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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Introducing a self-monitoring process in a teenage and young adult cancer ward: impact and implications for team culture and practice change

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Abstract

Background: The project took place in a cancer service for teenagers and young adults (13-24 years) in the UK, as part of a large service change project. Chemotherapy that had traditionally been given in an inpatient setting was to be transformed into an ambulatory care model.
Aim: The authors aimed to lead a change in practice whereby patients receiving chemotherapy would be taught to monitor and test their own urine output by the staff nurses. This meant challenging a matriarchal nursing culture within the team. Learning drawn from leading the project is discussed.
Methods: Various approaches were used to initiate and embed change within the ward, including producing learning tools and resources, listening to the team and providing creative opportunities for feedback. Critical reflection was used to facilitate learning about change leadership and practice development.
Findings: Initial resistance to change led to the development of leadership skills and a deeper understanding of team culture. Successful change leadership requires leaders to take the time to listen to stakeholders and provide real opportunities for feedback and collaboration. Critical reflection is essential.
Conclusions: The workbased learning project was effective in the simultaneous development of leadership skills and implementation of change in practice.
Implications for practice:

- Team culture must be understood for practice development to be successful
- Making time for critical reflection is essential for successful change leadership
- Nurse leaders should actively seek feedback about change from stakeholders by providing a variety of approaches to communication
- Workbased learning is an effective way of developing leadership skills

Keywords: Leadership, team culture, self-care, ambulatory cancer care, teenagers, young adults

Introduction

This paper is a critical reflection on the approaches used to lead a change in practice on a teenage and young adult (TYA) cancer ward. The implementation and embedding of the practice change formed a workbased learning project aimed at the development of leadership skills. The paper therefore has two aims: critical evaluation of the methods used to implement the change and reflection on the achievement of personal learning objectives to develop leadership skills from undertaking the project.

The practice change was to move from nurse-led to patient-led urinalysis and fluid balance monitoring for some routine chemotherapy. This was part of a much larger service delivery change project, where an ambulatory care model was being introduced as an alternative to a number of inpatient cancer treatments. The change challenged the established culture and philosophy of nursing care on the ward.

Background

As clinical practice facilitators (CPFs) for the children and young people's cancer service, the authors' roles involve leading on nurse education and practice development. The CPFs are senior nurses with significant expertise in the children and young people's cancer specialty. The particular cancer ward has undergone significant expansion over the past five years and is a leading principal treatment centre for teenage cancer. This once small ward for patients with bone tumours has evolved into a large, often high dependency, specialist cancer ward, delivering expert multimodal treatment.

Chemotherapy is given either on an inpatient or outpatient basis, depending on risk of toxicities and the administration time of the regimen. Patients may frequently be required to stay in hospital for monitoring and intravenous hydration fluids for several days after administration of chemotherapy. In 2010, an ambulatory care service for 13 to 24 year old cancer patients was introduced, offering a far more mobile approach to inpatient cancer treatments, facilitated through the use of a backpack infusion pump. This revolutionary service was modelled on an existing ambulatory care model in the adult cancer service at the hospital.

However, introducing the ambulatory model to the TYA age group presented new challenges; the model had to be redesigned to meet the particular needs of TYA cancer patients. There are three underpinning beliefs supporting the care of TYA patients, which have a strong influence on the care culture of the ward. These are:
- Peer support, where TYA patients are treated together, not alongside younger children or older adults
- TYA cancer expertise, which is treatment is from professionals who understand cancers affecting this age group and who have specialised skills in communicating and caring for these patients
- Tailored clinical environment, which means treatment is given in an environment suited to TYA patients' developmental needs, where they can maintain social contact and keep up with schoolwork. These are essential aspects of a successful transition from childhood to adulthood (Teenage Cancer Trust, 2012)

The new ambulatory model meant TYA patients could spend much more time away from the inpatient ward. This was a change with the potential to challenge the ward team's philosophy of care.

