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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

From fixer to facilitator: going round in circles promotes change!

Helen Hunnisett

East Sussex Healthcare NHS Trust, England. Email: Helen.Hunnisett@esht.nhs.uk

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Abstract

Context: My introduction to practice development came about in my work as a Senior Physiotherapist working in a re-enablement unit for older people.

Aims: To outline some of my practice development experience between 2008-2011.

Conclusions: There is a spiral effect with practice development in that it is on-going and continuous in nature. The first circle must begin with and be underpinned by shared values and beliefs. Healthcare is constantly changing yet our beliefs and values should remain fairly constant. Having a shared vision allows us to embrace the changes without feeling threatened. Stepping back and facilitating rather than fixing is a key skill for clinical managers and leaders and can be a catalyst for constant change and evolution.

Implications for practice: When I identified the need for change in team practice and our environment, I more readily become engaged in the process, felt valued and empowered to both challenge and support others. Learning such as through clinical supervision, was essential in order for the team to openly explore their achievements, frustrations and identify new areas for development of themselves and others.

Keywords: facilitation; physiotherapy leadership; practice development; workplace learning

Context

Date: March 2008

> 'Good morning, Helen can I introduce you to Lesley, [a pseudonym]. She is a practice development nurse consultant who will be spending some time with your teams looking at how you all work……'

'That's fine' I said with a smile on my face but inside I was thinking, 'Oh my word, what does that mean, and what will she see; we have worked like this for years?' I think these were amongst my first thoughts on the morning that I was first introduced to Lesley. I worked as a senior physiotherapist in a small, nurse led re-enablement unit, had just returned from maternity leave and this was about to be my first experience with practice development. I had never heard of it until then and had no idea what to expect. It's fair to say that initially it was all rather daunting for me.

This article is a short reflective piece of writing to give a flavour of my journey from those early days being introduced to practice development through to the England Practice Development School

(June 2010) and a year on, to now. These are my own personal reflections which I've never written about before. I'm very aware that there are very few physiotherapists involved in practice development as I've experienced it. I feel my journey has been both challenging and inspiring. Ultimately it has helped me to unite a team; then to build, monitor, support and evolve it as the challenges of the NHS are thrust upon us.

Workplace culture

The unit I work in has had many issues and was in desperate need of structure, purpose, unity and most importantly it needed to address the safety of the patients. The unit had lost its way and was being run to suit the needs of staff and not those of its vulnerable clients. So the thought of someone coming in and formalising what we all knew but either couldn't see or know how to change was terrifying. What I mean by this is that, as the clinical and managerial lead for this team, I felt responsible for the effectiveness of my team and now, on reflection, I did feel that any negative feedback would be a personal statement about my ability to manage a team.

As a member of a busy team in healthcare, as in most units or wards, it is too easy to just 'do your job' and not to see the issues that patients, relatives and visitors see. The staff-centred and task culture for us was long standing and unchallenged. I recall when I went to work there I initially felt very uneasy about some of the practices I saw, but I soon felt powerless to challenge the culture and our physiotherapy team subconsciously disassociated itself from the ward area, including the nurses. We assessed, we treated but rarely became involved in discharge planning and stood back while the nursing and occupational therapy teams facilitated the discharge of patients. However, the length of stay for patients was immense. Over time the number of patients who had been in the unit for over six months began to increase. The whole service was fragmenting and strong characters amongst the ward team appeared to rule the unit and I learnt never to challenge them. I think I didn't really know how to do that.

The road to change started on a staff away day in 2008 where all staff were invited to express their feelings, positive and negative and questions they had about the unit. This was what I called my 'light bulb' moment (Mezirow, 1990**,** p14). The majority of staff, who to be honest, I had probably never really spoken to, were stating exactly the same views as me. We could all see that we wanted to be proud of our unit and do the best for each individual that comes through our doors. Yet we could all see that we were miles away from that and could even identify how it could be better. At the same event, we were facilitated to work together to create our own vision (Warfield and Manley, 1990; Manley, 1992). The vision statement created by us gave us, I felt, a sense of the autonomy to challenge and also support anyone who was not upholding the standards that we all set.

