Developing the Reflective Healthcare Team

Professor Tony Ghaye

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The International Institute of Reflective Practice, UK
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Foreword

I first met Tony Ghaye in January 2004 and was impressed by his approach to developing reflective teams and reflective organisations. Being a strong advocate of reflection-in and on-practice my imagination was fired by the many approaches, developed by the international Institute of Reflective Practice-UK, to improve services rather than just focusing on individual development.

In the NHS we talk about changing cultures so that staff can better meet the health and social care needs of the population we serve. We know, however, that this takes a long time and is often ineffective if staff do not understand, or are not involved in the very changes that will develop more team-based cultures that support high quality, personalised care. This book gives us the inspiration and methods to do just this. We know that the future success of the NHS is reliant upon effective multi-disciplinary teams that can cope with ambiguity and uncertainty. By recognising the value of investing in teams to improve services, organisations can be transformed and staff will begin to think and act differently. The book offers much practical advice on how to develop more team-based working. It is therefore a 'must read' and excellent value for money.

The IRP-UK approach uses tried and tested methods to encourage better teamwork and team learning that promotes sustainable change. Does it sound too good to be true? I have personal experience of working in partnership with IRP-UK, for example on a 3 year sector-wide maternity project and also in one day workshops. The use of the approach set out in this book led to genuine innovation and real, sustainable improvement that would normally have taken longer to achieve, or perhaps been abandoned through lack of capability or capacity.

I am delighted to support the publication of this very informative text because it has much to offer health and social care professionals, managers, leaders and academics at all levels. The book captures the essence of effective teamwork. It is grounded in practice and enriched through an exploration of psychological and sociological theories that explain the complexity of team dynamics. It also clarifies different perspectives on the theory and practice of reflection, which is fundamental to understanding the value of the IRP-UK approach. It draws on a wide range of literature from a number of fields of working life. It therefore has an up-to-date and expansive feel to it. The book breaks genuinely new ground and

certainly makes you think! I particularly like the chapter that introduces the reader to a new type of leader, the 'quiet leader', a concept that will appeal to those who are implementing NHS initiatives that rely on effective teamwork to make patient-led and personalised care a reality.

In part, the book acts as a toolkit to help develop reflective teams, with helpful scenarios to discuss, exercises to perform. It helps us understand how more powerful and relevant forms of reflection can be used in practice. I thought at first that the text would replace the need to contract with the Institute, but I can't emphasise enough the value of having skilled and motivated facilitators working with you and doing behind the scenes 'donkey work'. Tony Ghaye (and IRP-UK) certainly walk-the-talk.

I hope you enjoy the book. You will certainly learn from it.

Jane Marr
Formerly Director of Nursing, North West London Strategic Health Authority
August 2005

Acknowledgements

This book has been 8 years in the making. During this time I have been deeply grateful to many people with whom I have worked. Thank you for sharing, so generously with me, your thoughts, successes and struggles in developing more reflective team-based workplace cultures. It is from your openness, your courage and commitment to improving care, through better team learning, that I have learned the most.

For providing the early encouragement and opportunity to explore team working and learning, across disciplines and workplaces, my sincere thanks go to the pioneering and inclusive work of Karen Deeny and the support offered by Linda Dunn, June Patel, Andrea Cudd, Ginny Snape, Simon Gartland, Jackie Stephen-Haynes, Pauline Wooliscroft and Sue Cuerden. I also owe a huge debt of gratitude to Gill Weale and a talented and caring group of staff particularly Rita Ridley, Bethan Stubbs, John Roberts, Angela Higgins, Maureen Webb, Linda Szaroleta, Angela Mottram, Jackie Derby and Bridget Slater.

I sincerely thank many colleagues and service users. In my conversations with them about better care through better team learning, I have come to appreciate many things. The professionalism, support and insight of Terri Wilson, Ava Gordon, Marie Tarplee, Caroline Nolan, Val Jones, David Stenson, Carol Howell, Mary Rutledge and Gwen Gerald has been much appreciated. I also wish to thank Jo Davis, Vanessa Foxall, Caroline Oliver, Ian Buchanan, Sandie Kimberley, Annette Hanny, Val Corcoran, Carole Howell, Angela Alexander, Elaine King, Heather Keating, Lorna Webley, Celia Shrimpton, Kim Probert, Ingrid Pfeiffer, Liz Vincent, Elizabeth O'Flynn, Nina Thomas and Karen Doyle. Special thanks go to Doris, Dot and a particular district nursing team.

