recognise gaps between the values and beliefs that are talked about (i.e. what we say that we do) and the reality of practice (i.e. what we actually do) (Manley and McCormack, 2003).

11 of the project teams used a values clarification exercise with the clinical teams. This was a challenging activity for many of the teams as unlike the CAI, which is a questionnaire with
pre-determined responses, the values clarification exercise required the staff to reflect on their own values and beliefs around infection control and prevention.

Initially the project leaders reported that responses were often short and lacking in detail. For example, when staff were asked about the significance of their role in relation to infection control and prevention, common responses included ‘hand washing’ and ‘policies’. The project leaders felt that this was because being asked about their perspectives was a new experience for the teams and they were unsure what to write. Despite this challenge, the project teams were able to use the responses to identify key themes that informed the development of the project work. One of the project teams (St Georges Hospital) were able to work with the themes to create a vision statement; however, other project leaders reported a number of factors that prevented them from being able to move the team from key themes to a vision statement including lack of time to get clinical teams together, the perceived length of the process, and their own confidence in facilitating this. In spite of these difficulties, many of the project teams reported that this exercise, along with the CAI, provided the foundation for the project’s direction. Of particular value was the opportunity for staff to share and discuss the responses. As one person stated:

‘Offered an opportunity to reflect and hear the different perspectives of each other’

Another project leader reported how they were able to learn what staff saw as the barriers to good infection control practice, for example:

‘Low morale’, ‘poor communication between MDT’, ‘lack of knowledge’

Similarly, useful insight was gained for the A&E team at Newham Hospital as they discovered that staff saw taking blood cultures as a simple task and not an advanced skill.

Six of the project teams repeated the values clarification exercise as part of their evaluation of the project. The project leaders reported that the responses to the exercise on this occasion showed more depth and knowledge and demonstrated that staff had learned about their practice through engaging in the practice development activities. For example:

‘It is my role to challenge poor practice in infection control’

‘We should keep up to date with the latest information on infection control’

4.4.2 Observing practice

As individuals and teams become used to their workplaces, they can stop noticing as much and start to take the characteristics of their workplace culture for granted. Observation of practice and/or the workplace can enable teams to ‘begin to see what was previously ignored’ (Dewing et al., 2011, p 3). When combined with values clarification and critical dialogue for example, observation of practice can enable teams to develop an awareness of the need for change by identifying contradictions between what is talked about (values and beliefs) and the reality of practice (as observed) (McCormack and McCance, 2010).
Observation of practice was used by nine of the project teams and overall, the teams reported that observing practice was of great value in that:

‘[observation] opened the teams’ eyes to current practice’

‘[observers] saw things that you might not have noticed’

Several of the teams used the Workplace Culture Critical Analysis Tool (WCCAT) (McCormack et al., 2009) (see Appendix 3); however, a few of the project leaders reported that some staff found using the WCCAT tool difficult. For example:

‘There are some exercises that the team may not want to engage in again ... the WCCAT observational tool is one that needs experienced help with to get the most out of it and would probably be used again in a more structured way. The team would like to undertake workshops and activities relating to practice as they tend to learn most from them.’

Project leaders felt that some staff found it difficult because of the level of objectivity expected by the tool, its length and the experience of having to stand back and reflect on practice. To help the teams develop the ability to ‘see’ practice, a ‘snap shot’ observation tool was developed by the FoNS practice development facilitator and was used by eight of the project teams to good effect.

Most project teams intended to focus on observing infection control practice; however, the teams that used the WCCAT in particular found that they captured a whole picture of practice in addition to factors that impacted on infection control practice; an example of this is provided by the project at Queen Mary’s Hospital:

- Noisy environment, with some clutter observed
- Some equipment and supplies stored in unsuitable/inappropriate way
- Cleaner used same cloth to clean two patient areas
- Hand gel not used consistently
- Very little interaction between some staff and patients, whilst other staff interacted well with both patients and colleagues
- No private area for patients or visitors to use
- Skill mix appropriate, although staffing levels sometimes felt by staff to be not sufficient for the number and type of patients
- Notice boards provided information on cardiac care, wound care and infection control
- Serving of lunch and commencement of midday medication round delayed

Observation of practice was most effective in enabling change when project teams were able to create opportunities to get clinical teams together for critique and discussion. In these cases it was possible to create opportunities to learn from practice by sharing the good practice that had been observed and reflecting on areas of concern e.g. cluttered environments, noise levels. This created a desire for action amongst staff who then identified plans to improve practice. The Charing Cross Hospital report provides an example
of how the snap shot tool, followed by reflection and critique of the findings by the staff team, was used to good effect to develop the team’s understanding of practice. Areas of good practice were celebrated (e.g. red clips in use on curtains to maintain privacy and dignity); areas of concern were highlighted (e.g. lots of staff and relatives at nurses’ station has the potential to break confidentiality) and appropriate actions were identified (a room was identified so that sensitive information could be discussed there).

4.4.3 Challenging poor practice
One of the key areas to arise from the observations of practice for several of the projects was the absence of challenge to poor infection control and prevention practice by staff. For example, one project reported observation of staff not being challenged when they did not wash their hands between patients or when carrying dirty linen to the linen skip instead of bringing the skip to the dirty linen. Similarly, some poor practice was observed during food handling which also went unchallenged. Staff in the projects admitted they avoided challenging colleagues or other members of the multidisciplinary team who entered the ward. Four of the projects ran workshops which were supported by the FoNS practice development facilitator on the importance of, and how to, challenge practice. This led to project leaders reporting that staff were challenging practice more and as such were more confident. Some of the project leaders stated that this had taken the focus off themselves as the people who challenged practice, as it had instead become part of the ward culture. For example, one ward manager reported that she now felt that she was not the only person asking visitors, including multidisciplinary team colleagues, to use hand gel as she now heard other staff making this request.

4.4.4 Auditing practice
All the teams had experience of audits being carried out in their clinical area, mainly by people from outside the ward such as the infection control nurse; however, the teams often reported not getting feedback on the results from the information collected. Audit was used within many of the projects, however the emphasis encouraged by the programme was on the teams within the clinical area collecting and analysing the information as a learning and development opportunity. As a consequence, staff reported that they felt an ownership of the findings from the audits and that they could see the relevance to their practice. One project (Ealing Hospital) developed their own wound inspection chart to identify staff knowledge, types of wounds and infections. This was then used to inform the staff wound care skills development. The wound inspection form is still in use. At Queen Mary’s House, as a mental health unit they had had limited input regarding infection control and prevention. They focused on hand hygiene and implemented hand hygiene audits. The project team fed back the results of the audits to the team and used these to change practice.

The audits were most effective when used in conjunction with practice development approaches as when used alone, audits were not enough to enable the teams to change practice.

4.5 Enabling factors
Section 4.4 outlines the key approaches that were used by the project teams to help clinical teams to develop a deeper understanding of current practice, thereby stimulating action for
development and change. The evaluation evidence identifies two factors in particular that enabled this process further; facilitation and time and space for reflection.

4.5.1 Value of facilitation
Skilled facilitation is a key element in the successful implementation of evidence into practice (Rycroft-Malone et al., 2002); the development of person-centred cultures (Manley et al., 2008) and effective workplace cultures (Manley et al., 2011). However, facilitation is a term that is now used widely in healthcare and it could be suggested that it is open to a range of definitions and interpretations, from task-focused activities to more holistic approaches which focus on the development of individuals and teams (Harvey et al., 2002).

The facilitation of practice development is complex and multifaceted (Manley, 2004; Simmons, 2004). It requires facilitators with the skills to enable healthcare teams to transform the cultures and contexts of care (McCormack and McCance, 2010), using reflection to help practitioners to understand what needs to change (i.e. the difference between what people say is done and what happens in reality) and identify actions to achieve practice change. Manley and Titchen (2012) suggest that practitioners need help to explore their own effectiveness and become skilled facilitators before they can assist others to become more effective in their work. The following reflection by one of the project leaders illustrates how the FoNS practice development facilitator was able to support their development:

‘As a novice to real practice development, it was reassuring to have a FoNS facilitator working alongside the team to ensure that the exercises were appropriate and effective. Practice development is never easy at the best of times but to change a whole team’s attitude, help is often needed to prevent disasters and give much needed support to the project lead. They can be a sounding board for all the moans and groans of the team members with the usual cries of ‘we are not getting anywhere’ as the project continued to the end. It is important to have an outsider to work with the team to prevent it naval gazing, drifting and giving up. It also ensures the team leads have someone to talk to prevent them moaning to the junior staff they are trying to support. The role of the FoNS facilitator was also important in being objective, keeping up the motivation and momentum, to keep to time and to ensure that the team stuck to its project. The experience and expertise of practice development is not something that can be learned overnight and project leads need to be mentored in this aspect of practice until they themselves are competent and comfortable in that role to lead and facilitate others.’