After this other practice development activities started to be introduced such as working or project groups and clinical supervision. The working groups were organised around topics that had been identified by us, the team, as areas for improvement and involved multiple disciplines of varying grades working collaboratively to identify what we did well, causes of ineffective working or gaps in our practice. In the past any changes seemed to come about simply by two pathways, that of a manager telling you it was to happen or a couple of staff members coming up with an idea and hoping it would be carried out by all staff; neither of which seemed to have any impact or be sustained. However, this new method saw staff raising questions, making observations and feeding back the information to their colleagues. Very slowly the culture started to change and many of the strong characters that did not buy into our new way decided to move onto pastures new.

My early steps

From this initial away day it was clear to me that I was extremely interested in the practice development approach and Lesley encouraged me to participate more with challenging and supporting the changes. Quite a bit on time wise, I was asked to chair our weekly multi-disciplinary team meeting which addresses the length of stay for each patient, raises questions surrounding gaps in care and promotes patient centred care and discharge planning. Initially this was highly challenging. I felt like the 'wicked witch' as I was constantly challenging people about practice. I did come out on several occasions and cry. However, I could see with the help of supervision from Lesley that slowly we were making changes for the better and that I was not telling people they were wrong but more allowing them to question their own practices. I had to learn how to give feedback in a skilled way and to receive feedback without taking it personally. Some people of course could accept these challenges and other did not see the need to change. On reflection, I learnt that I needed to 'toughen up' and that my job was not one of gaining popularity but to work as an advocate for the patients. At times this did make me unpopular, but now the majority of the time I do feel that as a team we can challenge each other and the respect for our roles and knowledge is upheld. I have also learnt how to talk to team members individually, outside of the multi-disciplinary team meetings, to offer more direct follow up support.

In 2010, I was asked by my service manager to manage the occupational therapy team within the unit. I was aware that the physiotherapy team should have been working more closely with the occupational therapists but we had struggled historically to unite. Taking on this role allowed me to use my growing skills set from practice development along with my desire to improve care to really make a difference. I put aside my preconceived ideas of the issues and of individuals and spent several sessions with all members of the team just gaining information, exactly what Lesley had done – yet on reflection, I did not fully take on board the anxiety the occupational therapy team members must have felt as this later emerged. Interestingly, I found out a lot about their practices and who in the team controlled those but also the fact that they were a very fragmented team with a difficult work place culture. I therefore knew what the difficulties were, but what I needed was the knowledge on how to respond and deal with it.

Moving away from being a 'fixer'

In the same year (2010), I was fortunate enough to be invited to the International Practice Development Collaborative Foundation practice development school. My biggest hope was that I would come away knowing where to start when facilitating practice development projects with my teams and that I would have the skills to get things fixed. Did I? Yes I did, but more importantly I learnt about the importance of knowing oneself (something I already thought I knew!), listening skills and how to give and receive feedback. It taught me that simply asking for a person's view verbally can for some give a very limited response and that by using creative techniques such as art, photographic cards, magazines and in fact all types of 'junk' you can help the most shy individuals to express their thoughts and feelings. The entire week was full of information, techniques, practical skills and reflection and by the second to last day I needed to run. I was at overload point and doubting my ability to put all of this into practice. I am a fixer, a doer and I like clear instructions and solutions that have plans and deadlines and what I was slowly realising was that this problem at work was not a quick fix. It would take time, patience and constant nurturing, people would come and go and challenge our culture and that I would need to stay focused and keep chiselling away at the old system.

I left the school with my folder and a head totally buzzing with ideas but I promised myself that I would slow down, reflect and observe first. So for several weeks that is exactly what I did. Then I got fidgety and worried that I would lose my skills. I could see the others from the school getting involved in projects and I had done nothing – well at least that is what I thought. After a clinical

supervision session I realised that practice development isn't just about projects that have short time frames and have a very clear focus, but that my day to day work on the unit and within my teams was just as valuable in contributing to workplace culture change. Observing day to day activity and challenging practices that are not acceptable or language that is disrespectful to patients is practice development and is vital in order to uphold our vision statement. In some ways this type of practice development has proven more of a challenge to me as I knew that I 'wanted to fix'. I have needed to learn to facilitate, to develop people and learn to let go of the control.

