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# Perspectives and experiences of nurses as facilitators within a Practice Development program

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ABSTRACT

*Background:* Health services are challenged to change and adapt to meet the changing needs of the populations they serve. To support this, the 'Essentials of Care' Practice Development program was developed in Australia. Local facilitators play a key role in its delivery and achievements.
*Aims:* This study aimed to gain insights into the experiences of clinical nurses in Practice Development facilitation roles in an acute hospital, including training for the role and changes occurring within themselves and their workplaces.
*Methods:* A qualitative interpretive design used purposive sampling for a two-phase study using semi structured interviews and focus groups with data analysed using Framework Analysis.
*Results:* Twelve Registered Nurses with an average of two years' experience in a facilitator role were interviewed and attended focus groups in 2011. Five key themes were identified: (1) facilitator as enabler, (2) the necessary team approach to facilitation, (3) valuing both internal and external models of facilitation, (4) preparation and training for role, and (5) perceived changes: to the facilitator and to the workplace. Individuals' ongoing development resulted from reflection, mentorship, role-modelling and co-facilitation; facilitation skills were recognised as relevant for nursing beyond their Program role. Ward culture gains were valued as distinct from measurable patient outcomes such as reduced medication errors.
*Conclusion:* Findings provide insights into facilitators' experiences of this Practice Development role and contribute to better understanding of effective processes for nursing practice change in acute health services. Recommendations were proposed to support future role and post-holder development.


## 1. Introduction

Ongoing evaluation and improvement are features of contemporary healthcare; staff need to ensure their practice keeps pace so patients continue to receive up to date, evidence based care. Practice development entails evidence based, supported intervention designed to improve care quality and promote patient centred care (Perry, 2013). Direct relationships have been described between the quantity and quality of facilitation available, the context within which the development is to occur, and the degree to which practice change is achieved and sustained (Kinley et al., 2014). Within PD, facilitation is used to create cultures which support nursing practice change (Crisp & Wilson, 2011; McCormack, Wright, Dewar, Harvey, & Ballantine, 2007).

Facilitation can be an effective method to bring about sustainable change as it empowers those at the front line of nursing practice to own both problems and solutions (Harvey et al., 2002). Facilitation underpins PD methodology but facilitation skills are not part of nursing educational curricula. Development of the skills, knowledge and confidence needed for effective facilitation of PD workplace activities is described as requiring an approach that is person centred, evidence based and systematic (Hardiman & Dewing, 2014). However, little is currently known about how the facilitator role functions within PD programs. This study aimed to address this omission by examining the perceptions and experiences of ward-based Registered Nurses facilitating a state-wide PD program in New South Wales (NSW), Australia, called the Essentials of Care (EOC) PD program.

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## 2. Background

In 2006, Registered Nurses at an acute tertiary hospital in Sydney, NSW, began a process to develop a program to support improvements to patient care delivery and workplace culture. In 2007 this program, named the 'Essentials of Care (EOC) Program' (Clarke, Kelleher, & Fairbrother, 2010) adopted and successfully piloted a PD approach. It was subsequently recommended in a state-wide public healthcare review (Garling, 2008) and launched as a NSW state initiative (New South Wales Health Nursing and Midwifery Office, 2011).

The EOC Program entails a six-phase iterative process concluding with an evaluation after which the cycle begins anew (Fig. 1) (New South Wales Health Nursing and Midwifery Office, 2015). Theoretically rooted in critical social science, it draws on schools of thought founded on self-reflective knowledge in pursuit of development of understanding and explanation of society as routes to emancipation from authoritarian systems of domination or dependence (Browne, 2000). It is values-based and uses participative, collaborative and inclusive approaches underpinned by person-centeredness, premising that this will achieve sustainable practice improvement and work-based learning (Garbett & McCormack, 2002; McCormack, 2003; McCormack, Manley, & Titchen, 2013; McCormack & McCance, 2006; Wilson & McCormack, 2006). Facilitation is intended to create positive and supportive workplace cultures (Walsh, Crisp, & Moss, 2011) and the six phases of the EOC Program use facilitation to engage and empower staff to examine their work environment and practices, identify areas for improvement and celebrate their strengths (New South Wales Health, 2009). The facilitator enables staff to reflect and engage in critical dialogue about their workplace beliefs, values and work practices to create an environment where staff can reflect and challenge rituals and assumptions, leading to action planning to improve workplace cultures and care quality. Within the EOC Program the facilitation role at ward and unit level is undertaken by clinical nurse members of the ward teams.

