



CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Developing an holistic assessment protocol on a hospice inpatient ward: staff engagement and my role as a practice development facilitator

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Abstract

Background: In 2014 I received the Richard Tompkins Nurse Development Scholarship, granted through the Foundation of Nursing Studies and including attendance at a five-day International Practice Development Collaborative practice development school, followed by a year's mentorship. The scholarship aims to foster the delivery of person-centred care, which I hoped to achieve by enhancing holistic nursing assessment on a hospice inpatient ward.

Aims: This article is a critical reflection on my learning through the scholarship, specifically related to staff engagement and my role as a practice development facilitator.

Conclusions: While the project has not yet reached its conclusion, the learning has been invaluable. I have deepened my understanding of the need for collaboration, inclusion and participation to foster engagement and cultural change. More fundamentally, understanding how different aspects of my role enable change has proved both challenging and constructive, resulting in greater self-awareness and confidence. I remain committed to refining holistic nursing assessment to allow a greater degree of person-centred care in the hospice.

Implications for practice:

- Practice development combines a variety of approaches to realise a shared vision; collaboration, inclusion and participation are central to fostering engagement
- Balancing different elements of a role (for instance, leader-manager-facilitator) has the potential to be confusing and contradictory; awareness of how these elements interrelate promotes effectiveness when introducing change
- Individuals in a practice development role must ensure they have good sources of support

Keywords: Practice development, holistic nursing assessment, leadership, engagement, facilitation, change

Introduction

As a practice development facilitator in a hospice, a key element of my role is to ensure a continuous improvement in clinical practice. In 2014 I was fortunate to be the recipient of the Richard Tompkins Nurse Development Scholarship – an award designed to enhance the delivery of person-centred care. This was granted through the Foundation of Nursing Studies (FoNS) and included attendance at a five-day International Practice Development Collaborative practice development school hosted by

Canterbury Christ Church University in association with FoNS. This was followed by a year's mentorship. This opportunity provided me with support to focus on the advancement of holistic nursing assessment within the hospice inpatient ward. An audit I conducted of documentation had shown a need to revise current practice in holistic nursing assessment to ensure we provide care that can be shown to be holistic and person-centred, thereby demonstrating delivery of end-of-life care that is the best it can be (National End of Life Programme, 2010).

The purpose of this article is to reflect critically on my learning using Mezirow's (1990) framework, which is founded on the notion that learning, and therefore change, occurs when an individual's assumptions are challenged through contact with alternative views. Questions that have guided my critical reflection – following Mezirow – relate to:

- Key insights, thoughts and feelings
- My values and beliefs, including value judgements
- Decisions I made and my perceptions underlying these
- Concepts and theories I have drawn on to develop my insights
- What this reflection means to my future practice

The focus of my reflection centres on the nature of staff engagement in the context of change, and on understanding the differing elements of the practice development role in enabling such change.

Description

I conducted a retrospective audit of patient records in 2014 to establish the evidence for holistic nursing assessment of patients on admission to the ward. Drawing on the *Holistic Common Assessment* guideline (National End of Life Programme, 2010) to establish standards (Box 1), there was evidence for individual elements of assessment but these did not constitute a complete holistic nursing assessment according to the guideline. This had implications for the nursing process at the hospice (Marquis and Huston, 2009) and, at a meeting of the hospice governance committee, I recommended that a clear protocol be developed to ensure holistic, person-centred nursing assessment is evident, evidence based and measurable. This necessitated a process of change.

Box 1: Core elements of an holistic nursing assessment

- Background information and preferences
- Physical needs
- Social and occupational needs
- Psychological wellbeing
- Spiritual wellbeing

One of the principles of practice development emphasises the importance of change at the 'micro-systems level' (McCormack et al., 2013, p 5). The implication is the need for a 'bottom-up' approach to implementing change that promotes effective engagement with the process to achieve a shared outcome. Fundamental to this is CIP – collaboration, inclusion and participation (Manley et al., 2013a).

