Title: **Perspectives and Experiences of Nurses as Facilitators within a Practice Development Program**

Short title: **Nurses as PD facilitators**

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ABSTRACT

Background: Health services are challenged to change and adapt to meet the changing needs of the populations they serve. To support this, the 'Essentials of Care' Practice Development program was developed in Australia. Local facilitators play a key role in its delivery and achievements.

Aims: This study aimed to gain insights into the experiences of clinical nurses in Practice Development facilitation roles in an acute hospital, including training for the role and changes occurring within themselves and their workplaces.

Methods: A qualitative interpretive design used purposive sampling for a two-phase study using semi structured interviews and focus groups with data analysed using Framework Analysis.

Results: Twelve Registered Nurses with an average of two years' experience in a facilitator role were interviewed and attended focus groups in 2011. Five key themes were identified: (1) facilitator as enabler, (2) the necessary team approach to facilitation, (3) valuing both internal and external models of facilitation, (4) preparation and training for role, and (5) perceived changes: to the facilitator and to the workplace. Individuals' ongoing development resulted from reflection, mentorship, role-modelling and co-facilitation; facilitation skills were recognised as relevant for nursing beyond their Program role. Ward culture gains were valued as distinct from measurable patient outcomes such as reduced medication errors.

Conclusion: Findings provide insights into facilitators' experiences of this Practice Development role and contribute to better understanding of effective processes for nursing practice change in acute health services. Recommendations were proposed to support future role and post-holder development.

Keywords: nursing, practice development, practice change, facilitation, evidence-based practice

INTRODUCTION

Ongoing evaluation and improvement are features of contemporary healthcare; staff need to ensure their practice keeps pace so patients continue to receive up to date, evidence based care. Practice development entails evidence based, supported intervention designed to improve care quality and promote patient centred care (Perry, 2013). Direct relationships have been described between the quantity and quality of facilitation available, the context within which the development is to occur, and the degree to which practice change is achieved and sustained (Kinley, et al., 2014). Within PD, facilitation is used to create cultures which support nursing practice change (Crisp & Wilson, 2011; McCormack, Wright, Dewar, Harvey, and Ballantine, 2007).

Facilitation can be an effective method to bring about sustainable change as it empowers those at the front line of nursing practice to own both problems and solutions (Harvey et al., 2002). Facilitation underpins PD methodology but facilitation skills are not part of nursing educational curricula. Development of the skills, knowledge and confidence needed for effective facilitation of PD workplace activities is described as requiring an approach that is person centred, evidence based and systematic (Hardiman & Dewing, 2014). However, little is currently known about how the facilitator role functions within PD programs. This study aimed to address this omission by examining the perceptions and experiences of ward-based Registered Nurses facilitating a state-wide PD program in New South Wales (NSW), Australia, called the Essentials of Care (EOC) PD program.

Background

In 2006, Registered Nurses at an acute tertiary hospital in Sydney, NSW, began a process to develop a program to support improvements to patient care delivery and

workplace culture. In 2007 this program, named the ‘Essentials of Care (EOC) Program’ (Clarke, Kelleher, and Fairbrother, 2010) adopted and successfully piloted a PD approach. It was subsequently recommended in a state-wide public healthcare review (Garling, 2008) and launched as a NSW state initiative (New South Wales [NSW] Health Nursing and Midwifery Office, 2011).

The EOC Program entails a six-phase iterative process concluding with an evaluation after which the cycle begins anew (Figure 1) (NSW Health Nursing and Midwifery Office, 2015). Theoretically rooted in critical social science, it draws on schools of thought founded on self-reflective knowledge in pursuit of development of understanding and explanation of society as routes to emancipation from authoritarian systems of domination or dependence (Browne, 2000). It is values-based and uses participative, collaborative and inclusive approaches underpinned by person centeredness, premising that this will achieve sustainable practice improvement and work-based learning (Garbett & McCormack, 2002; McCormack, 2003; McCormack, Manley, and Titchen, 2013; McCormack & McCance, 2006; Wilson & McCormack, 2006). Facilitation is intended to create positive and supportive workplace cultures (Walsh, Crisp, and Moss, 2011) and the six phases of the EOC Program use facilitation to engage and empower staff to examine their work environment and practices, identify areas for improvement and celebrate their strengths (NSW Health Nursing and Midwifery Office, 2009). The facilitator enables staff to reflect and engage in critical dialogue about their workplace beliefs, values and work practices to create an environment where staff can reflect and challenge rituals and assumptions, leading to action planning to improve workplace cultures and care quality. Within the EOC Program the facilitation role at ward and unit level is undertaken by clinical nurse members of the ward teams.

