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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Evaluation of a practice development programme: the emergence of the teamwork, learning and change model

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Abstract

Aim: The purpose of this paper is to present a model developed from the evaluation outcomes of a practice development programme in a special care nursery.

Background: A family-centred philosophy of care, where parents are viewed as integral partners in their care of their child, is central to paediatric nursing practice. Whilst nurses understand and subscribe to the notion of family-centred care they seem unable to achieve the principles in practice. It was thought that the implementation of a practice development programme with a focus on family-centred care might enable staff in the special care nursery to overcome barriers to this way of working.

Methods: A realistic evaluation was undertaken. The strength of the approach lies in the mechanism-context-outcome connections, which has the potential to offer researchers a more complete picture of what is happening with practice development and why it is happening. Consideration therefore is not just focussed on the outcomes achieved it also includes what conditions were present in the context that influenced the success or failure of an intervention and ultimately what factors assisted in achieving the outcomes.

Results: The importance of four key aspects that influenced the success of the practice development programme emerged from this work; teamwork; learning in practice; inevitability of change and the care environment. These findings were incorporated into a model (TLC model) with each element seen as fundamental in changing the overall culture of the special care nursery to one where family-centred care was part of everyday practice. The importance of culture mapping, facilitation development and leadership support within the context were also highlighted as central to the overall success.

Conclusions: It is suggested that this innovative model may help guide practitioners in all practice settings in achieving their espoused philosophy of care within the reality of everyday practice.

Implications for practice:

- Consideration should be given to using models such as TLC to provide a framework for practice development work within teams
- A first step in beginning any practice development work should include a review of how the team is working together
- Mapping workplace culture should incorporate a variety of methods and should consider ways in which staff will be engaged in the process

- Facilitation development (internal) is fundamental to the ongoing success of practice development programmes of work
- Leadership support is vital to the overall success of practice development

Keywords: practice development, teamwork, learning, realistic evaluation, workplace culture, family-centred care

Introduction

The purpose of this paper is to present a model developed from the evaluation outcomes of a practice development programme in a special care nursery. Previous publications (Wilson et al., 2005; Wilson and Walsh, 2008) have outlined the work that was undertaken in designing and implementing the practice development programme in order to achieve a family-centred approach to care. In assessing whether 'the implementation of practice development changed the culture of the special care nursery' pre and post implementation results were compared. From these findings the Teamwork/Learning/Change (TLC) model emerged as a way in which to challenge and support staff in achieving a family-centred approach to care. The model incorporates four key components: teamwork; learning in practice; inevitability of change and the care environment. It is suggested that this innovative model may help guide practitioners in all practice settings in achieving their espoused philosophy of care within the reality of everyday practice.

Background

Adoption of family-centred care has been somewhat successful in ensuring that parents are now more than ever a part of their child's care during hospitalisation (Callery and Smith, 1991; Daneman et al., 2003; Knight, 1995; Shields et al., 2008). Whilst family-centred care is often viewed as a predominantly paediatric practice, Mitchell and Chaboyer (2009) outline the value of family members participation in the care of a critically ill (adult) relative, whilst Nolan et al. (2002) argue that within dementia care a relationship-centred approach is more inclusive and values the person within their broader social context (and carers). Family-centred care must be cultivated within a context of person-centred care, where the workplace culture (a component of context) of the team can encompass respecting and valuing the uniqueness of each individual and their rights and engaging with them to promote their dignity, sense of worth and independence (McCance et al., 2009).

Despite these accomplishments there have however been many barriers to successful implementation of family-centred care such as nurses' attitudes (Gill, 1987; Rushton and Glover, 1990; Johnson and Lindschau, 1996; Trnobranski, 1994; Newton, 2000); nurses not wanting to get involved with families (Lee, 2007); fear of losing control (Fenwick, 2003); the technical nature of the environment (Gordin and Johnson, 1999; McGrath, 2000) and the discrepancy between what we say we do and what we achieve in practice (Petersen et al., 2004); all of which impact on sustaining change in practice. Whilst nurses understand and subscribe to the notion of family-centred care they seem unable to achieve the principles in practice (Petersen et al., 2004; Shields, 2010).