Successive endeavours have defined core elements of facilitation to comprise personal characteristics of the facilitator, their skills and knowledge, the relationships they create, and the way each role is structured, dependent upon specific role purposes (Dogherty, Harrison, & Graham, 2010; Harvey et al., 2002; Shaw et al., 2008; Simmons, 2004; Stetler et al., 2006). Interpersonal skills of the facilitator include reflection, critical thinking, and ability to work with their beliefs, values and attributes (Dogherty et al., 2010; McCormack & Garbett, 2003), such as, 'valuing people, authenticity, integrity, honesty and transparency' (Shaw et al., 2008; p. 160). Facilitators need to adopt a collaborative approach, recognising there are mutual benefits to be gained (Larsen, Maundrill, Morgan, & Mouland, 2005). Creation of learning partnerships are central, and environments safe for learning where practitioners can take ownership for action (Manley & McCormack, 2003). Framed overall within person-centeredness (Shaw et al., 2008), facilitation is characterised by distinctive interpersonal relationships (Stetler et al., 2006), requiring a high level of presence and self-awareness, with vision to see beyond routine and taken-for-granted aspects of practice.

In NSW, wards and departments were supported to implement the EOC Program with local facilitators (New South Wales Health, 2014). However, there has been little rigorous examination of these facilitation roles: scant description of effective preparation or staff function, and little attempt to measure fidelity in delivery or effectiveness in achievement of purpose. To address these omissions, this study aimed to gain insights into the PD facilitation role of clinical nurses, with the intention to use this information to make recommendations to support future role and post-holder development. Research aims were:

1. To identify the experiences of facilitators of the EOC Program: their preparation for the role, how their roles function and how they deliver them.
2. To identify any perceived changes occurring within the facilitators themselves whilst performing in the facilitation role.
3. To identify any changes that may have occurred in the workplace related to the EOC Program during their delivery of the facilitation role.

## 3. Methods

### 3.1. Design

This study employed a qualitative interpretive design (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004) for in-depth exploration of participants' experience. Two different approaches were chosen, to enable methods triangulation and maximise yield of rich data. First, individual interviews were used to enable participants to tell their individual stories and provide insight into their facilitation experiences and their perceived developmental needs. Semi-structured interviews were chosen; interview questions were developed to define topics to be explored but allow freedom to pursue promising avenues with confidentiality (Gill, Stewart, Treasure, & Chadwick, 2008). Focus groups were then utilised to gain further insights by reviewing preliminary interview analyses and enabling group critical discussion and elaboration of themes. Focus groups were chosen because they allow interaction between participants, in this case, individuals known to each other and with a common role. For these participants their shared experiences and the deliberate creation of a supportive environment was intended to enable discussion and the ability to challenge each other comfortably (Gill et al., 2008).

### 3.2. Sample

In this acute tertiary hospital in Sydney, Registered Nurses working on medical and surgical wards in an EOC facilitation role were purposively sampled. Fliers were distributed across the hospital seeking nurses with at least six months experience in such a role. Twelve participants for the individual interviews were recruited and analysis of interviews proceeded in tandem with data collection. Participants continued to be recruited until the research team determined that data saturation had been achieved, with no new material being produced; this occurred after twelve interviews. These twelve interviewees were invited to take part in the subsequent focus group meetings; six participated.

### 3.3. Data collection

#### 3.3.1. Individual interviews

The research team developed a semi-structured interview schedule to address the research objectives with input from independent senior nurses. Examples of questions are included in Table 1. Interviews were conducted by two members of the research team whose current roles in the organisation entailed supporting the EOC Program. These were not line managers; some but not all participants had worked with one or other of these interviewers in their professional roles. Participants had a choice of interviewer for the individual interviews, so they could be interviewed by someone they felt comfortable with to discuss their EOC role. Interviews were digitally audio recorded and lasted 25–50 min each. The interview schedule was reviewed and minor changes made following the first two interviews.

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