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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Don't fix – facilitate: the role of reflection in successful change processes

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Abstract

Background and context: The Foundation of Nursing Studies' Patients First Programme provides support and facilitation to clinically based nurse-led teams to help them develop, implement and evaluate locally focused innovations that improve patient care. This paper critically reflects on my experience as a newly appointed nurse consultant of leading one such project within a dementia assessment unit in Northern Ireland.

Aims and objectives: To highlight how engaging in critical reflection enabled me to gain insight into my assumptions and beliefs. It deepened my understanding of the role of project lead and helped me to overcome barriers I encountered.

Conclusions: From this process I learned that responsibility for the success of the project belonged to the team and did not rest with the lead. Furthermore, I realised I was repeating past behaviours that were not conducive to facilitation. Recognising this was instrumental in enabling me to develop effective facilitation skills.

Implications for practice: In future practice development initiatives I would ensure I had protected time for supervision with a critical companion. In addition I would develop a strategy for sharing action points with all project members and an appropriate mechanism for reporting progress.

Keywords: Dementia, person-centred care, culture, practice development, reflection, critical companion

Introduction

Reflection is concerned with consciously looking at and thinking about experiences, examining the actions involved, the feelings the situation invoked and responses that occurred, and then interpreting or analysing them in order to learn from them (Boud et al., 1985; Atkins and Murphy, 1994). A variety of models exist to facilitate this process, for example, Gibbs (1988), Johns and Graham (1996), de Bono (1999) and Mezirow (2000). Irrespective of which model is chosen, the ultimate goal is to gain a new understanding or perspective on the experience through encouraging the person critically to question and examine the issue and to consider what could have been done differently.

Gibbs' reflective cycle (1988) was used to structure a critical reflection on one aspect of a practice development project and demonstrate how this contributed to gaining insight and making sense of a particular aspect of the process. Although arguably one of the more basic models, it was chosen because it is viewed as straightforward and provides a cyclical framework to help guide reflective practice.

Background

The Northern Ireland Review of Public Administration resulted in the amalgamation of Ulster Community and Hospital Trust with the Down and Lisburn Trust to become the South Eastern Health and Social Care Trust on 1st April 2007. This meant the merger and relocation of two wards from the psychiatric hospital to the dementia assessment and treatment unit in the newly built general hospital.

I came into post as the nurse consultant for mental health services for older people during this transition and the ambit of my post included the clinical management of this unit. It was apparent from feedback from relatives and carers that care was not always person-centred, information was not always readily available and communication with staff could be improved. Around this time, the Foundation of Nursing Studies' (FoNS) Patients First Programme offered an opportunity for clinical teams to explore and improve practice. The ward sister and I applied as project leads in an initiative that sought to improve the care delivered. In addition to a grant of £3,000, FoNS also provided practice development workshops for the project leads and onsite visits from skilled facilitators.

Context

Traditionally the emphasis in dementia care has been predominantly on meeting a person's physical needs. This approach prioritised tasks such as toileting, washing, dressing and feeding, with little, if any, cognisance given to an individual's psychological wellbeing. Some of these 'old culture' (Kitwood, 1995, p 9) aspects had characterised the two old wards and were transferred to the new unit. This was apparent in the way patients had set bath days and were changed into night attire to accommodate staffing needs. This contrasted starkly with the 'new culture of care' (Kitwood, 1995, p 9), which suggested the impact of the social environment often constituted a 'malignant social psychology', whereby the manner in which care was delivered had the potential either to promote independence or foster helplessness, and to enhance wellbeing or induce ill being. These concepts were foreign to many of the staff.

The new unit provided single en suite bedrooms and small sitting rooms. This change from the dormitory style made observation difficult, causing anxiety for staff, which was manifested in resistance to change. The amalgamation into the new unit brought the staff together geographically but with two competing camps. The strategic direction (Department of Health, Social Services and Public Safety: Northern Ireland, 2006) altered the remit of the service, which no longer provided long stay beds. Patients were only admitted for assessment and treatment, so staff had to cope with a different patient profile, altered workload and a higher volume of admissions and discharges, which considerably altered the dynamics. Downsizing meant there was only one ward manager post, which tested staff loyalties. However, it is not unusual for a group to go through a storming stage before they bond and begin to work effectively (Tuckman, 1965). It was against this backdrop that the project leads sought to support the staff and navigate them through this change process to facilitate delivering the Trust's core values of providing accessible, safe and effective high quality person-centred care in collaboration with relatives.

