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Critical companionship part 2: using the framework

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Summary

Part 1 presented the critical companionship framework for facilitating experiential learning, with exemplars of expertise. The development and testing of the framework were outlined. In Part 2, we show the framework being used by new critical companions, without educational backgrounds or previous facilitation of learning experience. The reflective accounts of the critical companions not only show how they analysed their work using the framework, but also reveal that these early experiences helped those they were facilitating to unravel their practice and look critically at how they, and others, practise. Some accounts hint at the outcomes for patients and relatives and show how critical companionship became integrated with leadership roles. We conclude that the framework can be useful in helping new critical companions to acquire effective critical companionship skills. In addition, we tentatively suggest that the development of expertise, as demonstrated in Part 1, is likely to take at least five years, unless the individual is already a skilled facilitator.

THE CRITICAL companionship framework (Titchen 2000, 2001) is used in a range of emancipatory practice development projects in the Royal College of Nursing Practice Development Programme to promote:

- The articulation and development of evidence of nursing expertise for critical review and evaluation by colleagues.
- Experiential learning through clinical supervision, action learning, work-based learning, workshops and collaborative inquiries.
- Major organisational culture change.
- Practitioner research.

In the three-year collaborative Practice Development Programme (Dewing and Wright 2002, Wright and Dewing 2003) concerned here, critical companionship was used to enable clinical leaders to become critical companions capable of helping practitioners to develop genuinely person-centred care and to free themselves of practices that put obstacles in the way of their achievement of such care. The collaboration between Portsmouth NHS Trusts' Older People's Services (including mental health, acute and community services), the University of Portsmouth and the RCN Institute Practice Development Function began in February 2001.

Programme methodology

The multi-phased programme used a critical social science framework that emphasises emancipatory processes (Fay 1987) and used the work-based methods of critical companionship (Titchen 2001), action learning (McGill and Beaty 1997) and underpinning knowledge workshops.

In the project, the participants engaged in various work-based learning activities, such as listening to older people's stories or direct observation of practice. All these activities included a reflective element. The work-based learning approaches could be used as part of an education programme to master's level (multidisciplinary) centred on practice development in gerontology. The part of the programme described here comprised three phases involving community hospitals in the trust. East phase lasted one year.

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Key words

- Clinical supervision
- Developing expertise
- Education: experiential learning
- Leadership
- Practice development

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Programme aims

The overall aim in the programme was to enable the F and G grade nurses in clinical leadership positions to become practice developers of the ward culture to enable the growth of person-centred care. Equipped with the necessary skills and knowledge to develop others in the team, the clinical leaders were then to be in a position to ensure that practice development continues after the life of the programme and/or when they leave the trust. Furthermore, sustaining the development was to be achieved by the F and G grades working collectively at a strategic level to influence decision making in the trust.

The programme enabled the participants to explore the present culture in their workplaces to understand the beliefs, values and professional craft knowledge about older people that were embedded in their practice. Professional craft knowledge is practical know-how gained through professional experience and over time. It is often intuitive and difficult to talk about, because it is generally taken for granted (Titchen 2000). Through this process, the participants were helped to explore their role as clinical leaders in shaping the culture around them. This developed a shared vision that reflected shared meanings, values, beliefs and attitudes of the older people and the practitioners.

Critical companionship

The RCN provided external facilitation and project management to the programme, working collaboratively through a project steering group comprising key stakeholders internal to Portsmouth NHS Trust and Portsmouth University. The critical companion model was used in two ways in the programme, that is, as an outsider model in which the critical companion does not have authority in the clinical setting and as an insider model in which the critical companion does. Thus, the RCN facilitators adopted an outsider critical companion model in all three phases, to develop, as critical companions, a group of six volunteer senior nurses (G to I grade nurses) in each of the three phases. These nurses then adopted the insider critical companion model, each to work with a group of between six and eight clinical leaders (F and G grades). The insider critical companions helped the clinical leaders to learn from their experience and acquire, create and critique professional craft knowledge relevant to person-centred care and practice development. The insider critical companions in each phase were supported over one year by the outsider critical companion through action learning, one-to-one sessions and working alongside them during the workshops for staff, in addition to two one-day workshops dedicated to exploring and practising critical companionship with constructive feedback. Hereafter, when talking about 'critical companions' we are referring to the insider critical companions.