Under this model of care, patients are given a backpack infusion pump so that intravenous infusion of essential chemotherapy and hydration fluids can continue away from the hospital (Kelly, 2005). Instead of staying in hospital overnight, patients can stay in a charity funded 'home from home' near the hospital, where friends and family may also stay. This model aspires to offer the choice and control patients often lose on diagnosis and throughout cancer treatment (Wicks and Mitchell, 2010). However, it also creates new responsibilities for the patients and their carers, including undertaking self-monitoring of their own health during treatment. Monitoring had previously been carried out by nursing staff on the inpatient ward, so this meant a shift in the nursing role from direct caregiver to educator and facilitator of self-care. Nurses themselves needed to understand and support the ambulatory model in order to feel confident that patients and their families would remain safe and well while away from direct access to professional carers.

The first drug to be administered using the ambulatory model was high dose methotrexate (HD MTX). Strict monitoring of urine pH and fluid balance, and the administration of folinic acid, is considered essential nursing care (Euramos, 2011), and so had kept patients receiving HD MTX in hospital. Patients

would pass urine into labelled bottles and leave them in the ward's bathroom or beside their inpatient beds for nurses to collect for urinalysis. The nurses measured the urine and checked the pH was >7.5. Any problems could be detected immediately and managed by the nurses.

Despite this being the traditional approach to urinalysis, patients and nurses often complained that this arrangement was undignified, unhygienic and entailed a significant risk of cytotoxic spillage from the unsealed bottles of urine. Encouraging patients to self-test, measure, record and then clear away their own urine output seemed a practical and sensible solution to such issues. In addition, self-monitoring would enable the promotion of independence and be a first step to preparing patients for the ambulatory care model, which had given this project context. The timing was therefore right to introduce self-monitoring as an essential first step to facilitate the wider service change project (Rose-Gripper, 2000).

A lack of evidence to predict the potential impact of ambulatory care on TYA patients, families and the organisation led to the formation of an action research group to capture evidence gained from the change process and enable its immediate implementation in practice (Heron and Reason, 1997). Supported by an academic research supervisor, a nurse-led action research group was set up to capture learning from the development of the new ambulatory cancer care service. The group included the lead nurse, clinical practice facilitators, chemotherapy nurses, clinical nurse specialists, ward nurses and an activity coordinator. The project coordinator and healthcare librarian were also essential participants for organisation, administration and supporting literature searches. Since this was the first centre to set up ambulatory care for TYA patients in the UK, the group felt a responsibility to document and share its learning in a useful, meaningful and systematic way. The group was named STEER (Service Transformation, Education, Evaluation and Research) and a logo was designed to help develop a common purpose and a shared identity (Bower, 2000). This project was an action cycle within STEER's work and was led by the two CPFs. The project aims were to:

1. Implement and embed practice change from routine nurse-led to patient-led urinalysis and fluid balance monitoring on the TYA ward
2. Develop leadership skills through critical reflection and workbased learning

Project implementation
The implementation process is summarised in Table 1.

Table 1: Summary of methods and approaches	
Learning tools and resources	• Patient information booklet • Patient education checklist
Communication with team	• Information sessions facilitated by a PowerPoint presentation about ambulatory care *Period of listening:* • Claims, concerns and issues workshop • Enabling access to STEER meetings • 'Window of opportunity' • Direct observation and experience of the working environment (working among the team) • Spontaneous conversation
Personal learning outcomes	• Understanding team culture • Development of leadership skills • Critical thinking, facilitated through STEER group

Learning tools and resources
The first step in preparing patients to monitor their own urine was to produce written information about what they needed to do and why. The wider healthcare organisation had detailed guidelines on producing patient information and there are strict governance procedures to ensure quality (Department of Health, 2003). There were three review phases to the documentation before it was brought to the divisional governance panel for final approval. Drafts of the information leaflet were sent to doctors, pharmacy and senior nurses to check for accuracy. It was then reviewed by the activities coordinator, psychotherapist and other ward nurses for comment on the layout and wording. In the final phase of review, patients themselves were asked for their feedback on the usability of the document and any other comments they had.