Other reflections support this view:

‘It helped that the external facilitator came into our workplace as well and assisted us in applying some of the practice development tools...’

‘You helped me to see things from different aspects ...’

‘It gave the project natural supported momentum to understand the process and to get the project completed’
‘...I now understand my role and how my staff work a bit better than before. I have more understanding of the change process and will be utilising the strategies that worked for this project to deal with documentation practices in the unit’

However, working alongside the FoNS practice development facilitator was also seen as challenging at times, particularly when clinical workloads were perceived to be high and when current practice was being challenged:

‘It felt like an added pressure at times…’

‘It was hard to watch my staff and the unit put under the microscope by an outsider’

But despite this, some saw this as positive:

‘That the facilitator ...was strong enough not to accept excuses and kept pushing us in the right direction’

The evaluation evidence suggests that initially, many participants were more familiar with task focussed approaches to the facilitation of change, as there was a realisation that the enabling or holistic approaches that they were introduced to through the programme may be more effective in achieving sustainable changes in practice, as illustrated by the following reflections:

‘That you do not do everything yourself. You must involve staff’

‘That I need to facilitate and enable the staff to realise and be involved in change in order for change to happen, not just be imposed’

‘Strong feeling that I can influence change in practice through role modelling, engaging and empowering staff to take the lead in practice development initiatives’

This is supported further by evidence from the workshop evaluations, personal reflections and feedback from participants in relation to the role of the FoNS practice development facilitator. This evidence indicates that participants benefited from ‘seeing’ facilitation and ‘being facilitated’ i.e. they appreciated the facilitation that they received at the workshops;

‘Great facilitators (learn by example)’

and valued the opportunity to reflect upon and practice their own facilitation skills in a safe environment;

‘[The] ‘what facilitation feels like’ exercise and taking it into practice’

‘Think about my facilitation style when doing practice development work’
In particular, some participants appreciated the opportunities that the programme provided to develop a greater self awareness of their values, beliefs and assumptions about practice and facilitating change. For example;

‘...questioning my own values helps open and broaden my understanding’

‘Getting better at reminding myself not to make assumptions – to find out the reality. Trying harder to think deeper about my value judgements before I apply them’

With this greater awareness came recognition of how values, beliefs and assumptions can impact on decision making and the ways in which the project leaders were ‘facilitating others’;

‘More aware of the reasons behind my decisions and impact on the workplace’

‘I have become less assuming and am asking more questions’

A detailed example of how these opportunities impacted upon the individual and the clinical team that they were leading is provided by the ward manager from the Denham Unit, who is reflecting on her experience of facilitating a workshop for staff with the FoNS practice development facilitator;

‘I was aware that I usually answer for everyone when there is silence but on this occasion I sat back and watched the responses of the staff. The change in leadership style came about after exploring my own leadership and facilitation style at a workshop facilitated by FoNS to support project teams. During this workshop, I gained insight into my own directive style of facilitation (Hersey and Blanchard, 1996) and recognised how this approach had resulted in the staff being passive and over reliant on me to make decisions, especially at meetings, knowing that I would ‘fill the gaps’. In an effort to develop a more facilitative style of leadership, I explained to the staff that I would be providing more opportunity at the meeting for discussion. This was uncomfortable for me as I perceived discomfort in the staff. This may be because the staff team is very close knit and they felt unsure about discussing a topic that they were unclear about with an outsider (the FoNS practice development facilitator). However, this was a pivotal moment in the project as it showed the heavy dependence of the unit staff on me to solve problems and therefore, one focus of the project has been directed at trying to enable a greater participation in decision making by staff’

A framework to help practice developers to think ‘through self development and possible strategies for enhancing progress’ has been developed by Crisp and Wilson (2011, p 174). Influenced by the Piagetian concepts of assimilation and accommodation, the framework proposes that there are three stages of development; preliminary, progressive and propositional (see Table 6).
Table 6. Facilitating practice development: stages of development

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preliminary</td>
<td>Essentially an egocentric stage when practice developers will copy or imitate others as they are making sense of practice development methodology and its facilitation in relation to themselves and their practice</td>
</tr>
<tr>
<td>Progressive</td>
<td>Generally a lengthy stage with three phases (early, middle, and latter) which is largely activity based, whereby practice developers learn by repeating ‘rule’ based actions until they feel able to translate their learning and adopt more flexible ways of working</td>
</tr>
<tr>
<td>Propositional</td>
<td>This stage is characterised by flexibility of thought and action as the practice developer has a deep understanding of the principles, theories, actions and outcomes of practice development</td>
</tr>
</tbody>
</table>

Adapted from Crisp and Wilson (2011)

Crisp and Wilson (2011) argue that a fundamental difference between Piaget’s staged approach to development in infants and this framework lies in the practice developer’s ability to ‘critically examine their thinking and responses’ (p 175). Where project leaders actively engaged with the programme, they were able to benefit from the opportunities provided within the workshops and through the challenge and support offered by the FoNS practice development facilitator, as a means of enabling their development as facilitators.

4.5.2 Creating time and space for reflection

Time and space for the teams to reflect on and in practice was a vital part of the projects. Without this the teams were unable to make connections between the practice development approaches and improving infection control practice. This is illustrated in the project at Queen Mary’s Hospital, Sidcup where getting staff together was difficult. This meant that the team saw the CAI for example, as a task and did not see its relevance to their practice. The project leaders were unable to have the opportunity to feedback the findings and for the team to explore what they might mean to their practice. Another example is the ICU at The Royal London Hospital, where the project team carried out a values clarification exercise by placing flip charts on the walls for staff to add their comments to; however, this had limited impact as the teams did not have enough opportunity to explore their values and beliefs together and agree common themes, and therefore the process was mostly reduced to a paper exercise.

Those project teams that did organise workshops for staff and/or used other opportunities for staff reflections such as handovers and working alongside staff in practice, gained the greatest staff ownership and participation by the clinical teams in the projects. In those cases where the ward manager was one of the project leaders, it seemed more likely that space for reflection, feedback and planning could be created. For example, the project at St Georges Hospital led by a ward manager ran a series of staff workshops at each stage of the project. This gave the team an opportunity to understand and bring to the surface the values and beliefs embedded in practice leading to the creation of a vision for care. The workshops took place at key stages in the development of practice and were well attended. Similarly, at the Denham Unit the ward manager also ran workshops at key stages of the project and as a consequence of staff discussions, their active involvement in the project was enabled and
this led to changes in practice. Lastly, following the use of patient stories as part of the project at Ealing Hospital, the ward manager created time every Friday during staff handovers, to have a reflective space where patient feedback can be discussed. This has led to staff identifying and implementing improvements.

Supporting staff to understand the relevance of the practice development approaches to practice and gaining confidence in their use was further enhanced where the project team worked alongside staff in practice. This can be seen at Imperial Hospital where they supported staff to undertake observations of practice and to ask patients about their experiences of infection control. By engaging in critical conversations with staff, as well as being able to explore what they had seen and heard and how this might influence practice, staff were able to reflect on the process of gaining feedback from patients and how this might be used to involve patients more effectively in planning care.

5. Conclusions
This programme aimed to enable clinically based project teams to implement a strategy for developing, changing and evaluating practice to reduce/prevent healthcare associated infections. 16 project teams started the programme, 13 completed the programme/project, and 13 project teams provided a final report (11 reports as some teams combined reporting).

Practice development methodology and associated methods were used to enable project and clinical teams to question their current infection control practice and develop new understandings to stimulate development and change.

A variety of evaluation evidence was reviewed and analysed to determine if the programme had enabled project teams to reduce healthcare associated infections; raise staff awareness about the impact of context on culture on healthcare practice; develop the knowledge and skills of staff in relation to infection control and prevention; and improve patient satisfaction with care.

The evaluation provided evidence that nine project teams reported reductions in healthcare associated infections and/or improvements in practice that would contribute to reducing risks of healthcare associated infections. Whilst the projects demonstrated diverse case examples of how these improvements were achieved, it would appear that the projects with the most positive outcomes were those where, the project leaders were in clinical leadership positions (such as the ward manager); there was effective strategic support; the project teams utilised a wide range of practice development methods and they gained involvement of the clinical teams. Engaging in the activities outlined in this report provided opportunities for the clinical teams to explore and therefore develop a greater understanding about their practice and the significant role they had in reducing healthcare associated infections, thereby creating a desire to change practice.

