



## CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

### Visioning with service users: tensions and opportunities for a new facilitator

Jennifer Haynes\* and Nadine Janes

\*Corresponding author: West Park Healthcare Centre, Toronto, Canada. Email: [jennifer.haynes@westpark.org](mailto:jennifer.haynes@westpark.org)

Submitted for publication: 5<sup>th</sup> April 2011

Accepted for publication: 9<sup>th</sup> May 2011

**Keywords:** practice development, facilitator, service user

#### Introduction

*'Noise'* and *'clenched fists'*: those are the metaphors used by nursing staff during a culture collage activity to describe the context of the unit. This is where I began my facilitator journey; in a Complex Continuing Care and Rehabilitation setting.



Through my efforts to facilitate the creation of a shared vision for person-centred care on the unit, I became acutely aware of how accurate the metaphors are. I am brand new to the facilitator role in an organisation that is brand new to practice development. I am sharing, through this reflection, using John's framework (Johns, 2010), my learning about engaging service users in practice development while contending with my feelings of being 'caught in the middle' (McCormack and Garbett, 2002, p. 323); and dealing with relational complexities beyond what I have ever experienced or could have anticipated. I was nervous about my lack of experience and skill in facilitation and whether it was going to hinder the change that was required to improve the service users' care and quality of life (Rycroft-Malone, 2004).

**Figure 1.** Culture collage of unit depicting metaphors of 'noise' and 'fists' as well as their silencing effect portrayed by the three happy face 'masks'.

#### What happened?

Our facility introduced practice development in March 2010 after hosting the first five day practice development school in Canada. As the facility's Clinical Education Specialist, I don't have a point of care role on any particular unit and have therefore been positioned to develop a helping relationship (Heron,

2001), akin to an external Practice Development Facilitator, with two Registered Nurse Practice Development Facilitators and to support their unit specific work on one of our facility's Complex Continuing Care (CCC) units. Elements of the unit's culture include what Roberts and colleagues (2009) would call destructive oppressed group behaviours. There is hierarchy and fear which seems to be masked at times with the façade of the harmonious team (Johns, 1992). Patients on the unit have learned to 'pick their battles', 'complain only about the major things' and 'remain silent about the rest'.

In light of the strained relationships between service users and staff on the unit I made a hierarchical decision (Heron, 2010) to have the staff and service users create shared visions of person-centred care separately. The inclusion, collaboration and participation of the service users in the development of the shared vision was important because it reflected the principles of practice development (McCormack et al, 2007) and enabled an accurate representation of the service users' values and beliefs towards person-centred care (Dewing and Pritchard, 2004) to be combined with that of the staff to promote shared ownership and direction for transformation of the unit culture (Manley, 2000). And, this is where these people live – essentially it is their 'home'.

I began by focusing on creating a safe space for patients to speak about their values and beliefs (Heron, 2010; Rogers, 1993). In total, I engaged nine patients and three family members through a process of creating a shared vision for person-centred care from reflections on their experiences of being patients and family members. I met with patients and families one-on-one and in groups; I met them outside surrounded by our beautiful grounds and in their rooms amidst the noise of respirators and call bells; I read and wrote for those who couldn't; and I encouraged reflective writing for those who could manage.

Upon completion of their separate visions, all stakeholders collaborated to combine the separate visions into one vision that represented the shared values and beliefs of all stakeholders on the unit.

### **What are the key issues that I need to pay attention to?**

It is not usual practice to ask our patients to create a shared vision. I was therefore very hierarchical and clear about intent (Heron, 2010) so as to disassociate the process from more traditional processes for service user feedback including our Centre's complaints and compliments process or our bi-annual patient satisfaction survey. I provided constant reinforcing of how the sharing of experiences, values, and beliefs would be used to learn and inform the future patterns of behaviour on the unit rather than directing an immediate band aid fix to issues (Heron, 2010).