From a safety point of view, it was necessary to have some documentation to show that patients were aware of their responsibilities for self-monitoring and that they had consented to take these responsibilities on. A patient education checklist was produced for both nurse and patient to sign to ensure all aspects of information had been delivered and understood.

McKimm (2011) emphasises stakeholder involvement for successful change. The key stakeholders were the people who would be using these documents, that is, the ward nurses and the patients. In the group's initial enthusiasm for leading the project and under pressure of deadlines, the members produced drafts of all these documents themselves, referring to stakeholders only for review and feedback. On reflection, the involvement of the ward team at an earlier stage would have encouraged commitment, and a sense of ownership and accountability for the project (McCullogh and Sanders, 2000). However, the group was mindful of the timeframes and also cautious not to overburden the ward team with extra work. With hindsight, had participation from the ward team been invited at this early stage, key nurses could have been identified to help take the project forward.

Communication with the team
Initially, the concept of patient self-testing and measuring of urine was introduced within broader information meetings about ambulatory care. The sessions were structured with a PowerPoint presentation so that a clear agenda was set for the meetings (Iles, 2011). The PowerPoint was also printed and fixed to the wall in the nursing team room for further reference. The patient information leaflets were also introduced to the ward team during these meetings and explanations were given about how to assess patients' competence in using a checklist. At the time the group felt that the staff had been invited to discuss their feelings about the project during the meetings and was pleased that few negative comments were made, as it was believed that this indicated the team members were supportive of the idea and that the explanations had been clear.

The series of information sessions lasted about two weeks in order that all the staff had the opportunity to attend when on shift. However, evaluation of the progress of the project several weeks later showed that no patients were self-monitoring their urine output, practice continuing as before.

A deeper understanding of this resistance to change was needed, and this could primarily be gained by listening to the team (Sullivan and Garland, 2010). Although the group had thought the staff had been given an opportunity to discuss their feelings towards the project at the information sessions, it became clear they did not have insight into staff's resistance to the change (Schon, 1987). On reflection, the environment created in the information sessions may not have been conducive to open discussion. The presentations aimed to provide clarity and the group considered them the most time-efficient way to give the information. However, through the formal 'classroom-style' presentation, a sense of authority rather than collaboration may have been created.

Engaging in dialogue to enable the team members to express their views was important to establish shared expectations, mutual confidence and ongoing feedback (Iles, 2011). Manley (2011) states that

intentions must be collaborative and participative in the underpinning of transformational practice development. Although the group intended that the information sessions would be an opportunity for discussion, in reality they did not encourage participation. 'Any questions/comments' were invited on the final slide after the project had already been proposed; on reflection, it would have been more useful to ask 'how do you feel about this?' or 'how do you think we could achieve this?' throughout the meetings, rather than waiting until the end.

Period of listening
A period of listening followed, with nurses encouraged to express their views using five strategies:
- Claims, concerns and issues workshop
- 'Window of opportunity'
- Direct experience and observation in the ward environment (working among the team)
- Spontaneous conversation
- Access to STEER meetings

The claims, concerns and issues process aims to enable stakeholders to share assertions, favourable or otherwise, about a project, and develop questions arising from the assertions to set a platform from which to build the project (Koch, 1994). The workshop was facilitated by the academic supervisor who was external to the ward. This enabled the STEER group to take part on an equal footing. The workshop provided a useful forum for structured discussion and clarification of ideas. However, the group members who attended were senior nurses and therefore their roles largely did not involve direct patient care at ward level. Despite this, they were able to challenge each other and construct a deeper insight into patient self-monitoring from their different viewpoints. For example, the clinical nurse specialists could see the project from a different perspective from the lead nurse and together, they could construct a reality encompassing both perspectives. Nevertheless, it was unfortunate that the ward nurses did not attend as their input would have been valuable.

