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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Parking to achieve conscious competence: a reflection about practice development in the context of people with learning disabilities using hospital services

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Context

In qualifying as a learning disability nurse during the Project 2000 era, I was influenced by the Health of the Nation for people with learning disabilities (Department of Health, 1995). This document inspired my curiosity as to how to ensure individuals with learning disabilities received similar care to those of the general population. Combining this with experiences of services which practised within more rigid boundaries, prompted me to develop my skills in advocating for people with learning disabilities, enabling individuals to have their say, and more recently to work in partnership co-producing and facilitating training.

With the skills and experience I had, I acknowledged the best place to achieve a cultural change was in a mainstream organisation and hence my attraction to the role of practice development nurse working within a large hospital trust, supporting the organisation to improve the care provided to people with people with learning disabilities.

Since the publication of the Health of the Nation (1995) the weight of evidence regarding the health inequalities experienced by people with learning disabilities has increased (Department of Health, 2001; Disability Rights Commission, 2006). This culminated in Mencap's seminal campaign report 'Death by Indifference' (2007) which gathered six cases of people who died in acute care and claimed that NHS services were 'institutionally discriminatory'. The subsequent independent inquiry (Michaels, 2008) and Ombudsman's Review (2009) made a series of recommendations asking trust boards to assure themselves that systems were in place to deliver services based on individual need.

At the turn of the century the NHS Plan (2000), which enabled the nursing profession to develop and expand its role, influenced the development of the 'health facilitation' role cited in Valuing People (Department of Health, 2001). This became the model for emerging hospital learning disability liaison roles being developed by commissioners via the growing body of evidence from the Access to Acute Network (Cumella and Martin, 2000).

The study by Brown et al., (2010) on liaison nursing published last year, prompted me to reflect on the service that I provide as a resource in the trust and I was asked to write a report on the service the trust provides to people with learning disabilities. The experience of writing the report crystallised significant issues for me and provided insight into areas for inquiry and investigation.

The report took 12 months to develop influenced by three main periods of activity; the first, collecting and analysing information for presentation to the trust-wide safeguarding group; the second, prompted by the trust's restructure, and finally, reviewing the information, packaging it for use in the trust, refining the recommendations and reflecting upon the content and journey using John's model (1994).

This reflection draws upon several influential processes; the trust's specialist nurse review; attending the International Practice Development School; the service reorganisation; along with exploring the role with other specialist nurses, leading me to consider areas for development both for myself and the organisation. These influences have led me to focus on clinical leadership; developing a framework for clinical staff to provide care that is person centred and adapted to their needs and that of their family; and the possibility of developing a system of clinical links.

I chose to use John's simple reflective model (Johns, 1994) as in my experience, it provides me with a springboard to identify more specific questions, enabling me to delve deeper using alternative methods as required. Using this process, I found myself asking several key questions related to my report:

1. How have I developed myself as a practice developer in learning disability nursing?
2. What have I learnt about practice development through the process of reviewing the service delivered to people with learning disabilities?
3. How do I develop my role as a clinical leader?
4. How could I provide clinical leadership?

My internal drivers

The evolution of this piece of work I would liken to a journey, one which has required periods of reflection, and the concept of 'parking'. Parking is a period of time to reflect in an informal fashion, and an opportunity for ideas to develop and evolve. 'Parking' also provides me with an illustrative expression to indicate that while I am not actively working on an issue at present, it has not been forgotten and I will be returning to complete it. These periods have provided the time and space required to enquire into the themes that emerge, and to formulate ideas and actions.

