Redesigning models of patient care delivery and organisation: building collegial generosity in response to workplace challenges

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Abstract

This case study describes the New South Wales Nursing and Midwifery Office (NaMO) Models of Care Project, a project designed to identify, encourage and disseminate innovations in nursing care organisation and delivery. The project is a 4-year action research project, using a range of interactive engagements including workshops, seminars, questionnaires and websites to achieve the goals. This case study briefly describes the main stimuli for review and redesign of models of care identified through analysis of the clinicians' presentations, and explores the range of responses to the workplace challenges.

What is known about the topic?
A range of factors has been found to be associated with the ability of nurse managers to makes changes in models of care delivery.

What does this paper add?
This paper outlines three different types of ethos identified through the New South Wales Nursing and Midwifery Office Models of Care Project. These types of ethos included collective non-responsibility, individual accountability and collegial generosity. Collective non-responsibility and individual accountability did not support change.

What are the implications for practitioners?
Health care managers should aim for collegial generosity through emancipatory processes such as practice development, engaging with individual patients as a means of maintaining a realistic and relevant focus on patient care and providing quality data that give clear information about patient and staff outcomes and current practices.

THE NEW SOUTH WALES (NSW) Models of Care Project (MoCP) is a 4-year iterative process with goals to identify, encourage and disseminate innovations in nursing care organisation and delivery. The project was designed to respond to the following issues:

- Much-needed increases in nursing undergraduates, trainee enrolled nurses, enrolled nurses and new graduates will mean significantly greater numbers of staff in the workplace, who in their early days will require education and support.
- Introduction of nurse practitioner and other specialist advanced-practice roles will mean

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greater numbers of highly specialised staff across the workforce.

- Changes to care delivery patterns, such as clinical streaming, outreach and inreach programs will mean geographical and structural shifts to the nature and location of teams.
- The growing focus on multidisciplinary workforce development may mean changes to the allocation and ownership of work and will certainly require a more interdisciplinary approach to problem solving.

Anecdotal evidence suggested that significant innovation was occurring in NSW and that an ongoing need existed both to collect and disseminate information about innovative models of care. The first step in this process was a statewide Models of Care Roadshow in 2005, funded and organised through the NSW Nursing and Midwifery Office (NaMO) and conducted from Feb-

ruary to April 2005. Twenty-two venues were visited, from Bega in the south of the state to Ballina and Moree in the north and across to Broken Hill in the west. In addition to the presentations on workforce modelling and the literature pertaining to models of care and nurses' roles, 39 different groups of nurses, already involved in innovation related to care organisation and delivery processes, presented their work. Criteria for presentation included: rigorous measurement and analysis of the issue for change, a carefully planned implementation strategy, and re-measurement after implementation.

Early in 2006, a report was published providing analyses of the completed questionnaires and themes from the presentations.[1] The report, presentations from the Roadshow, the literature review and a range of analytical tools were included in a Virtual Toolkit (see http://www.health.nsw.gov.au/nursing/moc.html). In addition, the Minister for Health announced $100 000 worth of innovations scholarships to assist nurses in this work.

The significance of the MoCP methodological approach is that the project coordinator did not set out with a predetermined agenda for change or a preconceived notion of what a model of care should look like, only a recognition that change in care delivery organisation and practices was necessary for nurses to feel that they were achieving realisable clinical goals. Jones and Cheek, in a review of care practices across Australia, made the observation that no longer was there such a thing as a typical patient day.[2] Reviews of the nursing workforce literature revealed that nurses leave the profession for two major reasons; because they feel undervalued and are unable to deliver the care they feel they should.[3] Achievement correlated strongly with nurses finding joy at work,[4] thus it is critical for the retention of clinical nurses that their daily goals are realistic.[5]

The intent of the MoCP was not only to learn about current innovations, but also to seek information and advice about how best to make things happen from those who were implementing new and innovative models of patient care organisa-

tion and delivery. Earlier research demonstrated that nurses would continue to do what they believed to be in the patient's best interests, regardless of instructions to the contrary.[6] It was therefore important to learn about the innovations, to identify what motivated nurses to change, and to learn how to facilitate environments in which considered and planned experimentation and change was not only possible, but the norm. This was achieved through detailed analyses of the presentations and the workshop discussions with the presenters.

Information about the innovations and outcomes from the first Roadshow is available in the Report,[1] and presentations from both the Roadshow and the second year seminars and workshops are available on the NaMO website (www.health.nsw.gov.au/nursing). The intent of this case study is to analyse the professional ethos revealed through the Roadshow and feedback from the questionnaires.

