Practice development: a critique of the process to redesign an assessment

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KEY WORDS

practice development, assessment, acute care, facilitation, process

ABSTRACT

Objective
This paper presents a brief description of an activity to redesign a nursing assessment followed by a critique of the practice development process used.

Setting
Adult acute care general hospital wards.

Primary argument
Practice development can address shortfalls in clinical practice by using a systematic process to change practice so improving health care. Through the application of a professional development activity addressing assessment the described process provides the basis for a critique that gives directions for ongoing similar activities.

Conclusions
Directions identified for ongoing practice development activities are: engage all staff in the change process who own the practice; appoint alternative persons with delegated authority for key facilitators; build professional development into the practice change; provide service users (eg patient representatives) with mentoring; develop transformational strategies that address not only the dominant organisational culture but also existing subcultures; and employ an emancipatory practice development process. The main recommendation for practice development in bureaucratic organisations is to develop and establish the evidence base necessary to ensure the process is effective.

INTRODUCTION

Development of nursing practice, a critical professional activity, can improve clinical outcomes, increase patient satisfaction and contribute to quality health care provision by changing practice. These outcomes indicate practice development activities should target key components of nursing care where the process of practice development can achieve the most gain. Through critique, directions can be identified for refining the process employed in practice development. This paper presents an overview of practice development and its accompanying process; an outline of an application in an acute care setting; followed by a constructive critique highlighting how the process could be more effective.

Practice development

From a concept analysis of practice development Unsworth (2002) described the critical attributes to be: "new ways of working which lead to direct measurable improvement in care or service to the client; changes which occur as a response to a specific client need or problem; changes which lead to the development of effective services; and the maintenance or expansion of work" (p.323). Others confirm these attributes (eg Hanrahan 2004; Garbett and McCormack 2002) with Garbett and McCormack (2002) also indicating the process is systematic and requires various types of facilitation.

Practice development and the context

As the process of practice development always occurs within a context that can influence the process, attention to this aspect is mandatory, particularly as clinical settings have been described as complex and ever-changing (Bell and Proctor 1998) with many stakeholders to consider (Iles and Sutherland 2001). Organisational support (Barrett et al 2005) and a shared vision are essential (Stokes 2004; Iles and Sutherland 2001). The support needs to include time and resources (Garbett 2004).

Practice development process

Though a systematic process is valued by practice developers the process has mostly been described fragmentally. The beginning of the process has been identified as an opportunity for practice change that is engendered from a specific client need or problem (Unsworth 2002). This suggests the client-centred practice that needs to change would require clarification and refinement at the commencement of the process. Therefore the first step incorporates clarification of beliefs and values and assessment of the needs and perspectives of stakeholders, followed by planning, action and evaluation (McCormack et al 2004). A strategy often used within this process is facilitation. The use of facilitation is somewhat controversial as some (eg McCormack et al 2004; Kitson et al 1998) consider it necessary with others (eg Unsworth 2002) considering an identified facilitator it is not always required.

According to Harvey et al (2001) the defining characteristics of facilitation can be either an internal or external role in relation to the organization and involve helping and enabling that can range from support for a specific task to assistance with a review. The enabling characteristic is likely to be developmental (Harvey et al 2001) and can provide a pathway for individuals to empower themselves. This analysis of facilitation however, was in relation to its role and function in evidence-based practice. A more recent analysis pertinent to practice development by Simmons (2004) identifies facilitation as a non-specific general strategy of operation that necessitates critical thinking, shared decision-making, leadership, equity and helping. The apparent multiple dimensions of facilitation and the levels and intensity of the facilitative process preclude evaluation of the specific dimensions that are more or less effective. All that can be concluded is its usefulness at a generic level with the specific effectiveness of different attributes as yet to be determined.

In summary, the hallmarks of the process of practice development are a systematic approach perhaps with facilitation; and the phases of identification and refinement of the practice to be changed, planning, implementation and evaluation. These phases give the process of practice development a structure that presents as being unidirectional.

