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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

From fixers to facilitators: the start to our South African journey

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Abstract
Background: A community of practice was formed to address the research output of academic staff. The community consisted of five critical care nurses and one midwife who collaboratively agreed to embark on a practice development journey involving 11 intensive care units, to address the issues faced by these nurses and move current workplace culture to person-centred care.
Aims and objectives: The aim of this article is to reflect critically on the learning regarding facilitation experienced by the six members of a community of practice who participated as external facilitators during the first practice development school ever to be held in South Africa. The school was attended by 35 internal facilitators from 11 intensive care units in the public and private sectors.
Conclusions and implications for practice: The practice development journey has had a profound impact on the external facilitators in their personal and professional capacities. We realised that external facilitation is about assisting internal facilitators to find their own solution to challenges, not about fixing the problems ourselves.

Keywords: Facilitation, intensive care nursing, practice development, reflection

Background and context

The University of Pretoria, and consequently its department of nursing science, changed its strategic focus to become more research intensive. To increase the research output of academic staff members, the department opted to form communities of practice (CoPs). The initial ideas were to establish research areas, develop research programmes, collaboratively conduct research and thereby increase research publication. Six diverse academics with a passion for practice and involved in the education and training of clinical nurse specialists formed a CoP.

To find a focus for our research programme, we discussed various options and reached consensus on practice development – a methodology used by one of the CoP members in her PhD. What inspired and attracted us most was the potential for practice development to change practice by involving practitioners in their context through emancipatory and transformational learning to deliver quality patient care. The first project that we planned emerged from our realisation that the majority of our students on the intensive care programme in our department work in adult intensive care units. We felt that initiating a practice development project in those ICUs to move the workplace culture towards person-centredness could benefit the nurses in practice, the students, and the patients and

their families. An effective workplace culture that is person-centred has been shown to increase the wellbeing of staff and consequently of students, as well as improving patient outcomes and the experiences of families (Laird-Fick et al., 2011). The need to address intensive care was amplified by reports of poor standards of nursing care from the Critical Care Society of Southern Africa, nurse leaders and public opinion (Pillay, 2009; Mokoka et al., 2010; Oosthuizen, 2012; News24, 2013).

While mining further into practice development, we realised there are some attempts by healthcare services to resolve the poor standards of nursing care, for example by continuous professional development programmes. Data from two unpublished research studies reveal that CPD programmes using lectures and workshops presented at two private hospitals were not attended by the intensive care nurses, despite their having been allowed on-duty time to attend (Lategan et al., 2013; Viljoen et al., 2013). The critical care nurses reflected that the reasons they were not motivated to attend were that the topics covered during the lectures and workshops were mainly identified, planned and implemented by management, using a top-down approach. There was no consultation with intensive care nurses and they therefore thought the sessions would be 'boring' and not based on 'our needs'. A top-down approach is not congruent with sustainable change in clinical practice (Wilson and Walsh, 2008). The attempts by healthcare services had been based on an assumption that knowing evidence ensures action – thus focusing on technical practice development (Manley and McCormack, 2003). Therefore, the 'development of staff, if it occurs, is a consequence of practice development rather than a deliberate and intentional purpose' (Manley and McCormack, 2003, p 24). We realised that to deliberately and intentionally change practice, a bottom-up approach could be used where intensive care nurses are enabled to develop their individual and collective practice. A research proposal was developed to address the poor standards of nursing care in ICUs by one of the members of the CoP. An international expert in practice development was approached and agreed to act as our mentor and lead facilitator. To illustrate our journey of the first practice development school programme we facilitated as part of our practice development project, we used the model developed by Rolfe et al. (2001).

What?

Ethical approval was provided by the research ethics committee of the university's faculty of health sciences. In consultation with the international expert, the CoP members agreed to identify the ICUs to be included in the project and arrange access to the hospitals where units are situated. Baseline data were then collected, which focused on the context and workplace culture in the ICUs. Following the gathering of the data, a five-day practice development school for the internal facilitators was planned.

The ICUs were identified with the assistance of the clinical facilitators from the hospitals that enrolled the majority of students for the intensive care nursing programme presented at the department of nursing science. The facilitators were informed about the practice development project and, in collaboration with the unit managers, then identified ICUs in their hospitals that were to participate. A total of 11 ICUs, six from one public hospital and five from four private hospitals, agreed to participate. Access to the hospitals was then negotiated through hospital managers and nursing services managers. After management agreed the ICUs could participate, the project was presented to the ICU nurses. Approximately 45 information sessions to introduce the practice development project were presented in the 11 ICUs during day and night shifts to provide all the nurses with an opportunity to find out about the project, ask questions and volunteer to become internal facilitators. After the sessions the workplace culture was observed using the workplace culture critical analysis tool developed by McCormack et al. (2009). The observation sessions ranged from 30 to 90 minutes, and each was carried out by a member of the CoP and the nurses that offered to be internal facilitators as well as other nurse volunteers. A total of 230 hours of observation was done in the 11 units. The data from the observations were collated for analysis during the planned five-day practice development school.

Preparation for the school included the finalisation of the programme, provision of creative art material and allocation of roles. The International Practice Development Collaborative gave permission to use its programme. The international expert indicated that he would take on the role of lead facilitator and we as CoP members were allocated the role of external facilitators. The role of internal facilitators was assigned to the 35 nurses that volunteered from the 11 ICUs. The school was the first of its kind to be held in South Africa and also the external facilitator's first opportunity to attend and co-facilitate such a school.