A number of values clarification exercises were planned to seek the views of staff on the purpose of holistic nursing assessment and factors that impact on it. The initial sessions captured a third of the ward staff. Reflection on the number of attendees suggested that increased participation would have allowed more members of staff to have their voice heard, thereby promoting engagement with the process and ownership of the outcomes (Dewing, 2008). The format of the sessions was informed by the values and beliefs clarification activity guide in Dewing et al. (2014) and participants were invited to complete six statements (Box 2). Statement 5 (My role in holistic nursing assessment is:) was an addition to the template and was felt necessary as the participants included registered nurses and healthcare assistants, each with a discrete role to play in the assessment process. Running additional

sessions meant this initial stage took longer than anticipated; the benefit was that 81% of the ward nursing team contributed, allowing them to influence practice change directly. The remaining 11 nurses were offered opportunities to have input into this process but did not act on them.

Box 2: Statements for the values clarification exercise

1. I believe the ultimate purpose of holistic nursing assessment is:
2. I believe this purpose can be achieved by:
3. I believe the factors that enable an holistic nursing assessment are:
4. I believe the factors that inhibit an holistic nursing assessment are:
5. My role in holistic nursing assessment is:
6. Other values and beliefs I consider important in relation to holistic nursing assessment are:

A stakeholder group was formed comprising five members of the ward nursing team (one from each grade of staff) and two service users. The group met to review responses from the values clarification exercise, resulting in the identification of a series of themes and associated attributes, as suggested by Dewing et al. (2014). Statements were drafted and circulated to ward staff for comment, although no feedback was received. This suggested a drop in levels of engagement, most likely resulting from an increased workload on the ward and subsequent conflicting priorities. The stakeholder group met for a second time to consider the draft statements further, asking:

- Do the statements capture the essence of the input received?
- Does each statement describe the core elements of holistic nursing assessment as we would like it to be on the ward ?

Table 1: Values and beliefs statements

<p>We believe the ultimate purpose of an holistic nursing assessment process is: <i>To enable the delivery of excellent nursing care, by recognising the person as an individual with distinct needs and preferences and caring for them in a responsive way to promote comfort and alleviate distress</i></p>
<p>We believe this purpose can be achieved by:</p> <ul style="list-style-type: none"> • Getting to know our patients by listening, observing and accepting where they are coming from – without prejudice – and by developing trusting relationships with patients and those close to them • Reaching a common goal agreed with the patient by joined-up working across the multidisciplinary team, which is achieved through effective leadership, valuing colleagues and open and honest communication at all levels • Maintaining concise and relevant patient records that are clear and accurate, and form part of an ongoing assessment process
<p>We believe the factors that enable holistic nursing assessment are:</p> <ul style="list-style-type: none"> • Adequate resources, including staffing levels and skill mix where staff have been trained to assess patients, having the time to be focused and present without interruption • Use of excellent communication skills and assessment tools to help patients express what is important to them • An effective multidisciplinary team with clarification and understanding of roles, in which everyone works according to hospice values
<p>Assumptions: In order to implement the ultimate purpose of holistic nursing assessment process successfully, it is assumed that:</p> <ul style="list-style-type: none"> • We will encounter increasing complexity of patient and family needs and expectations • Holistic nursing assessment is seen as essential in providing effective, person-centred care • Uncontrolled symptoms will need to be minimised prior to carrying out the initial holistic nursing assessment

Template adapted from Dewing et al., 2014

Once the statements (Table 1) were agreed, the stakeholder group reflected on current practices. To facilitate this process, I chose to use a 'claims, concerns and issues' exercise (Dewing et al., 2014). The rationale for this approach was inclusion and ownership, in that it fosters reflective practice and allows individuals to offer their thoughts without being judged. Group discussion followed and perceptions were challenged, as there was a lack of agreement with some of the points, for example: 'All of the nurses are good at it [assessment]', but consensus was reached. The group then contemplated the way forward. Specific points included:

- What do we currently do well?
- How could we make this make happen more often?
- How can we do it better?
- How can we use the statements to inform/evaluate the care we give?
- What needs to change to make this happen?

Next steps for the project were agreed and included further meetings with the ward team to explore these questions more widely and re-engage staff. However, changing priorities in the organisation interrupted the process and, at the time of writing, the project is on hold with a plan to resume in 2016.