It was thought that the implementation of a practice development programme with a focus on family-centred care might enable staff in the special care nursery to overcome such barriers. This approach included working intensively with staff on changing practice. In order to enhance the sustainability of the changes it was important to use a structured approach (Buonocore, 2004) that was continuous and cyclical (Street, 1995), where staff themselves owned the changes in practice (Balfour and Clarke, 2001). Before this could begin, some of the barriers to change had to be challenged. This was done by questioning assumptions about the effectiveness of existing practice and the process of clinical decision making on the unit, challenging the contradictions and tensions that existed regarding change as well as supporting them in changes that they themselves might

wish to initiate. Changing practice often involves a technical approach to practice development where the development of technical knowledge and skills is paramount and development of the individual is a consequence of the intervention rather than its intent (Carr and Kemmis, 1986; McGrat, 2000; Henderson, 2006; Gordin and Johnson, 1999). In this practice development programme however, changing practice was also about developing and empowering staff who are involved in the process thereby creating a transformative culture (Manley and McCormack, 2003).

Overview of the study

The aim of the study was to obtain an in depth understanding and description of the culture of the special care nursery before and after the implementation of practice development strategies and to monitor any changes in the culture. Culture is commonly depicted as 'the way things are done around here' Drennan (1992, p3) and incorporates a shared understanding of beliefs and actions that are developed through socialisation and learning within the workplace. The key aspects of the study are captured in Table 1. As the purpose of this paper is to highlight the evaluation outcomes of the study, a brief description of the methodology is outlined below, a more thorough discussion of this and how this played out within the study has been previously published (Wilson and McCormack, 2006).

Table 1. Overview of the practice development study.

<p>Participants:</p> <ul style="list-style-type: none"> Mainly nursing staff, although some activities also included medical, allied and ancillary staff All nursing staff were female, length of neonatal experience ranged from a few months to over 25 years
<p>Ethics:</p> <ul style="list-style-type: none"> Special care nursery self-selected to be included in the study Participation in each activity was voluntary and process consent was obtained at each stage of the study (Dewing, 2002) Detailed de-identification data themes were shared with the special care nursery staff who then decided what actions they would take
<p>Practice development activities:</p> <ul style="list-style-type: none"> Range of activities offered to staff such as action learning, high challenge/high support, mentoring, values clarification Activities focused on improving teamwork, developing learning cultures, supporting change and implementing family-centred care
<p>Data collection and analysis:</p> <ul style="list-style-type: none"> Multi-dimensional collection of data that reflects the attitudes and beliefs of a wide range of stakeholders. Analysis informed by realistic evaluation Data collection is undertaken pre intervention, throughout intervention period and six months post intervention Data collection included surveys, participant observation, filed notes, staff interviews, notes from activities and practice changes. Cognitive mapping (Eden, Jones and Sims, 1983) was used to manage and analyse the data. This enabled the constant comparative method to be utilised in the process of the map formation and refinement (Northcott, 1996) The use of multiple data collection methods as well as comparing and contrasting the data enhanced the validity of the findings
<p>Overall research question:</p> <ul style="list-style-type: none"> What works (in the practice development programme), for whom does it work (staff, Patients families) and on what circumstances does it work?
<p>Outcomes:</p> <ul style="list-style-type: none"> Improvements in teamwork, multi-disciplinary communication and staff morale Development of self-directed learning culture Pro-active change processes resulting in changes to benefit babies, parents and staff Realisation of family-centred care as the core of workplace culture

Methodology

The overall methodology was realistic evaluation as developed by Pawson and Tilley (1997) which takes into account the context (setting) and mechanism (process characteristics) in deriving an outcome. Rather than asking if the intervention works, or comparing one intervention to another, realistic evaluation sets out to understand why a programme works, for whom it works, and in what circumstances it works. Pawson and Tilley (1997) developed the following formula to represent this: Context (C) + Mechanism (M) = Outcome (O). This means a programme (or initiative) includes all the players, the venue, the social norms, the rules of the workplace and its history.