One beneficial element of learning through this process relates to discovering new information and ways of handling data to provide analysis, specifically electronically. I had not previously come into contact with Excel spreadsheets apart from populating for administrative purposes; however, the trust's Clinical Coding Department (a valuable resource for gathering data relating to usage of trust services which can be used for baseline and evaluation purposes) gave me a list of approximately 990 admissions of people with learning disabilities including over 600 names of people who had used trust services over the past two years. This presented me with challenges, such as, what were the questions I wanted this Excel database to answer? How do I handle the data to provide me with the answers I needed? What was significant/insignificant information? I slowly realised through talking to others that no-one else was able to answer these questions for me, that the answers were in the 'doing' and so I made time to 'play' with the data, order and re-order the information, undo and re-do. From doing this I discovered useful information regarding primary and secondary health issues related to this client group and each individual admitted, together with the number of admissions and re admissions. I slowly developed graphs to present the information in a way that would be meaningful to those reading the report and to illustrate my presentations.

As time went on, it became clear that this data would also be valuable for focusing my attention, and that of other members of the health care team, on the pathways requiring attention, and the tools requiring development. I was also excited to think that the data may have national value, as while the data almost certainly exists in some form or other in many organisations I was aware that it is unusual for it to be collated. This was liberating to know that I was observing something quite unique, while also a weight of responsibility, as this information needed also to be shared. I always believed that the nursing process (Pearson, 1996) ought to be adapted to include sharing of experiences, as it is through reflection that new knowledge is developed, enabling others to learn.

Making sense of this journey drew me to the Four Stages of Learning a New Skill (Adam, 2011, see Table 1). I was given the database unaware of its existence. Initially I assessed the data not appreciating its significance, and then I began to develop questions that I wanted to answer. I subsequently found ways of handling the data to answer my queries. This process of reflection, establishing parameters or a frame in which to present the answers, analysing and extrapolating the data, helped me to make sense of the data and put it into context for others to understand the pertinent issues.

Table 1. Adam (2011) Four Stages of Learning a New Skill including the example of data understanding

	Competence	Incompetence
Conscious	Develop skills in extrapolating information from the data	Awareness of database
Unconscious	Establish and disseminate new knowledge from data	Unaware of the data

The external factors influencing me

The trust's reconfiguration and the specialist nurse review (a review commissioned by the trust to support nurses to evaluate their role in person centred care) provided the backdrop for my own review. These had significant influence on the questions I was asking myself for the report's recommendations, such as; what was to be included, excluded and what models were to be employed? Through this process of assessment, evaluation and reflection participants were asked to review their work in relation to a number of models relating to practice, leadership, facilitation, practice development, use/development of practice based evidence and consultancy. One pertinent example of my self assessment was the use of Caplan's model of consultancy (1970, see Table 2) as it focused my thoughts and processes around how to disseminate expertise about working with people with learning disabilities to as many clinicians as possible.

Due to my unique role I operate with a high degree of autonomy, and much of my work has been the systemic implementation of the database for identifying people with learning disabilities on the Patient Administration System; enabling clinical staff throughout the trust to make adjustments to care, thereby complying with legal requirements under the Equality Act (2010). This experience has caused me frustration at times. While I have since developed a circle of support to help me acknowledge these issues as advised by Mezirow (1990), I have also reflected and now make sense of this in relation to writing the report using the lens of Covey's (2004) sphere of influence and sphere of concern.

Table 2. The application of Caplan's (1970) Consultancy Model to the practice development nurse role

Type of consultancy	**Direct/indirect**	**Focus of consultancy**	**Practice development nurse examples**
Client centred consultancy	Direct to the patient/client/user and sometimes the care provider	Focus on the client and their health/illness	Clinical interventions outlined practice development nurse role
Consultee-centred consultancy	Indirectly focused on patients/clients	The consultee (health provider-individual/team) is the main focus of attention and is helped by their own activity, knowledge and learning	Practice development nurse education, and strategic activity including public involvement/patient experience events
Program-centred administrative consultancy	Direct focus on a programme of activity	The focus is on developing, implementing and evaluating a programme/system of activity across the organisation	Practice development nurse strategic activity
Consultee-centred administrative consultancy	Indirect	Focus is on supporting the consultee who is implementing a programme of activity	Policy, guideline and procedure feedback