Learning in the workplace

Within the occupational and physiotherapy team I lead, learning together as a group has been very effective for us. We have introduced a number of activities to achieve this and ones that have also stretched me to be more of a facilitator than a fixer.

Example 1

We began by setting up an action learning group where one individual poses a question or sets out a scenario that they need clarification on. The team ask questions of the presenter which helps them to answer their own questions. It is not intended to give advice or problem solve for them. This was an excellent way to improve the culture between the occupational therapy and physiotherapy team in order to join our working up for the needs of the patients. Our initial session looked at the issues around setting estimated discharge dates. It posed the questions; 'how do we set these and communicate them to the patient and families?' As this was born out of a complaint by several patients the team had decided that it needed addressing. The session required me to facilitate with minimal intervention but to keep the ground rules of allowing every member of staff to ask questions and not to let dominant characters take over the session. At the end of the session, I asked each member what they had learned and what they would change about their practice. The presenter had more questions than solutions but at least had a better understanding of the enormity of the issue and could identify what was in her control and what was beyond her control to change. The occupational therapists identified how their late intervention hindered the process and they agreed to look at new ways of organising their time and priority settings. Following on from this the lead occupational therapist and an assistant set up a coffee morning and invited relatives and carers in to give feedback to us on how the discharge process affected them and what we could do to address it. On reflection I can see that the team demonstrated respect for one another and had a desire to improve the services they deliver by continuously questioning and reflecting on feedback and their own observations.

Example 2

Another example of how we are using learning in our work is that the assistant staff have been supported to set up their own problem based learning group. The sessions were started with a photograph of a patient who had a stroke and the group raised questions or assumptions about the person. When a question was raised that they did not have the answer to they decided amongst themselves to go and investigate and feedback in a way they agreed to. From each of their subsequent sessions they then have more questions that the group decide which aspect they want to focus on for the following session. Now they also facilitate the group processes such as who will lead it. Initially, I was involved in the facilitation but this has now been passed on to two therapy assistants to continue.

Example 3

Recently, I have started to involve the nursing night staff in the therapy treatment and discharge planning of the patients. I started to attend the early morning handovers and realised that the night teams were 'coping' with issues surrounding such aspects of care as continence and mobility transfers but not really asking any questions about how these are key to the discharge process. After

several weeks of observations, I started to ask staff about their rationale for choosing a particular method for attending to a patient's need. It appeared that the decisions were born out of (i) what had been used at the acute hospital; (ii) what the patient requested; or (iii) what was easiest. There seemed little thought to what the patient did before as their usual level of activity, what they planned to do on discharge and what equipment is available for use in their home. I came in on several night shifts to share my feedback and to talk to staff about the multi-disciplinary team meeting and how goals for night time activities of living and care were vital to a safer discharge. I offered the team some space to decide what training or learning opportunities they required to enable them to offer more goal centred interventions and about how they will document and share this with the multi-disciplinary team at weekly meetings. This initiative is still in its infancy but is starting to address the needs of patients and at the same time contributes to empowering staff as they will decide how to make changes and engage with the patient to set patient centred goals.

Summary

Practice development for me has been a relatively easy set of related concepts to grasp. Once I attended the away day and was 'allowed' to express my views about the place where I worked and saw that the majority of the staff were trying to head in the same direction, I felt empowered to make those changes. I believe others can learn in this way too. There have been some really testing times when I felt that the vision was slipping away as new members of staff came in and challenged the model of practice development and/or our vision and I've felt as if I've gone round in circles. This is where the in-depth structured reflection with clinical supervision helped me. I've focused on the spiral of practice development, in that it is never complete but one of constant change and evolving with shared beliefs holding together the process. I strongly believe that once enough staff are engaged in the process then the work gets easier and the support grows.

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Helen Hunnisett (BSc Hons Physiotherapy), Therapy Lead, East Sussex Healthcare NHS Trust, UK.