Pawson and Tilley (1997) suggest that realistic evaluation provides researchers with an approach to evaluation that has a solid basis in the reality of practice. The strength of the approach lies in the mechanism-context-outcome connections, which has the potential to offer researchers a more complete picture of what is happening with practice development and why it is happening. It is guided by the ideals of realism, consisting of the real (mechanisms which may or may not fire), the actual (events which may or may not be observable) and the empirical (evidence of experiences and observable events). This results in rich descriptions of the relationship or non-relationship between the three components. Data was collected pre and post implementation and the findings from each phase compared.

The benefit of using a realist approach to evaluation is that it encompasses the context in which the change is occurring as well as the process for that change. Consideration therefore is not just focused on the outcomes achieved it also includes what conditions were present in the context that influenced the success or failure of an intervention and ultimately what factors assisted in achieving the outcomes. Tolson (1999), Redfern et al. (2003, Wilson and McCormack (2006) and Wand et al. (2010) support the use of a realistic evaluation approach within research and practice; they suggest that it not only provides nurses with a framework with which to evaluate innovation and change in nursing practice it also provides the means by which to explain how the change has come about and how this might influence future interventions.

The practice development programme

The process of the practice development programme is outlined in Figure 1 and incorporates the facilitator working with staff to use the outcomes of the pre-intervention cultural mapping to formulate and implement ideas and actions for change, this was then followed by a process of ongoing evaluation that continued throughout the study with post implementation mapping occurring some months after the facilitator left the unit.



Figure 1. Implementation stages of practice development programme.

The results of this study have been published in a number of journals and texts over a five year period. A review of key aspects of each publication along with conditions associated with the context, the mechanisms (interventions) being used in the context and the relationship this has to outcomes for patients (babies), parents (and families) and staff is contained in Table 2. Each paper in the table is identified by number for ease of reference. When a paper in the table is discussed in the text the number will be used to identify it rather than the authors. The current paper will look at examples of outcomes, their relationship to interventions (the mechanisms employed) and the influences of facilitation and leadership.

Table 2. Dissemination of findings.

	Paper/Book chapter	Context	Mechanisms	Examples of reported outcomes
1	Wilson, V., Keachie, P. and Engelsmann, M. (2003) Putting the action into learning: the experience of an action learning set. <i>Collegian</i> . Vol. 10. No. 3. pp 22-26.	<ul style="list-style-type: none"> • Voluntary participation • Monthly meetings • Staff supported to attend 	<ul style="list-style-type: none"> • Action learning • Facilitation 	<ul style="list-style-type: none"> • Development of skills and knowledge around action learning • Personal growth as a result of participation • Successful engagement of 7 nurses
2	Wilson, V., McCormack, B. and Ives, G. (2005) Understanding the workplace culture of a special care nursery. <i>Journal of Advanced Nursing</i> . Vol. 50. No. 1. pp 27-38.	<ul style="list-style-type: none"> • Pre intervention • Map existing culture • External researcher 	<ul style="list-style-type: none"> • Survey • Participant observation • Staff Interviews • Feedback 	<ul style="list-style-type: none"> • Overview of the workplace culture • Offers clarity around tensions in the workplace, differing values and beliefs • Provided a basis for 'change initiatives'
3	Wilson, V. (2005) Developing a vision for teamwork. <i>Practice Development in Health Care</i> . Vol. 4. No. 1. pp 40-48.	<ul style="list-style-type: none"> • Staff decide focus • Include all staff 	<ul style="list-style-type: none"> • Values Clarification • Facilitated process 	<ul style="list-style-type: none"> • Developed a shared vision about teamwork • Staff willingness to reflect on their clinical practice
4	Wilson, V., McCormack, B. and Ives, G. (2006) Re-generating the 'self' in learning: developing a culture of supportive learning in practice. <i>Learning in Health and Social Care</i> . Vol. 5. No. 2. pp 90-105.	<ul style="list-style-type: none"> • Includes all staff although participation in each activity is voluntary (process consent) 	<ul style="list-style-type: none"> • Facilitation of high challenge/ high support • Workshops • Role modelling 	<ul style="list-style-type: none"> • Staff driving their own learning, using reflection and asking enabling questions • Learning in and from practice • Emergence of a supportive learning culture
5	Wilson, V., Ho, A. and Walsh, R. (2007) Participatory action research: changing clinical practice in nursing handover and communication. <i>Journal of Children's and Young People's Nursing</i> . Vol. 1. No. 2. pp 85-92.	<ul style="list-style-type: none"> • Issue identified by a member of the action learning group who then drives the project and involves all staff 	<ul style="list-style-type: none"> • Action research • Active learning • Facilitation supported development of writing and presentation skills 	<ul style="list-style-type: none"> • Development and early adoption of a database tool • Improved multi-disciplinary communication • Increased staff satisfaction • Reduced time in handover • A focus on discharge planning and problem solving