Developing expertise in gerontological nursing

In common with most nurses (Benner 1984, Titchen 2000), the critical companions and clinical leaders had a vast wealth of professional craft knowledge and intuitive judgement gained through their clinical experience. However, as with many nurses, they often did not recognise their taken-for-granted skills and knowledge and considered them too 'ordinary' to mention or found them difficult to talk about. Therefore, in this programme, the critical companions were helped to explore, articulate and critically reflect on their own 'taken-for-granted' know-how and to share it with others, at the same time as learning how to help the participants to do the same with their staff.

Using reflective accounts, the critical companions and clinical leaders recorded their day-to-day routine practices and journeys of development, in addition to the impact the programme was having in developing person-centred care. Such practice experiences were shared during action learning sets, one-to-one interactions with critical companions or team discussions in the clinical area. We draw on some of these accounts to illustrate how critical companionship helped participants to journey towards expertise in person-centred gerontological nursing and in creating an infrastructure and culture to support it. The examples are drawn from some of a range of situations in which critical companionship was used, such as clinical supervision, action learning, workshops, opportunistic situations and working alongside staff in practice.

We have indicated the processes and strategies of critical companionship by using italics in the text below.

Beginning the journey as a critical companion

Boxes 1 and 2 show examples based on the reflective accounts of one of the insider critical companions who is working with a small group of clinical leaders. To ensure anonymity, details of these two examples have been changed. The critical companion has emphasised, in italics, the processes and strategies she used (for explanations of these processes and strategies, see Part 1). Using Benner's (1984) five stages of skill acquisition (novice, advanced beginner, competent, proficient, expert), we suggest these examples demonstrate Stage 2 – advanced beginner – in the facilitation and facilitative use of self domains and Stage 3 – competent – in the relationship and rationality-intuitive domains.

In Box 1 the critical companion focused on the

Box 1. Critical companion's reflective account of a session with clinical leader

The reflection the clinical leader brought was of a meeting with a recently discharged patient and her family at which we had both been present. This patient is admitted regularly for respite care. The clinical leader had led the meeting. I had been invited to give the clinical leader support as the meeting had been anticipated to be a difficult one. On reflection, after the supervision and on consulting the critical companion article (Titchen 2001), I realised I had used critical companionship strategies.

Our perceptions of the initial interactions were very different. A *critical dialogue* ensued based on what I had *observed and listened* to at the meeting. *Temporality* was important as we talked about how his perceptions and fears were linked to his past experiences with this patient and her family. *Graceful care* was important in terms of empathising, as he was anxious and angry about the situation that had developed during the patient's recent episode of respite care. *Saliency* (knowing what was important) helped me to focus on the outcomes for the patient rather than the process. The outcome of the meeting had, in my opinion, been a good compromise (using my own professional craft knowledge).

The clinical leader had been upset that the patient and family had wanted to involve someone more senior than himself. We used *self-reflection* to try to look at the situation in a more objective manner. I gave *feedback* on his role in the meeting, which was positive. I should have used more *questioning* as my interventions were based more on providing comfort than on 'digging a bit deeper'. I felt that the clinical leader was being defensive, but I did not explore this for fear of discouraging his engagement in debate with me again over difficult issues.

I should have used *higher challenge*, I think I backed off because his emotions would have blocked the support that would have followed.

I used *humour* and body language (smiling) to try to de-stress him, using *graceful care* and I aimed to bring some insight to the session. I may have achieved this to a certain extent, but feel lip service was paid to me. An answer would be for the practitioner to come up with the insight rather than leaving it to me.