Reflections

Staff engagement

Attendance at the values clarification sessions

My understanding of engagement at the outset of this project reflected the *Oxford English Dictionary* definition (Stevenson, 2010) where engagement can be seen as participation in, or active involvement with, an activity. This is fostered in practice development through the principles of collaboration, inclusion and participation (Dewing, 2008; Manley et al., 2013a). My perception of the number of attendees at the initial values clarification sessions was that the participation of just one-third of the ward staff was insufficient to produce any meaningful outcome; the project had the potential to impact on clinical practice for all staff and therefore as many voices as possible needed to be heard (Mezirow, 1990). However, I feel I missed the point here. Further reflection with my mentor – unpicking my assumptions and questioning my learning about the concepts behind collaboration, inclusion and participation – helped me understand that I could more reasonably infer all staff should be given the opportunity to input to the process. Linking theory to my practice, I adjusted my approach to increase flexibility of session times, including weekends, and to catch up with individuals on a one-to-one basis to help enable participation. Clearer communication with the ward manager and clinical leads also helped boost attendance, but I wonder whether this 'push' had the desired effect of actually engaging staff, as it felt to me as though the sessions became mandatory.

Staff confidence

It was interesting to me that staff articulated a high degree of confidence within the values clarification sessions, stating that '...we assess all the time'. While I assumed this was correct, as we cannot care for people effectively unless we have assessed them (National End of Life Care Programme, 2010), it was not supported by the audit results and there was no clear explanation of the difference between the statement and the evidence. Reflecting on concepts and theories (Mezirow, 1990), I felt critical social theory (Sumner and Danielson, 2007) provided insight when contemplating how to address this discrepancy, with its focus on critical reflection to enable enlightenment, empowerment and emancipation – key tenets of practice development (Sanders et al., 2013). Using this approach I was able to critique the audit results with the staff in a way that was objective, questioning and constructive, bringing a new perspective that resulted in the potential for change on the ward. This was demonstrated by staff expressing, at the end of the session, that both the process and documentation of holistic nursing assessment could be developed further.

A second theoretical framework – Schein’s model of transformative change (discussed in Cameron and Green, 2004) – was also beneficial in examining the level of staff confidence in holistic nursing assessment. Schein argued change occurs across three stages:

- Unfreezing – a rejection of previously held knowledge
- The process of change resulting from learning new concepts and meanings
- Refreezing – embedding learning into culture

The motivation for change is dependent on anxiety related to new learning (for instance, a fear of failure by not learning) and survival (or not wanting to be left behind as others develop). Schein argued survival anxiety must be greater than learning anxiety to produce change, so the focus should be on reducing learning anxiety; ways to achieve this include shared vision, involvement of participants, and role modelling. This is emulated in the principles and processes of practice development. The values clarification exercise created (for most of the staff) a motivation to change, or ‘unfreezing’, and began the process of ‘learning new concepts and new meanings’, as demonstrated through discussion in the sessions and beyond. Thinking through my decision making and judgements (Mezirow, 1990) I had the sense that challenging practice by involving staff in critiquing audit results, although not easy, is highly constructive and promotes the core principles of collaboration, inclusion and participation (Manley et al., 2013a; 2013b). My perception was that this process values staff input and promotes ownership of whatever system we implement, facilitating movement towards a person-centred approach to assessment – ‘refreezing’. Dialogue within the sessions showed staff did appreciate that if we can proactively rethink assessment processes and associated documentation, we will have a stronger and more consistent voice when advocating for the people we care for. This demonstrated ‘enlightenment’ to me, as staff began to acknowledge the need for change. Reflecting on my beliefs and feelings during the sessions, I felt that while challenge may bring discomfort, it is necessary to stimulate development (Sumner and Danielson, 2007; Dewing et al., 2014). For me, it has been important to recognise that the process of critical reflection to enable change can be painful and difficult at times, so good sources of support for those involved in leading projects such as this are highly recommended.

Changing culture

Reflecting on my original thoughts and feelings (Mezirow, 1990), I had seen this project as a collaborative venture to revise the assessment documentation used on the ward, possibly with a review of how nurses can conduct a more streamlined joint assessment with the medical staff. What became apparent when reflecting on my learning through the practice development school and the values clarification sessions was the need to look at the assessment process itself, particularly in the light of my increasing understanding of practice development within my clinical setting. For example, discussion in Shaw (2013) draws a distinction between service improvement (which aims to change systems and processes) and practice development (which changes people and practice). If a review of holistic nursing assessment is widely seen as simply about improving our service, this implies a limited impact on clinical practice as the emphasis becomes purely superficial (in this case, revision of the documentation). Insight into the need for cultural change also became evident to the steering group during the first few values clarification sessions, resulting in some confusion (for me as well as the ward staff) as the focus of the sessions appeared to shift slightly to encompass issues beyond documentation, such as the nature of joint assessments and communication skills – but without this being acknowledged. In relation to my future practice, I need to be aware of the development of new insights during a project and consider how to communicate these, both within the sessions and more widely, ensuring everyone has the option to extend their input if they attended an earlier session. Following Mezirow’s framework, I believe this will provide clarity of purpose from the outset and can further promote collaboration, inclusion and participation (Dewing, 2008; Manley et al., 2013a) through openness, transparency and shared learning, ideally avoiding any loss of engagement.