Methods

Evaluation forms were distributed at the workshops seeking feedback on the value of the workshops in meeting the aims, input from nurses on the three most important issues or ideas (positive or negative) arising from the workshop and, in keeping with an action research methodology, future ideas and issues nurses would like to form the second part of the project. This feedback provided the framework for activities in Year Two (2006). Participants were actively encouraged to identify the key issues from the workshop discussions in their evaluation forms, with three open-ended opportunities to comment:

- Please list the three major issues or ideas the workshop raised for you (these can be positive or negative).
- Please comment on any future directions or future issues you would like to see explored further.
- Other comments

In addition, key issues raised during discussions were recorded by one of the presenters and

checked against the evaluations afterwards to ensure they were not missed.

Overall 1140 nurses attended the 2005 Roadshow workshops; 56% from metropolitan sites and 44% from rural and remote sites.[1] The majority of those who attended were in senior clinical nursing roles, for example Nurse Unit Managers (NUMs), Clinical Nurse Consultants (CNCs), Clinical Nurse Specialists (CNSs) and Clinical Nurse Educators (CNEs).[1]

Evaluation forms were completed by 677 participants (response rate, 76%). Responses were entered into a Microsoft Access database (Microsoft Corporation, Redmond, Wash, USA). Thematic analysis of qualitative responses was undertaken and the results were coded before being entered into the database. SPSS, version 14.0 (SPSS Inc, Chicago, Ill, USA) was used to summarise the data. Categories were used to summarise the qualitative responses, and were then further condensed into themes. The themes were then independently checked for consistency. Themes from this feedback are set out in a concept map within the Roadshow Report,[1] and it was the text that informed these themes that led to the identification of the types of professional ethos and zones of practice discussed in this case study.

The types of professional ethos arose partly in response to the literature reported and reviewed and partly in response to discussions about the new models of care presented. What became clear from the discussions and feedback was that each type of ethos was likely to set up a particular practice zone or ward/ unit culture and that both the ethos and corresponding practice zone impacted on the degree of receptivity and willingness to change.

Results

Stimuli for change

Nurses reported the stimuli for change through a range of experiences. Several of the presenters explained that their units had introduced mentorship or clinical supervision programs, which encouraged the nurses to reflect on aspects of practice that had been particularly successful or aspects of practice that required improvement. Such strategies fostered professional and clinical development for less experienced staff and addressed work-related issues in a structured and timely manner. Clinical supervision has been defined as
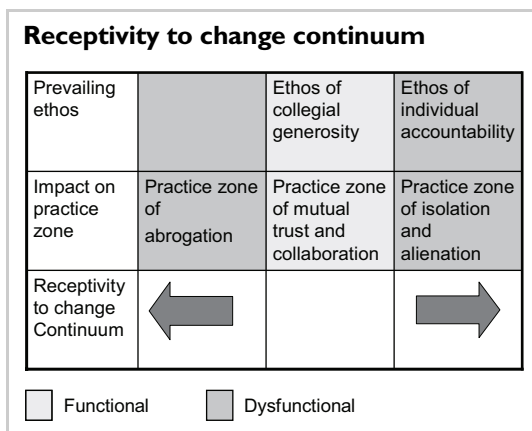
> . . . a support mechanism for practising professionals within which they can share clinical, organisational, developmental and emotional experiences with another professional in a secure, confidential environment in order to enhance knowledge and skills. This process will lead to an increased awareness of other concepts including accountability and reflective practice.[7] (p. 728)

Clinical supervision has been demonstrated to be "an effective format for exploring issues concerning professional practice, allowing nurses to learn from each other, offer support, recognise how others see them as fellow workers, and moderate concerns and anxiety related to their work".[8] Managing stressful situations through reflection and support reduces turnover and improves retention and wellbeing among nursing staff.[9]

Reflective practice, the process of taking structured "time out" to review and consider issues of importance in relation to care delivery practices, was identified as critical to professional development and practice improvement. Reflective practice can either occur through a structured mentoring process, through individual clinical supervision or through group activities. Reflective practice is defined as:

> The throwing back of thoughts and memories, in cognitive acts such as thinking, contemplation, meditation and any other form of attentive consideration, in order to make sense of them, and to make contextually appropriate changes if they are required.[10] (p. 3)

Many others reported that the stimuli for change came through analysis of data gathered either for safety and quality or human resource management purposes. Incident reports, including "near misses" and root cause analyses were reported as the trigger for further analysis of a practice issue or to collect more data to ascertain

Receptivity to change continuum

Prevailing ethos		Ethos of collegial generosity	Ethos of individual accountability
Impact on practice zone	Practice zone of abrogation	Practice zone of mutual trust and collaboration	Practice zone of isolation and alienation
Receptivity to change Continuum	←		→

☐ Functional ☐ Dysfunctional

the extent of a problem.* Similarly, human resource management issues such as sick leave and vacancies were often the prompt for a review of staff satisfaction, work practices and/or ward culture.[1]

Receptivity to change: types of ethos and corresponding practice zones

The identified ethos manifested across a continuum from a sense of collective non-responsibility at one end to a sense of overburdening individual accountability at the other. Both ends of the spectrum were relatively dysfunctional in receptivity to innovation and change, although these were the exceptions in most of the feedback and discussions. The ethos most receptive to change and innovation was one of collegial generosity, a term coined by the researcher after analysis of the presentations, discussion and feedback. These concepts are represented as a receptivity to change continuum in the Box.