During my first two years of work as a practice development nurse, my operational activity (sphere of concern) focused on improving clinicians' understanding and accountability in relation to the Mental Capacity Act (2005). This activity included writing business cases, supporting and presenting audit material. The subsequent appointment of a clinician to take a lead for this has freed me to consider the issues of the Mental Capacity Act more strategically (sphere of influence). Study of the Mental Capacity Act in an academic MSc module; signposting staff, carers and careworkers to the relevant professionals has enabled my understanding and that of others within the legal framework. I also understand how systems in place do not always encourage professionals to deliver equality of timely outcomes to people who may have issues with capacity to consent. In these incidences carers and care workers liaising with community experts have empowered them to have a greater voice to question practice.

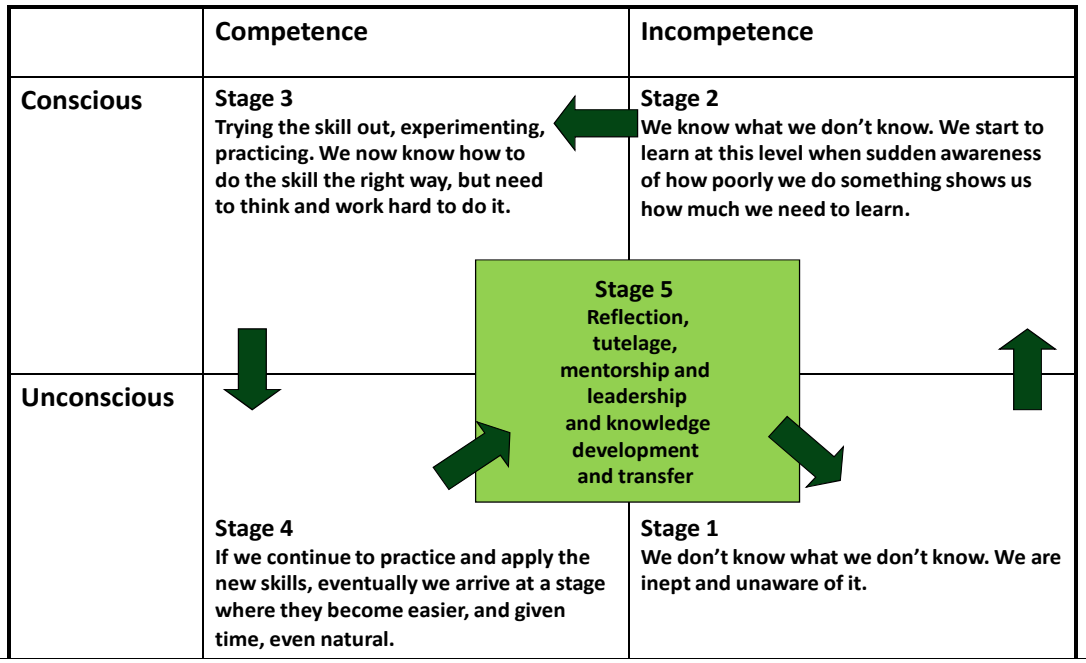
New insights and learning

Adam's (2011) model provides a vital context to my learning and that of the organisation, however to further reinforce the model, Howell (1982) suggested a fifth stage, which includes elements of tutelage, mentorship and leadership and knowledge development and transfer. Through this article I am pleased to be developing and sharing new knowledge.

Based on this, in Figure 2 I posit a new perspective of this model where one moves from sector to sector in a continuum, which in each new instance, event, project or programme, the transformational leader finds themselves unconscious and conscious incompetence. This illustrates

Turner's (1999) assertion regarding projects, that they are unique, and that the processes will never follow the same approach.

Figure 2. Adaptation of Adam's (2011) Four Stages of Learning a New Skill to include Howell's (1982) Fifth Stage and the continuum that could indicate transformational leadership



This observation provides a clearing for me to begin to assess the feedback from the 360 degree questionnaire about my role and the elements of the clinical report relating to gaps in the service and the need to increase my presence. This provokes further questions. How else could I have an impact on care through clinical leadership? Were there ways that I could improve and grow my skills, and that of clinicians working directly with patients to ensure person centred or reasonably adjusted care?