Maintaining engagement

While the values and beliefs statements (Table 1) identify holistic nursing assessment as a priority, the current pace of change on the ward is phenomenal, with a number of projects jostling for position. Reflecting on this aspect in terms of feelings, perceptions and concepts (Mezirow, 1990), I wonder whether a clearer ward strategy could mitigate the effect of potentially conflicting priorities by clarifying expectations. While I understand that engagement depends on intrinsic and extrinsic factors and that this will fluctuate over time according to organisational and individual demands, an overt strategic direction would help to facilitate a shared vision (Dewing et al., 2014), fostering collaboration, inclusion and participation (Dewing, 2008; Manley et al., 2013a). In this context, the new insights and personal theories I have developed through this project suggest to me that practice development can balance aspiration and pragmatism, resulting in change that is achievable and that supports a person-centred approach to care. Whatever the role, maintaining the momentum of a project and ensuring collaboration, inclusion and participation in such an environment necessitates a leadership style that is both strong and transformational (Manley et al., 2013b).

My role – facilitator, manager, leader?

Diverse roles

When I began this project to advance holistic nursing assessment on the ward, I thought – possibly naively – that my role would be that of a facilitator, enabling others to effect changes in practice for the benefit of patients. In reality I found myself moving between the roles of facilitator, manager and leader.

Reflecting on the concepts and theories (Mezirow, 1990) from a practice development perspective, I agree with Shaw (2013) that facilitation is about enabling others to reach a goal while optimising their learning. Within this project, my role as a facilitator has been to enable staff to make explicit their values and beliefs about holistic nursing assessment and consequently to support them to review their current practice critically, challenging the ‘norms’ and exploring alternatives (Dewing et al., 2014). This is reinforced by critical social theory (Sumner and Danielson, 2007), which questions how things are done through critical reflection to stimulate self-awareness and therefore change.

In contrast, I found myself faced with the challenge of empowering staff to leave the ward to attend sessions, when an often-cited reason not to go is ‘the ward is too busy’. Reflecting on my decision making, the setting of dates and times that I knew would maximise the opportunity for staff attendance, and seeking individuals out to ‘remind’ them a session was taking place, could be viewed as a managerial function, as defined by Cameron and Green (2004).

The leadership role is different again. Marquis and Huston (2009) identify that for change to occur, it has to be led. Contemplating this role from a practice development perspective, motivation of self and others is an essential prerequisite (Manley et al., 2011). Reflecting on my insights throughout this project, I suspect that my personal motivation has been central to moving the project forward. However, without engagement it seems to me that none of these roles individually can inspire change, nor ensure any change is sustained. Therefore, a combination of these differing roles is needed and I believe this is evident in the concept of transformational leadership (Manley et al., 2013b).

A combined approach

According to Manley et al. (2013b) transformational leadership supports enlightenment, empowerment and emancipation through a combination of management, leadership and facilitation skills, embracing the principles of practice development. For me, grappling with my shifting role identity has been one of the most challenging aspects of this project and the catalyst for much reflection (Mezirow, 1990). It seems to me the choice of role changes according to the task in hand. For example, keeping the project on track and paying attention to individual elements required a managerial aspect to my role (Cameron and Green, 2004; Dewing, 2008) whereas supporting the stakeholder group in theming group work and generating statements about holistic nursing assessment necessitated facilitation, notably questioning and clarification (Marquis and Huston, 2009). The leader provides innovation and

vision, and could be seen as the promoter of change (Manley et al., 2011). My thoughts surrounding these ideas suggest that understanding the function and purpose of each role is essential to allow flexibility and adaptability when required.

