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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Reflections of specialist community public health nurse practice development: transformative learning through Mezirow's reflective discourse

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Abstract

Background: A specialist community public health nursing service introduced practice development from the year 2000 to promote local innovative service and practice.

Aims and objectives: This article discusses experiences of practice development through Mezirow's reflective discourse.

Conclusions: Practice development promotes practitioner-led innovation and participating leads to transformative learning, challenging assumptions, group cohesion and consensus.

Implications for practice: Practice development within specialist community public health nursing practice reinforces a consensual process benefitting all participants and their employing organisations. Nursing socialisation and group membership are key themes emerging to drive successful practice-based innovation. Group membership affects the individual and vice versa through consensual communication to transform learning and practice.

Keywords: Health visiting, practice development, transformative reflection, accreditation

Introduction

Practice development is one of many action-orientated approaches promoting the United Kingdom's NHS quality improvement agenda (McCormack et al., 2007). Challenging the dominance of external reforms within the NHS and their impact on local practice, practice development principles aim to transform the context and culture of work through a systematic approach to innovation (McCormack et al., 2007). In the context of specialist community public health nursing (health visiting), practice development challenges organisational reforms and promotes closer application of evidence into practice through a practitioner-led innovation (Department of Health, 2001; 2011). It is at this level that real change occurs in perspective and practice (Department of Health, 2011). Support has been given to practice development from the United Kingdom's Department of Health through the publication of the health visitor practice development resource (Department of Health, 2001). This reinforced the benefits of practice development closely aligned to health visiting principles: searching for health needs; stimulating an awareness of health needs; influencing policies affecting health; and facilitating an awareness of health needs (Department of Health, 2011).

Background

Health visitors are specialist community public health nurses focused on identifying family, child and community health needs (Department of Health, 2011). Health visitors' primary concern is early detection, identification, intervention (or referral to other appropriate agencies) and promoting the best outcome for children and their families' health (Department of Health, 2011). They are gatekeepers to primary care and deliver the Healthy Child Programme: pregnancy and the first five years of life (Department of Health, 2009), which involves assessment of child development and early detection of child and family issues (Department of Health, 2009). Examples of this are identifying a child in need or at risk from significant harm (Department for Education and Skills, 2004), or a child with a developmental delay or disorder. Another example that illustrates the wide range of the role could be when a mother suffers with perinatal depression requiring assessment, support and a package of care. If this remains undetected then the mother's needs and those of her child or family will be adversely affected (Department of Health, 2011).

Purpose of the article

This article focuses primarily on reflective experiences and membership of a mature practice development unit from 2000 to 2010. Reflecting on practice development is one important method of communicating aspects of the process, including direct issues such as practice development process, and indirectly related issues such as national politics, reforms, policies and local service re-configuration. The reflective component is informed by the work of Mezirow (2000) and reference to autobiographical diary entries. The key themes discussed are both inter-related and complementary: first, transformative learning and consensual communication in the practice development groups; second, professional socialisation impacting on what, why and how learning occurs, applied to the clinical context (Barretti, 2004). The isolation experienced professionally before practice development was introduced contrasts sharply with afterwards. I wrote in my diary in 1999:

'Having worked in the NHS since 1982 we heard about change first on the television or radio ... change was done to rather than with staff ... we are not involved in the process and in reality it means the expert practitioner does not have a say in improving services. Organisational cultures that leave change in the hands of those in hierarchical positions appear not to trust staff to make the right changes, for the right reasons ... leaving it to those far removed from patient contact is flawed and one that should be viewed with scepticism.'

The entry identifies a sense of disappointment and a growing awareness of a need to participate in practitioner-led innovation and overcome institutional obstructions (McCormack et al., 2009). The reference to those 'far removed from patient contact' indicates a frustration with paternal attitudes and the overlooking of those closest to patients as a resource for innovation. It also identifies a perception of 'being done to', by those 'talking up' the merits of practitioner-led innovation (Foxcroft and Cole, 2003). This is not surprising because adults need to experience a sense of actualisation, of freedom – finding one's voice and being trusted to make decisions for autonomous practice (Mezirow, 2000). To ignore this basic motivational need further devalues professionals' potential for transformative practice and innovation (Mezirow, 2000).