6	Wilson, V., McCormack, B., and Ives, G. (2008) Developing healthcare practice through action learning: individual and group journeys. <i>Action Learning: Research and Practice</i> . Vol. 5. No. 1. pp 21-38.	<ul style="list-style-type: none"> Action learning group meets monthly for 15 months with ongoing evaluation throughout 	<ul style="list-style-type: none"> Action learning Action plans Evaluation by individuals and the group 	<ul style="list-style-type: none"> Clearer understanding of how action learning can be used within a practice development programme of work Rooming in protocol for parents Pain management – e.g. sucrose policy
7	Wilson, V. and Walsh, R. (2008) Changing the Culture and Context of Practice: Evaluating the Journey Towards Family-Centred Care. In: Manley, K., McCormack, B. and Wilson, V. (Eds.) <i>International Practice Development in Nursing and Healthcare</i> . Oxford: Blackwell.	<ul style="list-style-type: none"> 4 months post – intervention Re-map the culture External researcher/practice developer 	<ul style="list-style-type: none"> Participant observation Staff interviews Action plans Family stories Feedback and celebration 	<ul style="list-style-type: none"> Improved multi-disciplinary teamwork and communication and staff morale Increased problem solving and reflection Evidence informs changes i.e. noise levels Creation of an environment to support the baby and family

Mapping the culture

Prior to implementing the practice development programme of work a review of the existing culture was undertaken. This would be used as a means of measuring any changes that occurred through the change intervention. Understanding the context and culture of care is an essential first step in any realistic evaluation (McCormack et al., 2002). In order to achieve this a number of mechanisms were used; in the initial phase this encompassed gathering data through staff survey and observation, when this data proved to be conflicting a third data set of staff interviews was used as a means of discussing with staff the conflicting results in the first two data sets. Staff agreed that the participant observation was a more accurate reflection of their reality (increasing validity of this data); whereas they indicated the survey data they provided was more related to the picture of the culture 'they would like to see'. This was an important outcome for the study in that it highlighted a broader multi-modal data collection is required if we are to try and gain a 'realistic' picture of what the culture is depicting (paper 2). This third mode of data collection however proved to have an additional factor in that it served also to engage staff more directly in the process and gave them ownership over the data (rather than it being dominated by the participant observer views or the perceived superficial data collected through the survey).

Over 30% of staff were engaged in the interviews and therefore when it came time to feedback the overall results, they already had a heightened awareness of their own culture, the differing values and beliefs within it and the tensions and issues contained within it (paper 2). The feedback (mechanism) provided a platform for change in the unit and a number of ideas were generated from this that resulted in change initiatives. There was an agreement that teamwork should be the first component of the practice development work (the outcomes of this are reported in paper 3), as this had been outlined as an area of concern for staff. This was an important step as this intervention would include all staff (nurses, midwives, allied health, doctors and the ward clerk) and was therefore considered to be both an intervention and an engagement strategy for the overall programme.

The lessons from the pre mapping period informed the process of mapping the culture after the intervention period; data was collected through observation, staff interviews (50% of staff), action plans, and family stories. This provided a broad yet in-depth picture of the evolving culture (paper 7).

The involvement of staff through interviews (sharing their views of the culture), collection of action plans (engagement in ongoing work) and feedback of the data resulted in a recognition of their achievements, celebration of their successes and a sense of future direction for the work once the study was finished. The key messages (from the realistic evaluation) around culture mapping relate to:

- The use of varying data collection mechanisms to provide a clearer picture of the culture
- Involving staff in the process as a means of contributing to the data (it is about them)
- It is vital to engage staff in the beginning stages of the ongoing process

From this staff are able to recognise the findings as being an account of their 'everyday reality' and are also able to acknowledge what is good about their practice and where the opportunities for change exist. By focusing on something that is important to them in the first instance (in this case teamwork) you are able to get buy in for the work, engagement in the change process and in so doing establish a level of trust that change can be good for practice.