One particular challenge has been to review the style of leadership I have provided up until now. An article by Manley et al., (2008) reminded me that I had not studied or reflected on leadership for several years and in acknowledging this I recognised that this has not reflected the changes that were affecting the service, and I had not been reflexive enough to refer to my style as 'transformational'. Transformational leadership suggests to me someone who enables others to proactively respond to changes in service provision, and that from a clinical perspective I had established very strict boundaries relating to clinical work and clinical leadership. Yukl (1999) suggests four elements of successful transformational leadership:

1. Develop a challenging and attractive vision, together with the employees.
2. Develop the vision, specify and translate it to actions.
3. Express confidence, decisiveness and optimism about the vision and its implementation.
4. Realise the vision through small planned steps and small successes in the path for its full implementation.

Next steps

Through reviewing my style of leadership, I have begun to work with the clinical leaders in ward managers and sisters directly, to identify ways I could enable the ward teams to have pertinent knowledge to work with people with learning disabilities. This has begun with the development of a practical framework to enable the identification of particular patient needs and plan to resolve them.

Through this process we are also identifying the need for a communication network to ensure effective information is disseminated to and received from clinical staff. It is likely this will lead to establishing hospital champions – clinicians that work in particular parts of the trust by starting to support and grow individuals who may be interested in this role.

Yukl's (1999) observations related to transformational leadership are implicit with the actions planned or already in process. These will require the continuous process of learning illustrated in Figure 2. Reflection like this plays a vital role in not only learning from the experience, but also to remind myself of the uniqueness of the next activity and plan effectively for it.

Final thoughts

Whilst enthused to begin putting into action the new possibilities that I have become aware of through this reflective process, I am tempered by the realisation that the periods of inactivity when the work is 'parked' are as valuable as the times of action.

I now recognise that the patient administration system will enable me to not only identify and track people with learning disabilities through the trust system, but it will also enable me to account for my clinical work and the contact I have, that has an impact on the actions of others.

Further work with the Clinical Coding Department will provide a richer and more reliable source of data that will enable me to identify, with greater focus, the areas that require developments in practice and the facilitation of learning with staff, people with learning disabilities and their supporters.

Reflecting on my leadership and the process of identifying my style, it is clear that this can only be achieved through working with others, in the high support and high challenge culture that is being fostered within the trust. Through application of the model adapted from Adam (2011), it is clear that this is a process that is essential for my education, for organisational learning and transfer of knowledge within the trust.

Writing down this reflective work has inspired me to clarify and reinforce how I may rise to the challenge of systematic leadership and to inform and inspire others, this process was catalysed by the challenge and support of Kim Manley.

I am interested in repeating this exercise in a review of a multi stakeholder group, and working with a learning disability nurse and a matron to do this. I feel more able to consider and provide this challenge having experienced this process.

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A commentary on this paper by Angie Titchen follows on the next page.

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COMMENTARY

Parking to achieve conscious competence: a reflection about practice development in the context of people with learning disabilities using hospital services

Angie Titchen

As each of us read the work of others, we consciously or unconsciously bring our own frames and passions to our meaning making of the other person's work. My frames and passions spiral around how we learn and create new knowledge from experience and inquiry in our own practice and how we can facilitate these processes in the workplace. So for me, the practice development you describe and your reflection upon it are beautiful examples of work-based learning as inquiry. Your account shows us how you have discovered new knowledge in and from your practice and how you have used this new knowledge to integrate evaluation, learning and development and further evaluation of your own transformational leadership role and the hospital services for people with learning disabilities. You also point us to the processes required for creating theory from practice and practice from theory and how they can be facilitated through high challenge/high support.

For me, there are three significant things underlying what you present. First, parking is a creative and often unacknowledged process that enables the human brain and body to work their wonders unconsciously. Second, courage is required to step into and embrace the unknown in order to access creativity for learning and knowledge generation. Third, the interplay of multiple intelligences, imagination and different ways of knowing enables us to move through the five stages of learning and create new knowledge.