I need to encourage insightful responses (through *self-reflection*) from the practitioner, rather than make suggestions myself.

facilitation domain in her reflection, perhaps because this was where she felt there was the most need for development. She stated that she used the strategies of *observing and listening*, to understand something of the clinical leader's experience and thus enter into a *critical dialogue*, and that she recognised that she could have used *questioning* more effectively. The helpfulness of *observing and listening* could have been maximised by asking focused questions such as 'What sense were you making of the situation?', 'What options were running through your head?', 'Why did you make the choice you did?', 'What was the consequence?' or 'Why did you say or do (a specific thing) at that point?'. This questioning strategy brings embedded know-how to consciousness, offering the opportunity for critical review and evaluation. Such questioning might have offered a challenge to the clinical leader. Nevertheless, the clinical leader in Box 1 has examined his personal feelings and professional issues, and the relationship between these feelings and issues in this particular work situation.

The critical companion is also aware that she could have used 'higher challenge'. Here she is referring to *high challenge/high support*, which means offering challenge in a supportive way. High challenge does not mean confronting the practitioner in a blaming or threatening way. Rather, it means making a judgment; in this case, that the clinical leader may have allowed his negative emotions to enter into his interaction with the patient and her family.

Judgments are not shared with the individual, but a critical companion is prompted into action by it. In the example in Box 1, appropriate action would be *feedback on performance* and skilled questioning to help the clinical leader to see the important features of the situation, so that he could make his own evaluation of the impact his feelings may have had on the relatives and the patient. This is a supportive way of challenging as it feels less daunting when we are offered the opportunity to identify our own weaknesses and then have our critical companion agree. It is only then that we are more likely to hear and use constructive feedback from the companion to improve our practice (Titchen 2000). Note that this critical companion in Box 1 is seeing support as separate from, and coming after, challenge, rather than being blended with it and coming before.

There are many other ways in which support can be blended, especially through *graceful care*, and nurses are often particularly good at this as demonstrated in the reflective account above (Box 1). What nurses find more difficult is getting the balance

right. With too much challenge, individuals can feel overwhelmed and attacked, whereas with overwhelming support they are likely to stay in their 'comfort zone'. Getting the balance right enables the practitioner to accept challenges to his or her own practice, while feeling supported in the process (Johns 1997).

In this example (Box 1), it is evident that the companion is aware of the *relationship* and *rationality-intuitive domains* in action. For example, there is *graceful care*, demonstrated through the companion's use of presence, humour and body language to convey empathy (presumably to lower the clinical leader's defences so that he can take a more critical look at himself). From the rationality-intuitive domain, the companion has identified *saliency* and *temporality*. The former is shown in the critical companion's knowing consciously, and possibly intuitively, what matters and is of concern to the clinical leader. This knowing helps the critical companion to enable him to focus on the outcome for the patient, rather than on his own loss of face in the eyes of the patient and relatives. *Temporality* is concerned with past, present and future, making focused time and appropriate timing and pacing. The critical companion made focused time by setting up a supervision session and being fully attentive to the clinical leader's reflections. The critical companion recognised that the clinical leader's past experience with the patient and relatives was influencing the clinical leader's current response to them. The critical companion knew that the time was not right for her to challenge the clinical leader.

What is missing from the reflection in Box 1 may indicate how much of what the companion did is so taken for granted by her that she has not thought it worth mentioning. For example, it would appear that she knows this clinical leader both as a person and professional (*particularity*) and that she is experiencing *reciprocity* because she is identifying her own learning needs from reflecting on this experience. It can also be assumed that they have negotiated some form of working partnership (*mutuality*) for their reflective sessions. To help this critical companion to develop her own critical companion we might want to probe about the way the relationship was set up with the clinical leader; did she negotiate a high challenge/high support way of working with him? Is there a culture yet in the relationship with the leader where both feel it is okay to admit weaknesses and experience constructive criticism as a learning opportunity?

This discussion shows how rationality-intuitive strategies need to be used to make the most of relationship and facilitation strategies. This is what is meant by the rationality-intuitive domain being requisite to the relationship and facilitation domains. Critical companions will not be fully effective if they merely know how, for example, to challenge in a supportive way. It is also necessary for them to know whether it is the most important issue to challenge and then when to make that challenge.