The role of facilitation and leadership

It can be seen from table 2 that outcomes of the practice development programme initially centred on staff as well as working on interventions that would influence staff engagement in the change process. The external facilitator (researcher) had a key role to play in affecting the context within which changes were occurring, in working with staff who were developing their own facilitation skills (through the action learning group) and engaging other staff in the process to ensure they could influence and drive the change process (Harvey et al., 2002). It was important at the outset of the practice development programme for staff to feel it was their programme and that they could drive the changes. Rycroft-Malone et al. (2002) suggest there are three elements to successful implementation of change; evidence, context and facilitation. A framework developed to guide implementation of evidence-based practice indicates when there is a high level of evidence, in this case evidence derived in part from the culture mapping that occurred in the pre-implementation phase (paper 2), when the context is receptive to change (culture, leadership and evaluative processes) and the implementation is supported by appropriate facilitation, then the chances of success are more likely (Rycroft-Malone, 2004). One of the key aspects of this work was for the facilitator to work with staff in developing the external-internal facilitation mode whereby internal facilitators would develop their own skills and knowledge in managing change whilst be supported by the external facilitator to implement what they were learning (Johns and Kingston, 1990; Binnie and Titchen, 1999; McCormack and Wright, 1999). The value of the facilitator role was in:

- Supporting the ongoing practice development work
- Using action learning as a mechanism for staff to develop facilitation skills
- Establishing the external-internal facilitation approach

This influenced the transformation of the context and culture and the development of a more effective family-centred approach to care.

The setting up of the action learning group was a key mechanism being tested within the realistic evaluation. The action learning group process (including engagement), membership of the group, the skills being developed and the leadership around change were all indicators that contributed to a new reality emerging in the special care nursery. Paper 1 reports the process of setting up the group and the early indicators of skills development and staff engagement which was further enhanced as the group progressed to developing high level critical reflection skills (paper 6). The voluntary nature of the group and the support they received to attend in work time, and the support of their colleagues to take time away from the unit ensured participation was maintained. The members of the group were then integral to the overall work and their facilitation was evident in a number of initiatives such as supporting the values clarification process (paper 3); the role modelling of high

challenge/high support (paper 4); driving the action research project on changing handover practice (paper 5); evaluating their individual and group journeys (paper 6); action planning for change initiatives (paper 6 and 7); and participation in writing and disseminating the results (papers 1, 5 and 7).

The influence of the members of the action learning group was demonstrated by:

- How they worked together and with all staff in the special care nursery (*teamwork*)
- The facilitation skills they brought into the special care nursery
- Their role modelling of techniques such as using enabling questions to support critical reflection (*learning*)
- Their leadership in projects to improve practice (*change*) such as developing the rooming-in protocol (*family-centred care*) is evident

Whilst in the initial stages the group was heavily supported by the external facilitator, as time went on and their confidence grew they became less dependent on that support and were able to work and support one another (and other staff in the special care nursery) in the change process (paper 6). As the work progressed, outcomes began to go beyond changes for staff themselves (such as increasing staff satisfaction with teamwork, papers 3 and 5) to outcomes for families (i.e. rooming in policy established to encourage parents to stay with their newborn prior to discharge, paper 6) and for babies (i.e. reducing noise levels in the special care nursery, paper 7). This was viewed as an important step in the process where the immediate change processes and actions focused on what impacted directly on staff themselves (i.e. increased participation in decision making) and once these began to see positive results moving beyond this to embrace changes that would impact on the environment (i.e. such as the level of noise in the special care nursery), the delivery of care to babies (i.e. sucrose to manage procedural pain) and the involvement of families in the care process (i.e. discharge planning).

