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The Development and Implementation of a Participatory and Solution-Focused Framework for Clinical Research: A case example

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ABSTRACT

Implementing evidence-based practice change in healthcare can be difficult. However, a number of factors can enable the implementation of evidence-based care. Some of these factors are: commitment to a shared purpose, openness and sharing of ideas, and relationships building. This paper focuses on the translational research methodological processes that were developed and used to implement practice change, and draws on a case example of a multidisciplinary project in a Tasmanian hospital. The project aimed to improve patient outcomes by reducing the incidence of omitted or delayed administration of prescribed medications. The participatory, collaborative research framework developed drew upon principles from practice development, knowledge translation and facilitation.

Central to the work was a person-centred and solution-focused, strengths-based approach. The approach incorporated a framework made up of six key elements: engagement, evidence, context, facilitation, implementation and evaluation. Staff were acknowledged as context experts and the work was informed by the view that sustainable, effective solutions should be developed in collaboration with staff. Staff, including technicians, volunteers, medical, nursing and pharmacy staff, were co-researchers in identifying, implementing and evaluating context-specific solutions. Their participation and inclusion led to the identification of a number of innovative solutions to the complex, shared practice puzzle of omitted medications. Person-centred ways of working that were respectful and collaborative meant there was effective engagement and changes to practice. Staff evaluations of the overall study approach were very positive. Whilst the study was led by a team of pharmacists and nurses, the framework used is applicable to nursing-led initiatives and is transferable to other clinical contexts.

1. Introduction

This paper reports on the development and implementation of a participatory research framework for clinical research and redesign in nursing and other health care disciplines, using a medication safety project in an acute care setting as a case example. The interdisciplinary project around safe medication management incorporated an implementation framework and solution-focused approach designed to maximise engagement and effect sustained change. The paper stresses the often overlooked importance of human relations in clinical research and redesign.

In 2014 a group of clinical nurses and pharmacists from the Royal Hobart Hospital and academics from the University of Tasmania designed and led a funded project aimed at reducing the incidence of omitted or delayed administration of charted medications to hospitalised patients, in order to reduce associated adverse outcomes. The study was known as the "Right Time, Every Time" project. Other staff, including technicians, volunteers, medical, nursing and pharmacy staff, were co-researchers in identifying, implementing and evaluating context-specific solutions.

1.1. Considerations in framing the study design

From the outset, the project was specifically designed to be participatory, focused on team and organisational strengths and the collaborative development of context-specific solutions. A criticism of clinical research aimed at changing practice is that it often brings

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preconceived solutions to poorly understood problems, imposing these from the top down and that clinical evidence (often in the form of audit data) is used in a punitive way (Walsh, Crisp, & Moss, 2011; Walsh, Moss, Lawless, McKelvie, & Duncan, 2008). Such approaches can fail to consider context-specific conditions and can alienate clinical staff, leading to resistance and a failure to embed the solutions in practice (Burnes & Cooke, 2012).

Based on this, it was reasoned that to get the best outcomes (in the form of practice change) from this research it was necessary to approach it from a fundamentally different perspective. Drawing upon the literature and our experience of participatory, collaborative clinical research (Bergold & Thomas, 2012; Walsh & Moss, 2010), key principles considered to be important to the success of clinical research initiatives were listed. Foremost amongst these was the need to work in person-centred ways. Person-centredness in this context meant recognising the shared humanity of people, shifting focus from the general to the individual in an environment where patients and practitioners feel personally valued (McCrae, 2014), using processes that put the needs of patients and staff at the centre of considerations and acknowledging the positive possibilities that stem from working together with a shared purpose (Walsh, 1999). Other considerations included engaging in a respectful way with clinicians (Walsh, Lawless, Moss, & Allbon, 2005); being open about our intent and transparent in our approach; recognising the clinicians as being the experts in their own context; acknowledging the problem as the problem (the people are not the problem) (Walsh, Moss, & FitzGerald, 2006; White & Epston, 1989); engaging in a genuine puzzle to be solved, rather than a predetermined solution to be implemented; having faith in the wisdom of the collective in generating solutions for the context; and finally understanding what goes right and why, rather than just what goes wrong (Walsh et al., 2008).