An issue for me as a facilitator is how best to engage the service manager on this unit in the visioning work as such involvement is key to creating sustained changes in patterns (Fitzgerald and Soloman, 2003). The manager expresses a sincere intent to support the practice development work but neither of us is certain what that "support" should look like. Practice development represents a radical shift from traditional leadership models whereby hierarchal command and control practices were endorsed. In truth, there still may be times when the unit manager has to assume a more traditional hierarchal approach to dealing with performance issues that don't resolve through practice development efforts. Tension mounted for me as a new facilitator without a clear sense of how to enable the manager to unlearn and relearn in regards to leadership practices. I appreciate the challenging personal and professional work required of him and experience the same in my enabling efforts as a facilitator.

Another form of tension arose when leadership issues were at times cited by service users as a factor that impedes the realisation of person-centred care on the unit. I felt the strain of 'being in the middle' (McCormack and Garbett, 2002). I had one side of the story so-to-speak and struggled with how best to

facilitate a high challenge/high support opportunity whereby the unit manager could hear, process, and respond to service user concerns (Daloz, 1986). In my experience, unit managers in general are often struggling with keeping everyone happy. Inevitably, someone will be dissatisfied with a manager's decisions and strategies. I am concerned about contributing to the struggles of the manager when service users express their dissatisfactions.

Also of note is that more than one 'in the middle' emerged for me as a facilitator during the entirety of the visioning work on the unit: between management and staff; between management and service users; between allied health professionals and nursing; and finally, between service users and staff. However, I feel that being in between service users and staff was the most complex. In large part, this was because the stakes are the highest. As committed as I am to helping facilitate a better workplace culture for the staff, I feel as though I have a greater moral obligation to make things better for the service users. If we do not get it right, or somehow make the culture worse, the staff can go home or leave the organisation, but the service users are the ones that are truly 'stuck' with the consequences; this is their home; this is their life.

#### **What was I trying to achieve?**

Many authors speak to the importance of involving service users in practice development (Dewing and Pritchard, 2004). It was important to me that all stakeholder voices were a part of the unit's vision for person-centred care, as from my experience, healthcare providers all too often assume that they know what it is that patients want. I was also trying to bridge the gap between two worlds that felt so far apart on the unit: the staff and the patients with their families. I wanted to break through the us-versus-them barrier. Some patients assumed that their views were too different from those of staff and that their relationships were too strained to ever create a shared vision and some family members stated that they had given up advocating on behalf of their loved one for fear that their care would suffer. I was intentional in my efforts to translate some very painful and personal narratives from service users into a vision statement that was constructive and that could be received by staff without feelings of blame and without undermining the way patients really felt about their experiences (Heron, 2010).

#### **Why did I act as I did?**

Although aware of power dynamics, strained relationships and hurts on the unit, I was somewhat naïve to their depth and severity. As a result, my emotive responses to the visioning work were frequently troubling. My intention to include service users in the development of the shared vision was to model person-centeredness, flatten hierarchy, promote shared decision-making, inform future behavioural norms, and break down the destructive norms that were a part of the culture (McCormack et al., 2008). The realisation of these intentions was certainly threatened by my feelings of upset, anger, sorrow and futility that could minimise my effectiveness as a facilitator.

At times I questioned the wisdom of focusing exclusively on the micro-culture of the unit to make things better. While I understand that this focus is key to shifting care practices (McCormack et al., 2008), I was coming to appreciate how the macro-culture of the organisation was serving to perpetuate some of the unit's unhealthy patterns. Could I facilitate sustained change if parallel culture shifts were not being facilitated at a broader level within the organisation? Ultimately, while I recognised this as a potential barrier, I became more determined to make a difference at the unit level, at least for the time being, as I felt morally obligated to help.

Working with the service users and listening to their narratives was a painful and challenging process. Being a nurse myself and knowing the nursing context, I found myself sometimes feeling defensive. I

wanted to stand by the nurses, especially when patient and/or family frustrations were based on what I perceived as a complete misunderstanding about nursing work. I struggled to bracket these emotions so as to remain open and nonjudgmental (Heron, 2010). Taking sides could hinder my relationship with the service users (Rogers, 1993). I had to critically reflect on and work through my own feelings (Mezirow, 1981) so that I could be authentic (Rogers, 1993) and able to provide the appropriate interventions (Heron, 2001).