Description

An appropriate starting point was to find a way of bringing the staff together within a safe milieu where we could begin to build up trusting relationships and sow the seeds of effective team working. The grant offered as part of the FoNS Patients First Programme enabled us to commission the Royal College of Nursing to facilitate a culture workshop at which staff could explore their values and beliefs about what person-centred care encompassed and, importantly, how this could be achieved. Methods and approaches aimed at engaging staff were used from the outset. These initially proved successful with staff participating and culminated in action plans to take forward, which included ways of involving patients and relatives. One example was implementing lifestory work, which was instigated by the nursing auxiliaries following training delivered by the Reminiscence Network. However, the realities of practice seemed to impact on the successful implementation of the action plans following the

workshops. I empathised with the staff, so I found myself taking ownership and responsibility for trying to move forward.

Feelings

My initial euphoria at the success of the workshops was rapidly replaced by concern over slow progress. Being new to the nurse consultant post I also felt, rightly or wrongly, that I had to 'prove myself' and this weighed heavily on my mind when leading the project. I was concerned that the project would flounder before it had really got off the ground. My previous post was as a practice development facilitator and while I was used to staff citing work commitments as reasons for lack of progress with initiatives, this post brought me closer to the front line and I was able to see firsthand that these were not excuses but valid reasons. Nevertheless, I experienced anxiety and internalised a sense of responsibility for this failure to advance what we as a team had aspired to.

Evaluation

The Patients First Programme included workshops for the project leads and site visits from FoNS facilitators. This format enabled the project leads to explore the reasons the project had hit a stalemate. Moreover, it helped me to reflect on the distinction between my roles and responsibilities as project lead and manager. I was able objectively to scrutinise my motives and appreciate that taking ownership of the project was not helpful within a practice development framework.

Analysis

Attending the facilitation workshops gave me the opportunity to become aware of and reflect on the difficulties experienced in advancing the action plans. Rather than focus on what others were or were not doing I began to challenge my own assumptions to make sense of the situation. Being able to discuss honestly my concerns helped me to appreciate the situation from a different perspective. In a previous post I had been aware that practice development wasn't as high on staff's agenda as it was on mine. Although I would try to visit wards at less busy times, I invariably spent long periods standing around. To build rapport and credibility I would help out with whatever was going on at the time. On some occasions and with some less enthusiastic folk, I did suspect 'being busy' was used as an excuse for not engaging with me. These suspicions were, however, severely tested when I realised that in the unit I was now managing, the staff were indeed extremely busy. Despite this, I recognised I was in danger of buying into a nihilistic belief that we were powerless to bring about changes.

I welcomed the FoNS facilitators' suggestion of a site visit, believing that they would see the issues confronting us and concur with me in respect of these difficulties. When they visited I showed them around the facility and pointed out the challenges, including environmental constraints, staff shortages and the acuity of patients whose cognitive impairment was compounded by their co-morbidities of acute and chronic physical illnesses. To their credit I found the facilitators listened and were empathetic. An example of the help they offered was when one of the facilitators undertook an observation of practice along with a staff member. This occurred over a mealtime and helped us concentrate on the positive aspects of care as well as illuminating where improvements could be made. Despite this I still felt despondent at our lack to progress. The FoNS facilitators remained positive and further discussions during a second visit were productive in teasing out how best to tackle the stalemate.

The time spent with the FoNS facilitators and more importantly the critical dialogue in which they engaged me enabled me to gain perspective and move away from the negativity I had been feeling. Critical dialogue goes beyond talking and encourages identifying and challenging assumptions, and imagining and exploring alternatives (Brookfield, 1993). By engaging in this reflective process I came to appreciate that I had been buying into a pessimistic belief. The facilitators struck the right balance between validating the difficulties and confronting me within an arena of high support/high challenge, which Manley and Titchen (2012, p 20) argue is a key value underpinning practice development approaches. This was achieved through the strategy of graceful care (Titchen, 2004) – by gently