Practice development accreditation

In 2000, community managers of a health visiting service initiated plans to become an accredited practice development unit. The first stage established links to a higher education institute (HEI) in engaging accreditation procedures (see Figure 1), such as creating a practice development steering group to plan and evaluate the innovation process, and training two facilitators to act as coaches with direct links to and supervision from the HEI. A two-stage HEI accreditation scheme involved first a recognition stage – a diagnostic visit by the HEI team, a three-day kick start programme with the

facilitators and managers and a development planning workshop to discuss issues of evaluation, creativity and innovation. This was followed by the practice development unit submitting an evidence-based document identifying significant improvements made against specific innovation criteria appraised by a visiting HEI team (see Figure 1). Monthly meetings for all of the team reported progress, discussion and consensus of opinion. The second stage was a biannual reaccreditation evaluation of the practice development unit's achievements so far through a progress report, conference presentations and quantifying the effects of innovation. The practice development steering group decided to develop concurrent practice-based projects and proactively engage all of the team to work more cohesively and productively together (Kanter, 1977). In short, involving patient and staff innovation in practice had to be systematically planned, be sustainable and build on resource capacity of the whole team (Figure 1; Department of Health, 2001).

Figure 1: Adapted Higher Education Institute (HEI) accreditation criteria (North West of England HEI)

- Clear, defined client group focus
- Leadership facilitating sustainable development, evaluation and dissemination of work
- Explicit framework to organise and develop best practice, devolved decision making, and staff and patient empowerment
- Proactive membership, self-development, clearly related to patient care, need and development of the team as a whole
- Development plan identifies resource requirements
- Reciprocal relationship with an HEI to support practice development and theory
- Rigorous, evidence-based approach to practice
- Evidence of creativity and innovation, promote best practice
- Developments are evaluated and reviewed in terms of impact
- Practice development unit acts as an agent of innovation
- Steering group co-ordinates the strategic direction of the unit

Reflective discourse

Going beyond a descriptive report of the process identifies the benefit of transformative learning and reframing experience (Mezirow, 2000). One interpretation of the verb discourse is to 'find one's voice' (Mezirow, 2000 p 11) and this parallels the practice development process through reflection. Reflective discourse has a peculiar effect on adult learning because of our innate capacity to defend ourselves (reflectively) against ourselves (Nietzsche, 1989 pp 179-180). This self-examination difficulty requires a critical assessment of taken-for-granted assumptions (bias, beliefs, preconceptions), identifying any supporting evidence and influential communication with others (Mezirow, 2000). A number of cognitive processes shape thinking and action. Kitchener (1983) suggests three levels of cognitive processes relevant to reflection. The first level is memorising, reading and comprehending. The second stage monitors the process and products (meta-cognition). Third is reflecting on the limits of experience (epistemic cognition). The latter refers to transformative learning evolving from previously owned perceptions and reflective discourse opening up the individual to new possibilities (Mezirow, 2000; Gadamer, 2004).

Mezirow and transformative learning

The term transformation refers to 'making a marked change in the form, nature, or appearance...' (Oxford Dictionary, 2011) of phenomena as objects of awareness (Gadamer, 2004). Transformative learning is a way of problem solving by defining, redefining or reframing the assumptions made by others (objective reframing) and one's own critical self-reflection (subjective reframing) (Mezirow,

2000). Assumptions are established frames of reference and 'meaning perspectives ... structures of assumptions and expectations through which we filter sense impressions ...' acting as natural cognitive short cuts (Mezirow, 2000 p 16). They exist to filter the mass of stimuli experienced in everyday life and need to be shallow enough for new experience to overcome the conscious or unconscious short cuts (Mezirow, 2000).

