# Reflecting on 10 years as a Practice Developer

## Introduction and Background:

This month marks my introduction to Practice Development (PD) presenting me a valuable opportunity to critically reflect on what I've experienced and learned during that time. I was really inspired by this approach to engaging and helping people flourish when I attended International Practice Development School in September 2004. I realise the title says 10 years, however I consider the first year as a period of being excited about what I'd learned at PD School but wondering how to implement it into practice! I've captured here the 7 top areas that set PD (definition of PD) apart from other approaches for me in those 10 years. I also pose questions to invoke some reflection and dialogue about each topic.

## The Focus of Practice Development

I've experienced firsthand how PD engages staff at all levels in a critical way and enables them to achieve lasting improvements. Missing the focus can be disruptive and unhelpful!

I facilitated a workshop with teams who'd been involved in PD for over a year. Halfway through the day an 'ah ha' moment; since their initial introduction in the work they had understood the approach to be solely about staff, about creating a happy workplace for them and nothing to do with patient care. Understandably many disengaged! The team had missed the point (or were misled!) about PD and inadvertently misconstrued its focus.

On the other hand I experienced the completely opposite approach; using PD to address isolated problems, to replicate these outcomes across the board, and to direct clinicians to do the job they are employed to do. Whilst there is interest in terminal outcomes, I've seen the greatest gains when teams focus on creating effective care environments – the place where care is delivered and experienced by all involved[1] – patients, carers, nurses, doctors, allied health staff and others who have reason to be in that environment. Any strategy for improving workplace culture aims to demonstrate a variety of outcomes attributable to increasingly effective care environments – for patients, carers, staff *and* organisations[2,3].

*Reflection: How can the focus on workplace culture be maintained and reassure sponsors and managers that outcomes of this work, including patient outcomes, are highly sought after?*

## Terminology relating to PD and language use in practice

Some find the terminology of PD challenging, even exclusive. In reality PD is not dissimilar to any other methodology, profession, practice or program - they all come with a language of their own. Project managers learn project management language, health specialists learn the language of their specialty, and organisational leaders and managers similarly learn the appropriate language for them to engage in their work effectively. Maintaining a strong focus on PD theory is important so that the 'science' underpinning the work is not lost or that it becomes a-theoretical[5]. What's more imperative is how people work with the concepts, theory and principles in practice. In my experience, the language is rarely used whilst practicing with clinicians who don't need to delve into the theory, but when it does crop up it creates an opportunity to further explore the meaning of PD and its intent;

a Practice Developer whose work is values driven, who uses approaches to include all members, asks enabling questions, engages staff in critical dialogue and uses the principles of collaboration, inclusiveness and participation is using emancipatory and transformational methods without any need to use these terms. Interestingly PD terminology is integrating into everyday language and practice now; phrases such as 'shared values and beliefs', 'ways of working' and 'critical reflection' are accepted as part of the routine discourse amongst health professionals and executives[6]. Such terms are now an expectation, not an exception as was the case ten years ago.

*Reflection: What are the responsibilities of leaders in PD and healthcare to enable participation whilst preserving the 'science' of this work and it's intent to empower clinicians and patients towards dignified, compassionate and person-centred care?*

**Outcomes from PD:**

When first engaging in PD teams worked on shared values and relationships, organisation of the team and their work, staff meal breaks, staff facilities, and streamlining of processes and tasks[7]. These were priorities at that time, necessary to engage teams and demonstrate that PD is truly about staff having ownership over what happens in their workplace and in how changes occur. This often led to misinterpretation that PD is only about staff-centric changes in the face of other, evidently more pressing issues such as high rates of patient incidents or complaints. The most relevant outcomes in those early days were engagement and empowerment of staff, necessary conditions for the work to continue long-term and for patients in their care to be similarly empowered[8].

As people became more skilled at PD the progression towards patient and organisational outcomes manifested. To achieve this teams needed to be supported by all involved in care delivery, including clinical *and* support staff, or they struggled to produce evidence of outcomes that have meaning to managers and administrators. This often led to negative opinions about the work and pressure to succumb to technical approaches. Teams required remarkable resilience to continue the work they were passionate about; sometimes the very culture they were trying to change was the greatest barrier to achieving person-centred care. When PD work was adequately supported and as it evolved, actions that aligned with strategic goals increased as well as more patient centred actions and outcomes, many of which demonstrated savings to the organisation and changes in systems, as well as increased engagement and effectiveness of teams[9].

*Reflection: How can the value of the less tangible outcomes relating to effective workplace cultures be emphasised and promoted in a context where quick, quantifiable, end point (or terminal) outcomes are more highly valued and sought after?*

**Facilitative approach to PD:**

A facilitative approach[10] is fundamental to PD with the intent to increase the capacity within individuals and teams to own their practice and the practice changes that they deem necessary; that is transformational facilitation. A key feature of this facilitative approach is the use of various methods[5, 11], strategies and tools to enable, predominantly teams, to shift

into an environment where they experience the right level of support required to engage in highly challenging dialogue, critical reflection and action, so as to achieve growth and development; an environment of high support and high challenge. High support and high challenge is a strategy used by leaders in all sorts of contexts to motivate, engage and create high performing teams[12]. It requires a high level of skill to adjust consistently to the appropriate balance of support *and* challenge.

