CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Enabling innovation and sustainable improvement in person-centred healthcare during the first wave of the Covid-19 pandemic – a reflective account

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Abstract
Background: Covid -19 placed new limitations and challenges on how healthcare could be provided. To pursue person-centred care during the initial and subsequent waves of the virus, organisations needed to find quick solutions to ethically challenging clinical scenarios.
Aim: This critical reflection aims to describe how practice developers, quality improvement advisors and practitioners worked together in a large healthcare provider in the North-East of Scotland. We combined the theoretical principles of person-centredness, service design, complexity and organisational learning to develop, enable and implement innovative solutions to providing person-centred care.
Conclusion: Working collaboratively with colleagues, we co-designed changes to treatment escalation planning, end-of-life care and hospital visiting. We found that improvement approaches need to focus not only on processes but also on the experience of patients and staff. This balanced approach had a synergistic effect on improving effectiveness and moderating moral distress.
Implications for practice:
- It is only possible for healthcare organisations to truly act on the needs of those using services when person-centred approaches are built into operational planning and performance management, alongside learning networks that foster innovation

Keywords: Person-centredness, ethics, quality improvement, staff engagement, Covid-19 response

Introduction

The first wave of the Covid-19 pandemic in early 2020 presented a number of ethical dilemmas, especially for those providing direct clinical care (Jeffrey, 2020; McKenna, 2020; Morley et al., 2020). Healthcare professionals had to select treatments for people – and prioritise people for treatment – where resources did not always match demand. They had to discuss imminent death with alert patients whose respiratory support was being discontinued, deny people access to their loved ones even when at their most vulnerable, and limit human touch between professionals and patients. Never before had healthcare professionals experienced ethical concerns on this scale.

Holding knowledge of individuals' suffering and need, and making decisions within the harsh utilitarian values imposed by Covid-19, has been recognised as extremely difficult. Jeffrey (2020) suggests that when healthcare professionals have to shift their focus on benefits and harms from the individual to the whole population, such harsh strictures can be softened by adopting relational ethical values: solidarity, duty, equity, relational autonomy, trust and reciprocity.

This article outlines how we, in a large healthcare provider in the North-East of Scotland, acknowledged the need for the approach suggested by Jeffrey (2020). We drew on principles of practice development, service design and complexity theory to create a structure and a culture that facilitated the identification of moral issues, and the development and rapid implementation of change ideas needed to ensure person-centred care. We use John's (2000) model for reflection to present our critical reflection.

Reflections

1. Description of the experience

In the first wave of the pandemic we established a person-centred care group for nurses, doctors, allied health professionals and chaplains, which met at least weekly to discuss and address person-centred care issues. Membership was open and fluid. People came to raise issues, offer support and learn from others. They could come to all meetings or only to engage with topics relevant to their practice.

We drew on principles and methods from service design, complexity theory and practice development to facilitate this group work. Specifically, we used the principle of involving those closest to the problem (Design Council, 2019; McCormack et al., 2013). We also used the 'double diamond' approach from service design (Figure 1), to help us navigate complexity. This approach encourages the engagement of those closest to issues in a discovery phase before defining problems and then identifying and implementing solutions. We spent much of our time in the discovery phase, listening to our colleagues and ensuring we heard their voices and, through them, the voices of patients and families.