A number of frameworks were drawn upon to inform the work, including our experience in practice development; knowledge translation (McCauley et al., 2014; Walsh et al., 2012); and group facilitation and coaching (Crisp and Wilson, 2011; Walsh & Andersen, 2013). Practice development helps create environments that support clinician engagement in evaluating and improving their practice (Manley, McCormack, & Wilson, 2008). Effective facilitation, that is integral to practice development work, helps the development of individual, team and organisational qualities required for effective workplace cultures (Crisp & Wilson, 2011; Manley, 2004). Our approach also blended and adapted a theoretical implementation framework (PARIHS) and a coaching or counselling approach (Solution-Focused Approach). These are discussed in turn below.

1.2. PARIHS framework

The Promoting Action on Research Implementation in Health Services (PARIHS) framework is a midrange explanatory theory about implementation (Kitson, Harvey, & McCormack, 1998; Rycroft-Malone, Seers, Chandler, Hawkes, & Crichton, 2013). PARIHS considers the interplay between three core elements and their subthemes when implementing research into practice. These elements are (i) evidence, (ii) context and (iii) facilitation. PARIHS suggests that if the evidence is robust and people agree with it, if the context is receptive and if there is skilled facilitation, then it is more likely that evidence will be implemented into practice and sustained (Rycroft-Malone et al., 2013). Our experience with PARIHS prior to the present study was that whilst the framework was useful, there is little information on implementation strategies (Ullrich, Anju, & Stetler, 2014) and the additional element of evaluation which is not specifically addressed in PARIHS requires careful consideration. Our experience also indicated that engagement is an important element that has a strong bearing on an initiative's success or otherwise, but has to a large extent been ignored (Tillott, Walsh, & Moxham, 2013; Walsh et al., 2005). We have found that a well-planned and robust, ongoing engagement process with all key stakeholders is pivotal to successful outcomes. Each of these elements of PARIHS and the additional elements of engagement, implementation and evaluation, raised questions which needed to be answered in order to realise a successful project. The elements of the approach underpinning our research design and the questions they raised for us are depicted in Table 1 below. These were not used in a linear or stepwise fashion but informed all the activities in each phase of the project (see Table 3 below). Whilst all the elements were active in each phase of the project some were more prominent in some phases than others.

1.3. The solution-focused approach

In addition to the amended PARIHS framework detailed above, we saw the need for a positively framed, strengths-based approach to operationalise the framework and sustain clinician engagement. By collaboratively identifying what works and the strengths inherent in the context, clinicians could be engaged in the process and develop solutions that worked in and were supported by the context (Bloor & Pearson, 2004).

The solution-focused approach used in the project is derived from Solution-Focused Brief Therapy (De Shazer & Berg, 1997) and adapted to a research (rather than a therapeutic) context. It is based on the premise that helping people to . . . "disengage from problem focused and problem saturated thinking" can assist the individual to spend more time finding possible solutions and pathways to preferred outcomes and goals (Grant, 2013, p. 36). The solution-focused approach is as much about understanding what goes right and why, as it is about understanding the problem. This is summed up by Bloor and Pearson as: find out what works and do more of it and stop doing what does not work and do something different (2004).

In contrast, the problem focus on deficits and what's wrong has entered our language and is so ubiquitous it is almost invisible. Problems have blame and ownership and negative connotations which give rise to comments such as: "that's going to be a problem"; "that's not my problem, that's your problem"; "who caused the problem in the first place?" (Walsh et al., 2008). Problem-saturated thinking can psychologically disengage the thinker from the problem by mobilising anxiety and putting the thinker into a psychological "away state" (Rock, 2008), which can rob them of psychological resources required to solve the problem (Walsh et al., 2011). "Problems" can trigger stress and confusion, and thinking can be clouded as a result. Such psychological disengagement and clouded thinking applied to the clinical research context may have a detrimental effect on the group's ability to develop shared solutions.

The contrasting features of problem and solution-focused approaches, from Jackson and McKergow (2001, p. 27) are outlined in Table 2.

Drawing on the PARIHS framework and Solution-Focused approaches, a participatory study to collaboratively develop solutions to the problem of delayed or omitted medications in a large health service was designed.

1.4. Study design

The aim of the project was to improve patient outcomes by reducing the incidence of omitted or delayed administration of charted medications to hospitalised patients. Following ethical approval (ethics approval number H14111) the project was conducted in four phases (see Table 3 below). It is not our intent in this paper to focus on each phase of the research or to report in detail