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DEVELOPING PRACTICE: INDIVIDUAL AND ORGANISATIONAL RESPONSIBILITIES

Health care practice is currently dominated by discussions about the need for evidence-based practice. Much of this discussion adopts a reified perspective of this issue, with the underlying assumption being that: 'the evidence exists, if only we knew how to access it and use it!' This perspective is evident in the drive towards the development of approaches that enable practitioners to read literature critically, make sense of published literature in their own practice and change the culture of practice within their sphere of influence.

Despite growing acknowledgement within the research community that the implementation of research into practice is a complex and 'messy' task, conceptual models describing the process still tend to be uni-dimensional, suggesting some linearity and logic.

Ironically, despite a plethora of research and publications about organisational development, learning cultures, barriers to research utilisation, practice development, effective practice cultures and staff empowerment, there remains a 'top down' academically driven inductive approach to the utilisation of research in practice and an over-reliance on 'normative-reeducative' strategies, ie strategies that are based on traditional notions of education, dissemination and utilisation through protocol and guideline development. While such frameworks have superficial appeal, if applied literally, they often fail to help those involved in change processes capture their complexity thereby reducing the potential for successful implementation and practice development. If these approaches really did result in successfully changing practices, then we wouldn't continue to have as many concerns about the quality of practice 'on the ground' and the reality of the use of evidence in practice.

In much of the research policy and reports of strategic development initiatives it is not recognised that the reality of practice is messy, complex and enmeshed in ethical conflict. Practice is contextually located and embedded in multiple cultures that are created and re-created by the 'actors' in that context. Individuals can influence the context of practice but this influence can only be translated into sustainable change when the culture is receptive to it. Cultural change happens from 'within' and Manley (2000) refers to this as 'workplace culture', ie the multiple cultures that make up the setting of practice (the workplace or context).

In a concept analysis of practice development, Garbett and McCormack (2002, p.100) highlight the role that practice development plays in bringing about such

changes to the context of practice. Practice development is defined as:

'...a continuous process of improvement designed to promote increased 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 committed 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.'

The key element of this definition is the emphasis on practice development being a continuous commitment to improvement that focuses on the implementation of effective patient-centred care. However, this is not just about the changing of particular practice interventions, but necessitates a focus on changing the context and cultures in which care is delivered at individual client, organisational and strategic levels. Developing patient-centred practices requires both 'personal bravery' and supported development to make the necessary changes. The personal bravery arises from individual recognition of the need for change that necessitates the practitioner to be 'self-critical' and reflective in order to find different ways of working. In addition, once the recognition of a need for change is identified then issues within the organisation may need to be challenged in order to create a learning culture to support sustained development. Thus, the achievement of sustained high quality patient-centred care is not just the responsibility of individual nurses, but instead it requires active organisational commitment to supporting practising nurses in developing practice. While individual nurses clearly have a responsibility for the quality of their practice and the way that practice develops, much organisational change is needed to realise the full potential of what is possible in practice.

In terms of dealing with the kinds of contextual factors that may come into play when developing practice, it could be argued that a key activity is planning for, and anticipating, the problems that may arise. It would appear that clear planning is more likely to take place when funding or some other form of support is being sought or if an accreditation process is being entered into. Being clear about values and beliefs is an important first step. Similarly, being clear and realistic about what can be achieved is also vital. Ensuring managerial support may be helpful in terms of securing assistance and resources. One strategy to achieve this would seem to be identifying local change with initiatives on a regional or national level. It is also important to be strategic in recruiting support from

influential stakeholders to influence key groups. Increasingly service users have assumed key importance as stakeholders. Being clear about the roles and responsibilities of those involved in change may prevent conflict, confusion and disillusion. Ensuring that mechanisms are in place to ensure that feedback can be given to those involved and those with an interest in practice change is important in terms of evaluation and as a means for being responsive to problems as they arise.

Resources to underpin practice development work are important, not only in terms of money, but also supervision, support, knowledge, skills, time and motivation. However, it is clear that these are hard to come by and there is a persistent perception of practice development as a poor relation to research. Nonetheless, it could be argued that a systematic approach to practice development that takes account of the complexity and variety of clinical practice could be organised so as to provide an account of the 'messiness' of practice. Such an

account is the only way that a picture of the processes and outcomes of practice development can be compiled. Such an organisation of practice development work can allow for the spontaneous response to ideas from practice settings and give space for all the strategies that may need to be employed to secure progress. But without any sense of direction or intent it is unlikely that the effect of practice development activities on practice itself can be described, valued or promoted. The key challenge therefore is for academic and service organisations to develop meaningful partnerships in the generation, translation, implementation and utilisation of knowledge in practice, using models, frameworks and approaches that embrace the realities of practice.

REFERENCES

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