(Figure 1 about here)

Successive endeavours have defined core elements of facilitation to comprise personal characteristics of the facilitator, their skills and knowledge, the relationships they create, and the way each role is structured, dependent upon specific role purposes (Dogherty, Harrison, and Graham, 2010; Harvey et al., 2002, Shaw et al., 2008; Simmons, 2004; Stetler et al., 2006). Interpersonal skills of the facilitator include reflection, critical thinking, and ability to work with their beliefs, values and attributes (Dogherty, Harrison, & Graham, 2010; McCormack & Garbett, 2003), such as, 'valuing people, authenticity, integrity, honesty and transparency' (Shaw et al., 2008, p. 160). Facilitators need to adopt a collaborative approach, recognising there are mutual benefits to be gained (Larsen, Maundrill, Morgan, and Mouland, 2005). Creation of learning partnerships are central, and environments safe for learning where practitioners can take ownership for action (Manley & McCormack, 2003). Framed overall within person-centeredness (Shaw et al., 2008), facilitation is characterised by distinctive interpersonal relationships (Stetler et al., 2006), requiring a high level of presence and self-awareness, with vision to see beyond routine and taken-for-granted aspects of practice.

In NSW, wards and departments were supported to implement the EOC Program with local facilitators (NSW Health Nursing and Midwifery Office, 2014). However, there has been little rigorous examination of these facilitation roles: scant description of effective preparation or staff function, and little attempt to measure fidelity in delivery or effectiveness in achievement of purpose. To address these omissions, this study aimed to gain insights into the PD facilitation role of clinical nurses, with the intention to use this information to make recommendations to support future role and post-holder development. Research aims were:

1. To identify the experiences of facilitators of the EOC Program: their preparation for the role, how their roles function and how they deliver them.
2. To identify any perceived changes occurring within the facilitators themselves whilst performing in the facilitation role.
3. To identify any changes that may have occurred in the workplace related to the EOC Program during their delivery of the facilitation role.

METHODS

Design

This study employed a qualitative interpretive design (Thorne, Jensen, Kearney, Noblit, and Sandelowski, 2004) for in-depth exploration of participants' experience. Two different approaches were chosen, to enable methods triangulation and maximise yield of rich data. First, individual interviews were used to enable participants to tell their individual stories and provide insight into their facilitation experiences and their perceived developmental needs. Semi-structured interviews were chosen; interview questions were developed to define topics to be explored but allow freedom to pursue promising avenues with confidentiality (Gill, Stewart, Treasure, and Chadwick, 2008). Focus groups were then utilised to gain further insights by reviewing preliminary interview analyses and enabling group critical discussion and elaboration of themes. Focus groups were chosen because they allow interaction between participants, in this case, individuals known to each other and with a common role. For these participants their shared experiences and the deliberate creation of a supportive environment was intended to enable discussion and the ability to challenge each other comfortably (Gill, Stewart, Treasure, & Chadwick., 2008).

Sample

In this acute tertiary hospital in Sydney, Registered Nurses working on medical and surgical wards in an EOC facilitation role were purposively sampled. Fliers were distributed across the hospital seeking nurses with at least six months experience in such a role. Twelve participants for the individual interviews were recruited and analysis of interviews proceeded in tandem with data collection. Participants continued to be recruited until the research team determined that data saturation had been achieved, with no new material being produced; this occurred after twelve interviews. These twelve interviewees were invited to take part in the subsequent focus group meetings; six participated.

Data Collection

Individual interviews

The research team developed a semi-structured interview schedule to address the research objectives with input from independent senior nurses. Examples of questions are included in Table 1. Interviews were conducted by two members of the research team whose current roles in the organisation entailed supporting the EOC Program. These were not line managers; some but not all participants had worked with one or other of these interviewers in their professional roles. Participants had a choice of interviewer for the individual interviews, so they could be interviewed by someone they felt comfortable with to discuss their EOC role. Interviews were digitally audio recorded and lasted 25-50mins each. The interview schedule was reviewed and minor changes made following the first two interviews.