Figure 1: Double Diamond approach to service design (Design Council, 2019)
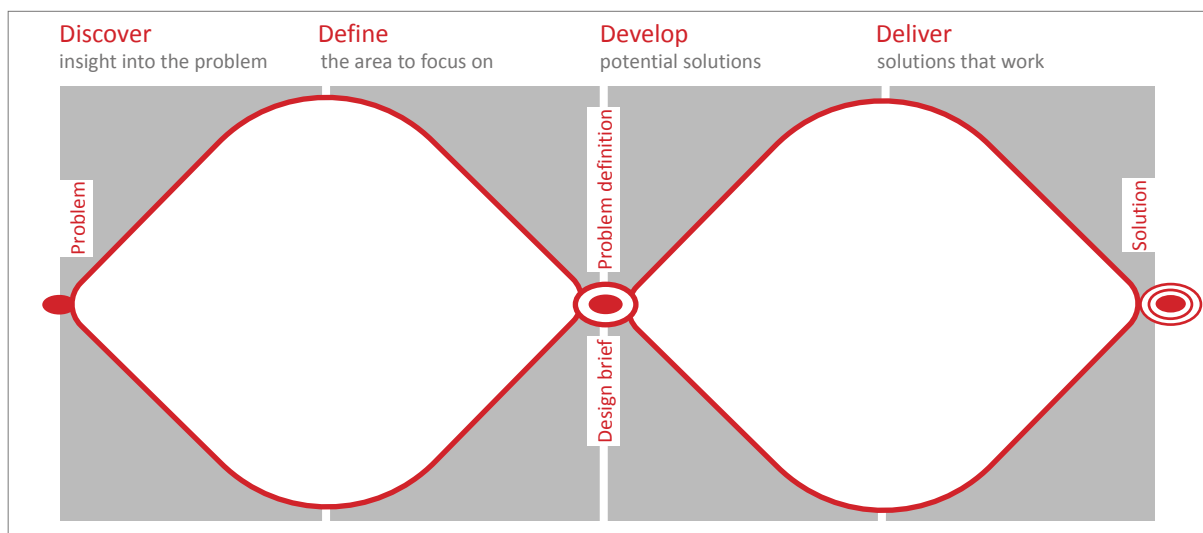
We used the collaborative, inclusive and participatory approach (McCormack et al., 2007) central to practice development methodology to enable democratic and systematic decision making. We created a brave space where people could share practice stories and associated emotions, explore their ethical perspectives and consider potential solutions (Arao and Clemens, 2013). One of the co-authors (ST) shared the facilitation with group members, who became emergent subject leads. Facilitation was holistic, entailing sharing of experiences, synthesis of emotional responses, and identification of problem statements and potential solutions. Individuals self-selected to work on issues that were of most importance to them. The pace of change appeared to alleviate any disagreements, with active learning instead allowing proposed solutions to be tested in practice and confirmed if effective. The solutions included those listed in Table 1.

Table 1: Co-designed solutions	
Problem identified	**Co-designed solutions**
Lack of experience/ anxiety relating to how to make decisions about escalating or discontinuing active treatment and how to discuss this with patients and families	• Treatment escalation guidance documents • Treatment escalation plan form • Critical Care clinical guidelines
National requirements to stop all hospital visiting and concerns over patients' and families' needs and distress	• Virtual visiting hardware and procedures • Face to face visiting guidance
Lack of familiarity with end of life care particularly among practitioners deployed	• End of Life Care guidance
Lack of visiting and its impact on patient's connection to outside world and boredom	• Provision of newspapers free of charge for inpatients
No central resource for clinical teams to access guidance on current guidance on how to maintain person-centred care or address morally difficult issues	• Web presence for person centred care guidance

Throughout this critical reflection we draw on the perspectives of 10 group members who attended an evaluative focus group at the end of the first wave.

2. Thinking and feeling
What was significant? What were we thinking? What were we trying to achieve and how do we feel about the outcome?

We sought to:
- Create space for staff to discuss morally distressing issues on a regular basis
- Identify solutions that would improve person-centred care
- Reduce variability in how ethical issues were being managed
- Alleviate some of the distress we all felt

Creating space in every meeting to talk informally through concerns acted as a support mechanism for all – helping us feel less isolated, more supported and reassured that our thinking was in alignment with that of others. It also enabled gentle appraisal of ethical standpoints through cross-system debate; for example, paediatric practitioners challenged the word 'visitor' as they consider family members as members of the team caring for the child.

Colleagues shared that our approach of creating this brave space had fostered solidarity and built trust across disciplines and specialties, as well as facilitating equity of care and access for relatives. We were therefore confident that we had embodied the relational values that Jeffrey (2020) suggests are helpful when faced with decision making based on utilitarian values.