The leadership demonstrated by the staff was integral to the success of the programme. In particular the manager of the unit provided guidance to staff, she used enabling techniques to engage them in the work, to challenge them to learn new skills and to question one another about their own practice and to come up with ideas that would influence practice change (Parker and Gadbois, 2000). The manager reflected on her role as leader and actively worked with an enabling model that resulted in staff being less dependent on the manager to make all the decisions. She along with other members of the team remained enthusiastic and committed to the change process, they role modelled changes within their own practice and this served to demonstrate that change was possible, could be positive and that staff themselves could influence (Byram, 2000; Boyatzis, McKee and Goleman, 2002; Porter-O'Grady, 2003). In essence they inspired staff to accomplish above and beyond their expectations of what they themselves could achieve (Bass and Avolio, 1994). Leadership was a key driver in the ongoing success of the programme.

What does this mean for family-centred care?

As indicated earlier in the initial phases of the work, the change initiatives focused on things that would make a difference to staff themselves. As they progressed the work, they began to look more broadly at the way in which they delivered care. They had articulated a family-centred approach to care, however the initial data mapping had revealed that this was merely an espoused notion of how they worked with the reality being quite different (paper 2). A number of initiatives and indeed the way staff went about their everyday business (how they worked together, cared for babies, engaged parents and changed the environment of the special care nursery) resulted in significant practice change (papers 4, 5, 6 and 7). The following examples provide an illustration of how such changes impacted on the delivery of family-centred care.

Welcoming families

Nurses also recognised the multi-dimensional aspects of family-centred care:

'... it is also being able to give the emotional support, social support ... which to me is important ... it is just as important as delivering care ... what I like about it is being able to involve the parents, the grandparents ... involving parents, educating them, embracing them, welcoming them.'

Welcoming families into the unit was very important especially during the admission process as first impressions often set the scene for the future care (Newton, 2000). Families were made to feel comfortable in the environment as nurses considered how they *'speak to people'* and displayed positive welcoming behaviours such as smiling, introducing themselves, giving parents a chair to sit by the baby, explaining what is going on with the baby and answering questions. This change in attitudes towards parents meant they were more willing to become actively involved in care, to ask questions and to be part of the decision making team (Rushton and Glover, 1990; Trnobranski, 1994; Casey, 1995; Newton, 2000; Eckle and MacLean, 2001; Daneman et al., 2003). Nurses were more aware of how *'parents were feeling'* about having a sick baby in the special care nursery environment (Fisher, 2001; Davis et al., 2003) and they realised that *'although the baby is the patient, it is the parents you are caring for as well'*.

Empowering families

Much of the evidence of the early culture indicated that families received mixed messages, where behaviour and language sometimes served to distance rather than include them (Fenwick et al., 2001), where nurses sometimes took on a paternalistic role (Maxton, 1997; Newton, 2000), families were viewed as an adjunct rather than intrinsic to delivery of care and where parental participation was usually based on nurses working on rather than working with parents (Rushton and Glover, 1990; Callery and Smith, 1991; Casey, 1995; Knight, 1995; Daneman, Macaluso and Guzzetta, 2003). Caty, Larocque and Koren (2001) suggest that whilst nurses have good knowledge of family-centred care principles they are unable to consistently implement them in practice as they have difficulty moving from a *'medical helping'* model to an *'enabling model'* which is the foundation of family-centred care. Staff worked hard to overcome the barriers to empowerment and to shift the focus of care from what was predominantly a nurse-centred model to one that was focused on the family and the empowerment of parents where *'most staff are pretty big on getting the family involved'*. This included *'involving parents in the decision making'*, ensuring that care was primarily for the baby *'but at the heart of the family unit'* and that families were made to *'feel it's their baby and it is not ours'*. Each of these factors is important in creating a climate that supports collaboration (Paavilainen and AstedtKurkl, 1997; Fenwick Barclay and Schmied, 1999; Eckle and MacLean, 2001).

Discussion: development of a new model

The evaluation of the culture of the special care nursery post intervention revealed a very different culture from the one initially reviewed. Staff had achieved an enormous amount of personal and professional growth and development as they worked together to create a culture that promotes effective family-centred care. Changing the culture of the special care nursery to one that achieved an authentic model of family-centred care was about creating meaning for staff to ensure that the family-centred ethos of care became intrinsic to everyday practice where nurses worked alongside parents and families in order to deliver effective care.