Transformative learning means moving 'beyond' narrow interpretations of experience (Mezirow, 2000), subjective reframing through discourse with others, theory and the understanding of once taken-for-granted views (objective reframing). A search for common understanding and interpretation of a person's habit of mind identifies the effects of beliefs, assumptions and the meaning of generalisations to reflective experience, depending on the social context we share with others (communicative learning, Mezirow, 2000).

Learning therefore occurs with others through the concept of understanding and '... grasping what people say or write ... convey by other means such as gestures or facial expressions ...' (Rickman, 1979, p 74). Making the unfamiliar familiar and identifying what patterns and codes are in use are important steps to learning how to conform and adapt behaviour (Mezirow, 2000).

Nursing socialisation

Learning in groups significantly enables transformative learning (Mezirow, 2000). Groups impact on the human consciousness through social learning and being motivated to understand the assumptions we make about the value of life when in close contact with the lives of other people (Mezirow, 2000). My diary entry read:

'I don't want to let my practice development team down. Being less involved could be construed as losing interest in the groups goals which were consensually agreed ... in relation to the accreditation process I think it would be useful to ask ourselves more searching questions as to how and why we achieved what we have done and for so long?'

'... the key factor in this and any previous re-accreditation was motivating myself and each other to keep involved in the practice development projects, in other words to do it all again every two years, despite the increased stress on staff.'

Practice development enables practitioner-led innovation at a grassroots level (McCormack et al., 2009) and appears to be driven by socialisation processes (Barretti, 2004). Mezirow suggests the participatory involvement of others is difficult to develop due to the essential adversarial aspect of competition between human beings. However, professional socialisation overcomes this to a certain extent by referring to the learning of social roles and conforming according to the social context (Barretti, 2004). This relates to my experiences as a practice development group member and not wanting to let the team down (McNally et al., 2012). Socialisation history, from a professional perspective, was originally developed through medical students, and later adapted to incorporate social work and nursing (Barretti, 2004). Nursing socialisation involves action in praxis, in other words thinking and acting within a practical setting relating to what patients and services require (Barretti, 2004). It involves identifying with the goals and purpose of the profession (working for the common good through nursing and health visiting) and viewing practice development as a process ensuring those goals are achieved (Department of Health, 2001; 2011).

The socio-cultural effects of groups are influential factors in the modelling of professional nursing behaviours (Nursing and Midwifery Council, 2008; McNally et al., 2012) and learning is invariably shared and shaped by membership of the group for its own benefit (Foulkes, 1984). Modelling and attitudes are observed and recreated due to the process of adaptation and identifying how to be

successful in practice (Allan et al., 2011). When watching and listening to others (their behaviours, professional demeanour, vocal intonation and content of speech) learning occurs through critical reflection, empathy and a shared practice development philosophy (McNally et al., 2012). Members learn to identify what others expect from them and deliver on those expectations due to the social contract (McNally et al., 2012). The 'can do' attitude of the group is demonstrated by those held in esteem within the group, reinforced and imitated by others in the group, with new members adapting their perspectives to conform to the shared goals (Hopper, 2009). Therefore observing others in the practice development group reinforces the positive benefits of co-operation and collegiality (McNally et al., 2012) and the perceived benefits and rewards of group membership and conforming to group norms bring with it a welcome sense of belonging (Foulkes, 1984).

Conclusion

The social nature of practice development involves group participation leading to practitioner-led innovation. It requires organisational permission for practice development to be successful and sustainable. This article discusses the issues of nursing socialisation, which has the potential to adapt professional behaviours to conform to the norms of the group. Group experiences identify a strong sense of shared human learning through watching, modelling, discussing, conforming and being accepted (Foulkes, 1984). The active engagement within the practice development group leads to consensual discussion and new perspectives (Foulkes, 1984). As a condition for being a conforming member of the group, this consensual communication consciously and unconsciously leads inevitably to transformative learning (Mezirow, 2000). The difficult part is then to take notice of assumptions made and reflect on what has been learnt.