3. Evaluation
What was good and bad about the experience and what were the consequences of our actions?

We are confident that our inclusive and systematic approach ensured we spent our time addressing the things of most importance to practitioners and created a space where they felt supported to deal with morally distressing issues through dialogue and actions with others. However, we did not include practitioners working in social care services or members of the public. Their inclusion could have informed our programme of work and the solutions we implemented.

A key strength of our approach was the bringing together of clinicians with and without service improvement skills and knowledge. Dickson and colleagues (2008) propose that healthcare staff will more effectively engage in process improvement if supported by colleagues who have improvement expertise, rather than by industry consultants. Jones and Woodhead (2015) and Teeling et al. (2020, 2021) suggest the 'nurturing' of staff is best supported by other colleagues acting as mentors or coaches and not by delegating the implementation of improvement to external or internal consultants, which staff view negatively (Flynn et al., 2019). Similarly, practice development methodology is most effective when it operates at the micro level and is systematically facilitated in ways that are enabling and empowering (McCormack et al., 2013).

The consequence of our approach was the development of high levels of clinician engagement across specialties and disciplines, with a space to discuss relational aspects of care and treatment and to agree rapid deployment of innovations in person-centred care.

Our time was limited so we fell short of taking a systematic and evidence-informed approach to implementing innovations or change in practice. We instead relied on group members to support implementation among their network, which is likely to have led to some variability in implementation.

4. Analysis
Could we have dealt with the situation better? What sense can we make of the experience? What sources of knowledge influenced, or should have influenced, our actions? What other choices did we have and what were those consequences?

We addressed complex ethical issues with a seemingly simple solution – creating a space to talk and agree action. By integrating complexity theory (Schneider and Somers, 2006) and practice development methodology (McCormack et al., 2013) with the application of the service design double diamond model (Design Council, 2019) we were able to facilitate democratic discussion and decision making. This superseded traditional hierarchical engagement, acknowledging differences across the system and adapting solutions to multiple contexts. Our facilitation focused on understanding problems from a range of perspectives before defining the cause of moral distress. It also focused on checking whether a problem's definition held true in all contexts or needed adjustment to hold face validity. This enabled us to have nuanced definitions suitable to each context and to create solutions with minor adjustments for different patient groups.

We believe that replacing a committee approach, where a well-worded proposal gains commitment and leads to a 'one solution fits all' approach, with a space to talk was a basis for creating real change in practice and in interdisciplinary cultural norms. By ensuring the discursive space was underpinned by appropriate theoretical frameworks, we were able systematically to explore complex issues from different perspectives, reduce them to key issues, consider various solutions and then test them in a variety of contexts. By accepting complexity theory we welcomed diversity in the group and used it to share power rather than perceiving it as a barrier to cohesion and collective action. This became our biggest asset, enabling us to be responsive and agile. It led to the creation of principles of practice rather than policies. Practitioners embraced the autonomy this offered and used it as a guiding principle for local adoption of new practices.

We found that buddying clinicians with improvement skills with those who didn't reduced time from development of an idea to developing guidance to support its adoption in practice. Holistic facilitation in the group enabled all to value the diverse skills and knowledge people brought and to weave them in ways that enabled quick testing and adoption of changes in practice.

While we acknowledge that the high level of clinician engagement was influenced by the urgency of the situation and the additional availability of some colleagues whose services had been fully or partly suspended, we also suggest that certain aspects of our approach were instrumental in its success (Table 2).

Table 2: Factors contributing to success	
Contributory factor	**Approach**
Involve those closest to the problem	The majority of group members were frontline clinicians who were personally delivering care to people with Covid
Encourage diversity and expose difference	Bringing people together from different disciplines, such as medicine and nursing, adult and paediatrics, surgery and clinical, acute and hospice care, led to a much richer conversation. The different perspectives helped to improve the detail of ideas the group produced
Relationship building	The meetings were less formal than a committee style and did not mandate attendance. This open approach allowed relationships to form around a shared challenge. In turn, this allowed for a more open and constructive sharing of ideas as well as the sharing of emotionally disturbing experiences – something that is not common in traditional NHS structures
Access to additional resources for improvement	The person-centred care group was supported by those with improvement skills who were able to help gather information, draft change ideas and so on, to remove that burden from the clinicians involved
Shared power	The ideas developed by the group came from the group so they were responsive to members' needs. Those in the group with positions of influence helped to progress change ideas through departmental structures