Initially the level of support was higher as trusting relationships were built. There were subsequent misunderstandings about the relationship between support and challenge; that this approach means all support with the complete omission of challenge. Some have criticised the approach as indulgent, an impression of this proven approach that needs to be dispelled so that it can be promoted and effectively utilised at all levels.

Too much support and 'rescue syndrome' tend to smother people and keep them in their comfort zone creating a status quo, with little opportunity for high performance, and a culture of inertia. Too much challenge, such as focus on bottom line and mistakes, allocating tasks that are out of ones capability, and undervaluing contributions, can be stressful and inhibit achievements, leading to burn out. In an environment with the right amount of support and challenge there is also positive regard and graceful care for all people, genuine praise and criticism where needed, and an expectation that people will do the right thing. Mediocrity and superficial praise don't exist in such an environment[13].

*Reflection: How can the effective use of a high support, high challenge approach be promoted at all levels to increase engagement and bring about change for the better?*

**Capacity building for implementing PD:**

Capacity building to facilitate the sustainable implementation of PD is required at all levels so that those actively facilitating teams are adequately skilled and feel valued and well supported within the organisation[14].

The facilitation skills and knowledge required to enable teams to engage in PD work are paramount to both the method and sustainability of the work. Skills include the ability to create safe spaces for high support and challenge, to facilitate clarification of shared values, to ask enabling and probing questions, to challenge assumptions, enable critical reflection, lead critical dialogue, encourage participation, show compassion, to interpret information from multiple sources, motivate people into action and to ensure rigorous processes and evaluation. An enormous task for a clinician, who also carries clinical responsibilities; impossible without the support of the whole team and key positions in the organisation! Individuals who were supported and engaged in facilitation development advanced from being incompletely prepared for a role that can be very challenging, to a state of self awareness and facilitative ability in planned situations, and on to facilitate groups in a variety of challenging and unpredictable situations. Facilitation competency requires opportunities to practice safely with the support of more experienced facilitators, to step out of ones comfort zone and try new ways, and a commitment to lifelong learning.

*Reflection: What capacity is required for PD to succeed and how can the skill of facilitation be embedded in practice and promoted as a core skill for nursing and health care leaders?*

**Roles and responsibilities in PD**

Confusion over roles and responsibilities in PD can lead to facilitators being left to manage the whole program single-handedly and being held responsible for its progress and outcomes, or lack thereof. In such circumstances the work invariably falls over or reverts to a technical, project approach to change, the very opposite to the intent of PD. The notion that team managers feel restrained from active involvement in a 'grass roots' program suggests a culture where there's an implicit expectation that they too comply with orders, however inappropriate, about the very unit and team they are responsible for. Unsupported facilitators are overwhelmed by the notion of carrying the full responsibility for improving practice and care. Generally speaking, they are not in positions to achieve this; they don't have access to all the information required to make sound decisions, nor the organisational knowledge to negotiate the task, and they don't have the positional influence to challenge aspects of their culture and context that may be inhibiting their ability to achieve. The facilitator does have connection with and support of their colleagues to enable collaboration, participation and inclusiveness of the whole team, whose practice is at the heart of PD. But to sustain this the active, strong support and leadership of the manager is vital; I've come to believe that PD should not go ahead without the manager's explicit commitment. Likewise there's a need for clarity about the expectations and limitations of the facilitator's role. Otherwise it's an ethical dilemma for all involved.

*Reflection: What's working and what needs to be in place to enable effective facilitation and leadership of PD work in complex and diverse contexts?*

**Governance and Leadership for PD**

Inconsistent and sporadic governance to support implementation of PD is detrimental to any possible progress or outcomes. In organisations where governance frameworks exist and consist of people who have good understanding of the methodology, where issues and challenges are collaboratively explored, and where people at the table are empowered to speak up, the work progresses well. Use of a shared governance approach and facilitation skills can free governance groups from the traditional agenda-driven meetings so commonplace in health. Experience shows that a flattened hierarchy, open dialogue and shared decision-making in a no-blame context enables teams to work through challenges, identify new opportunities and celebrate achievements that all feel a part of[15,1].

*Reflection: How can shared governance structures in health be enabled; genuine two-way communication and shared decision-making in a necessarily directive, hierarchical context?*

**Conclusion:**

In the ten years I have been involved in PD I have embraced it as rigorous and effective method for enabling change at all levels. The work is dynamic and has to be able to change in response to the needs of clinical reality. This requires clarifications of a number of aspects including roles and responsibilities, purpose, realistic goals and outcomes and persistence with the principles in an increasingly complex context.

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*For more information and support with facilitation, whole person learning, workplace engagement strategies and mentorship, or to arrange a free strategy meeting contact pauline@7sensesconsulting.com.au*