There was an acknowledgement by many of the project leaders that the process of change had been complex and often slower than desired; however, the teams became aware of the barriers to developing practice within their clinical settings which resulted in recognition of the need to get the workplace culture ‘ready’ for practice development before they could
make any significant impact on infection control practice. This view is reflected below by two of the project leaders:

‘I don’t feel we made the amount of progress we wished. At the least the project has led to staff being more aware of their practice and infection control. It’s kept it on the agenda’

‘It’s all just falling into place partly because we needed to get the culture right first before tackling infection issues. The work ... has set us up to really improve practice now with renewed confidence and skills’

One of the planned outcomes of the programme was that patient satisfaction with care would increase. Whilst information provided from the clinical areas suggests that care had improved, there is limited evaluation evidence to demonstrate if this increased the patients’ satisfaction with care. Although many areas planned to gain patient experiences of care, generally the project teams found this challenging and most were not able to achieve this within the timescales of the programme.

Most of the project teams were working within complex organisational contexts and for some, these complexities e.g. ward moves, closures, staffing changes were too significant to overcome within the timescale of the programme. Whilst some of these teams were able to make initial progress and create a foundation for future development, others were not able to achieve anything notable. Continuing investment at a strategic level would be required to enable these teams to move forward in an effective and meaningful way.

6. Key Learning
This evaluation has enabled the identification of a number of points of learning that could be used to inform the development of similar programmes, or could be used by clinically based teams or organisations when planning programmes of change:

1. Core project teams were most effective when at least one of its members was in a leadership position at clinical level (such as a ward manager).
2. Active support from someone in a strategic position (such as an Assistant Director of Nursing or Matron) was valuable.
3. It took some teams a long time (for some 12 months) to engage with the principles and processes associated with practice development (a methodology with associated methods that aims to work collaboratively with individuals and teams to achieve transformatory change), because for many it was a new approach to improving practice. However, this investment was seen by many project teams to be valuable as they could see how the approach could be used to enable future changes in practice beyond the scope of this programme.
4. Project teams utilised the practice development methods most effectively when they worked collaboratively with the FoNS practice development facilitator (an external facilitator), even though this was sometimes a challenging relationship.
5. Project teams that underpinned their projects with practice development principles e.g. working collaboratively with stakeholders, gained greater ownership by clinical staff.
6. Project teams that were able to provide support and opportunities for staff to engage in critical reflection and/or to learn in and from practice and to use this new understanding to inform practice change were more effective in achieving meaningful and effective project outcomes.

7. For some staff, exploring and understanding patients’ experiences of care requires the development of new skills.

8. Through involvement in the programme, some clinical teams recognised that their workplace culture was not conducive to change at the outset. In some cases, foundation work needs to take place to prepare staff for change.

9. Changes within the NHS following the election of a new Government brought about added pressure to staff and greater demands on their time and resources. For some project teams, this meant the projects were unable to continue. Achieving meaningful and sustainable changes in practice and culture can be a complex and slow process that requires commitment at all levels of an organisation.
References


Appendix 1. Programme Terms and Conditions

FoNS Developing Practice Programme: Developing and Sustaining a Practice Based Strategy for Reducing Hospital Associated Infections
In Partnership with London Strategic Health Authority

Terms and Conditions

Congratulations on being selected to take part in the above Practice Development Programme. FoNS is committed to offering you a grant of £5,000 and an external facilitator to support and enable you project and are subject to the terms and condition outlines below.

Team Leader(s): …………………………………………………………………………………………………………………………………………………………………………………

Location/Address: …………………………………………………………………………………………………………………………………………………………………………………

I/We agree to the following terms and conditions:

- Work collaboratively with the FoNS Practice Development Facilitator to develop, implement and evaluate a systematic action plan which will fulfil our project and the programmes aims
- Secure funding in a ‘ring fenced’ account to ensure that it is used only for the purpose of supporting participation in the programme
- Actively communicate with the FoNS Practice Development Facilitator to enable ongoing review of the progress and development of the project and their support and facilitation needs
- Submit a six-monthly progress report including an update of the project plan, ongoing evaluation and expenditure of funding. This must be signed by the Director of Nursing
- Participate in the workshop days, ongoing networking and information sharing activities as part of this programme
- Allow FoNS/London SHA to publicise the project in newsletters, annual report, website etc.
- Be actively involved with FoNS/London SHA in the wider dissemination of the project for example, information sharing and conference presentations
- Acknowledge the support from FoNS/London SHA with any publications/materials produced as a result of the project. The following wording is suggested: ‘...supported by the Foundation of Nursing Studies’ and London Strategic Health Authority’s Developing and Sustaining a Practice Based Strategy for Reducing Hospital Associated Infections ...’
- Submit a final report to FoNS/London SHA within 3 months of completing the project. This will be edited as appropriate and published as part of the FoNS’ ‘Developing Practice Improving Care’ Dissemination Series
- If contacted, participate in any review undertaken by FoNS as part of its commitment to evaluate the longer-term outcomes of projects and the work of FoNS/London SHA

I/We understand that FoNS may withdraw support and funding if we do not comply with these terms and conditions

Agreed and signed by:

Project Leaders (s): …………………………………………………………………………………………………………………………………………………………………………………

Print Name(s): …………………………………………………………………………………………………………………………………………………………………………………

Director of Nursing: …………………………………………………………………………………………………………………………………………………………………………………

Print Name: …………………………………………………………………………………………………………………………………………………………………………………

Date: …………………………………………………………………………………………………………………………………………………………………………………
Appendix 2. Programme Overview

Developing and Sustaining a Practice Based Strategy for Reducing Healthcare Associated Infections (HAIs) Programme
Cohort 2

The Foundation of Nursing Studies (FoNS)
In Partnership with London Strategic Health Authority (LSHA)

Programme Overview
November 2009
Dear Participant

Congratulations on being selected to take part in this exciting practice development programme.

I would like to introduce myself as the FoNS facilitator who will be working with you on the programme for the next 18 months. You will also have the opportunity to meet other members of the FoNS team at the workshops or they may come with me when I meet with you and your team.

Enclosed is an overview of the programme including the development and support workshops. At the first meeting we can go through this information and I can answer any questions you may have. As you read the information remember that we will be supporting you through the programme so don’t worry if it all seems new and strange.

There are some valuable resources that we use as our core material throughout the programme. FoNS will purchase and give you the RCN Workplace Resources for Practice Development on a CD-ROM. If you wish to, you can purchase the printed pack from the RCN, the details are below:

- RCN Resources for practice development. Phone RCN Direct on 08457726100. The code for the folder is 003533 and costs £60

Other resources we recommend and which you can purchase using your grant money are:


I hope that you find the information helpful and please do get in touch if you would like to discuss any aspects of the programme or just to say hello!

Kind regards

Jayne Wright
Practice Development Facilitator
Foundation of Nursing Studies
32 Buckingham Palace Road
London
SW1W ORE
0207 233 5750
jayne.wright@FoNS.org
Background

‘In our dynamic times professional practitioners face many external pressures which create and demand changes to our work environments and practices’. (Titchen et al, 2001).

Everyone agrees it is essential that people experience hospital care that is safe and of high quality. Whilst the responsibility for continuously improving the quality of care lies with all healthcare professionals, nurses as direct care givers have a key role in identifying potential problems and leading change.

The ultimate purpose of FoNS is to improve the patients’ experience of care. We achieve this through our practice development programmes which provide expert facilitation that is underpinned by the principles of critical theory. This enables:

- individuals and healthcare teams to develop knowledge and skills that directly impact on how they work with, and care for, patients
- changes in practice that are sustainable
- the development of person-centred cultures

We acknowledge that identifying and understanding practice problems can be challenging and implementing change and/or getting evidence into practice can be a complex process. To be successful and effective it is paramount that we examine and understand how we work and find effective strategies for developing and improving the services and care we give to patients. We can achieve this by supporting and enabling staff, listening to the voices of service users and integrating reflection and evaluation into all our practice.