### **What are the consequences of my actions?**

The service users were ultimately comfortable sharing their narratives with me and each other, which may not have happened if some of the staff were present (Rogers, 1993). The creation of a safe space was successful. After the completion of their separate visions, all stakeholders had the opportunity to view that of the other group. Some of the statements that the service users had made surprised the staff and vice versa. Patients were troubled to hear of staff struggles with '*bullying*'; empathy surfaced. Staff were surprised and humbled to hear of patient and family valuing of '*forgiveness*' and '*mutual respect*' as well as their desire to contribute to a '*better place to work for staff*'; bonds began to form. The merging of the two visions occurred easily as staff and service users realised that they were committed to very similar goals (Manley, 2000). I felt proud that both 'sides' had moved from a place where they felt this was impossible, to having actually developed a shared vision that they were happy with.

During sessions, I provided some informative interventions (Heron, 2010). As an example, at times I felt guilty and wondered if it was okay to clarify service users' obvious misunderstandings about nurses' behaviours. Would this help? When is it okay to 'correct' the service users and when should I probe and help them to come to their own understanding and learning from experiences? Would my 'telling' get them to the point of perspective transformation (Mezirow, 1981) and ready them to collaborate with the healthcare team towards better care patterns? I was not sure. I did not know when to be informative or to challenge (Heron, 2001) the service users and when to remain quiet so as not to risk undermining their feelings and breaking their trust or feeling of safety (Rogers, 1993). I do feel that the provision of some informative interventions helped to answer the service users' questions and promote a greater understanding of the nurses' perspectives, but I appreciate that 'correcting' could be detrimental at times (Heron, 2001).

### **What factors influenced my decision-making and actions?**

Why was it so easy to engage the service users in developing this vision despite the emotional weight I felt in relation to some of their narratives and my 'in the middle' feelings? Perhaps patients were at their wits end, ready and looking for a way to change and were therefore motivated and willing to participate in anything that might give them hope. I also think my position enabled the engagement as I was seen as an 'outsider' to the unit rather than one of 'them' (i.e. unit staff or manager). I posed less of a threat which gave me leverage to develop the trusting relationship that was needed in order for the service users to feel comfortable sharing their stories with me.

### **How can I make sense of this experience?**

Freedom from distractions enables the visioning process. Unlike staff, patients have the option of engaging in practice development activities outside of the unit. It was beneficial for patients to remove themselves from the context of their struggles to really engage in the process of reflection. The constant ringing of the call bells and chiming of the ventilators can be a distraction. I often worked with patients outside surrounded by nature which provided them with clarity and calmness to fully engage in the process away from the perpetual 'noise' and tension of the 'clenching fists'.

Involvement of the service users promoted their reflection on and questioning of their assumptions leading to new insights and depths of understanding (Mezirow, 1981). They had the opportunity to think about care situations with more depth and acknowledge patterns of their own behaviour that may be contributing to unhealthy relational dynamics with staff. This is something that we don't normally do with our patients. I had the opportunity to challenge service users in a supportive way to reveal the implications of their behaviours (Heron, 2010).

The most important opportunity that the service users' involvement presented was that it gave me a greater understanding of what is important to them (Rogers, 1993). It allowed me to understand the importance of the little things that we take for granted. For example, patients bemoaned being dependent on others to have their legs shaved in the summer when they wear shorts and to have their braids taken out so their hair could be brushed. Hearing about the disappointment and emotional strain experienced by patients when these things go undone was a valuable and sensitising experience.



**Figure 2.** Jennifer Haynes with Nick Leocadio and Patricia Godin.

Finally, the inclusion of the service users in the development of a shared vision, although challenging, was necessary to raise their voice that all too often goes unheard. I have learned that it is possible to bridge the gap between two seemingly very disparate groups and that this requires acceptance, authenticity, encouragement, resiliency, commitment and passion. The collaboration, inclusion and participation of all stakeholders were important to provide direction for the future and will hopefully contribute to the quieting of the noise and unclenching of the metaphorical fists that are the unit culture.

### Disclaimer

The views expressed in this publication are our own and do not necessarily represent those of West Park Healthcare Centre.