I hope that the book suitably reflects the influence, insight and wisdom of all IRP-UK staff, Institute Members and affiliated consultants especially Nick Cripps, Sue Lillyman, Helen Gardner, Rachel Moule, Andrew Jeffrey, Sandy Nelson, Paul Wyatt, George Gregg, Ros Carnwell, Dennis Beach, Tomas Kroksmark, Eva Alerby, Maj-Lis Hörnqvist, Ed Errington, Jonathan Middleburgh, Chris Johns and John Sparrow. The on-going support of all the team at Carfax Publishing and especially Ian White, the Editorial Board and International Advisory Board members of the peer reviewed journal *Reflective Practice* is also much appreciated and is a continuous source of regeneration.

More recently I wish to acknowledge the stimulating conversations and innovative work with Jeff Lake, Pam Richards and Hamish Telfer about high performing teams, Jane Marr and Suzanne Truttero about modernizing maternity services through reflective team working, with Art Langer about the links between reflective teams, sustainable performance improvement and overall technology innovation, Russell Chalmers and The Holst Group about non-adversarial dialogue and creativity, and Mosi Kisari, Wangui Karanja and the EASUN team about the way they are undertaking excellent work with civil society organisations. Finally, I thank Robert Chambers for his inspirational work in participatory practices.

I could not have asked for a better team of staff to bring this book to fruition. My thanks go to Beth Knight and the team at Blackwell Publishing, Jules in East Africa and Kay, at IRP-UK, for their careful preparation and proof reading of the manuscript. Finally, I thank those who read and critiqued drafts of the book and to all my colleagues and family who have offered unconditional and greatly appreciated advice and moral support.

Dedication

This book is dedicated to all those teams involved in emergency care, relief, reconstruction and community rebuilding work after the tsunami disaster in December 2004, in S.E. Asia. The essence of the book is emotionally connected to, and spiritually aligned with, teams who give so generously and selflessly to others in trying to improve the livelihoods and well-being.

Part One

An Orientation to the Book

Chapter 1

The book's structure, the central question and some challenges

Structure

This is a book about meaningful learning through the practices of reflection. The purpose of this learning is to develop reflective healthcare teams that are able to sustain high quality, personalised care. After this brief orientation I describe some general starting points. These are important because the book looks at the development of reflective teams through some new and different lenses. The rest of the book is then structured in three parts (see Fig. 1.1). The first is about reflection and the practices of it. The second is about teams and how they work. The third part is about developing reflective healthcare teams through a facilitated reflective process called **TA^{2}LK.**

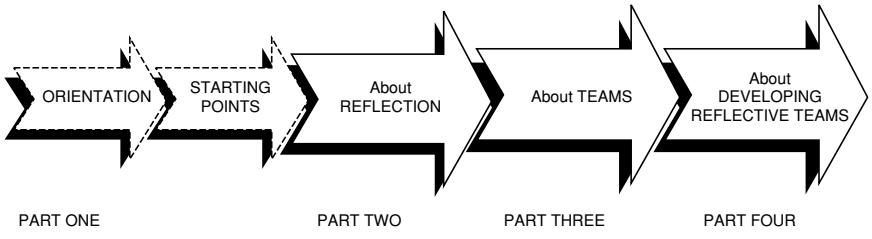

Fig 1.1 The structure of the book.

In general this book is framed by the following action-oriented question. **'How can we develop reflective healthcare teams that are able to sustain high quality, personalised care?'** In this way it responds to 'The next stage in the NHS's journey to ensure that a drive for responsive, convenient and personalised services takes root across the whole of the NHS and for all patients' (Department of Health (DoH) 2004d, p. 1). With regard to team learning and working, this book supports the much greater emphasis on developing high performing teams across the whole of the National Health Service in the UK. Fig. 1.2 shows how I begin to illuminate this question. I do so by focusing on five challenges of change. The first is the challenge of gaining and sustaining a sense that we are generally moving forwards. Without this we get stuck, practice gets outdated, we feel in a rut and go nowhere. Second is the challenge of learning through failure and how this can act as a catalyst for improving services. The third challenge is