Practice development process – an application

In general medical and surgical wards, a practice shortfall in the admission assessment of adult patients was identified. Findings showed patient assessments were not providing adequate information from which to plan care (Cioffi 2005). Nursing management responded to this shortfall by resourcing a practice development activity. The activity was facilitated by a collaborative partnership between two health service managers, one the Director of Nursing of the hospital and the other from The Diversity Health Institute in the area health service and a university lecturer. The approach to this practice development activity was technical as knowledge was applied in practice with staff development arising as a consequence (Manley and McCormack 2003). Two groups, 'Steering' and 'Implementation', were formed to guide the activity. Membership of the Steering group included patient representatives, a bilingual liaison officer, nurse managers, key clinical nurse consultants and specialists, with some common members across both groups being the nurse educator, the discharge planner, experienced clinicians from the pre-admission clinic, medical and surgical wards; and two facilitators. The process this practice development activity followed is outlined below using the phases: identification and refinement of the practice issue; planning; implementation; and evaluation.

Identification and refinement of practice issue

The activity commenced with the scope of the current adult assessment being more comprehensively understood through focus group discussion with patients from diverse backgrounds and staff, including nurses, physiotherapist, medical officer, bilingual liaison officer and social worker. From the focus group findings the complexity of the diversity of the patient population was identified as the main issue contributing to the assessment shortfall. In response to this the Steering group critically appraised the current assessment, highlighting discrepancies between assessment information actually obtained and the assessment information considered to be required to care for patients from diverse backgrounds. The facilitators stimulated critical reflection within group discussions using challenging, provocative, nonjudgmental probes. This led to the practice development activity being refined to focus on a redesign of the existing assessment.

Planning, implementation and evaluation

The Steering group redesigned the assessment through a series of regular meetings using information gathering, exploration of literature, concept mapping (Sutherland and Katz 2005; Trochim 1989), discussion, critical reflection (Williams 2001) and consultation with other health professionals, for example the social worker. During this process group cohesiveness and morale increased as did ownership of the practice development activity, as noted to have occurred in such processes by others (Kathol et al 1998; All and Havens 1997). The facilitators supported the process by scheduling and preparing resources for meetings according to the agreed agenda; encouraging and stimulating involvement of the members of the group; assisting with pacing discussion to increase depth; and recording and distributing meeting notes.

During the process, findings from the focus groups and information from the literature review were accessed to resource the decision-making of both groups. Specific findings from the focus groups showed the information was incomplete for planning care as key aspects of diversity of patients and their families were not obtained, for example the family's desired involvement in care. Recognition of this weakness was further appreciated as previous studies (eg Callen and Pinelli 2004; Walsh et al 2002; Hyndman et al 2000) had shown the importance of the influence of diversity on understanding health behaviour and the outcomes of people from diverse backgrounds. Using literature of this nature resulted in the following aspects being integrated into the assessment by the Steering group: health literacy; understanding of present situation and expectations; values and beliefs; family involvement; language literacy; and financial circumstances, with some compacting, reordering and formatting of the items

on the form. The Implementation group with key clinicians from each of the proposed trial areas piloted the redesigned assessment, reviewed its utilisation and made recommendations to the Steering group that led to further modifications based on comments from some staff in each trial area.

Using Bausell's (1986) criteria, the redesigned assessment was then confirmed to have content validity by a panel of international and local experts who were clinicians and academics. Written comments received from this panel also indicated a number of policies would be required to support patient care planned from the redesigned assessment, for example arrangements for visiting outside visiting hours and access of families over 24 hour periods. As Steering and Implementation groups were both in agreement that recommendations for policies were necessary, they were referred to the hospital executive.

With approval from the Forms Committee of the area health service a trial of the redesigned assessment was held. Each trial area was prepared by the key clinical nurse of the area in the Implementation group. Preparation involved consulting with the ward staff to arrange the eight week trial; providing the education program of three sessions designed by the Implementation group; supporting ward staff; and setting up ward-based resources including an information folder with assessment examples and support material. During the eight weeks all adult patients in the trial areas were assessed using the new assessment form. The trial was evaluated by the Steering and Implementation groups using a multi-method approach as recommended by Patton (1997). This consisted of a quantitative evaluation executed through an audit of medical records; and a qualitative evaluation involving a series of focus groups with nurses and managers from the trial areas. The main finding from the quantitative evaluation was completion of the nursing assessment needed to be more comprehensive with the qualitative evaluation showing nurses had an overall preference for continuing to use the new form based on the information available for planning care. However nurses described difficulty and discomfort with asking questions about some aspects, for example the financial situation of the patient.