(Table 1 about here)

Interviews and focus groups were conducted in late 2011 in locations of participants' choice that allowed for privacy, usually a private space on their wards.

Focus groups

Following preliminary analysis of interview data, interview participants were invited by email to attend a focus group. Two focus groups with three participants each were held, lasting for around one hour each. Two members of the research team conducted the focus groups; one moderated the meeting and the other recorded field notes. Preliminary outline analyses of de-identified interview data were presented with the interview schedule questions (Table 1) to trigger critical discussion and progress development of recommendations.

Trustworthiness

The trustworthiness of the study was established using four approaches (Lincoln & Guba, 1985). Confidence in the credibility of the work was attained through member-checking of interview transcripts and through methods triangulation of interview and focus group findings. Dependability was shown through keeping memos and notes of the data collection and analysis process which were discussed with the research team. Confirmability was achieved by the reflexivity of the researchers, through creation of an auditable trail for the research, by use of methods triangulation and discussion with the research team at all stages. Transferability was achieved through provision of thick description of the research context, participants and findings.

Ethical considerations

Approval was obtained from the relevant Human Research Ethics Committee. Confidentiality of participant identities was assured, during focus groups and participants were assigned pseudonyms for analysis and reporting.

Data analysis

Framework Analysis was employed to analyse interview and focus group data (Srivastava & Thomas, 2009). This qualitative thematic methodology enables organisation of textual data through an iterative process of summarisation, creating a matrix that, 'provides transparent results and offers conclusions that can be related back to original data' (Johnston, Milligan, Foster, and Kearney, 2011, p. 2425) which has been advocated for analysis of healthcare and nursing research. Interview and focus group data were analysed sequentially; interview data were analysed first, then the process repeated to integrate focus group data and achieve a final summation of analyses. First, audio files were transcribed and audio files, field notes and transcripts were repeatedly listened to and read for immersion in the data. Next, using the framework of the research objectives, data were indexed, with memos kept throughout the process. The indexed data were then arranged within themes ('charted'), alongside an iterative process of review which allowed identification of recurrent patterns, themes and sub-themes to emerge. In the final stage of interpretation themes and sub-themes were compared again to the transcripts and notes, enabling refinement as similarities and differences were identified across interviews and focus groups. Themes were adjusted to better match the data. The material was reduced to summarise each theme and sub-theme, with illustrative quotations from the transcripts. At each stage, analyses were discussed with all members of the research team to achieve a common understanding of emergent themes.

FINDINGS

Of the twelve interview participants four were Clinical Nurse Consultants, seven Nurse Educators/Clinical Nurse Educators, one a Clinical Nurse Specialist; nine were female and three male. Time in their facilitation roles ranged 18 months to four years, with an average of approximately two years of experience. Participants came from a diverse range of clinical areas.

Five key themes were identified from the interviews: (1) facilitator as enabler, (2) the necessity of a team approach to facilitation, (3) the value of both internal and external models of facilitation, (4) preparation and training for role, (5) perceived changes: to the facilitator and to the workplace during their tenure of the role. Focus group critical discussion of a preliminary form of analyses enabled refinement of key themes and recommendations to support future nurse facilitators' roles (Figure 2); no new findings emerged. Participants were assigned pseudonyms for reporting.

(Figure 2 about here)

(1) Facilitator as Enabler

Participants described their facilitation roles as essentially about helping others to come to their own solutions, rather than directing or providing answers. They talked of finding the focus of the role needed to be on their groups, not on themselves. Despite being seen as a 'leadership' function, the role was not about being directive or exerting control. For the majority it was, 'about always asking questions, never putting themselves in there with their own opinions' (Michelle); using 'conversation-provoking questions' (Anna). Awareness of group dynamics and making sure everyone had the opportunity to contribute were pivotal communication skills.

All participants noted that being an enabler required patience; it was time-consuming, and much easier (and initially very tempting) to offer solutions. This was

repeatedly identified as a challenge of the role. Michelle described herself as, ‘a bit of a rescuer’ who initially tended to jump in with suggestions. She described particular difficulties in not doing this when she was also part of the team, and had her own opinions and agenda for the issue.