The development and support workshop days are underpinned by the principles of adult learning theories and active learning processes. As participants, you will be invited to participate in a range of activities including presentations, critical dialogue, experiential learning and reflective practice.
Programme aims

FoNS in partnership with the LSHA is offering expert support and facilitation to nurse-led teams over an 18 month period to:

- Explore issues around the responsibility of nursing teams in reducing/preventing HAIs
- Identify practice problems related to reducing/preventing healthcare infection
- Develop a proposal for a practice development project/initiative to improve an aspect(s) of practice that will reduce/prevent healthcare infection
- Enable the implementation of a strategy for developing, changing and evaluating practice

This programme of support and development aims to explore and enable effective ways of working to develop and change practice including:

- Sharing experiences
- Encouraging critical reflection
- Using a variety of evidence to inform practice
- Identifying and working with stakeholders
- Understanding the impact of and working with values and beliefs
- Clarifying practice issues
- Enabling development and change
- Developing effective workplace cultures which are patient centred
- Evaluating processes and outcomes
FoNS and the programme facilitators

The Foundation of Nursing Studies (FoNS)

FoNS is a small independent charity that is committed to supporting and enabling nurses to lead and develop new and innovative ways of working that improve the care of patients and healthcare service users. FoNS’ activities centre on four key strands:

- Advancing healthcare practice
- Networking and sharing
- Rewarding excellence
- Facilitation and collaboration

Facilitators

All FoNS’ facilitators are registered nurses and have extensive experience in leading and facilitating practice based development and research. They are:

Theresa Shaw, theresa.shaw@FoNS.org
Kate Sanders, kate.sanders@FoNS.org
Jayne Wright, jayne.wright@FoNS.org
Diana Calcraft, diana.calcraft@FoNS.org

All are happy to be contacted by email

Administration

The FoNS Team Administrator, Beth Chidgey is responsible for the programme administration, for example, organising the workshops and visits.

Contact details:

Email: beth.chidgey@FoNS.org

Office Address: Foundation of Nursing Studies
32 Buckingham Palace Road
London SW1W 0RE
Tel: 0207 233 5750

Website: www.FoNS.org
**What happens next?**

There is a lot to think about and take in when starting anything new. With this in mind, we have created some frequently asked questions that you might find helpful when setting up and planning the beginning of the project.

**Q. Is there anything I need to do before the first workshop?**

If you don’t have a **project team** already then it would be a good idea to set one up. This should include the key people who can help to take the project forward such as the ward manager, infection control lead or practice development nurse. If they were not part of the original application then make sure they are really signed up to being part of the core team. Start to think about how you will **make time** to carry out the project. The terms and conditions need signing by your **Director of Nursing** so it would be helpful to go and see them so that you can discuss the project and make sure you have their support. Have a look at the **FoNS website** and get an idea of what we do and the other projects we are/have supported. Speak to Jayne Wright, the **programme facilitator**, just give her a ring. She will be happy to discuss your ideas and answer any queries. There is also some **preparation work** for the workshops (details are included later in the pack).

**Q. How much time will the project take for the project team and staff?**

It is hard to say exactly how much time as all projects and teams vary. However, time will be needed for the project team to attend the five workshop days. There is also **pre-work** for the workshops which is always linked to or about the work you are undertaking in practice. You will need time for staff to get together to plan and reflect on learning and they will also need to undertake other related activities e.g. observation of practice or patient stories etc. The project team will also need time to plan and carry out the facilitation of the development work and to discuss the projects progress and to write a final report.

**Q. Do I need to worry because we don’t have a clear project plan?**

Don’t worry as sometimes it’s best to let the project emerge as the programme develops.

**Q. Do I have to attend the workshop?**

Yes, if you are part of the core project team. The workshops are an essential part of the programme as they underpin the development work by taking the team, step by step through the process of undertaking a practice development project using emancipatory practice development (EPD). For some this maybe all new but others may have experienced EPD before. Please do not worry as we will facilitate you through the stages.

**Q. How do we get our money?**

We need you to return a signed copy of your terms and conditions (Beth, our Team Administrator will have emailed it to you). Then you need to provide us with the details of an account for the money to be transferred into that is ‘ring fenced’ so that the money is secure for your project.

**Q. What can I use the money for?**

It cannot be used for anything that should be provided by the NHS such as statutory training and education and resources e.g. hoists or trolleys. You can use it to buy time out of practice
for the project team, pay staff overtime for coming to meetings or replacement costs for bank staff. You could also use it to fund the cost of rooms and refreshments for meetings and workshops. It may also support the involvement of service users by funding their travelling costs. There are lots of ways and we say try and be creative to support the project.

**Q. What can I expect from my FoNS facilitator?**

Jayne Wright is the FoNS Practice Development Facilitator that is leading this programme. She is responsible for a programme of projects from the time of advertising right through to the completion of project reports. Jayne is an experienced facilitator of practice development methods and processes. She will work collaboratively with you, facilitating the project team through the project. Jayne will be supported at the workshops by other members of the FoNS team. The team members may also visit you in practice where appropriate. How much time you spend with the facilitator depends on your project but it is expected that you’ll meet about every six weeks. Jayne will also email and phone you to discuss the project and offer support. Because it is a collaborative relationship there is an expectation that you will contact the facilitator as well as them contact you.

**Q. What if we are struggling to keep going and meet the deadlines?**

We are well aware of the challenges practitioners face in the NHS and the impact this can have on developing practice. If you are experiencing difficulty with the project for any reason then please contact the project facilitator and discuss this with them. They may be able to help you develop a solution to the issue or identify an alternative strategy. There may also be occasions when it is helpful for us to meet with you and your supporting Director of Nursing to discuss and seek reasonable solutions for any problems or issues that arise. On very rare occasions when it becomes clear that the team is unable to carry out the project, we have made a joint decision between the project team, Director of Nursing and FoNS, to discontinue the project.

**Q. How do I access the FoNS Developing Practice Subscribers website and what do I get access to?**

All project leaders get free access to the FoNS subscribers area (usually £40 per year) for the duration of the project. You will receive information from the FoNS administrator once your account is set up. The website has an easy to use network and share facility which is a great way to keep in touch with the other project teams in between the workshops and to network with others nationally who are undertaking practice development work. Much of the pre-reading, tools and resources we use are also on the website. You will also get a monthly e-newsletter which highlights new resources, events and recent publications of interest.
**Overview of the practice development programme workshops**

There are 5 workshops over the course of the programme. These are an essential part of the development programme and the core project team will be expected to attend all 5 workshops. Details of the workshops are below and prior to the workshops there will be preparation work and reading for the participants to undertake. The workshops run from 09.15-16.30.

Each workshop has aims and learning outcomes that support the overall aims of the programme. However, there are core aims that span all the workshops which enable the participants to:

- Network and share with the other participants
- Engage in active learning
- Reflect on their own learning and the transfer of learning into and from their own workplace
- Develop knowledge, skills and understanding about practice development with and from others
- Implement and evaluate the development of practice

**Aims and learning outcomes for each workshop**

**Workshop 1 - Practice Development**

**Aims:**

- To provide an introduction to practice development
- To provide an opportunity to develop a shared understanding of practice development
- To explore the relationship between practice development, evidence based practice and research
- To enable participants to explore work based culture and context

**Learning outcomes:**

Participants will be able to:

- Describe what they understand by practice development and its relevance alongside other activities to person centred care
- Use a collaborative method of exploring beliefs and values regarding practice development
- Demonstrate an understanding of the other relevant frameworks such as the Promoting Action Research in Health Service (PARIHS)
- Reflect on and critique their own work based culture and desired cultures

**Workshop 2 - Facilitation**

**Aims:**

- To introduce facilitation theory and to enable participants to explore their own facilitation style
- To explore the concept of collaboration, inclusion and participation
- To identify and critique the approaches used in practice development to gain evidence of current practice
- To explore the value of active learning to enhance practitioners understanding and learning from practice
- To consider the characteristics of effective project action plans

**Learning outcomes:**

Participants will be able to:
- Demonstrate knowledge and understanding of being an effective facilitator of others
- Reflect on own facilitation style and its impact on other individuals and practice
- Describe and critique the value of working with stakeholders and the value of collaboration, inclusion and participation to improving patient care
- Demonstrate the range of evidence that can be collected to help understanding of current practice
- Work with their teams to develop an action plan

**Workshop 3 - Evaluation**

**Aims:**
- To introduce theoretical and practical approaches to evaluation
- To explore the key components of an effective evaluation strategy for practice development, incorporating elements learnt within the workshops and workplace and embraces collaboration, inclusion and participation
- To critique in-depth effectiveness and success in relation to the facilitation of the projects

**Learning outcomes:**

Participants will be able to:
- Demonstrate an understanding of different approaches to evaluation
- Develop an evaluation strategy for own project
- Enhance the opportunity for collaboration, inclusion and participation of stakeholders
- Reflect and critique their own journey as a facilitator and the impact this has had on practice and the progress of the project

**Workshop 4 - Gathering evidence and trouble shooting**

**Aims:**
- To examine evidence from practice and consider what this illustrates in relation to practice
- To reflect on and critique the enablers and hindrances to developing practice
- To explore the use of evidence in reviewing the project plans and progress

**Learning outcomes:**
Participants will be able to:

- Appraise and analyse evidence about current practice
- Demonstrate a greater understanding of current practice
- Identify any gaps in, and hindrances to, the project plans
- Plan solutions to enable the ongoing progress of project plans

Workshop 5 - Reporting and disseminating

Aims:

- To provide an opportunity to interpret evaluation evidence/data and identify project outcome
- To develop understanding of good quality project reports
- To explore means of sustaining the development of practice
- To enable participants to evaluate own learning

Learning outcomes:

Participants will be able to:

- Identify clear outcomes from the project that are practice focused and understand how these demonstrate improvements in patient care
- Draft a report of the project
- Return to the workplace with methods/strategies for sustaining the project
- Critique and describe own learning and development through the programme

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Appendix 3. Core practice development methods and approaches

1. Context Assessment Index (CAI)
The CAI (McCormack et al., 2008) is a self-administered questionnaire that enables practitioners to assess the context (leadership, culture and evaluation) within which care is being provided in clinical areas to identify the characteristics of the existing context that enhance or hinder person-centred care and determine its readiness for implementing evidence into practice.