The findings from the trial evaluation were presented to the Steering Group with areas of concern being flagged. Specific group members were allocated responsibility for operationalising the recommendations. These recommendations involved: modification of the nursing assessment form; provision of assessment and documentation skills workshops for nurses; obtaining permission to continue using the redesigned assessment; and introducing it into all the other relevant clinical areas.

Critique of practice development process

By reflecting on the practice development process used in this activity it is possible to gain insight into areas that could be managed more effectively. These areas are the nursing practice selected for development, that is the assessment; the process of facilitation to enable the change; and the culture and context within which the process took place.

The practice for development - assessment

The decision to address the assessment of medical and surgical patients was based on the findings from focus groups with patients, their family members and staff, and from a study that showed assessments of patients from diverse backgrounds were often incomplete (Cioffi 2005). Hence, the practice development activity emerged from both the user and provider perspectives, which is a strength, as service users' experiences have previously been recognised as an essential element of practice development (Dewing and Pritchard 2004; Weir and Kendrick 1994) to ensure a patient-centred focus. Though the members of the Steering and Implementation groups had these findings from which to work, the staff in the clinical areas did not. In hindsight the practice development activity could have been communicated more effectively if these findings had been presented overtly and their implications identified with staff in the clinical areas to establish a strong raison d'être for practice development. From the perspective of change theory (Duffield and Lewis

2000), the staff in the trial areas were not given the appropriate preparation to enable them to appreciate the inadequacy of the existing assessment format and process. It is therefore essential in all practice development that staff can clearly identify the need for practice change and place value on it so cohesion can be built to support the activity.

The facilitative process

The challenge for the three facilitators was to enable the change. Facilitation did foster reflective discussion within the groups developing an awareness of the shortfall in practice. This led to the groups working collaboratively to achieve a common goal. The Director of Nursing, a facilitator, expedited many of the organisational hurdles particularly in the early stages of the process by: prioritising the practice development; freeing up nurses to take part; and providing advice regarding procedures to follow, for example approval of form for trial. Several months into the activity other organisational demands deflected the Director of Nursing's time away from the activity. However, the activity ended with strong support and all the recommendations have now been implemented. In ongoing practice development it maybe useful to consider the appointment of an alternative person with delegated authority to support the activity when an organisational facilitator has a demanding role.

The other two facilitators worked in partnership with both the Steering and Implementation groups to facilitate the change. They accepted responsibility for supporting the groups by collaboratively structuring meetings, obtaining resource materials and encouraging a process of engagement with the practice development activity by promoting members of groups to coordinate various tasks, for example designing the new form and developing the case studies. The enthusiastic involvement of nurses through these two groups brought specific contextual information to the practice development activity increasing its ecological validity. However a limitation was the facilitator partnership did not go beyond the Steering and Implementation groups. In retrospect, though the members of the Implementation group who came from each clinical area accepted the responsibility for providing communication and education to nurses in their areas, these members required strong support at the ward level to create change. In the future this failing could be addressed by facilitating collaborative engagement of staff with the use of a fortnightly news update sheet, encouraging staff to initial they have read practice development material, facilitators being available at staff handovers to answer questions, and stronger support by nurse managers who were inclined to leave this practice development to the nurse who was the member of the Implementation group.

Further, the distance between the facilitators and the ward nurses led to assumptions being made about the existing assessment skills of the ward nurses. In the evaluation it was recognised nurses were not as skilled at interviewing patients as had been assumed. Earlier recognition of this could have led to skill development workshops being held by educators in each area during the redesign of the assessment. This would have placed ward nurses in a stronger position to manage the change and would also have addressed their need for professional development more comprehensively.

As a formal part of the planning process, patient representation on the Steering group was sought prior to its establishment. This effort was initially rewarded with good attendance at the first meeting. However later attendance was ad hoc and when in attendance, contribution was either timid despite encouragement or personalised to specific hospital experiences. This supports McCallum and Gieselhart (1996) view that participation of service users in service design is inhibited in bureaucratic structures. The size of the Steering group and the professional background of the members may have contributed to patient representative discomfort. Though involving patients in practice development activities is essential to ensure a patient-centred focus, this experience indicates the involvement of patients in such activities needs to be actively and sensitively managed. The inclusion of patient representatives may have worked better if the facilitators and members of the Steering

group had met with all the patient representatives prior to the first meeting. This would have provided an opportunity to explain the project and the required time commitments in more detail; answer questions; and guide participants in their role of representation. Further, mentoring roles could have been assigned to group members. Such a strategy could enhance the representatives understanding of the health system and build rapport between staff and representatives so fostering possible increased participation. By gaining confidence in this manner the patient representatives may have felt more comfortable engaging in group discussion.