The value of parking or incubating uncertainty, half understandings, a puzzle or a vague feeling is well-known in the field of creativity and the arts. By parking your questions about how you could work with the Clinical Coding department's excel sheet data as part of a practice development journey, you have revealed the power of sitting with uncertainty when we have worked on something as far as we can go - for now. In today's healthcare world, with the emphasis on short-term action and quick results, being comfortable with parking work-in-progress is unusual. Facilitators therefore can help by creating conditions for people to feel that it is legitimate to wait for unfolding insights and understandings. When conditions are right, our minds, imaginations and bodies continue working on the puzzle without any effort on our part. Then they present us with insights and connections of amazing clarity! Within the critical creativity worldview of practice development, this is called 'movement in stillness'. Movement that occurs in some way within us, without us taking intentional action, is one of the principles for promoting human flourishing, along with 'embodied knowing', 'circles of connection', 'creative effectiveness' and 'energising forces' (Titchen et al., 2011).

So 'parking' your puzzle seemed to be one way that you accessed your creativity. Other ways include, for me, your taking a risk to do something that no-one in the organisation could advise you on, your leaping into the unknown and being playful.

> 'I slowly realised through talking to others that no-one else was able to answer these questions for me, that the answers were in the 'doing' and so I made time to 'play' with the data, order and re-order the information, undo and re-do'.

As we have so often been socialised to regard playfulness as inappropriate at work, we often have to find the child inside us and re-ignite our natural curiosity and exploration. You seemed to do this as you played with the data and the questions to which the data seemed to provide some answers. This takes courage. You took the risk to find out how to work with the data by actually doing it and then evaluating the result and identifying your own learning. Facilitators can help by encouraging others to trust what their bodies and the symbolic metaphors they use (like parking) are telling them and so act on their intuition, hunches, vague ideas and feelings. In other words, the facilitator enables people to use their imagination and multiple intelligences (e.g. emotional and bodily intelligences) to overcome fear of the unknown.

This leads to my third point. As well as the use of creative imagination and multiple intelligences in knowledge creation, acquisition and use, pre-reflective, cognitive, metacognitive and reflexive ways knowing are also involved. Usually learning, inquiry and knowledge creation are associated with using our cognitive knowing (head knowledge) and reflexive knowing (knowledge of self and of our impact in interaction with others). Your reflection seems to privilege the articulation of your cognitive and reflexive ways of knowing, but I can see your metacognitive knowing (thinking about thinking) in the quote above where you name the different cognitive processes you used; 'order and re-order', 'undo and re-do'. I also see your metacognition in your acknowledgement of the importance of sharing new Stage 4 (see Figure 2) unconscious competence (i.e. your embedded, embodied practical know-how) with others. Promoting a move to Stage 5 will necessarily involve you in metacognition because you will have to reveal your unconscious competence (embodied, embedded practical know-how) first to yourself and then others; for instance, how you are thinking differently as analyse, synthesise and interpret data and use theory in practice and practice in theory. For example, in your presentation of Caplan's (1970) Consultancy Model theory, you appear to have used the theory to identify aspects that you could develop in your role, but I speculate that your thinking about your thinking on these aspects might have included a decision to blend or use the different types of consultancy in response to diverse contexts.

Finally, I wonder whether I can see your pre-reflective knowing between the lines of your writing. Pre-reflective knowing precedes and is necessary for cognitive knowing, so it is always at least one step ahead of it. It is what we know that has never been located in our heads. Rather it is body, heart and, if you like, soul knowing. Was this the kind of knowing that you were tapping that enabled you to park uncertainty and to know that you would need to actually do the analysis and synthesis of the coding data it in order to find out how to do it and how the insights could be used for practice development? Do you think that you will need to use all these ways of knowing as well as creative imagination and multiple intelligences as you move into Stage 5 learning? What do others think?

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