The CAI has 37 questions to which the practitioners answer either 'strongly agree', 'agree', 'strongly disagree', 'disagree'. These responses will reflect the individual perceptions of the context of the clinical area. The individual responses are transferred to a grid that enables the calculation of a score for the 3 elements; culture, leadership and evaluation. Finally, the scores are totalled in order to derive an overall or team context score (0-100%) indicating a strong (receptive to change) or a weak (not receptive to change) context.

Areas for potential development can be identified by focusing on areas that were collectively scored low.

2. Values clarification exercise
Clarifying values and beliefs and agreeing a common or shared vision is the first step in creating collaborative working within practice development. Values clarification is a starting point for cultural change as our values and beliefs influence our behaviour. A match between what we say we believe in and what we do is one of the hallmarks of effective individuals, teams and organisations (Manley, 2000).

A values clarification exercise is an uncomplicated exercise designed to access and clarify the values and beliefs that individuals hold about something. It consists of a number of stem questions that can be adapted according to the focus of the development work. An example relating to infection control and prevention is provided below:

I believe the ultimate purpose of infection prevention and control is...
I believe this purpose can be achieved by...
I believe my role in achieving this purpose is...
I believe the factors that inhibit or enable this purpose to be achieved include...
Other values/beliefs that I hold about infection prevention and control are...

The values and beliefs of individuals can be collected using questionnaires, which are then themed and shared. Alternatively, values clarification can be done as a group exercise starting with individual contributions but involving the group in theming individual responses and moving on to create a shared vision.

3. Observations of practice
Key to the development of cultures of effectiveness is the observation of practice. This process can enable individuals and teams to begin to see aspects of healthcare that have become taken from granted. When combined with values clarification and critical dialogue, observation can help practitioners to see what elements of practice need to change.
Two approaches to observation were used. Firstly, the Workplace Culture Critical Analysis Tool (WCCAT) (McCormack et al., 2009) was developed to help people involved in the development of practice to undertake observational studies of workplace settings in order to inform changes in practice. The framework underpinning the tool enables a systematic approach to observation; however, it requires skilled facilitators to support clinical teams to use it effectively. To this end, some teams found the WCCAT to be complex and therefore was only partially completed. For this reason, a ‘snap shot’ observation tool was produced. This was used as a means of introducing the participants to observing practice and to develop skills in reflecting on practice. The FoNS practice development facilitator provided support with using this approach.

4. Audits
Audit of various aspects of practice such as hand washing, infection rates etc. were standard practice in the project sites. For many the audits were imposed by others external to the clinical area and the results fed back to the team. In line with the philosophy of practice development, the focus in the projects was on the participants carrying out the audits and using the outcomes directly in their clinical area. The aim was therefore for staff to take ownership of the audit process by deciding what needed to be audited and the identifying practice changes from the outcome of the audit.

5. Patient stories
The aim was to involve the patients in the project through gaining their experiences of care, primarily using patient stories. For many teams this process was informed using the resources developed by the NHS Institute for Innovation and Improvement (2009) experience based design approach. These resources set out clearly all the steps involved in gaining patient’s experiences of care including raising awareness of the process using posters in the ward area and gaining consent from patients.
### Appendix 4. Evaluation Aims and Processes

#### Box 1. For the organisation

<table>
<thead>
<tr>
<th>Aims:</th>
<th>Evaluation processes</th>
<th>Collection and analysis processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce hospital associated infections</td>
<td>Quantitative data on infection rates related to the specific of the project</td>
<td>Data collected locally by project leads</td>
</tr>
<tr>
<td>• Develop a local strategy for reducing HAI</td>
<td>Evidence of an action plan</td>
<td>Developed by project teams with support from FoNS facilitator in the workplace and workshops. To include all aspects of project from aims to outcomes</td>
</tr>
<tr>
<td>• Increase staff knowledge and skills in their role to reduce healthcare associated infections</td>
<td>Active learning activity by the healthcare team such as staff reflections, observation of practice, claims, concerns and issues</td>
<td>Evidence collected locally and analysed by teams to identify themes from the evidence leading to developments in practice</td>
</tr>
<tr>
<td>• Develop project leaders’ knowledge and skills of developing practice</td>
<td>Reflections on their experience/learning within the project using reflective framework on becoming a practice developer - ongoing through the project</td>
<td>Process supported by project lead in practice and at workshops</td>
</tr>
<tr>
<td>• Increase patient satisfaction with care</td>
<td>Creative work on their journey through the project</td>
<td>Collected locally and analysed by project teams, supported by FoNS practice development facilitator using thematic analysis</td>
</tr>
</tbody>
</table>
### Box 2. For the staff involved

<table>
<thead>
<tr>
<th>Aims:</th>
<th>Evaluation processes</th>
<th>Collection and analysis processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Understand the contextual factors that enhance or hinder the implementation of best practice</td>
<td>Context Assessment Index. Indicates staff perception of current practice and changes overtime. Effect of context on developing practice</td>
<td>Led locally by the project leader with the team. Analysed using quantitative process</td>
</tr>
<tr>
<td>• Develop knowledge and skills relating to HAIs</td>
<td>Values and beliefs of their role in reducing HAIs</td>
<td>Collected locally by project leader and analysed using thematic analysis</td>
</tr>
<tr>
<td>• Raise awareness of the individual and the team regarding roles and attitudes towards HAIs</td>
<td>Reflections on their experience/learning within the project, questionnaires etc.</td>
<td>Collected locally by project leader and analysed</td>
</tr>
<tr>
<td>• Understand the significance of their practice to patients’ experiences of care</td>
<td>Healthcare team exploring current practice such as; observation of practice, patient stories/interviews, claims, concerns and issues Insight into practice. Indicate changes overtime. Identify aspects of practice related to HAI that need to be changed</td>
<td>Teams locally explore practice and evidence themed using thematic analysis</td>
</tr>
<tr>
<td>Aims:</td>
<td>Evaluation processes</td>
<td>Collection and analysis processes</td>
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</tr>
<tr>
<td>- Understand contextual factors that enhance or hinder implementation of best practice</td>
<td>Context Assessment Index in their workplace to indicate staff perception of workplace culture [Values and beliefs on their role as a practice developers]</td>
<td>Led locally by the project leader with the team. Analysed using quantitative process [Collected locally by project leader and analysed using thematic analysis]</td>
</tr>
<tr>
<td>- Develop a strategy/project to reduce HAI s</td>
<td>Evidence of a project plan</td>
<td>Developed by project teams with support from FoNS facilitator in the workplace and workshops. To include all aspects of project from aims to outcomes</td>
</tr>
<tr>
<td>- Develop knowledge and skills as facilitators of practice development</td>
<td>Reflect on role and responsibly within the project in engaging with staff to undertake active learning such as; observation of practice, patient stories/interviews, receiving feedback on their facilitation</td>
<td>Completed reflection on their own development as a practice developer using framework at each workshop. Analysed individually by project lead and collectively by FoNS facilitator to identify the leader’s development through the project. Creative piece at end of project at last workshop</td>
</tr>
<tr>
<td>- Understand the significance of their practice to patient care</td>
<td>Healthcare team exploring current practice such as; observation of practice, patient stories/interviews, claims, concerns and issues</td>
<td>Teams locally explore practice and evidence themed using thematic analysis</td>
</tr>
</tbody>
</table>
### Box 4. For FoNS

