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Staff Development in the Australian context: Engaging with clinical contexts for successful knowledge transfer and utilisation.

The relationship of nursing education and research with the development of quality patient outcomes is clearly acknowledged in contemporary health care. While education and research positions within nursing structures aim to facilitate the dissemination and integration of knowledge into clinical interventions, there are still many limitations with the translation of knowledge into care work and also, useful projects to inform clinical practice. By providing multifaceted initiatives that target the individual and the organisation a central Nursing Practice Development Unit can be a strategic resource to improve clinical outcomes. A modus operandi that moves away from classroom based education of clinical knowledge and research methods, to the establishment of cross organisational structures and processes that facilitate their integration is powerful in effecting clinical practice that makes a difference. This contrasts with education and research activities targeted at individuals that fall short of their anticipated outcomes because of external influence.

Key words: knowledge, utilisation, organisation, context, education, research.

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Introduction

Health Care services have always needed to parallel the demands and complexity of the society that they serve (Winch, Henderson and Creedy, 2005). The well known pressures in western industrialised nations include: the growth of older persons as a percentage of the population (Australian Bureau of Statistics 2003), concomitant increase in the incidence of co-morbidities of the general population, increased use of technology in health care (Kirkman-Liff 2002), the development of strategies for enhanced consumer involvement, and the blurring and changing of health care roles and educational needs in response to these demands (Lundgren & Houseman 2002). Given the multitude of pressures on health care systems, strategies for the advancement of nurses need to be carefully planned, structured and organised to ensure their maximum contribution.

The need for rigorous scientific knowledge to inform nursing work and access to this knowledge through adequate educational preparation has never been more pressing. Acknowledged as early as the late 1800s, by Florence Nightingale, one of the earliest nurses to advance nursing as scholarly work, nursing education can promote health across a number of domains. Nightingale is best known for her carefully collected information in relation to the environment, namely the concepts of ventilation, warmth, light, diet, cleanliness and noise (Tomey & Alligood 1998). Significantly, her advocacy for appropriate reporting and analysis of information became seminal work for many health professionals. Accordingly, she recognised

that nurses required an education if this was to be achieved. From these foundations the discipline of nursing has consistently developed through practice, research and education.

Significant progress in the educational preparation of nurses has occurred relatively recently in the long history of nursing. In Australia by 1993, the educational preparation of nurses moved from the apprentice type system to tertiary based education (Reid 1994). Moreover, the value of such a highly educated workforce has been clearly demonstrated (McClure et al 1983). For those nurses working in staff development roles within health care facilities the challenge has been twofold. First, to establish appropriate career paths and opportunities to ensure the continued development of professional practice for graduate and experienced nurses; second, to demonstrate the importance and value of this within medically dominated and economically challenged health care services. Despite the importance of continuing education in the workforce there is little evidence about the value of its contribution (Griscti & Jacono 2006) or how the value can be enhanced.

This discussion outlines how a Nursing Practice Development Unit realigned the organisation and operation of staff in a tertiary teaching hospital to advance the utilisation of knowledge in practice as opposed to just the transfer of knowledge drawn upon in traditional teaching techniques.

The response of least resistance: educating individual nurses

Globally, a plethora of education programs are available to individual clinicians and have been developed to stimulate interest in their work, facilitate transferability of skills and improve skill mix in line with changing service provision needs. The content areas of these programs invariably reflect current trends to assist staff to better meet the needs of the organisation and client. Similarly, strategies for the delivery of these programs reflect the contemporary educational push for multi-modal methods of teaching and evidence-based practice. Efforts to support the attendance and participation at such education sessions are promoted through diverse initiatives, namely, locating clinicians close to the clinical context to improve accessibility if deemed necessary, and also away from the clinical context to assist in participants being 'more focused' because of the difficulty of being 'called away'. The modes of delivery of these programs are commensurate with the need for greater accessibility of programs and participation by staff in their continuous professional development.

The limitation of many such continuing education programmes is that they commonly focus on clinical skill acquisition rather than the application of this knowledge (Barriball *et al.* 1992); and direct financial benefits are difficult to prove (Lundgren & Houseman 2002). Nonetheless, education programmes are frequently evaluated by the clinicians who attend them as informative and enjoyable yet their change to clinical practice is difficult to establish (Turner 1991). The notion that these programs change clinicians' attitudes to make modifications to their work practice is often uncritically assumed and ignores the complex socio-political reality in which health care service delivery occurs. While clinicians can complete these programs with a high degree of

motivation and return to their areas with the best of intentions these plans rarely translate to improvement in clinical practice unless significant organisational structures are in place to support such change.

Harnessing resources: ‘realigning systems’ and ‘capacity building’

The Nursing Practice Development Unit (NPDU) was formed to facilitate knowledge transfer and utilisation in the broader clinical context, taking into consideration the well documented difficulties with organisational change. This initiative is pursued through a focus on the implementation of evidence into practice, the conduct of nursing research and the evaluation and review of supported learning in the clinical context. A number of issues were targeted related to nursing education and research, including the development of support structures and capacity building within the current nursing environment.

The NPDU is a support structure to a major tertiary and quarternary teaching facility of 700 beds. Twelve staff employed at a level commensurate with middle management, in conjunction with two administrative officers, and a number of clinical staff demonstrating good communication skills with education experience work in the unit to support the integration of knowledge to promote learning and the delivery of quality care across approximately 2000 nursing staff. The twelve staff interact with the middle management involved in direct clinical practice, such as the Nurse Unit Managers, to identify areas where staff are requiring skill development to enhance practice. Structures and processes are jointly agreed about how the initiatives will be progressed.