References

- Allan, H.T., Smith, P. and O'Driscoll, M. (2011) Experiences of supernumerary status and the hidden curriculum in nursing: a new twist in the theory practice gap? *Journal of Clinical Nursing*. Vol. 20. No. 5-6. pp 847-855.
- Barretti, M. (2004) What do we know about the professional socialisation of our students? *Journal of Social Work Education*. Vol. 40. No. 2. pp 255-283.
- Department for Education and Skills (2004) *Children Act*. London: HMSO. Retrieved from: www.legislation.gov.uk/ukpga/2004/31/contents. (Last accessed 24 September 2012).
- Department of Health (2001) *Health Visitor Practice Development Resource*. London: Crown Copyright. Retrieved from: www.dh.gov.uk/en/DH_4083498. (Last accessed 24 September 2012).
- Department of Health Healthy (2009) *Healthy Child Programme: Pregnancy and the First Five Years of Life*. London: Crown Copyright. Retrieved from: www.dh.gov.uk/en/DH_107563. (Last accessed 24 September 2012).
- Department of Health (2011) *Health Visitor Implementation Plan 2011-15: A Call to Action*. London: Crown Copyright. Retrieved from: www.dh.gov.uk/en/DH_124202. (Last accessed 24 September 2012).
- Foulkes, S.H. (1984) *Therapeutic Group Analysis*. London: Karnac Books.
- Foxcroft, D. and Cole, N. (2003) Organisational infrastructures to promote evidence based nursing practice. *Cochrane Database of Systematic Reviews*. Vol. 4. CD002212.
- Gadamer, H.G. (2004) *Truth and Method, 2nd edition*. Translation revised by Weinsheimer, J. and Marshall, D.G. London: Continuum.
- Heidegger, M. (2003) *Being and Time, 21st edition*. Translated by Maquarrie, J. and Robinson, E. Oxford: Blackwell Science.
- Hopper, K. and Hopper, W. (2009) *The Puritan Gift; Reclaiming the American Dream Amidst Global Financial Chaos*. New York: I.B. Tauris.
- Kanter, R.M. (1977) *Men and Women of the Corporation*. New York: Basic Books.
- Kitchener, K. (1983) Cognition, metacognition and epistemic cognition: a three-level model of cognitive processing. *Human Development*. Vol. 26. No. 4. pp 222-232.

- Nietzsche, F. (1989) *Human – All-Too-Human: A Book for Free Spirits*. Translated by Hollingdale, R.J. Cambridge: Cambridge University Press
- Mezirow, J. (2000) Learning to think like an adult. In Mezirow, J. et al. *Learning as Transformation: Critical Perspectives on a Theory in Progress*. San Francisco: Jossey-Bass. pp 3-33.
- McCormack, B., Wright, J., Dewar, B., Garvey, G. and Ballantyne, K. (2007) A realist synthesis of evidence relating to practice development: findings from the literature analysis. *Practice Development in Health Care*. Vol. 6. No. 1. pp 25-55.
- McCormack, B., Henderson, E., Wilson, V. and Wright, J. (2009) Making practice visible: the workplace culture critical analysis tool (WCCAT). *Practice Development in Health Care*. Vol. 8. No. 1. pp 28–43.
- McNally, L., Brown, S.P. and Jackson, A.L. (2012) Cooperation and the evolution of intelligence. *Proceedings of the Royal Society*. Vol. 279. No. 1740. pp 3027–3034.
- Nursing and Midwifery Council (2008) *The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives*. London: NMC.
- Oxford Dictionary (2011).Oxford: Oxford University Press.
- Rickman, H.P. (1979) *Wilhelm Dilthey: Pioneer of the Human Studies*. London: Paul Elek.

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