Facilitation required self-awareness, and ability to control the urge to ‘tell’ rather than ‘guide’. This was echoed in focus group discussion, alongside the space to grow this; ‘Facilitators need opportunities to practice to get good at it in a place where you are not going to be judged’ (Jenny).

Important role characteristics included being solution-focused and positive as it could be, ‘easy to get drawn into a negative space’ (Rebecca). Being an effective enabler entailed confidence and a positive belief in self, in the process and in the team: really believing in the staff’s capabilities to come up with solutions, ‘what makes it work is when you really believe in the process yourself’ (Richard). Participants described the, ‘tangible change of energy’ that occurred when facilitation was at its best (Sally) leading to ‘greater autonomy for staff’ (Jenny) as well as improvements for patients. The inherent value of this approach was apparent and satisfying to facilitators, ‘when the door opens, and there is that spark in the eye’ (Sally), signifying some positive change within the team.

(2) The necessity of a team approach to facilitation

A team approach was identified as crucial to the success of the facilitator role and the progress of the EOC Program. The role was too much for one person in relation to the time commitment and the personal energy and emotional labour that it entailed. For a single person to facilitate a unit undertaking the EOC Program was, ‘an uphill battle’ (Robert); a sentiment echoed by others. However, the demands of

the role were not initially recognised, with some participants given sole responsibility. This was perceived as unfair, and contributed to negative experiences. The Program progressed better with more than one facilitator per location; with reliance on one person the process stalled if that person had conflicting commitments. There was then disappointment when momentum was lost and planned activities not achieved within agreed time frames. All facilitators raised the issue of juggling the EOC Program with competing priorities; the Program was time consuming and 'frustrations arise when one doesn't have the time to keep the momentum going' (Richard). A team approach ameliorated such pressures.

Joint working also enabled more experienced facilitators to work with and support those with less experience, strengthening the professional development of individuals and benefiting progress. This was not initially recognised, with Jill describing how, when she returned to a senior role mid-EOC cycle, the facilitator on her unit stood back and expected her to take over. The Program stalled as she worked out her role.

Focus groups corroborated and extended this theme. With the benefit of hindsight there might have been clearer enactment of the Program ethos of equality with the early identification of facilitation teams. Facilitation team membership was identified as motivating staff engagement with the EOC Program. Three facilitators described how much more favourably the staff viewed the EOC Program, and how much more willing they were to participate when their manager was involved. Without active involvement of key senior staff to drive the program, 'there was great difficulty in getting staff engaged' (Jan/ Robert). A virtuous circle could be created, where having the right people contributing to facilitation (and hence perceived leadership) of the EOC Program resulted in staff engagement with the process, which eased the

facilitation role: ‘there has to be a strong desire from nursing staff to drive EOC and then I can facilitate it’ (Sally).

(3) Internal and external models of facilitation

Facilitators valued both internal and external models of facilitation for practice change and their own development. Internal facilitation (i.e. within their own workplace) could place facilitators in the conflicted position of simultaneously non-directive enabler and member of the local workforce with their own opinions. Internal facilitation was better for driving local change and keeping the process on track, but in this role participants withheld their own contributions, especially in analysis and action planning. This disenfranchised them, and could be detrimental as these were not just facilitators but members of the clinical team with expertise and a right to be heard. External facilitation (by someone from another area) was a way to address this.

External facilitators could question and challenge practices as they had no local allegiances and were independent of local influence; it was easier for them not to get involved in ‘unit politics’. This independence could change the energy of the process as they were unaffected by team dynamics. It also underlined the value of what they were doing, sending a, ‘powerful message to staff, helping them feel what they were doing was important, that it was recognised and supported from the outside’ (Richard).

4) Preparation and training for the role

This theme was subdivided into Initial Training and Ongoing Development.

Initial Training

Training to deliver facilitation was seen as essential. However, the timing of this was not always optimal for nomination in the role. Facilitation skills were required from the outset, but participants felt nomination had not always occurred on that basis. Some participants found the role, ‘thrust upon them’ (Anna), before they had adequate preparation or understanding of it. For some this was part of an initial general progressive development of understanding and appreciation of how the Program and facilitation fitted with their roles and responsibilities, rather than the result of specific learning.