From a structural perspective the initiatives for the staff development of nurses needed to move from the periphery of day to day practice, that is, fitting in when 'time allowed' to becoming a commitment of the organisation, that is, included in core business and planning of clinical activities. In accordance with this, the NPDU ceased to generate its own committees but rather lead and participated in committees responsible for the clinical governance of the organisation (Henderson et al 2005). Staff members of the NPDU attended clinical unit and divisional meetings as appropriate to situate evidence and learning within the matrix of maintaining standards of care.

At the outset, the NPDU identified those needs fundamental to good nursing practice that would be best addressed through education and research initiatives. Development of staff and students across the spectrum of the clinical workforce was the fundamental need that drove the initiatives. Structures were therefore implemented to provide support, mostly through resource staff (that is, the clinical staff demonstrating good communication skills with education experience), from the pre-registration placement student to new graduate, through to the development of experienced staff. The 12 staff who work with at the middle management level have a strong knowledge base in the following areas, the placement of students, maintenance of skills through mandatory training, safe practice through effective new graduate orientation and guidance, and facilitated continued clinical practice improvement through the implementation of evidence and capacity building for research, to improve practice. Designation of a staff member to work within particular areas of expertise resulted in each staff member developing expertise about the pragmatics of building capacity of the workforce in each requisite area. Staff within the NPDU worked with clinical staff

to facilitate the success of operationalising these priorities that, in turn, facilitated improved patient care in the clinical context.

Facilitation and support for learning

Major health facilities have an important responsibility to teach. The alternative approach adopted by staff within the NPDU recognised that the value of teaching was achieved through building capacity ‘on the floor’ as opposed to delivery of classroom sessions, still a common approach to education (Griscti & Jacono 2006). It is recognised that enhancing the capacity of Registered Nurses (RNs) to facilitate learning of students and new staff is a key component in enhancing clinical teaching across the organisation (Twentyman, Henderson, Eaton 2006). Support and facilitation is needed for RNs who work as buddies, preceptors, and facilitators (Malloch & Porter O’Grady 2006). In addition, when new clinicians enter the organisation it is appropriate to provide a structured program with clearly delineated supports through preceptors and appropriate rostering to assist them develop the requisite local knowledge and practices to ensure good patient outcomes (Fox et al. 2005). To this end the NPDU staff work closely with local teams to organise appropriate resources, back-up structures, facilitate sessions and also role-model support for learning in clinical contexts (Eaton *et al.* 2007). These strategies that promote participation and engagement of learners within the learning context have been recognised as more effective in changing professional practice (O’Brien, Freemantle, Oxman, Wolf, Davies & Herrin 2003).

The sustainability of expertise and skill mix is made possible through peer and team learning. The NPDU resource staff support RNs to facilitate clinical learning across the spectrum of staff experience, from students and new graduates to experienced clinicians. Such support is ideally enabled through the conceptual model Partner, Learn, Progress (Henderson et al. 2006). This model advocates that nurses 'partner' with learners through a mutual respect and positive association, and that learning occurs when the experienced practitioner assists the learner make sense of theoretical knowledge through practical examples. Encouragement of the learner in a supportive environment assists the learner to further 'progress'. This eventually assists in the further development and refinement of knowledge. The key consideration for the staff within the NPDU when guiding such staff development is locating the specific needs of the nurse and furthermore addressing the constraints (that often operate at an organisational level) that can impede the transfer and utilisation of the requisite knowledge.

Solving problems through the application of research evidence

In response to the challenge of incorporating evidence into practice the staff of the NPDU developed a process that addresses not only the social and organisational context of health care but recognises the often covert knowledge embedded within health care practice. *'Read, Think, Do!'* acknowledges the complexity of the problem solving processes from the outset by looking for the evidence, assessing the value to practice, and addressing the social and cultural milieu (Winch et al, 2005). The '*Read'* step involves accessing the breadth of research findings that will sufficiently inform a change to learning and practice. Step 2, '*Think'* involves critical thought about the

applicability to the clinical setting, while the final step *'Do!'* involves organisation of the effective implementation of the practice change within a local culture. This attempt to incorporate the knowledge embedded in complex contexts of care with evidence obtained from the research literature through a simplified problem solving approach is currently being tested in a number of Australian hospitals. The success of this is largely dependant on the capabilities of the facilitator to make sense of evidence that is largely theoretical, distal to practice, and bring it into the practicing domain of the clinician (proximal knowledge) (Eaton *et al.* 2007). Such facilitation skills are a priority building the capacity of nurses to enhance staff learning.

Integration of contemporary concepts and practices

It is this reconfiguration of staff development education into a facilitation role that departs significantly from how education and research departments have traditionally been established within clinical facilities. Traditionally, clinicians are facilitated to gain an understanding of education and research that invariably includes, to different degrees, educational theories and modes of learning, and the complexity of research method and statistical analysis. Furthermore, journal clubs have been a popular strategy to understanding the literature. While journal clubs are often developed with this intent they invariably are not established long enough under consistent leadership and membership to reach a degree of maturity whereby they explore the contribution of knowledge development, and research into practice (Sidorov 1995). Through re-focusing the NPDU activities on the application of knowledge, and on the integration of evidence into practice, efforts can be channelled into, not just 'knowledge

acquisition' nor 'doing' research but rather the application of knowledge and strategies to implement research findings into clinical practice settings.

Conclusion

Through the adoption of these facilitative processes integral to the sustainability of changing behaviours and practices, education and research strategies within the NPDU are directed toward knowledge utilisation within the clinical practice setting rather than the presentation of information/knowledge or activity focused on research processes. Strategies encompassing support for individual learning coupled with organisational initiatives are essential for practice change to improve patient outcomes. Knowledge utilisation is able to be successfully effected and, is referred to in its broadest sense, that is, to both the techniques used for the transfer of knowledge together with its application within the clinical context.

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