Through reflection on her own practice (Box 1), the critical companion rightly picked up that she needed to develop her capacity to help practitioners arrive at their own insights and find their own way and solutions to difficulties and problems through *self-reflection*, evaluation and *critique*. She appears to be aware that critical companions avoid telling practitioners what is happening and giving advice about what they should or should not do. This is not to say that critical companions never share their insights and knowledge; they do (*articulation of craft knowledge*) – it is all about the timing of the sharing. The critical companion also recognised that she needed to practise challenge in a way that is right for where the person is, in terms of his or her emotional state about the issue at hand. In addition, companions need to be sensitive to people's ability to cope with the feelings of vulnerability that they often feel when getting used to learning from constructive feedback.

Reflection on how the critical companionship framework is used is an essential part of developing expertise in its use. It helps critical companions to become more aware of the strategies they were using and to be more intentional next time. This leads us to *intentionality*, the conscious, self-aware and thoughtful use of the critical companion strategies. The example in Box 2 demonstrates how the critical companion is becoming more deliberate.

In this session (Box 2), the critical companion acknowledged that the clinical leader was angry and offered her the opportunity to share her thoughts. The critical companion is using *graceful care* by 'being there' for the clinical leader to talk through her feelings.

In relation to *mutuality*, the critical companion 'asked the clinical leader to do some preparation'. This begs the question whether this was negotiated in a collegiate way consistent with *mutuality*. Did she say something like: 'Would it be helpful to you if you did some preparation before we meet, so that you could make best use of the time?' or did she adopt a more hierarchical, authoritarian approach?

The critical companion challenged the leader's use of 'us' and 'them' language. By so doing, the critical companion could have been putting *consciousness-raising* and *problematisation* into action. This would be the case if she was trying to help the leader to see that talking about these colleagues, routinely and unconsciously, as if they and nursing were two opposing camps, rather than as an integrated team, is contributing to the problem. Importantly, the critical companion offers support to the leader to balance her level of challenge.

The critical companion could see that the leader

Box 2. Critical companion's reflective account of a meeting to discuss issues raised during telephone conversation with clinical leader

We (the critical companion and the clinical leader) met in a reflective session. I had asked the clinical leader to do some preparation (reflection). I planned to use critical companion strategies, rather than a normal supervision session.

I *challenged* her use of 'us' and 'them' language (in her reference to the nursing team and their colleagues), which she reflected back to me later in the session. I offered *support*, as she was obviously angry. I tried to concentrate on *saliency* – focusing on her relationships with colleagues rather than the individual issues she was stressed about. I suggested that she needed to address this as a priority and the rest should wait until after this had been tackled. She revisited this in part (by saying, but what about?).

I should have *challenged* this resistance as I think it may have led to a better understanding of the breakdown in the relationship with colleagues. She agreed to attend a joint meeting of nursing and allied professionals which would be managed by an outside professional. She did suggest that it might be her, but I reinforced that this would not place her as part of the nursing team. We ended with an action plan that the clinical leader had written during our meeting.

Follow up

Feedback given to me – a meeting has been organised. The clinical leader has spoken to the colleagues concerned and they discussed the meeting; the clinical leader has made it clear to them how distressing she and the nursing team are finding the current situation. She has also spoken to a key individual who was very confrontational. She says she found our reflection together helpful.

Challenge was received and the insights gained were used to design action that has good potential for change in team relationships.

was angry about particular behaviour and that she was not recognising that the behaviour was only a symptom of a more deep-seated problem with the relationship (*saliency*). So, she redirected the leader's reflection towards the more important issue. In doing this, she was drawing on her own expertise in practice (*craft knowledge*). But, it is unclear whether she tried to use her previous decision to help practitioners to come to their own insights, rather than pointing them out herself: 'I suggested that she needed to address this as a priority.' Also, did she help the leader to think through the consequences of facilitating the joint meeting herself, before sharing her craft knowledge that doing this would exclude her from contributing her views as a member of the team?

From the record, we do not know whether the critical companion encouraged a collaborative critical reflection on the experience. The companion and clinical leader (Box 2) could have *critiqued*, for example, the cultural, social, historical and political factors that were shaping this particular situation. A refined understanding of these factors could be used to begin the development of transformational culture (Manley 2002), in which improved working relationships between staff would flourish.