In this respect, an important point of learning for me was reflecting on the need to be intentional when selecting a role; understanding both the role and the nature of the activity, alongside potential consequences, is necessary to make the right choice and to increase effectiveness. For example, considering the values clarification exercises in terms of my perceptions and decisions (Mezirow, 1990), I could identify that a facilitative style was required to draw out thoughts, ideas and experiences (Dewing et al., 2014). Had I chosen a leadership approach I may, by definition, have controlled the discussion, thereby negating the principles of collaboration, inclusion and participation (Dewing, 2008; Manley et al., 2013a).

Developing my personal theories and insights (Mezirow, 1990), I feel transformational leadership combines elements from the manager-leader-facilitator roles effectively to support staff through the process of change, specifically by challenging perceptions and providing clarity about what needs to change and how this might be achieved (Cameron and Green, 2004; Dewing, 2008; Manley et al., 2013a; 2013b). By innovating in this way, I believe practice development can influence change in a positive way.

Conclusions

This article set out to reflect critically on my learning experience through the process of developing a clear protocol to ensure holistic, person-centred nursing assessment is evident, evidence based and measurable. While the project itself has yet to reach its conclusion, the learning has been invaluable. My deeper understanding of engagement has enhanced my awareness of the need to advance collaboration, inclusion and participation (Manley et al., 2013a; 2013b). Although not necessarily straightforward, recognising and acknowledging the challenges, alongside clearly stated outcomes, can help foster engagement and cultural change (Shaw, 2013). Perhaps more fundamentally I have developed my understanding of my different roles within the process (Marquis and Huston, 2009). Through a supportive and challenging mentor relationship, I have learned how to select an appropriate role dependent on the context, specifically centring on a transformational leadership style. While this has been a constructive experience for me as a practice development facilitator, I recognise that I do not always get it right! However, remaining authentic and open to critique (Sanders et al., 2013) I have found my level of self-awareness and confidence in my role has grown. I remain committed to refining holistic nursing assessment to enable a greater degree of person-centred care in the hospice.

References

- Cameron, E. and Green, M. (2004) *Making Sense of Change Management*. London: Kogan Page.
- Dewing, J. (2008) Implications for nursing managers from a systematic review of practice development. *Journal of Nursing Management*. Vol. 16. No. 2. pp 134-140. doi: 10.1111/j.1365-2834.2008.00844.x.
- Dewing, J., McCormack, B. and Titchen, A. (2014) *Practice Development Workbook for Nursing, Health and Social Care Teams*. Chichester: Wiley-Blackwell.
- Manley, K., Sanders, K., Cardiff, S. and Webster, J. (2011) Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Practice Development Journal*. Vol 1. No. 2. Article 1. Retrieved from: fons.org/library/journal/volume1-issue2/article1. (Last accessed 30th November 2015).
- Manley, K., Titchen, A. and McCormack, B. (2013a) What is practice development and what are the starting points? Chp 3 in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Healthcare*. (2nd edition). Chichester: Wiley-Blackwell.
- Manley, K., Solman, A. and Jackson, C. (2013b) Working towards a culture of effectiveness in the workplace. Chp 8 in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Healthcare*. (2nd edition). Chichester: Wiley-Blackwell.

- Marquis, B. and Huston, C. (2009) *Leadership Roles and Management Functions in Nursing: Theory and Application*. Philadelphia: Lippincott Williams & Wilkins.
- McCormack, B., Manley, K. and Titchen, A. (2013) Introduction. Chp 1 in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Healthcare*. (2nd edition). Chichester: Wiley-Blackwell.
- Mezirow, J. (1990) *Fostering Critical Reflection in Adulthood*. San Francisco: Jossey-Bass.
- National End of Life Programme (2010) *Holistic Common Assessment*. London: National End of Life Programme.
- Sanders, K., Odell, J. and Webster, J. (2013) Learning to be a practice developer. Chp 2 in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Healthcare*. (2nd edition). Chichester: Wiley-Blackwell.
- Shaw, T. (2013) Approaches to practice development. Chp 4 in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing and Healthcare*. (2nd edition). Chichester: Wiley-Blackwell.
- Stevenson, A. (Ed.) (2010) *Oxford English Dictionary*. (3rd edition). Oxford: Oxford University Press.
- Sumner, J. and Danielson, E. (2007) Critical social theory as a means of analysis for caring in nursing. *International Journal for Human Caring*. Vol. 11. No. 1. pp 30-37.

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