The lead facilitator had to facilitate the external and internal facilitators simultaneously. The school programme was adapted to accommodate the analysis of the baseline data collected during the observation of workplace culture. The data were analysed using creative hermeneutic data analysis as described by Boomer and McCormack (2010). During the analysis, paint, pictures, crayons and other art materials where made available to the internal facilitators; other creative expressions endorsed were storytelling as well as singing and dancing true to African culture.

So what?

Our perception at the beginning of the practice development school was that roles would be pretty straightforward; we felt our experience in facilitating learning in the classroom and clinical setting would be adequate. However, we quickly discovered that external facilitation is an art that does not involve 'telling' the internal facilitators how to 'fix' things, but instead helping them to find their own solutions.

Since person-centredness is a central tenet of practice development, it was essential to clarify its meaning and how we should work towards it in the school. However, we found this challenge akin to being in a maze and initially we were not sure if we would ever find the exit. Based on our experience we made assumptions that eliciting the meaning of person-centredness in an ICU would include PowerPoint presentations, explaining theory behind the concept and possibly a short discussion with the internal facilitators. These assumptions were annihilated by the lead facilitator when he indicated we were expected to enable the internal facilitators through active learning. The lead facilitator challenged us to use innovative and creative activities, as well as asking challenging questions to guide them towards their own understanding of person-centredness. During the active learning activities we experienced moments of brilliance and extended times absorbing the facilitation skills that unfolded before us. We observed the way the lead facilitator worked and tried our best to follow his example but sometimes caught ourselves regressing back to being fixers and telling people what to do. One of the most thought-provoking challenges to us was when the lead facilitator asked us to provide feedback to the group using creative expressions such as singing, dancing, role play and poetry. We were used to making and watching other people use creative expressions, but to us it was a complete new experience – and one that not all of us were comfortable with. As the week progressed, though, it became easier and later even fun. The experience of really facilitating the process as well as giving and receiving feedback resulted in a bond forming among the external facilitators and, even though we are a diverse assortment of individuals, we began to function as a unit.

The fact that observations were done before the school began enabled the internal facilitators to work with real data about their existing workplace culture. The lead facilitator was astonished by the amount of data collected. Using creative hermeneutic data analysis (Boomer and McCormack, 2010), we grasped for the first time what it meant to do research 'with' practitioners and not 'on' them. The internal facilitators were enabled to explore and uncover challenges existing in their workplace culture. The use of creative expression was completely new to us and we had some doubt that it could work, as neither us nor the internal facilitators had ever had an opportunity to express ourselves creatively in our professional capacity.

The internal facilitators were to create solutions for the challenges uncovered to move their workplace culture towards person-centredness. We found it difficult to ask the right questions and allow them to stumble in the dark while the answers were clear as daylight to us. The internal facilitators came up with practical solutions naming their projects, for example 'the Noise Police' and 'Say-Your-Say' (a communication platform). We had to acknowledge that we underestimated their ability for problem solving, as they found excellent solutions and made better plans than those we had thought of.

As the practice development school drew to an end, we as external facilitators started questioning our own ability to facilitate change in the ICUs through the internal facilitators. We viewed ourselves as novices in the art of facilitation and recognised that the school was only the beginning of our development as facilitators. Therefore, when the school closed and the lead facilitator was on his way home, we experienced both anticipation and apprehensiveness about the journey ahead.

Now what?

True to our 'fixer' tradition, planning the next phase was the easiest for us all. We organised weekly CoP meetings to follow up on activities in the ICUs and share learning about facilitation. In addition, we scheduled six weekly video conferences with the lead facilitator for progress reports and further facilitation guidance. Workshops for the internal facilitators were arranged every eight weeks for the remaining 11 months of the year. The meetings and workshops were set up to learn from practice and each other, and to provide opportunities for both internal and external facilitators to develop their facilitation skills. During these meetings we realised that to ensure our external facilitation was person-centred we had to do a values and beliefs clarification; this was to guide our conduct with each other and the internal facilitators. It also brought our unit closer together and we really started to know each other. We collectively started reading literature on facilitation and found ourselves 'telling' each other how to facilitate – although there is always someone in the CoP who reminds us to focus on facilitation, not fixing. We realised that facilitation is a skill that will develop continuously over time. Quick fixes are not a solution in our practice as facilitators and neither are they appropriate for changing workplace culture and practice.

Conclusions

In order to change workplace culture, nurses working at the bedside must be actively involved in order to bring about sustainable change. The traditional methods used to educate and train nurses are regarded as top-down and ineffective by those receiving the training. Conversely, facilitation provides opportunities to collaborate and actively engage with nurses in the workplace. During the practice development school we realised that facilitation is a skill that must be developed, exercised and consciously practised on a continuous basis. As external facilitators, we acknowledge that we needed guidance to appreciate the essence of our role and its potential impact on internal facilitators, nurses and consequently practice. We recognised that we had to move away from 'fixing' problems experienced in practice and towards allowing internal facilitators and nurses to find and implement their own unique solutions to address workplace culture. The practice development school also raised awareness among internal facilitators and provided them with an opportunity to critically reflect on their workplace culture and plan the changes needed for a move towards person-centred care.

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