### References

- Argyris, M., and Schön, D. (1978) *Organisational Learning: A Theory of Action Perspective*. Mass: Addison Wesley.
- Daloz, L.A. (1986) *Effective Teaching and Mentoring: Realising the Transformational Potential Power of Adult Learning Experiences*. San Francisco: Jossey-Bass.
- Dewing, J., and Pritchard, E. (2004) Including the older person with dementia in practice development. Chp. 8 in Manley, K., McCormack, B., and Wilson, V. (2004) *Practice Development in Nursing*. Oxford: Blackwell Publishing, pp 177-196.
- Fitzgerald, M., and Soloman, A. (2003) Clinical practice development in central coast health. *Collegian*. Vol. 10. No. 3. pp 8-12.
- Heron, J. (2001) *Helping the Client: A Creative Practical Guide* (5<sup>th</sup> edition). London: Sage Publications.
- Heron, J. (2010) *The Complete Facilitator's Handbook* (5<sup>th</sup> edition). London: Kogan Page.

- Manley, K. (2000) Organisational culture and consultant nurse outcomes: Part 2 organisational culture. *Nursing Standard*. Vol. 14. No. 37. pp 34-38.
- Johns, C. (1992) Ownership and the harmonious team. *Journal of Clinical Nursing*. Vol. 10. No. 3. pp 89-94.
- Johns, C. (2010) *Guided reflection: a narrative approach to advancing professional practice*. Oxford: Blackwell Publishing.
- Manley, K. (2004) Transformational culture: A culture of effectiveness. Chp. 4 in McCormack, B., Manley, K. and Garbett, R. (Eds) (2004) *Practice Development in Nursing*. Oxford: Blackwell Publishing. pp 51-82.
- McCormack, B., and Garbett, R. (2002) Characteristics, qualities, and skills of practiced developers. *Journal of Clinical Nursing*. Vol. 12. No. 3. pp 317-325.
- McCormack, B., Wright, J., Dewar, B., Harvey, G., and Ballantine, K. (2007) A realist synthesis of the evidence relating to practice development: findings from the literature analysis, *Practice Development in Health Care*. Vol. 6. No. 1. pp 25-55.
- McCormack, B., Manley, K., and Walsh, K. (2008) Person-centred systems and processes. Chp. 2 in Manley, K., McCormack, B., and Wilson, V. (Eds) (2008) *International Practice Development in Nursing and Healthcare*. Oxford: Blackwell Publishing. pp 17-41.
- McCormack, B. (2009) Practitioner research. Chp. 2 in Hardy, S., Titchen, A., McCormack, B. and Manley, K. (Eds) (2009) *Revealing Nursing Expertise through Practitioner Inquiry*. Oxford: Blackwell Publishing. pp 31-54.
- Mezirow, J. (1981) A critical theory of adult learning and education, *Adult Education Quarterly*. Vol. 32. No. 1. pp 3-24.
- Plesk, P.E. (2001) Redesigning healthcare with insights from the science of complex adaptive systems. In Institute of Medicine (2001) *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. Washington: National Academy Press.
- Roberts, S., Demarco, R., Griffin, M. (2009) The effect of oppressed group behaviours on the culture of the nursing workplace: a review of the evidence and interventions for change. *Journal of Nursing Management*. Vol.17. No. 3. pp 288-293.
- Rogers, C.R. (1993) *Freedom to Learn* (3<sup>rd</sup> Edition). New York: Merrill. Boston: Houghton-Mifflin.
- Rycroft-Malone, J. (2004) Research implementation: evidence, context and facilitation – the PARIHS framework. Chp. 6. in McCormack, B., Manley, K., Garbett, R. (Eds) (2004) *Practice Development in Nursing*. Oxford: Blackwell Publishing. pp 118.

### **Acknowledgements**

The practice development work at West Park Healthcare Centre has been generously funded by the TD Bank Financial Group.

**Jennifer Haynes** (RN, MN), Clinical Education and Practice Development Specialist, West Park Healthcare Centre, Toronto, Canada.

**Nadine Janes** (PhD, RN), Manager, Professional Practice, West Park Healthcare Centre, Toronto, Canada.