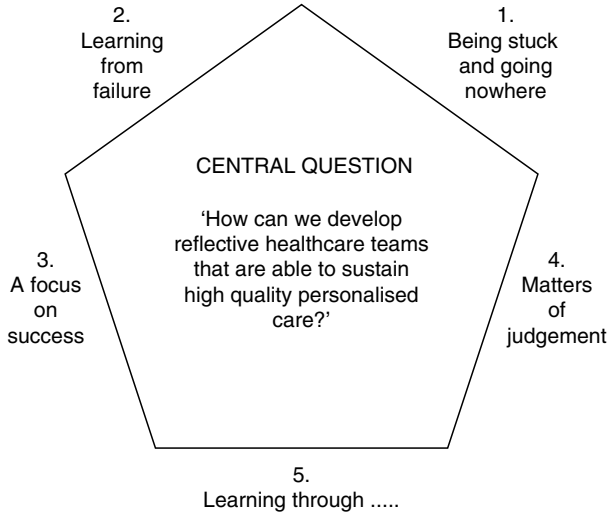

Fig 1.2 Five challenges of change.

to find ways to focus on learning from success, to notice and celebrate the successful aspects of our work, no matter how small. The fourth challenge is somewhat different. It is the challenge of making judgements about the nature, purposes, means and ends of practice. These matters embrace the notion of evidence. The fifth and final challenge is about how we might respond positively and creatively to this central question of this book, by learning through the processes of reflection.

This book is aligned with those who want even better care through improved team learning. To do this, those involved need support and a preparedness to share, reflect upon and respond positively to experiences and knowledge from a variety of sources. Three in particular are 'personal experience', 'collective knowing' and 'actionable knowledge'. The latter I define as an important synthesis of the first two. It is knowledge for improved (future) action, which we co-construct on the basis of learning about what works, as well as what does not, in particular settings and circumstances. This view has a strong pragmatic and humanistic feel to it. Of necessity then, it is also about what leads to success. Knowledge alone is insufficient for service improvement. It has to be useable. Developing reflective healthcare teams requires that we find, generate and use different kinds of knowledge that have a good impact on the quality of our own and other people's working lives and on care. The book questions the notion that all knowledge belongs to 'experts', that it is always fixed rather than constantly open to refinement and that it has to be general, to be useful, rather than situated. By implication then, reflection and the various practices of it, are couched as having an interest in understanding and improving self and the actions of others, in a context. To do this, the practices of reflection have to transform personal experience and collective knowing-through-practice into publicly accessible and useable know-

ledge. One such use of this kind of knowledge is to sustain high quality, personalised care in particular settings.

So this is a book that goes beyond personal development. It focuses on the 'we' rather than the 'I'. The 'we' being the notion of the 'team'. Nicolini *et al*. (2004, p. 81) offer a sombre warning about the limited power of one particular, and much used, kind of reflective practice for developing teams that can transform services and workplaces. '*Individualised, private reflection is incapable of reaching and affecting the institutionalised assumptions and logic that regulates organisational action, and it is also at risk of being a sterile effort, given that individuals alone are seldom in positions to make substantial organisational changes*' However, more public forms of team (collective) reflection can only happen when they are organised (Reynolds & Vince 2004) and authorised. The process needs to be seen as legitimate and time invested in it needs to be well spent. So how can we make this happen in practice? How can we bridge the gaps between the individual, group/team and the whole organisation? I return to this later. What is important at this point is to clearly state that this book is about reflection for improved collective action not just better plans for action. Reflection is not so much valued in itself. It has to do something. It has to make a difference. It has to achieve tangible rewards to self, the team (collective) and the organisation, within certain conditions. My view on the practices of reflection is that they can enable us to 'go forwards', go further and perhaps faster, but certainly with more confidence and justification. The practices of reflection give priority to practice. What we reflect upon is that which is generated by our practice itself. It links reflective knowing with improved action, a view that needs to treat knowing seriously and sceptically. This means that we need to embrace knowing but also query it (Barnett 1996). One characteristic of the reflective team is that members acknowledge that there are many kinds of knowing that help them improve their practices. They are also aware that knowledge is partial and transient. It goes past its 'sell by date'! So knowledge about, and for, improved care needs to be constantly reviewed and put under pressure to see if it (still) helps us deliver the best for our patients and clients. Reflective teams subject themselves, their practices and the values that guide their work to planned, systematic and public scrutiny. It is fruitless therefore to try to construct a single, agreed definition of 'reflective practice'. Its meaning is to be found in the purposes of its use in particular healthcare contexts.