This process had aimed to involve all stakeholders in evaluating the progress of the project so that a shared vision could be established (Manley et al., 2005). However, this aim was not fully achieved because the claims, concerns and issues workshop was held within the context of the STEER group where representation of ward nurses was limited. Although ward nurses were invited to take part, the workshop was held away from the ward, making it difficult for many to access, while attendance was also a challenge for ward nurses working shifts. To achieve complete stakeholder involvement, opportunities to voice opinions must be made truly accessible and convenient for all.

The STEER group seemed to have unintentionally created a disparity between what occurred in the STEER meetings and how this work was perceived by the ward team. STEER meetings initially took place on Friday afternoons in an environment away from the ward, and many of the group members held senior nursing positions. This made the group appear detached from the ward and is likely to have contributed to the nurses' initial resistance to the project. In working towards a shared identity for the working group, they had unintentionally isolated themselves from the key stakeholders.

Ward nurses were openly invited to take part in the group and their contribution was enormously appreciated. However, ward representation dwindled quickly. Comments such as, 'what do you talk about in those meetings?' led the group to re-evaluate the meetings' purpose, venue and membership. A decision was made to bring the meetings back onto the ward, using the ward seminar room so that they were seen in the environment where change was taking place. This also meant ward nurses could drop into meetings during their shifts. Immediately attendance improved and the group became more productive. The desire to create time to reflect away from the clinical environment had to be balanced with making the group accessible and relevant to the ward. The initial move away from the ward had cemented the group's identity and ability to work critically but it had become isolated and seen as elitist, which was counter to its intention to remain an open source of learning and transformational change.

Outcomes from the claims, concerns and issues workshop were combined with other listening strategies to develop a rich understanding of the team culture and consequently had great significance for the project (McCormack et al., 2004). For team members who were not able to attend the workshop or who did not want to express their worries verbally, a 'window of opportunity' was introduced. A large piece of paper, designed like a window, was attached to the wall of the nursing team room. All the nurses were invited to write anonymous comments about the ambulatory care process on sticky notes and then attach these to the 'window'. This strategy ensured nurses could express their views in a safe environment, promoting honesty and removing any concerns regarding the need to please more senior colleagues (Tamkin et al., 2010).

Although this approach did promote honesty and was convenient for ward nurses, anonymity meant it was not possible to approach those leaving the comments to seek better understanding of their concerns. However, there was greater appreciation of the meaning behind the comments made on the 'window' because the CPFs also worked alongside ward nurses. As part of the ward team the CPFs experienced and observed nursing challenges and were able to engage in informal and timely discussions about self-monitoring and ambulatory care. By using a combination of the 'window', informal discussion, experience in the normal clinical environment and ideas from the workshop, the CPFs were able to construct a multidimensional interpretation of nursing culture within the ward.

Tamkin et al. (2010, p 5) suggest that outstanding leadership requires an understanding that 'talk is work' and that it is essential to spend significant time talking to people to understand what motivates them. We ensured that nurses who were not present at the claims, concerns and issues workshop or STEER meetings had the opportunity to voice their opinions and the CPFs engaged in conversations with staff about the self-monitoring project informally.

The principles of thematic analysis (Braun and Clarke, 2006) were applied to analyse the outcomes from the listening period. Relevant themes arising from all the data were identified and then defined as either barriers or enablers to the project. Since thematic analysis is subjective, some examples of stakeholder comments made during the listening period are given alongside the themes (Horsburgh, 2003). The findings are presented in Tables 2 and 3.