exploring my negative feelings with me. In this approach the assumption was that I might have allowed my negative emotions to affect my role as project lead. Crucially, this gave me the space to reflect on my actions, offering me insight and the chance to explore solutions. Importantly, this was done in a non-judgmental way that felt safe. I began to think about how I could address this as I became aware that I had lost sight of the fact that practice development should not be something that is added on; it should be incorporated into the fabric of what we do. In my anxiety to see the project succeed I was at risk of hampering progress. Furthermore, I began to realise I was making an assumption that staff would not have the solutions. As I began to make sense of this I could see that the origins of my approach were more concerned with driving through an action plan. This 'top down' change-management style conflicted with the ethos of emancipatory practice development. The latter is couched in a 'bottom up' approach and is concerned with developing and empowering staff (Sanders, 2004) to take ownership of their practice. Indeed, my approach said more about my concern at the lack of progress. I was enabled to reflect on my actions and more importantly the reasons behind them. This was quite revealing and illuminated a familiar pattern of behaviour that went beyond what was happening in the project. I began to see that in other areas of my life I would rush in to try to fix problems my way and that I needed to step back and consider the consequences. This resonated with Eldridge's (2011, p 3) question 'Where does your need to 'jump in' come from and what situations trigger it?' and to an extent with Hunnisett's (2011) experiences. This was a crucial turning point for me as I began to 'trust the processes', which is an inherent part of practice development.

Essentially I acknowledged that I needed to distance myself from the situation and critically analyse my role. In essence I learned that it was not helpful nor was it my function to try to solve issues independently. Ownership of the project rested with the staff. By taking control I was doing them a disservice and demonstrating a lack of confidence in their ability to find ways of overcoming barriers and come up with creative ideas that supported progress while acknowledging the difficulties faced. I realised that sustainable change occurs within a transformed culture that values the contribution of all staff (Manley, 2004). Other methods may provide a quick fix to a problem in the short term but this is merely shifting sands as the status quo is quickly restored because valuable learning is missed and mindsets remain unchanged.

Conclusion

I was able to approach my role as lead differently. Instead of thinking the success of the project rested on my shoulders I appreciated I needed to share this responsibility with the rest of the staff. I therefore arranged a meeting and brought my concerns over the lack of progress out for open discussion. Then I listened to what the staff had to say and learned that the impetus to move forward still existed. Rather than making suggestions about how this could be achieved, I adopted a facilitative approach that was more enabling (Shaw et al., 2008, p 161) and supported them to think outside the box. I adopted the skills the FoNS facilitators had employed with me and used a high challenge/high support approach to good effect, concerning myself more with the role of capturing the suggestions the staff came up with. It quickly became apparent that while there was consensus that the unit was busy, there was agreement that there were other ways of achieving objectives. Creative solutions emerged for how this could be done. The buzz of enthusiasm engendered affirmed this was a productive meeting with staff being empowered to take ownership of their project. The meeting concluded with action plans on how to get back on track with everyone involved. From my perspective I felt empowered as opposed to anxious. I was able to relax in my role as project lead with the knowledge that the project was back in the hands of those who owned it. Contrary to my earlier belief that it was my responsibility to move things forward, this was achieved by the staff with the support of facilitation.

Action plan

This process has taught me the value of engaging in critical dialogue. For me this means a deliberate, conscious exchange of asking and answering questions that would enable me to view a situation differently or 'contribute to a perspective transformation' (McCormack, 2011, p 2). I found that this

was essential in enabling me to view the situation from another point of view. It has shown me the benefit of having a critical companion (Titchen, 2007) with the relevant facilitation skills to support me in exploring and making sense of what is happening. My approach now will be to step back and question whether what I'm doing is adding value or not. I will also use supervision more effectively as a means of having protected time to reflect on my practice.

Summary

The life of the project came to an end but practice development is a continuous process towards excellence and therefore never ends. Engaging in the project revealed characteristics within me that had previously been obscured and I learned a lot about myself. I now feel more confident in approaching another project and have learned to curb my natural instinct to try to fix things myself. The life story work training, which was attended by 16 nursing auxiliaries, was instrumental in cementing positive relationships with staff, patients and families as they worked in unison to compile memorabilia relevant to the individual. The staff valued the culture workshop and the dedicated time this provided to reflect on the current position, and consider the direction they wished to go in and the outcomes that improved care can deliver.

A full project report is available at: <http://fons.org/library/report-details.aspx?nstdid=12471>.

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