Being stuck and going nowhere

In responding to the book's central action-oriented question, I will be drawing upon the work of staff at the international Institute of Reflective Practice-UK, its healthcare partners and affiliated consultants during the period 1999–2004. The data base constitutes work with 753 teams in

health and social care in the UK and 3211 service users. Somewhat depressingly during this period of data gathering, I have come across many teams who doubt that they can have any real and lasting influence on improving care. Sometimes this seems to be due to some genuine humility or self-doubt. Sometimes it is due to the extra work that any improvement effort requires. For others it is a consequence of two kinds of fear. First, fear that their proposed improvement will be a failure (real or imagined) and being blamed for this. Second, a fear linked with opening a floodgate of raised expectations, new possibilities and different challenges that might drown both themselves and their colleagues. So here we have the ingredients of a difficult situation on our hands. Staff end up doubting their own ability to make a difference. They end up disenchanted, disaffected and disconnected. Some 'put up and shut up', others leave the profession.

Sadly, staff within a particular healthcare organisation may know how things might be improved, but think they have no means to act, and the organisation in which they work, which would have the means to act, behaves as if it did not know. The result is impasse. Staff then behave as if investing in the status quo is the only way to survive (Rosenfeld & Tardieu 2000). So how might we get out of such an impasse? Learning through the practices of reflection gives us such an opportunity (see Part Two), but in so doing we have to get past the double-think we often get caught up in. We want change but we also want stability. We want to be responsive to others' needs but within limits. We want to develop ourselves but adopt coping strategies so that any disturbance to the ego is minimised.

Learning from failure

Many of us have a predisposition to more readily reflect on past problems and failures because these are the things we feel we need to prioritise and 'fix'. Often our encounters with technology, treatments or procedures that were 'less than hoped for', is reductionist in kind. This means we have a tendency to want to troubleshoot and fix things. In essence to break down the ambiguity, resolve any paradox, achieve more certainty and agreement, and move into the comfort zone. These 'failings' may indeed require our urgent attention. In certain circumstances this may be perfectly justified. One great influence on many of the practices of reflection reinforces this point. Dewey (1933) stated that a function of reflection is, 'to transform a situation in which there is experienced obscurity, doubt, conflict, disturbance of some sort, into a situation that is clear, coherent, settled, harmonious' (Dewey 1933, pp. 100–101). Interestingly, some (Sitkin 1996) have argued that failure stimulates a greater willingness, or readiness, to consider alternatives. It can encourage us to be more critical of current working practices. Alternatively, it can be associated with responses of denial and avoidance.

Other writers (Schein 1992) suggest that what is regarded as a failure can stimulate an 'unfreezing' process. In other words things get loosened up, un-locked and take on a different form. In turn this can initiate a new look at existing practices and policies. In healthcare there is a natural and necessary predilection for learning from failure and then turning this learning into better, safer care. Past failures and 'near misses' can be powerful catalysts for learning. The creation of the National Patient Safety Agency (NPSA) in July 2001 in the UK is a good example of this. In its remit are sustained references to improving the safety and quality of care through reporting, analysing and learning from adverse incidents and 'near misses' involving patients in the National Health Service. In essence it has reporting and learning functions, specifically learning from mistakes and problems that affect patient safety.

An essential prerequisite for becoming more proactive, rather than reactive, is the NPSA's intention to try to promote an open and fair culture in the National Health Service (NHS), encouraging all healthcare staff to report incidents without undue fear of personal reprimand. This is a cultural transformation issue where concerns like pervasive failure avoidance norms, risk aversion behaviours, self-protection, over- and under–responsibility, denial and defensiveness, have to be confronted. If we cannot be the best, the most successful at our work, then we can, at least, aspire to be the best we can. In Part Four of this book I explore the critical attributes of workplace cultures supportive of an intent to develop and sustain team learning so that we can be the best we can. I return to expressions of openness and fairness then.

A focus on success

Failures are only one kind of motivation for improving care. Another is to learn from successful and 'best' practice. The book addresses this important aspect of service improvement, specifically developing success through teams and what the constituents and conditions for this are. A central question then becomes: What constitutes success? Supportive of this are questions like: 'What does success look like?' In what ways did those involved feel that progress was being made and things were moving forwards? Like failures, successes should not be left unchallenged and certainly not unexamined, even though a dominant mindset in your workplace may well be, 'if it is not broken, then don't fiddle with it'. Success is situated in time (today's, yesterday's, last year's success) and place (in a particular speciality, in a particular hospital or community setting). It may also be limited to a particular patient or client group. Additionally, we must bear in mind that learning to learn from success is a complex, not a simple, process. For example, Sitkin (1996) suggests that success can lead to actions that preserve the status quo, an avoidance of risk taking, an over-confidence from practitioners and possibly actions

where they become blind to even more effective ways of doing things. This is potentially dangerous.