Table 2: Enablers drawn from the listening period, with supporting examples	
Enablers	**Examples**
Improved hygiene, dignity and safety by not having bottles of urine in the bathrooms	*'Patients hate bottles (of urine) in the bathroom and they hate (passing urine) in jugs'* (spontaneous conversation)
A growing belief in empowerment of TYA patients	*'Partnership model rather than paediatric model – teenager at the centre but family supported as well'* (claims, concerns and issues workshop)
Improved sense of working in partnership in care delivery	

Table 3: Barriers drawn from the listening period, with supporting examples	
Barriers	**Examples**
Patients were too sick to self-care	*'All they (TYA patients) want to do is sleep when they come in for chemo'* (spontaneous conversation) *'Do the patients want this?'* (concerns, claims and issues workshop)
Burden of care – concern that self-monitoring would increase burden of care for informal caregivers	*'Additional responsibility for carers'* (claims, concerns and issues workshop) *'An adult model in TYA setting?'* ('Window of opportunity')
Safety concerns	*'Is it safe?'* ('Window of opportunity')
Time – inadequate time for educating and giving information to TYAs and family members	*'It's just easier to do it yourself... what if something gets missed or they just go in the toilet?'* (spontaneous conversation)

Personal learning outcomes

Understanding team culture

Culture is a set of basic assumptions that members of an organisation hold, which tend to cause them to act in certain ways (McCormack et al., 2004). The group's interpretation was that the culture of care on the ward was to take on all aspects of the care of TYA patients and their families. The intention of this was perhaps to avoid burdening patients and carers with new responsibility when they are already dealing with cancer. It was widely felt that patients were too sick to be burdened with self-care and should be allowed to sleep when attending for chemotherapy. This concept could be challenged if it could be demonstrated that patients and families might benefit from the increased opportunity to self-care and take back some control (Wicks and Mitchell, 2010).

Another reason for nurses wishing to carry out all care themselves rather than support self-care appeared to be to save valuable time in the busy ward. They felt they lacked the time needed to educate each patient in self-care and ensure that they had understood, and perceived performing tasks themselves to be quicker and safer. This concept was difficult to challenge in the short term as the ward was very busy and finding the time to educate patients was difficult. The group's hypothesis was that, as patients became increasingly self-caring, the time available to spend sharing information with patients and listening to them might also increase. The challenge was how to convince the nursing team of this when there was as yet no evidence to support it.

McCormack et al. (2004) suggest that practice development primarily involves implementation and dissemination of research into practice, and that practice developers need to make clear the evidence underpinning their change. However, when practice is innovative, there may be no underpinning evidence available to support the change. A literature search of the BNI and CINHAL databases using the keywords young adult, adolescent, teenager, chemotherapy, self-monitoring, self-testing and self-care produced no useful evidence to support the safety and appropriateness of this project. Although self-monitoring of urine was successful in the established adult ambulatory care model, some of the TYA nursing team remained unconvinced. The TYA philosophy of care (Teenage Cancer Trust, 2013) was frequently referred to in conversations to emphasise the specialist care TYA patients should receive.

Nurses within STEER often talked of a sense of pride in the age appropriate, specialised care provided on the TYA cancer ward. This was interpreted as a matriarchal culture of protecting the younger patients and their carers. Performing all aspects of technical care was perhaps supported by the TYA philosophy that care should be provided by 'teenage cancer experts, in the best place for them'

(Teenage Cancer Trust, 2013). Furthermore, the concept of peer support and caring for patients in a tailormade environment appeared to be at odds with the ambulatory care model, where patients were encouraged to feel able to leave the hospital site.

Listening to those who were resistant to change had a positive effect in that it enabled us to clarify why change was needed (Sullivan and Garland, 2010) but also to understand the legitimate fears and reasons for resistance.

Having understood that the main reasons for resistance may have been nurses' protectiveness of their patients and the belief that self-care was not something patients desired, the group realised that only the patients themselves could provide evidence convincing enough to drive the change in practice. The group began to work more closely with those nurses who recognised the benefits for patients in the changes and engaged them in educating the first patient to pioneer self-monitoring of urine (Sullivan and Garland, 2010).

The first patient to undertake successful ambulatory treatment marked a turning point in the project. The patient fed back a sense of independence and normality at being able to receive treatment outside the hospital while monitoring their own fluid balance. As a direct result, an enthusiasm for ambulatory care began to emerge within the nursing team and more nurses began actively to engage in teaching their patients how to undertake an increased level of self-care. This supports the interpretation that much of their initial resistance stemmed from a feeling that they were protecting patients from an unwanted model of care.