Education and training opportunities were available locally but many had taken on the facilitation role prior to any formal training. Some had little preliminary understanding of PD, having been deterred by what they saw as obscure terminology and nebulous concepts. For others, it was intuitive; there was a natural fit. Richard felt he was doing PD before he knew what it was: it ‘was down my street, it clarified many things I had previously thought in terms of being nursing-centric’.

On-going development

Recognition of the value of facilitation skills could take time. Over time participants became aware of the value of facilitation skills they were learning through the Program for performance of their roles outside of it. Michelle didn’t originally see the connection between the EOC Program and her job’s core business but time and reflection enabled her to apply her learning to create change as an educator. For many, ongoing development resulted from individual learning, including through reflection and co-facilitation which could be difficult in time-pressured hospital wards. The role could pose challenges, particularly in relation to taking things personally, and there was benefit in reflection during and after facilitation sessions.

Learning on the job was a steep learning experience. Some were helped by working with someone; co-facilitation and being, ‘buddied with someone who has experience’ (Jenny and Jill) were beneficial. Observing others and gaining feedback on one’s facilitation were important learning opportunities; writing the two year evaluation report could help crystallize the experience (Rebecca). Support was gained from professional peers: ‘we often challenge each other and reflect together continually, looking for ways to keep staff engaged and motivated’ (Michelle). Confidence in communication skills and dealing with confrontation grew over time as did recognising the energy within the room and ‘what was not being said’ (Michelle).

(5) Perceived changes

Participants shared the changes they perceived in themselves in their nursing roles. Many noted they had become more able to sit back and let others speak, and keep things in control rather than being controlling. Confidence developed in speaking in front of others and talking to groups. Listening and enabling skills improved, with Melissa noting awareness of being more inclusive. Confidence developed in dealing with conflict, becoming, ‘more comfortable in challenging others in a supportive manner’ (Melissa).

Changes to workplace culture were more difficult to recognise and measure: ‘the culture of nursing is used to quick fix-it solutions and in reality cultural change is slow and time consuming’ (Dan). All participants agreed the Program could be slow-moving but continuity and momentum were imperative, and a challenge for facilitators to achieve and sustain. Ward leadership was important, and facilitation was a tool for effective leadership (Melissa).

Many of the same changes in ward cultures were reported. Communication was felt to have improved between staff, multi-disciplinary teams and patients; staff were seen as having greater engagement with their units, were more ready to take on projects, and to seek solutions rather than ask to have things fixed; team-working improved, with staff more willing to help and more confident in their ability to effect change. An overall atmosphere of greater ease was reported, with more patient-centred attitudes. As a result, staff retention and workforce stability were felt to have improved. However, with the EOC Program driven solely by nurses during this period, miscommunication could occur between disciplines; 'not including others has been the primary problem' (Dan).

Reports of clinical practice change were mixed. Some facilitators felt, 'measures show we are improving patient outcomes' (Richard). Such measures included better completion of patient risk assessments and documentation of observations; greater efficiency of staff handover and nutrition processes. Reorganisation of medication administration procedures decreased errors and reduced the time of medication rounds, allowing more staff time for patient care. Improved communication between staff and patients was reported to increase patients' involvement with care, which resulted in their feeling better cared for. However, Dan saw no real changes to clinical practice and questioned the evidence that the EOC Program made a difference to patients. Others suggested that staff engagement made the difference, and was the essential element to effect change. Further, where nursing care deficits related to inadequate knowledge, the Program by itself could not 'fix' this (Sally).

DISCUSSION

Currently within the literature there are no systematic studies of ward-based facilitators as a core component of a major PD program. This was the first such study. Whilst facilitation roles have been examined in relation to mentoring and clinical supervision (Kelly, Simpson, and Brown, 2002; Maggs & Biley, 2000) and discussed in relation to what they should and could comprise within PD (Dogherty, Harrison & Graham, 2010; Harvey et al., 2002; Simmons, 2004), the real-life experience of this role for those who assume it has received little attention. This is important not just for those individuals engaged with this role but also for the current and future effective delivery of PD programs.