Alternatively, learning from success can reaffirm both our capability and capacity for delivering and managing high quality care. Through the practices of team reflection we can learn to notice the successful aspects of our work, no matter how small, and the practical wisdom, within the team, that has led to them. This often goes unnoticed. If recorded in some way, these successes can create positive team memories. These can balance feelings derived from conversations dominated by frustration and a sense of helplessness to change things, anything, for the better. Learning to learn from reflections on success is a good preparation for learning from 'failures'. I suggest that 'troubled teams' have a tendency to be more reactive and learn in response to real performance difficulties and crises (failures). Higher performing teams have a combination of attributes that enable them to be more proactive and learn from successes as a means of 'staying sharp' and sustaining high performance. More of this in Parts Three and Four.

Matters of judgement

Success and failure are extremes. Often in our daily work 'being good enough' or 'doing the best we can in the circumstances' has to suffice. These expressions and many others like 'we did what we could' and 'this is all we could manage' occupy the ground between these two extremes and are all matters of judgement. In order to make such judgements, I suggest we need to ask ourselves three fundamental questions. They are:

1. *What are we trying to accomplish?* This helps us focus on the improvements we wish to make, on how we would like things to be better and what would constitute success. Having a clear and agreed view of how we plan to improve services is vital. We also need to know what criteria we are going to use in order to make a judgement about the relative success or failure (worthwhileness) of our actions. Some criteria can and should be pre-specified. Other criteria might emerge naturally during the course of action.
2. *What practical action can we take that might lead to success?* This is about being realistic and pragmatic. Teams should be open to considering evidence from other team efforts, in order to learn more about what might work for them. Staff should ask themselves: 'What have other people done that we could try?' Confident and committed teams gather as many ideas as they can before they act. They also discuss their 'sphere of influence'. In other words, a team might usefully ask:

'What is it we feel we can do ourselves and what are the things we feel we need help with?'

3 *How will we know that something is a success?* This can be a tricky question. Clearly not all change is a success. Not all change improves the existing situation. Much depends on the evidence used to make such judgements and how it is interpreted. We must not forget that important attributes of either success or (relative) failure cannot always be easily measured.

The nature of the debates around the question 'Does reflection make a difference?' have changed radically in recent years. More specifically, debates about the nature of evidence, its use in healthcare and the call for evidence-based practice (Exworthy & Scott 2004) have served to focus minds and actions. Expectations are now high that any claims that reflection is good, useful, essential for learning and therefore justifiable, must be grounded in evidence. For some, these claims also have to be theoretically informed. The importance of reflective practices can no longer simply be juxtaposed with notions of staff-centredness, bottom-up and empowerment processes. Neither is reflection some kind of alternative to top-down, management-led modernisation. Modern forms of reflective practices blur this separation in a number of important ways, for example by becoming more inclusively participatory and by a broadening of its agenda to include issues of organisational governance, thereby linking with improvements in policy as well as practice. In turn, these shifts in attention invite us to engage with wider debates concerning the changing state and with UK Department of Health processes of democratisation and decentralisation (Department of Health 2004a, 2004b, 2004c, 2004d, 2004e, 2005). Bevington *et al*. (2004, p. 29) state that, 'In order to produce more rounded judgements on the performance of trusts, the NHS should work towards creating a collage of hard and soft data. Soft information is here to stay. The key to success is the degree of rigour and imagination involved in its collection, interpretation and use'.

Oldham (2004) offers a PDSA cycle to help achieve success. This is a traditional learning cycle where you 'Plan' a change, 'Do' it, 'Study' the results you get, and then 'Act' on the results. He emphasises small-scale improvement efforts and using many consecutive cycles to build up information about how effective the change is. He suggests that success is more likely to happen if we plan well, take small steps and use the PDSA cycle repeatedly. Oldham says this makes it easier to reduce the risk of something going wrong. What is overtly missing from each stage of the cycle is the necessity for collegial, team-based reflective learning conversations. These act as a comfort, give us courage to keep going or change the course of action in a principled manner and can be used to check that what we set out to do, is what we are still doing!