At the time of writing, ward nurses are now regularly engaged in preparing TYA patients for ambulatory care, and a major first step is teaching them to monitor their urinalysis and output. Somewhat ironically however, the nurses still routinely perform this task for TYA patients who are not eligible for ambulatory care, for example, bone marrow transplant patients, even if they are considered well enough and able to perform the task themselves.

The ward nurses appear to recognise the benefits of increased patient self-monitoring for all TYA ambulatory care patients or, at least accept it as part of the preparation for patients to feel safe to leave the hospital environment. However, the culture of protecting patients and handling all aspects of care remains active in other areas of ward practice. The next steps in the project will therefore aim to offer education to all patients who are well enough, to monitor their own urine output from diagnosis. The underpinning belief is that this may promote dignity, independence and control among the adolescent patient group (Wicks and Mitchell, 2010). The Teenage Cancer Trust philosophy emphasises the young person before the cancer diagnosis (Teenage Cancer Trust, 2013). That is to say, young person-centred care is at the heart of TYA cancer nursing practice. Investigation into the feasibility of self-monitoring of urine will continue through auditing of current practice and ongoing critical evaluation involving gathering the opinion and responses of staff and patients. Further investigation into the concept of patient and family burden resulting from self-care is currently being undertaken as a cycle of inquiry within the STEER group.

Development of leadership skills
A secondary aim of taking the lead in this practice change was as a workbased learning project to develop leadership skills. Although there is a body of evidence identifying the personality traits of successful leaders, it is well established that these 'traits' can be effectively learned and practised (Antrobus and Kitson, 1999; Bower, 2000; Iles, 2011). Over the past decade there have been numerous UK government policies focused on continuous learning for NHS staff to improve services (Department of Health, 2000a; 2000b; 2001; 2009). In spite of this apparent support for continuing professional development (CPD), it is increasingly challenging for nurses to continue with meaningful lifelong learning in the face of cuts to educational funds and increasing clinical, managerial and financial

demands on their time (McKimm and Swanwick, 2011). Nurses on the ward struggle for access to the study time and funding required to support their lifelong learning through, for example, traditional university routes.

Staniland (2011) describes workbased learning as a mechanism for integrating university level learning with 'real life' work issues. It is, therefore, a process of individual learning through real life problem solving, which will also benefit the organisation. The patient self-monitoring of urine project was ideal for this approach. The concept of workbased learning may be a solution to continued development of nursing practice in the current challenging economic crisis. This project was undertaken as a university accredited workbased learning module to develop leadership as part of an advanced nursing programme. Here, a necessary practice change has been implemented, and through critical reflection and reference to leadership literature, formal learning objectives have been achieved.

By its nature, workbased learning may be more cost-effective than traditional classroom based learning because it takes place predominantly on the job. Staff require less time away to attend university and are able to produce tangible organisational benefits from personal learning, as has been demonstrated here. However, for it to be successful, protected time for reflection, reading and support is essential (Manley et al., 2008). Workbased learning may clash with the day-to-day professional demands of the learner and cause conflict within teams struggling to differentiate between roles as learner and worker (Wareing, 2010). This was demonstrated in the group's initial approach to change, where all the patient information was produced by the STEER group and presented in classroom style to the ward nurses. It was initially felt that this approach would be less time consuming than involving a number of stakeholders in producing the patient information. However, after time was taken to listen and reflect, a new more successful leadership approach was developed. This demonstrates personal learning and, as a result, a more successful outcome for the project.