<table>
<thead>
<tr>
<th>Aims:</th>
<th>Evaluation processes</th>
<th>Collection and analysis processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Significance of FoNS to meeting project aims and developing internal leaders as practice developers</td>
<td>Data collected from each site stated in boxes 1, 2, 3, 4, and 5</td>
<td>As boxes 1, 2, 3 and 5</td>
</tr>
<tr>
<td></td>
<td>Material and evaluations from workshop days</td>
<td>Thematic analysis of the data from each area and collectively from all sites by FoNS facilitator. Process of thematic analysis will identify whether the projects have met their project aims</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Analysis of feedback on the role of FoNS from workshops</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post programme questionnaire to project leaders on the role of FoNS</td>
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</table>

### Box 5. For patients

<table>
<thead>
<tr>
<th>Aims:</th>
<th>Evaluation processes</th>
<th>Collection and analysis processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reduce healthcare associated infections</td>
<td>Quantitative data on infection rates</td>
<td>Data collected locally by project leads</td>
</tr>
<tr>
<td>• Improved patient care</td>
<td>Patient stories, interviews, questionnaires, Observation of practice</td>
<td>Thematic analysis of patient data by local teams support by project leader and FoNS facilitator. Identification of the significant aspects of practice that are important to patients</td>
</tr>
</tbody>
</table>
Appendix 5. Workshop evaluations

At the end of workshops 2-5, the participants were invited to say what they liked most and least about the workshop and one point of learning/action they would be taking away from the day. The participants wrote these on ‘post its’ which they stuck onto flip charts. After each workshop, the feedback was typed up and returned to the participants via email.

The feedback from all of the workshops was reviewed by Jayne Wright and key themes identified. These are outlined below.

What the participants liked best

Sharing with and learning from others
The key theme to emerge was how the workshops enabled the project leaders to share and learn from each other. They valued the space the workshops provided to learn and share ideas beyond their own workplace. Some of the many comments the participants provided include;

‘Hearing about other teams and their progress’

‘Chance to speak to other participant’

‘Sharing ideas with colleagues and exercises were extremely useful’

‘Opportunity to discuss wider issues of practice development with a wider mix of staff’

‘Group work, group interaction, exploring my beliefs and values in comparison to the other participants’

This opportunity to network also led to the breaking down of barriers between senior and junior staff and the removal of some of the preconceived ideas held by junior staff about senior staff:

‘Meeting senior staff and being able to feel comfortable, the values and beliefs exercise – understanding that although we have different values and beliefs essentially they boil down to being similar’

Value of facilitation
The participants appreciated the facilitation they received at the workshops and valued the opportunity to develop and practice their own facilitation skills:

‘Enabling facilitation’

‘Think about my facilitation style when doing practice development work’

‘Support of the facilitators’
‘Great facilitations (learn by example)’

‘Energy of the facilitators’

‘Practicing facilitation’

‘The obvious support I see from facilitators, friendliness of facilitators’

**Time to focus and reflect**
Within their roles in the NHS time to reflect seemed to be limited. Therefore the participants particularly valued the time that the workshops provided to stop and reflect personally on themselves as individuals and their practice. It also provided time to focus on the project and the next step.

‘Time to work on action plan’

‘Opportunity to draft an action plan’

‘Allowing me to explore my own attitudes’

‘Looking at where we are’

‘Time to address our issues’

**Learning about practice development**
The participants found the various tools beneficial and valued learning about what practice development means to their practice:

‘Sharing different cultures and structured matrix’

‘The notion of going back to basics around values’

‘Claims, concerns and issues’

‘Practice tools’

‘CAI and using it on practice’

‘What practice development is to me at work’

**What they liked least**

**Practical issues**
Feedback about what participants liked least was limited and usually related to issues about the workshop room or the journey to workshop:

‘Journey – not used to it’
‘Room acoustics and layout’

Unanswered questions
The participants did leave the workshop at times with questions such as:

‘Still unsure that project is what is required’

‘How to do the evaluation’

Evaluation
The session on evaluation was unpopular with some as they found it challenging and complex:

‘The evaluation’

‘The evaluation sheet’

Using creativity
Practice development methods draw on a wide range of approaches to enable practitioners to learn from practice and tap into their sub conscious self. One way is by engaging in creative activity such as painting, collages etc. The creative work seemed to be less popular with some. This could be because it was a very different way of learning for most at the workshops:

‘Scrabbling on floor for pictures’

‘Pictures on the floor’

‘Drawing!’

‘Creative’

Learning/actions to take away from the workshops
The participants were asked what key learning/action they would be taking away from the day. Some made comments about the day itself whilst others commented on what they would do in the workplace from what they had learnt at the workshop. A number of common themes emerged.

Implementing learning
The participants took away activities and skills learnt at the workshop to use in practice. The transference of learning from the workshops to the workplace and vice versa was an important part of the workshops and therefore participants seemed to value the opportunity to develop new skills and practice new approaches in a safe environment:

‘Try to change my facilitation style sometimes’

‘What facilitation feels like exercise taking it to practice!’
‘To work with the teams to learn about beliefs and values’

‘Evaluate from beginning’

Practice development tools
Participants felt that they had learnt about tools that they could use that would enhance the understanding of staff and enable the development of practice:

‘Tools we used’

‘PARIHS scorecard’

‘Reference material and DP subscription/website’

‘Resources available’

‘Looking in to using some of visionary tools within my team’

‘Tools to evaluate effectively’

‘Culture assessment of workplace’

Ability to make a difference
The workshops seem to have enabled the participants to develop a greater insight into their ability to understand and develop practice:

‘We can make a difference if we keep at it – not giving up’

‘Today has opened a can of worms and enabled me to consider how the unit operates re HAI’

‘How values and beliefs could affect one’s role and performance’

Engaging staff
The workshops helped the participants to recognise that working with their clinical teams was vital but some were having difficulty knowing how to do this:

‘Who do I really need to engage with???’

‘I need to involve the ward staff more in the project’

‘I’ve done too much of this, do the nurses really know what it’s about?’

Focus and structure to project
The participants found the workshops helped them to focus on the planning and structure of the project and how to ensure it was manageable:
‘Now more focussed on smaller project’

‘How to sustain project’

‘To prepare a proper action plan, audit tool’

‘Project planning process’

‘The different perceptions and ideas that different projects have formulated’

**Ending/continuing**

At the last workshop the actions to take away reflected that the projects were coming to an end. The comments also reflected how the participants had started to think about how the projects would continue after the end of the programme and support from FoNS:

‘To tidy up loose ends of project and finish report’

‘Read more on practice development’

‘Start moving to completion of project’

‘Continue to sustain the ongoing good work’

‘Start focus on writing up project’

**Summary**

The feedback suggests that the participants found the workshops of value in a number of ways. They appreciated the time out of practice to reflect and focus on the project, learning about practice development and how to apply new methods and approaches to their practice. The workshops also provided the opportunity to share with and learn from participants from different trusts. This was highly valued, yet interestingly, other opportunities to network with participants outside of the workshop e.g. using the FoNS website, were not taken up.

Some participants found some of the concepts challenging e.g. evaluation and did not always feel comfortable using creative approaches to learning.
Appendix 6. Reflective critique and learning

At the end of each workshop the participants were invited to complete a reflection based on Mezirow’s (1981) perspective transformation model of critical reflection. This model is based in the theory that critical reflection can enable an individual to re-evaluate past beliefs and experiences developed over time; thereby allowing them to consciously make and implement plans that bring about new ways of defining their worlds. The purpose of using this approach was threefold; firstly, to enable participants to develop greater awareness of their learning (progress and needs); secondly, to provide information to inform the workshop programme and the work of the FoNS practice development facilitator with the project leaders; and thirdly, to provide evaluation evidence relating to the impact of the programme on the development of individuals as facilitators of practice development.

The reflections were initially collected by the FoNS practice development facilitator and copied (with the permission of participants), thereby enabling them to be analysed; following copying the reflections were returned to participants for their own use.

An overview of the analysis of the completed reflections is provided below and is structured around the questions that form the reflective model. Where there are significant differences between the reflections of participants from the two cohorts, this will be noted.

1. Your feelings about your work
When participants first reflected on their work they described it as ‘exhausting’ ‘crisis management’ ‘frustration’. As the following examples illustrate;

‘Enjoyable but, challenging, difficult to manage workload, difficult to be proactive, but learning ways in which to empower other staff to improve practice’

‘That it is like riding a roller coaster, up down, happy sad, frustrated; fulfilled, ever changing! But often fascinating’

These reflect many of the comments which were divided between wanting to improve practice and in particular engaging staff in the process, yet feeling overwhelmed by the demands of the service.