The culture and context

As the context was an acute care hospital inevitably the organisational culture was bureaucratic (Crookes and Knight 2001). Each clinical area was part of this larger culture and also had its own idiosyncratic nature. The trial was planned to fit each ward's slightly different admission procedures and different patient types. Consideration of these specifics was successful. However other aspects of difference, such as the subculture of nursing staff in each clinical area, could have received more attention. The culture in one trial area for example, created tension between a manager and an Implementation group member, leading to the member's initial retreat from the activity. Despite negotiation by facilitators this group member only returned by choice to her role in a limited way. This situation is an indication of the need for culture to be addressed within practice development activities as recommended by Manley and McCormack (2003) and McCormack et al (1999).

The technical approach to practice development applied in this activity focused mainly on the outcome of the activity. Using emancipatory practice development that "... assist groups' enlightenment (increased awareness) through nurturing a culture which enables individuals and groups to act" (Manley and McCormack 2003, p.26) may have led to more effective change. However the use of an emanicipatory practice development approach in a complex clinical setting involving high numbers of nursing staff with varying skill levels in very busy clinical areas with high patient loads, would require skilful facilitation. The skills for this level of facilitation need to be identified and developed.

Other factors that inhibited the practice change in the areas were: all staff did not receive the three education sessions and therefore lacked awareness of information resources available; support from the nurse responsible for the trial in each area was spasmodic and not accessible on all shifts; and time to reflect on the change during the trial in a formative manner was not taken. This strongly suggests opportunities for aspects of staff professional development were poorly addressed. In future practice development activities professional development of staff requires more meticulous planning and implementation to enable staff to empower themselves to change.

Though the systematic process enabled engagement with the practice environment as Cutcliffe et al (1998) recommends, the degree of engagement in each area was not as deep as had been expected despite the use of key nurses. Though the facilitators had considered ownership and credibility of the redesigned assessment would be better nurtured by Implementation group members in the clinical areas, on reflection they overestimated the capacity of the Implementation members to be conduits of information, to engage ward staff with the development and to provide the necessary education and support. An extension of the collaborative partnership between the facilitators and Implementation group members at the workface throughout the activity needs to be employed to overtly strengthen the capacity for embedding the new practice.

This critique is in the most part from the perspective of the facilitators. By referring to the findings from the focus groups with nurses who trialed the assessment in the clinical areas their voices can be added. Findings for example showed some nurses recognised their need for education to improve their interviewing skills for more competent assessment. This and other findings support conclusions that

the consultation process at ward level during the development of the assessment format had not achieved engagement of enough clinical staff to the desired degree and the educative process used to introduce the trial was flawed. Further, the policy revisions required to accompany the use of the new assessment information were not completed by the organisation prior to the trial. This reinforced some skepticism from clinicians as the policies required to support their work and overcome particular challenges faced daily on the wards were not available. These findings support directions for more effective professional development to bring greater opportunity for staff empowerment as noted previously.

CONCLUSION

Though the practice development activity achieved redesign of the assessment there were aspects stifled by the technical practice development approach. Practice development particularly in bureaucratic organisations is complex with the process of generating changes in practice with both service users and providers a major challenge. Facilitation is critical to the dimensions of the change, as is the degree of collaboration that unites clinicians together with a common aim. Practice development was found to require widespread participation, be demanding of time and effort and a challenge to the existing culture. Recommendations able to be made for ongoing practice development activities in clinical settings from reflection on the process are:

- engage all staff in the change process;
- set up alternatives with delegated authority for key facilitators;
- build professional development into the practice change;
- ensure service users (eg patient representatives) are mentored;
- provide capacity at the workface for embedding the new practice;
- develop transformational strategies that address not only the dominant organisational culture but also existing subcultures; and
- use an emancipatory practice development process.

Further and most importantly, there is an urgent need to identify the evidence base for achieving effective practice development in bureaucratic organisations to ensure best use of resources.

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