We recognise the synergies between these factors and practice development principles and return to this in our conclusions, but these ways of working were not familiar to the majority of practitioners who work in systems that mainly focus on efficiency and productivity (Teeling et al., 2020, 2021), taking a reductionist approach to healthcare and ignoring its inherent complexities.

We could have used the 'command and control' model adopted nationally to manage the pandemic but we believe this would have limited our knowledge of the key issues causing concern and negatively impacted on engagement of clinicians. This would have affected our ability to create a space where practitioners could give and receive support around the moral distress faced by many and, ultimately, compromised our collective ability to implement solutions to overcome such issues in timely and holistic ways.

5. Conclusions and action plan
How do we reflect on the experience? Would we change our approach in a similar situation? What lessons have we learned and what are their implications for wider practice? What factors might get in the way of us applying our learning?

Ethical dilemmas are inherent in healthcare and particularly so in developing/facilitating person-centred care. The evidence surrounding the effectiveness of interventions aimed at mitigating moral distress in healthcare practitioners has limited scientific rigour (Morley et al., 2021). While that evidence continues to develop, we propose that more space and time to have cross-system critical debates about practice issues are needed. The debates' effectiveness should be rigorously evaluated to enable an evidence-based approach to addressing longstanding issues known to lead to burnout, stress and attrition (Rushton et al., 2015; Morley, 2018; Morley et al., 2021).

We found that, rather than being juxtaposed approaches, complexity theory, service design and practice development used together can aid rapid change that takes account of the mediating effects of different actors and social structures. However, this does require a collective, moral and authentic intent to work in collaborative, inclusive and participative ways. Practice development principles (McCormack et al., 2013) and complexity theory (Schneider and Somers, 2006) predominantly guided the relational aspects of our work. Service design principles (Design Council, 2019) guided the technical aspects of defining problems, and the development, testing and refining of solutions.

We propose that instead of bureaucratic structures such as working groups and committees, healthcare organisations could create spaces to address so-called 'wicked problems' with those close to practice. In this way, systems leaders, practitioners and patients can work together towards better solutions.

While we identified significant synergies across approaches, we failed to integrate two practice development methods: values clarification and effective workplace cultures. We do not suggest these are not instrumental in creating person-centred healthcare; instead we conclude that in the context of the first Covid wave, unspoken, commonly held values of colleagues appeared to draw in people with similar values and thus quickly enabled us to work in empowering and enabling ways. The working relationships were highly effective from the outset and the value of working in non-hierarchical ways, shared by the facilitator and group members, enabled an effective culture where team members would gently remind each other that was our goal throughout each piece of work.

We did not use creativity in this work. This can be explained by three key factors: time pressures; the need to adapt quickly to online working; and the inclusion of a range of disciplines, many of which had little exposure to critical creativity in learning. Again, we do not dismiss the importance of creativity but instead acknowledge its absence from our approach. Our decision was informed by the risk that its use might, even temporarily, distance people whom we wanted to stay engaged in this work. We did not have time to enable people to see the contribution it could make.

Our reflections have led to the abandonment of the previous committee approach to enhancing person-centred care and culture in favour of a more dynamic, learning-focused network. We anticipate that this will engage clinicians in positive ways and create opportunities to implement change in areas that matter most to patients and practitioners.

Conclusion
Covid brought into sharp focus the inadequacy of a reductionist approach to healthcare management. It created the space to rebalance our attention to the humanity of healthcare through learning and giving voice to those who had tragic experiences of loss, loneliness and isolation, as well as to healthcare professionals' feelings of disempowerment and inadequacy (Aguglia et al., 2021). Careful blending and weaving of a number of theoretical perspectives that embrace complexity can support rapid implementation of change in cultures and practice.

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