Moore et al. (2003, p457) suggest the integration of family-centred care is *'more of a journey than a destination'* whilst Titchen and Binnie (1995) consider being patient-centred is always a state of *'becoming'*. Therefore having a model to guide the ongoing journey and stretch the boundaries of practice is essential. The work undertaken in the special care nursery provided the basis for a new

model (as depicted in Figure 2) to help elucidate the ongoing journey towards family-centred care. As stated earlier in this paper an in-depth review of the culture is fundamental and sets the scene for engaging staff in the process and creating a sense of ownership in potential changes. To support this you require external facilitation support, the development of facilitation skills in staff and a way to engage leaders in the using a practice development approach and in using the model as a means of undertaking significant cultural change. The model does not work in isolation; it requires careful consideration in relation to how, when and why it will be used in the practice setting. The success of the model is predicated by the availability of supportive leadership (within the environment) as well as access to skilled facilitators who understand the principles upon which the model is based.

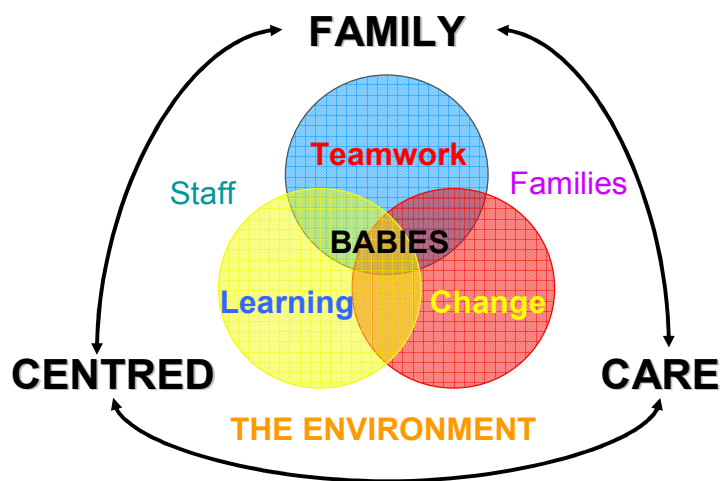


Figure 2. A model of authentic family-centred care.

The key components of this model will be presented and the principles developed from this inductive inquiry articulated.

Teamwork

Cultivating a shared vision to underpin cultural development is an essential first step in the overall strategy of achieving authentic family-centred care.

Within this model, teamwork is seen as central to the successful implementation of any changes in practice. Initially the team struggled to create meaningful working relationships with one another and their differing values and beliefs resulted in a recurring tension and ineffective team culture. Care delivery was dependent on the individual and often adopted a nurse (or doctor) centred approach to care whereby parents had limited influence about care practices or decision-making. In order for the team to review the effectiveness of the care they delivered, it was imperative that they first of all looked at the effectiveness of themselves as a team.

Values clarification work enabled them to understand and challenge their value system, establish mutual respect and create a shared meaning of teamwork. They used this as the basis for re-shaping their team; this resulted in changing staff attitudes, a less threatening atmosphere and the creation of a successful team where the focus was now on patient care, rather than on the de-stabilising influence of the ineffective team.

Learning

Establishing a supportive learning culture where nurses actively engage in their own learning and development is an important step in achieving authentic family-centred care.

Once the team had established values and beliefs about how they wished to work together they were then able to focus on establishing a supportive learning culture. The learning culture was one where staff seemed at times to work against one another rather than support one another in learning; this impacted on how they went about their everyday work. Following the study there was evidence of a supportive learning culture where learning was valued and seen as important. Staff now shared learning with one another and took responsibility for driving their own learning. This resulted in them actively seeking new knowledge and understanding about effective care delivery. They were now well equipped to deal with the changing context of care.

Change

Barriers to change need to be challenged and nurses need to be supported to actively engage in the change process if they are to achieve their goal of implementing authentic family-centred care.

Staff on the unit were in a constant state of anxiety about the changes that had occurred as well as the changes that were evolving. There was evidence of resistance to change, and although staff would discuss their unhappiness within the special care nursery, there remained a reluctance to challenge the status quo. Perceived barriers were challenged by questioning assumptions about the effectiveness of practice as well as the process of clinical decision making on the unit. A structured approach to change was adopted and nursing staff were encouraged to actively participate in the change process and to challenge one another. This resulted in staff not only accepting but embracing the changing context of practice as change became part of the everyday world of the special care nursery. This served to increase confidence in the team's ability to take on significant cultural as well as practice change and to move towards achieving their goal of family-centred care.