The examples in Boxes 1 and 2 reveal the overarching *facilitative use of self*, in which the relationship, rationality-intuitive and facilitation processes and strategies can be seen in different patterns and relationships to each other. They are shaped by who the critical companion is as a person; each critical companion will have different past experiences, knowledge and skills of nursing or health care. Therefore, the *facilitative use of self* domain will be unique to each companion and to each situation. Bringing this all together in a way that helps others to transform themselves and their practices requires *professional artistry*.

Part 1 showed the impact of critical companionship at the expert stage, but what is the impact of advanced beginner critical companionship on staff and patients?

Critical companionship becoming integral to leadership

As the critical companions developed through the programme, critical companionship became integral to their own leadership roles – even in opportunistic encounters in the corridors, which one critical companion described as 'five minute wonders'. The following extracts are taken from reflective accounts during later stages of the programme.

The critical companions worked alongside the participants in the clinical areas where they were able to give the participants feedback on their practice and engage in reflective conversations: 'I gave feedback to both (two team leaders)... I tried to ask (one of them) to analyse what it was that was so good about her practice and how this (her craft knowledge) is passed on... I wanted them to see what good role models they were to others.'

The critical companions came to see the value, to staff and the older person, of maintaining a clinical

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focus within a leadership role: 'Participation (as a critical companion) in the programme has helped me personally to maintain a clinical and practice development focus alongside my senior management role – beneficial in this time of reconfiguration and organisational change. It also helps me consider and recognise that service developments should be first and foremost patient/person-focused.'

They also experienced critical companionship as helpful in other aspects of the leadership role: 'I have tried to use critical companionship strategies in a wide range of situations. I now find that it is my preferred mode of communicating with staff members on a one-to-one basis. I have also used the strategies in teaching sessions for students. I feel that critical companionship has become, for me, a more focused way of helping staff reflect than the models of reflection that I am used to.'

Outcomes of critical companionship

Critical companionship changed the relationships and roles between practitioners and shaped the culture in which care was delivered. A person-centred culture was developing where staff felt valued and had a supportive framework in which to reflect and learn about their practice. In this changed culture, practitioners gained new insights into their practice and began to move away from routine and ritualistic practice to care that focuses on the uniqueness of the individual person. The following extracts illustrate the impact of critical companionship:

'A staff nurse overheard a member of staff talking about a person with dementia using language that did not promote dignity and respect. She reflected after the workshop that although she previously might not have felt able to challenge the member of staff, on this occasion she did so, and discussed with her the reasons for her challenge. The result was that she felt very good about her own performance, and the fact that she had been able to pass on her rationale and methods for a person-centred approach to another member of staff.'

A reflective account submitted at a workshop detailed how a person with dementia had exhibited behaviour that staff and other patients found disturbing. The team worked hard at looking beyond the behavioural manifestations and assessing the person's emotional needs. Care was planned accordingly and the behaviour that had been causing the consternation diminished markedly. The nurse summarised the team's interventions: 'This lady's behaviour was often labelled "challenging" and attributed to her dementia but was obviously an expression of unmet emotional need or ill-being. When we stopped trying to control the behaviour and began to understand the message behind the behaviour, we met the emotional need.'

The ongoing journey

We have presented evidence that suggests clinical nurses without educational backgrounds and/or extensive facilitation experience can quickly become 'advanced beginner' critical companions. They were able to understand the framework sufficiently, in a few months, to use it to articulate their practice and help others to begin to transform their practices and workplace cultures. As with other nurses, they appear to have most difficulty in developing *high challenge*, getting an appropriate balance with *high support* and engaging in *critique* in a *critical dialogue*.

We suggest that the development of a novice critical companion to expert level is likely to take several years. Benner's (1984) five-year time span for the development of novice to expertise in a new field seems about right here. Some three years on, collaboration with the critical companion who is depicted in Boxes 1 and 2 suggests she is now working at level 4 (proficient) and in a year or so is likely to be working at level 5 (expert). If the new critical companion is already a skilled facilitator, the framework may be useful in articulating and refining those skills. Acquiring expertise will take considerably less time for such an individual. Overall, the time and effort it takes to develop such a role cannot be underestimated. Critical companion and practitioner have to have a high level of personal commitment to the relationship; it is only through critical companions' extraordinary generosity that facilitative challenge and support can happen (Hardy *et al*, in press)

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