Making time for reflection was challenging. Nurses are accustomed to being busy providing direct care at work. During this project, the group members had to give themselves permission to stand back and listen and reflect, which required a shift in perception of themselves and their roles. Sullivan and Garland (2010) discuss the concept of time management as a misnomer; they emphasise personal responsibility in how time is used, stating that time should be allocated to activities to bring about desired results. The group felt pressured by time and conflicting clinical priorities to produce the learning resources for the project and get the concept introduced quickly. Consequently, the desired results were not initially achieved. Once the group members allowed themselves time to reflect and listen to the nurses' and patients' own views of what was occurring, they developed a clearer understanding of the project and an intuitive understanding of the impact and importance of team culture (Schon, 1987). An important learning point from this process has been that taking time to talk and to think critically increases productivity (Tamkin et al., 2010). At the beginning of the project the group felt compelled to get on and be 'doing' the project without properly engaging stakeholders. They had previously felt that attending meetings and critical discussion was a luxury and not real work, rather than essential to achieving sustainable results.

Critical thinking, facilitated through the STEER group
Manley et al. (2005) advocate clinical supervision and structured reflection for nurses at all levels to develop and maintain effectiveness. The STEER group was invaluable in supporting personal learning as a result of critical reflection and exchange of ideas, enabling analysis and creativity to occur. Many of the more successful strategies for the project, such as the 'window of opportunity' were developed during STEER meetings. King (2011) states that the use of other team members supports effective leadership. At frustrating times during the project, membership of STEER enabled colleagues to challenge their approaches in the role of critical companions and facilitated the development of new ideas (Manley et al., 2005).

Critical thinking is the process of examining underlying assumptions, gathering and interpreting information and evaluating alternatives (Sullivan and Garland, 2010). Analysis of team culture was key to the group's understanding of why the project had not initially been embraced by the team. Formal information sharing sessions were useful to introduce the project but not to gather information about how the team felt about it. Initially we interpreted the lack of questions at the information sessions as acceptance of the project. When the practice change did not take place as expected they were prompted to think critically about this assumption and gather further information to understand the situation in greater depth. The nature of working with a team of people meant that interpretation of the information they gathered about team culture and feelings towards the self-monitoring project were subjective (Cowan, 2009). Working within the team and experiencing the world through the team members' eyes helped create an intuitive understanding of their underlying feelings. This led the group to the interpretation that there was a culture of overprotectiveness towards patients. However, the team is also made up of individuals, each with their own ideas, motivations and beliefs, so a more complex set of problems to leading practice change is created.

Schon (1987) discusses the complexity of problem analysis when dealing with human beings. Many aspects shaped the resistance of the ward team, as a whole and as individuals, to the change process. The generalised conclusions about team culture that the group drew from the data were heavily influenced by their own experiences and feelings as part of the team. The group then identified allies in those who appeared to share similar thoughts and feelings about the project and who expressed a willingness to engage with it. Individual nurses' reasons for resistance remain not fully understood. Further investigation is required into the continued reluctance to expand self-monitoring to all inpatients as well as to ambulating patients.

Conclusion
In conclusion, transferable lessons in leadership have been learned from the undertaking of and critical reflection on this project. It is essential to take time to listen to teams when leading change in nursing practice. To achieve true stakeholder collaboration, individual opinions need to be actively sought using a variety of non-threatening, creative and accessible approaches. This process takes time and leaders need to recognise that sustainable change is unlikely to be achieved by doing everything themselves in the belief it will save time.

In the STEER group's experience, giving themselves permission to use time away from the ward was initially challenging and required them to change the way they viewed their roles. These feelings may be common for nurses new to leadership, where direct patient caregiving has been at the forefront of activity. There is a need to recognise that taking time to listen, reflect and plan change produces more successful results in improving patient care in the long term.

Once listening has taken place, critical reflection on what has been heard should take place in order to draw conclusions and inform action planning. A team is a dynamic and complex mix of individuals who have their own beliefs and opinions as well as common underpinning assumptions that influence culture. Leaders should be prepared to question their own beliefs and interpretations in order to understand their team better. Working groups like STEER may facilitate critical reflection by suggesting alternative viewpoints and stimulating discussion about challenges faced when leading change.

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