The types of ethos emerged when these stimuli were described and/or discussed within the Roadshow groups, as did the impact these types of ethos had on the practice zones in which the nurses and other health care professionals worked. Overwhelmingly the dominant and highly functional ethos described by presenters

was one of collegial generosity, where mutual trust and collaboration was the norm.

However, some presenters reported encountering dysfunctional types of ethos in the early days of their work,[†] and some members of the audience also expressed comments that were indicative of a degree of dysfunctionality. Strategically it was hoped that an outcome of the Roadshow would be to inculcate a readiness for change through processes similar to those used by "policy entrepreneurs,"[11] whose role is described as being to "soften[s] up the system by presenting to the different . . . participants in the network alternative representations of their realities".[12]

Ethos of collective non-responsibility

At one end of the continuum, when presenters described problems they had encountered and dealt with in the workplace, the ethos of collective non-responsibility was manifested by comments such as "Well, management should do something about that", or "We told the union about this problem at our place ages ago and nobody has done anything". This expectation that someone else would solve the identified problem leads to a practice zone of abrogation, where the problem is neither tackled nor solved, because no-one in the immediate vicinity of the problem owns it.

Presenters described strategies they had used to overcome this ethos, including the use of practice development[‡] (PD) as a means of developing a shared value base.[13] PD has been defined as:

> A continuous piece of improvement designed to increase effectiveness in patient-centred care. It is brought about by enabling health care teams to develop their knowledge and skills and in doing so, transform the culture and context of care. It is enabled and supported by facilitators who are com-

mitted to systematic, rigorous and continuous processes of change that will free practitioners to act in new ways that better reflect the perspectives of both service users and service providers.[14] (p. 88)

Several presenters had attended PD schools to train as PD facilitators and had then worked comprehensively with their own staff to identify the core values of the unit, develop understanding of staff roles and responsibilities and identify goals and strategies for changing care delivery and organisation.§

Ethos of individual accountability

At the opposite end of the spectrum, and equally dysfunctional, was an ethos of overwhelming individual accountability, where the clinician clearly felt as though they personally carried total responsibility for everything that might go wrong on the unit/ward, where there was no sense of shared responsibility and certainly no trust. An example from the Roadshow was the ongoing discussion around the increasing (and much needed) numbers of undergraduates, trainee enrolled nurses and new graduates currently coming into the system and how they might be mentored and supported in the workplace. Some of the presentations made specific reference to the initial concerns nursing staff felt about changes to skill mix.¶

A comment made by several discussion participants that demonstrates the ethos of individual accountability was "I already have *x* patients to look after: I couldn't possibly look after two students/less qualified staff members as well". Such comments discount any possibility that the students/less qualified staff members may assist the nurse in the care of the patients. The nurses indicated that introduction of less skilled staff was another impost on the nurse's time and workload. Such an ethos is not confined to nurses. Medical organisations, despite complaints about insufficient numbers of medical staff and increasing workload demands, have expressed concerns about the introduction of nurse practitioners. Medical practitioners (erroneously) claimed that they would be tortuously liable for mistakes of the nurse practitioner.**

This ethos is symptomatic of a practice zone where staff feel isolated and alienated. A number of presenters successfully explored team nursing as a solution to this ethos,[15] where experienced nurses worked together with less experienced nurses to look after a group of patients.[16] Presenters described a range of models based on teaming up experienced permanent nursing staff (both registered and enrolled nurses) with less experienced or casual staff.