However Cohort 2 seemed from the beginning to be more positive about their work as captured in the following comment;

‘I enjoy developing individuals and areas and take pride in their achievements. I often feel frustrated at lack of time, resources’

Generally from both cohorts, the more positive comments appeared to be where they felt other staff were already engaged in the project. This is captured in the comments below:

‘Positive about being involved – approach and commitment by staff/ward manager’.
‘Initiating a new project may be easy as most members of staff are enthusiastic and I have a lot of support from my lead nurse, team leader and PD sister’

As they progressed through the programme the participants appeared more insightful into how in their role they could influence the development of practice by using practice development approaches. This appeared to lead to a more positive view of their work. For example;

‘The influence I could have as a manager, role model, facilitator, enabler, supervisor, mentor and appraiser, less crisis management’

‘Strong feeling that I can influence change in practice through role modelling, engaging and empowering staff to take the lead in practice development initiation’

This was enhanced by a raised awareness of self which was noted by participants in cohort 2 such as;

‘Need to be open minded, need to take time to explore staff’s values, beliefs, perceptions’

‘How you have to be a role model and really motivated to develop the practice. That you do not do everything yourself. You must involve other staff’

‘I am paying more attention to conscious awareness of using different techniques’

Their confidence in their role at work seemed to increase as the programme progressed

‘I feel I am more confident and motivated to facilitate meetings and learning in the work setting’

Again with cohort 2 they provide more information and evidence of how their feelings about their work had developed over the programme.

‘Excited now that I understand it all better, i.e. using the skills of a practice developer to implement change’

‘We are go through a productive phase of changes and challenges. There is evidence of improvement but there is room for ongoing improvement’

2. Your decisions and perceptions
The participants through their reflections talked about the need to involve others in decision making and the need to be open and listen more. They clearly recognised the significance of involving stakeholders in decision making. This is captured in the following comments;

‘Need to ensure I listen to all views – reflect on participants views before making decisions’
‘Reminding myself of staying open to suggestions/different ways of thinking/working’

‘I try and work collaboratively with the nursing team. Be less impatient – give time for others to understand and engage’

Some of the participants however found that the process of engaging the team would not be straight forward;

‘I am still concerned that integrating with team may not be easy’

‘Commitment to project, difficult to engage staff − medical, nursing, AMP(?)’

Cohort 2 talked of self awareness and its importance to being good at decision making and in being able to understand others perceptions. The importance of listening to others and knowing that as leaders they might not always be right

‘Being aware of my perceptions and also my esteemed colleagues, make decisions for longer term benefits rather than short term goals’

‘Acknowledging that my perceptions about myself might be different from others’

‘My decisions and perceptions need to be more inclusive, I need to be more aware of ‘others’ decisions and perceptions and the reasons for them’

Once introduced to practice development tools they saw how these could help inform their decision making.

‘In terms of doing right tools, skills and knowledge to empower and engage staff in practice development’

‘Can use tools we have used here to help me work more with the team and engage them’

‘Important to take time to review current practice, review evidence base, read more about culture and context’

‘To encourage more team work and building. I should get more theory behind me, to help make a better decision’

‘Trying to link the theory in to practice i.e. facilitation roles etc.’

Significantly, over the course of the programme they could see the wider picture and that their decisions could influence the culture;

‘That it may change the culture, that it can improve the patient’s experience, improve quality in my organisation’

‘More aware of the reasons behind my decisions and impact on the workplace’
‘Practice development is empowering. I have more insight in to the initiation of changing practice’

All the following comments come from cohort 2. Cohort 2 seemed to have developed a greater awareness of the significance of taking time over decisions and using evidence to support their decisions. This shows their development in understanding the importance of knowing why they are making certain decisions and move away from making reactive decisions.

‘My decisions and perceptions of my role as a practice developer is changing each time I attend these study sessions’

‘My decisions are more evidence based! My perceptions are often built on facts’

‘That you need to be able to understand why you make set decisions, what you may perceive needs to be analysed before making decisions’

‘Think a lot deeper before I judge, try not to judge and try not to make assumptions as they can often be inaccurate’

3. Your value judgements and assumptions

The participants gained insight into how at times they made assumptions of others and that this could affect how they worked with the other person.

‘Staying positive – not making assumptions, beliefs in peoples strengths and abilities’

‘My assumptions are not always correct – people surprise me’

‘To not assume and to utilize tools to inform my understanding of staff values’

And as time went on they were able to ‘stand back’ and look in at the culture and had raised awareness of practice. This led them to be less judgmental and recognise that others may not share their beliefs and values.

‘Things are not always as they seem’

‘That my beliefs may not be shared by stakeholders, that may not be aware of my beliefs’

‘That questioning my own values helps open and broaden my understanding’

‘In a specialist role it is easy to become too involved in own role – need to consider colleagues on wards and how practice development fits in to their role’

‘I have become less assuming and am asking more questions and my judgements are becoming more confident’
‘Getting better at reminding myself not to make assumptions – to find out the reality. Trying harder to think deeper about my value judgements before I apply them’

‘Learning to use a wider range of approaches and techniques also means I have to consider more carefully what approach to take with each’

4. The concepts underpinning practice development and your learning about these concepts

At the first few workshops when they were asked this question, the participants appeared to have some difficulty in identifying practice development concepts and their learning about these concepts. This was reflected in the limited amount of information that was recorded. The reflections recorded also seem to be broad and not such as the statement below;

‘Feel I have a start of the concept of practice development and these I hope to apply to practice’.

‘That I am very much at the beginning of my journey as a practice developer’

Cohort 2 right from the first workshop showed more understanding;

‘Exploration of team’s values and beliefs, understanding and shared understanding of language used, sustainability is the key to success’

Recognised the depth and breadth of PD’

The key practice development approach both cohorts reflected as the workshops progressed was the importance of collaboration, inclusion and participation (CIP). This approach was recorded in the reflections at each workshop as the participants understood the importance of CIP and the challenge of achieving true CIP within their project. The participants stated;

‘Involving all – key stakeholders, ensure we have a robust action plan with all involved’

‘Ensuring that all involved have a full understanding and not feel threatened by changes that may come as a result of the project’

The reflections on the practice development concepts learnt seem to reflect the theme of the workshop such as identifying practice development as being systematic; the significance of understanding the team’s beliefs and values; and the role of facilitation in practice development. As the workshops progressed they appeared to understand more clearly how the concepts of practice development can be applied to practice;

‘Doesn’t feel (PD) is not relevant to my team now. Learning how to adapt these concepts to everyday practice, sharing this with the team’

‘Now see that its essential to engage staff to link their values with practice in order to deliver person centred care, culture is important’
‘The concepts of collaboration, communication, goal setting and action planning review an evaluation are a priority and should remain a focus during the project’

The participants saw the range and breadth of practice development;

‘Having read more about the underpinning concepts it continually surprises me how little about it a good proportion of senior staff know’

‘There is more to PD than meets the eye e.g. theories, concepts, context and how these inform practice (personal)’

‘As with a number of things, the more one knows and understands, the more one realises that one doesn’t know’

‘PD is huge!! Lots more theories I had no idea about. Some very useful tools which will hopefully make our job easier’

On the whole the reflections on the concepts of practice development were limited from cohort 1. This could reflect that there were having difficulty making links to the practice development concepts and the work they were undertaking in practice. Cohort 2 seemed to gain a greater insight into the concepts and what they mean in practice.

5. The links between the concepts and the personal theories you are developing

The reflections to this question were the most minimal. This is of no surprise because if participants were having difficulty in identifying concepts, they would therefore have difficulty in linking those to personal theories. However, though at first this section was mostly left empty, over the course of the workshops the participants did attempt to make some links and showed how their knowledge base and understanding were developing.

Responses following the first few workshops included;

‘Tenuous at present’

‘Have to yet formulate any – need to think about it and have more experiences’

‘That unless you give some thought to your values and beliefs and that of rest of your team your personal theories may become inhibitors to practice development’

As the workshops progressed they recognised some tentative links to the concepts underpinning practice development and were able to attempt to develop personal theories. This centred on themselves as facilitators and the significance of this role to the success of the project.

‘That I need to facilitate and enable the staff to realise and be involved in change in order for change to happen, not just be imposed’
‘Facilitation is key and now see that about me. Need to practice and see how I can use it to make change happen’

‘Understanding practice development links facilitation, CAI’

This was supported by the insight that they needed to understand practice and what it means to them as well as the staff.

‘That I first need to be myself embedded in my everyday practice, to fully understand what it means to me’

The participants saw the link between practice development tools and practice activity. They saw that their role was to join up these activities.