Environment

There is a need for nurses to evaluate the effectiveness of their environment (the context) in which they deliver care and to work towards developing an environment in which an authentic family-centred approach to care is achieved.

When each of the three principles described above were achieved, staff were then able to create an environment conducive to cultural change, where challenge and support became part of everyday practice and where team members value and respect one another and family members. A feature of the environment is that babies are central to the notion of care delivery. In other words care decisions are based around what is best for the baby within the context of the family unit. This has not always been evident in the unit as nurses and other healthcare providers appeared to put their needs above that of the baby i.e. delivering care when it suited them rather than responding to the cues of the baby. Nursing staff have made significant changes in their behaviour and attitudes to ensure that environmental stressors are reduced and that the environment is now less about the competing interests of the individual and more about creating the conditions which sustain the growing baby in an individualised developmentally supportive way.

Family-centred care

The evidence from this study suggests that only when each of these principles is in place can staff realistically explore ways in which they can make the transition from their espoused philosophy to one that forms the basis of everyday clinical practice. The implementation of practice development strategies enabled staff to identify organisational as well as personal barriers, develop support strategies as well as explore ways in which they could achieve their goal of implementing family-centred care in the special care nursery. The achievement of this has resulted from the dedication of a team of nurses and other healthcare providers in establishing a new workplace culture that is innovative, vibrant, supportive, creative, challenging and pro-active.

Since the release of the Platt report in 1959, nurses have been struggling with the implementation and realisation of family-centred care in practice (Darbyshire, 1994). This study shows what is possible if practice development strategies are adopted in order to challenge and support practice changes. The model developed from the study adds to the growing literature on family-centred care and serves to highlight not only a model of care but the means by which this model can be achieved in practice.

Where to from here

These findings give credence to the notion that successful change is enhanced when driven by those who implement care (Street, 1995) and that nurses are in the best position to ensure changes are sustained (Balfour and Clarke, 2001). The combined strategies used in this and other studies have been shown to be successful in facilitating practice change and the range of opportunities for engaging practitioner enhanced sustainability (Clarke et al., 1998). This has not only resulted in changes within the special care nursery but has reached other parts of the organisation and impacted on practice changes elsewhere. As practice development is about creating transformational cultures that continue to evolve it is not dependent on an individual (facilitator or leader) and the emphasis therefore is on developing staff who carry on the work after the study period has finished (Garbett and McCormack, 2004).

Where to in testing the model

The next phase involves testing the model in other contexts. This began in a paediatric hospital in Australia where three very different clinical areas elected to participate in using the model. Since then it has been rolled out across twenty clinical units in five hospitals. Ongoing evaluation and refinement of the model is part of this process. Findings from these developments will be the subject of future publications.

Conclusion

The paper has illustrated through the use of realistic evaluation how the journey of the changing context and culture of the special care nursery was facilitated by the TLC model. The evaluation verified the importance of leadership and facilitation (mechanisms) in supporting the change process. The engagement of a number of staff within an active learning group enabled the development of leadership and facilitation skills and this in turn fostered a sense of confidence in their ability to influence change. It was important for staff (in the context) to be cognisant of their own values and beliefs and the way they worked together (mechanisms) in order to create the bridge between the espoused philosophy of family-centred care and translating this into practice (outcomes). This evaluation has established culture mapping, facilitator development and leadership as key aspects in undertaking and supporting practice development work. Cultivating a shared vision to underpin the cultural development of the team was an essential first step in engaging staff in the work and in the overall strategy of improving patient care. In order for teams to explore the effectiveness of the care they delivered, it was imperative that they first of all reflected on their effectiveness as a team. They were then able to adopt practice development strategies to review the existing state of play in the unit, freeing themselves from the oppressive elements of the tension laden culture as they worked through a system of development opportunities that resulted in effective change. Whilst this work was set within a special care nursery and reviewed family-centred care, the TLC model has relevance for all healthcare settings. The significance of this work may go some way towards answering the question of how an espoused philosophy of care is successfully translated into practice.

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