> Team Nursing is based on a philosophy that supports the achievement of goals through group action. Each member is encouraged to make suggestions and share ideas. When team members see their suggestions implemented, their job satisfaction increases, and they are motivated to give better care.[17] (p. 328)

Ethos of collegial generosity

Predominantly the exemplars of innovation, problem solving and change demonstrated an ethos of collegial generosity, where staff were focussed on optimal patient care as the desired outcome. In addition, turf wars over ownership of

§ For examples of this work, see the PowerPoint presentations of: Dempsey J. Fighting falls with action research: a practice development project. 2005; Jones A, Rivas K, Fairbrother G. The Prince of Wales Hospital Models of Care Project: moving toward team based acute care nursing models — a hospital wide Action Research Project 2005; and Rivas K, Murray S, Davis J, Butler S. 12 hour shift trial Respiratory and Infectious Diseases Unit POWH. 2005, at http://www.health.nsw.gov.au/nursing/moc.html

¶ For examples of PowerPoint presentations that identify some of these as initial concerns (later overcome) see Wilson R. Introduction of undergraduate AINs into the emergency department. 2005; and O'Connor C, Bolsom S. Catch them and keep them: the introduction of undergraduate AINs into Intensive Care. 2005; and Livingstone G. Reasonable workloads: Ward 1C Port Macquarie Base Hospital. 2005, at http://www.health.nsw.gov.au/nursing/moc.html

** Although there is far greater medical support and understanding of the role of nurse practitioners in Australia today, these concerns and views are still documented in: Victorian Government Department of Human Services. Victorian Nurse Practitioner Project: Final Report of the Taskforce. Melbourne: DHS Policy Development and Planning Division, 1999: 90-4. Available at: http://www.dhs.vic.gov.au/pdpd/pdfs/nurseprac.pdf (accessed Feb 2007).

tasks or roles were overridden by a desire to give the best possible care to patients. In order for such an ethos to dominate, the practice zone needed to be one where staff trusted each other and worked together collaboratively to improve both patient and staff outcomes. An amalgam of factors was shown to facilitate such an ethos, both in the MoCP and the literature. Firstly, the personality and leadership style of the NUM was significant in determining how work was both coordinated and allocated.[15,18] Secondly, emancipatory processes such as practice development[14] were shown to be extremely successful in engaging nurses and giving them a sense of ownership and trust in decisions to change practice. Thirdly, engaging with individual patients as a means of maintaining a realistic and relevant focus on patient care was highly influential in developing consensus and moving opinion. The NaMO Clinical Leadership Program[19] encouraged nurses to elicit patients' stories about their experiences, and these stories proved to be a strong motivator to improve patient care. Fourthly, access to quality data that gave the nurses clear information about aspects of patient and staff outcomes and current practices was highly influential in creating an openness to change.

The combination of factors influencing change resonates with much of the relevant theoretical literature relating to change management,[20-23] particularly the earlier work of Kitson, Harvey and McCormack, who argue that:

> ... successful implementation of research into practice is a function of the interplay of three core elements — the level and nature of the evidence, the context or environment into which the research is to be placed, and the method or way in which the process is facilitated.[24] (p. 149)

They also recommended that, "because current research is inconclusive as to which of these elements is most important in successful implementation they all should have equal standing".[24] (p. 149) There is no doubt that the ethos of collegial generosity was dependent on a mix of factors, rather than any one single factor. Data,

however compelling, would not necessarily have inculcated receptivity for change unless the nurses felt that they owned both the data and the processes of change and had agreed the values and goals within the unit. Yet, once those criteria were in place, patient-focused care innovations flourished, even in units where staff turnover had previously been high — in other words, in units where nurses had previously chosen to leave, rather than to address the sources of their dissatisfaction.[††] Recently, participatory engagement in change processes has also been found to be successful in engaging patients in changing models of care delivery.[25]

Conclusion

The aim of this case study has been to highlight the types of ethos that manifest in response to stimuli for change and the impact on practice zones and consequent receptivity to change. The optimal conditions for change in response to a range of stimuli occur when there is a preparedness to take ownership of the issue, rather than an abrogation of responsibility for the problem by, (at best) reporting it to some other party and imagining that is the end of the matter, or at worst ignoring it. Ownership of problems requires a level of confidence and mutual trust that others will share the problems and help to resolve them. However, it is also critical that the extent of the ownership does not become so excessively burdensome that the individual feels alienated and/or isolated, but is in fact prepared to assist others without fear that all responsibility and blame might fall on them. Such an optimal ethos is described in this paper as the ethos of collegial

†† For examples of units where staff turnover decreased significantly as a result of the change processes used and the subsequent types of ethos engendered, see: Bothe J, Donoghue J, Hawley K. Patient-centred, safe and effective model of care: Day Surgery Unit, St George Hospital. 2005; Hallam J. Goulburn Community Health community nursing clinic. 2005; Kemsley J. When the going gets tough… 2005; and Walker K. Project Possibility: from patient allocation to partnerships in care: introducing AINs and ENs to an all-RN workforce. 2005, at http://www.health.nsw.gov.au/nursing/moc.html.

generosity. A number of strategies have been identified through analysis of the first yield of data from the MoCP Roadshow that not only promote this ethos of collegial generosity, but go some way to ameliorating the ethos of collective non-responsibility and the ethos of overburdening individual accountability.

Acknowledgement

Competing interests

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