‘That practice development is more than tools. Use self to get more joined up working as we utilise them with others in practice’

‘Personal development is about ownership of yourself and how you develop, good to know there are concepts to support these’

**Conclusion**

In summary, the reflections on becoming a facilitator of practice development illustrated that over the course of the programme, the participants developed greater insight into and understanding about their role as facilitators and the practice development concepts that underpinned the role. In particular, the value of greater self awareness and its importance to and influence on decision making, taking into account the views and perspectives of others; the importance of working collaboratively with stakeholders and the opportunities and challenges this presented; the value of practice development tools and methods as a means of engaging with others and informing and stimulating change.

The amount of information recorded increased overtime however; in some cases this was still quite limited. This raises a question as to whether the FoNS practice development facilitators could having given more time to discussing the reflections and the value/meaning of the process.

It was noted that participants in cohort 2 had recorded more reflections than those in cohort 1 and also seemed to have been able to reflect in greater depth. Additionally, the reflections from participants in cohort 2 seemed generally to have been more positive throughout the programme.
Appendix 7. Creating a picture of the project leader’s journey through the programme

At the last workshop, participants were invited to use any of the creative material provided (pens, glitter, paints etc.) to create a picture that represented their journey through the programme.

Each person then described their creation to the group. Exploring our own creativity can enable greater emotional intelligence and provides the opportunity to learn about ourselves and the ways in which we work with patients and colleagues in the workplace (Freshwater, 2004). This can lead to an enhanced professional insight and understanding of workplace culture.

During the feedback, the FoNS practice development facilitator captured the words and expressions used by the participants to describe their journey through the programme. Some of the words and expressions seem to fall naturally into describing start, middle and the outcomes of the journey, therefore these headings have been used to record the information gathered in the session. These comments illustrate the range of feelings and emotions that participants felt during the programme. However, all expressed positive feelings by the end of the journey when reflecting on what they had achieved.

The start of the journey
Ups and downs ● Help! ● Confused ● Opps, what’s this all about? ● Steep uphill ● Engaging and challenging ● Taking off point

<table>
<thead>
<tr>
<th>Start of the journey</th>
<th>Description</th>
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<tbody>
<tr>
<td>Ups and downs</td>
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<td></td>
<td>Engaging and challenging</td>
</tr>
<tr>
<td></td>
<td>Taking off point</td>
</tr>
</tbody>
</table>
Middle of the journey
Like a rollercoaster ● Swimming against the tide ● Fuzzy felt ● Walking through treacle ● Questions ● Pulling ideas together ● Networking/partnership ● Ideas/tools ● Clarifying goals ● Coming out of a dark tunnel
The end of the project
Achievements ● Celebrate success ● Feeling good about me ● Enlightened ● Enhanced knowledge ● Roller coaster ● Continuous ● Empowerment of others
Appendix 8. Evaluation of FoNS practice development facilitator by programme participants

The project teams were asked to complete a questionnaire on their experience of working with FoNS, in particular the FoNS practice development facilitator. Sixteen questionnaires were sent out and five were returned. The findings from the questionnaire are presented below along with three personal reflections from the project leaders. Some of these personal reflections can also be found in the full project reports.

1. What expectations did you have of the FoNS practice development facilitator?

‘I expected exactly what I got regular contact support and visits’

‘To be a support for myself and my colleague as we were doing the project by reviewing our work as we went along, listening to our ideas and giving us feedback’

‘My expectation of the project and external facilitation was completely different to what actually occurred. I was expecting more clinical discussion and auditing of the environments, not change management. I probably expected the facilitator to lead the project which was totally wrong. It led to me leading the project supported by the external facilitator which was the right path to take’

2. How far these expectations were met?

‘They were met completely. It helped that the external facilitator came into our workplace as well and assisted us in applying some of the practice development tools in practice’

‘From a change management and facilitation exercise it was fully met’

3. What has been the benefit of having eternal facilitation from FoNS?

a. For you:

‘You helped me see things from different aspects and it was good to have an outsider looking it’

‘I really enjoyed the workshops there was some really interesting and creative ways to carry out practice development and it was great to network with other health care professionals and see their ways of working, the problems they were facing and how they were trying to overcome them. It was very useful to have all that PD expertise to tap into with the external facilitators’

‘Support for me from outside the organisation, objectivity and feedback’

‘It gave the project a natural supported momentum to understand the process and to get the project completed’
b. For the project:

‘It helped the team as they had a new face that was supporting them and listening to their concerns and their ideas’

‘Guidance as we progressed with the project’

c. For the organisation:

‘It ensured that we were using our time effectively this benefiting the trust’

‘I feel it has been very valuable for the organisation as the project work has real measurable outcomes’

‘It has supported change in an area that is of great importance to a health organisation’

d. For services user:

‘It helped support us in a way that helped the service user’

‘The project has the patient and quality at its centre so I felt it had the most value for our service users’

‘Improved infection control practices and delivered safer care’

4. What did you like least about having an external facilitator?

‘It did feel an added pressure at times when the clinical workload was high alongside the project workload which was also high’

‘It was challenging and didn’t always understand the pressures that the staff are under. But it did ensure deadlines were met. It was hard to watch my staff and unit put under the microscope by an outsider’

5. What did you like most about having an external facilitator?

‘Regular support and knowing that you was always at the end of the phone if needed’

‘That the facilitator had a nursing background and understood the pressures but was strong enough not to accept excuses and kept pushing us in the right direction’

‘The fact that it did challenge, support and meet deadlines. It changed the way I as a manager worked with staff. I enjoyed the support and to have someone to discuss issues with who could look at things objectively in a non judgemental way’
6. If you had the opportunity to work with a FoNS practice development facilitator again, is there anything you would like to be different?

‘No, on reflection I don’t think there is a need to do it differently apart from I think I would have appreciated the report guidelines earlier in the project’

7. Any other comments you would like to make:

‘I have really enjoyed the project and I feel that your support made it more enjoyable. I was grateful for the opportunity you gave us to attend and present at the British Gerontology Society at Brunel University’

‘Thank you very much for your time, effort and perseverance – I am sure it wasn’t easy at times but we really did appreciate it’

‘On the whole it has been a useful exercise, I enjoyed it more toward the end when a clear path had been identified and organised. I now understand my role and how my staff work a bit better than before. I have more of an understanding of change management and will be utilising the strategies that worked from this project to deal with documentation practices in the unit’

‘My personal thoughts are: projects such as these are wonderful opportunities to get grass root ideas and staff commitment to improving patients care. Staff were initially enthused about the project but Trust re-organisation and staff shortages affected the project and staff commitment’

**Personal reflections from project leaders**

The reflections here mirror the feedback at the last workshop when the project leaders were asked to produce a picture of their journey. The reflections show how challenging they found practice development and the time it takes yet also how rewarding as they saw the impact practice development had on staff empowerment.

‘This type of project is time consuming, can be emotionally draining and seriously frustrating but it can also be enlightening, team building and can encourage reflection on practice toward positive changes. In the long run it may make working life easier if work can be delegated and changes managed in a systematic way using tools you know work, as in this project......’

‘Many lessons have already been learnt from all staff that have been involved in this project. It has been a challenging process for the key project team. To lead a practice development project whilst doing an already challenging job is a mammoth task and careful consideration must be applied before agreeing to take on this remit. Whilst, practice development is necessary to ensure that service delivery responds to the ever changing health care system and demanding need for improved patient care, it requires a level of skills and expertise. Nevertheless, it is possible to gain as I have found a level of knowledge and understanding around practice development to support change within the clinical area. Moreover, whilst it
has proved a challenge, it is extremely rewarding to see staff that were once disempowered taking forward changes on their own ward. The project has triggered discussion around other aspects of care that staff believe require change’

‘For the project team doing this project it has made us appreciate that there is no quick fix, that you have to persevere and be prepared to go back to the drawing board. It is a skill to be able to look at what you are doing with ‘fresh eyes’ when you are so close to the practice. What you think might constitute good practice can always benefit from a closer inspection. It has made us realise that it is important to know the culture of the environment into which you may wish to effect change’

‘As a novice to real practice development, it was reassuring to have a FoNS facilitator working alongside the team to ensure that the exercises were appropriate and effective. Practice development is never easy at the best of times but to change a whole team’s attitude, help is often needed to prevent disasters and give much needed support to the project lead. They can be a sounding board for all the moans and groans of the team members with the usual cries of ‘we are not getting anywhere’ as the project continued to the end. It is important to have an outsider to work with the team to prevent it naval gazing, drifting and giving up. It also ensures the team leads have someone to talk to prevent them moaning to the junior staff they are trying to support. The role of the FoNS facilitator was also important in being objective keeping up the motivation and momentum, to keep to time and to ensure that the team stuck to its project. The experience and expertise of practice development is not something that can be learned overnight and project leads need to be mentored in this aspect of practice until they themselves are competent and comfortable in that role to lead and facilitate others’