This paper reports the experiences of a self-selected group of nurses occupying facilitation roles within the EOC PD Program on their wards. Although the Program had a four-year history at the site, the work of these four years was not just of making the EOC Program work (i.e. achieving the benefits expected from it) but also of working out how to make it work. Other programs have appointed staff with specific expertise into such roles; intentionally and uniquely, this did not occur for the EOC Program. Consistent with its ethos of a ground up approach or 'grass-roots' empowerment, facilitators were sought within ward nursing teams.

Enabling effective facilitation has seen to be an integral process in PD, and core to achieving effective results (McCormack, Manley & Titchen, 2013). Fundamental to this success is that facilitators espouse a number of core values and beliefs: namely participation and inclusion, which subsequently lead to enhanced care experiences for nurses and their patients (McCormack, Manley & Titchen, 2013).

The style of facilitation taught and advocated through the EOC Program has resonance with that described in other PD programs. As in our study, key enablers to facilitation development recently highlighted were access to training, provision of

opportunities to practice skills and where facilitators can learn from more experienced facilitators (Watling, 2015). Facilitation within the EOC PD Program was purposefully weighted towards cultivation of individuals' professional development and empowerment both as a means to enhance the quality of individuals' nursing care and as a means to achieve team cultural change with a person-centred focus as ascribed the role by Shaw et al. (2008). Identifying 'enablement' as core to their experience located their roles within the 'emancipatory' rather than 'technical' sphere (Shaw et al., 2008, p.157), consistent with the role intent set out by NSW Health (2009) and indicating fidelity to the role intention.

In order for emancipatory cultures to grow and thrive, there needs to be a supportive learning culture that embraces and is invested in its development, where patients and service users can benefit (Dewing, McCormack, and Titchen, 2013). Development was a core theme within the work: development of facilitators' skills in the role; development of teams' ways of working, of their relationships, including with patients, and their care quality. Crisp and Wilson (2011) described a framework for facilitation development in three phases by which PD facilitators gain increasing understanding of the process, develop the ability to contextualise PD 'rules' and eventually facilitation becomes an embodied way of working. Whilst not demarcated, movement through various phases of facilitation development was evident for these participants.

At the same time, as a state-wide quality improvement project, measurable outcomes were expected. This may have created some degree of mixed message for the role, warned against by Harvey et al. (2002), and possibly reflected in some accounts of conflicted situations. The importance of demonstrating 'outcomes' – and how these may be defined and measured – has been a matter of debate and some

tension throughout the roll-out of the EOC Program (Walsh et al., 2012). Most study participants reported, and valued, the cultural gains of the program as distinct from measurable patient outcomes, such as reduced medication errors.

Further blurring of role purpose may have occurred in relation to program leadership. The EOC Program ethos described distributed leadership with all participants playing a part to lead and drive it (NSW Health Nursing and Midwifery Office, 2009). However, the prominent nature of the facilitation role attracted individual leadership responsibility, particularly when occupied by senior staff members. Participants resisted this as too onerous and conceptually inconsistent, and a team facilitation approach was preferred, providing peer support, role-modelling and reflective feedback for on-going development; a sharing of the load and time commitment, to maintain the motivation and momentum needed for success.

The experiences of participants were not uniformly positive or of success but were overwhelmingly stories of nursing development and learning. Most described their experience as being a steep learning curve but over time recognised its relevance for their nursing roles outside the Program, also noted by Dogherty, Harrison & Graham (2010). Facilitation skills were effective means to promote learning and change (Crisp & Wilson, 2011; Harvey et al., 2002), and therefore contributed to these nurses' core business. This highlights the merit of such training and skills development and their implications for nursing professional and career development. However, managers and facilitators need to appreciate the demands of the role in relation to time and skills required; an important message for other sites considering adoption of a PD model.

Study limitations

This study was limited in that it derived from a single site, and recruited a relatively small group of nurse facilitators. However, this site has a long history of working with a facilitation approach and has played a major role in the development and roll-out of the form of PD practised in NSW. The experiences and recommendations from this group of facilitators, obtained through rigorous data collection and analysis, will serve as a platform for further study.

Recommendations for practice

Recommendations to maximise the success of facilitation within PD were developed and refined during focus group discussions. Firstly, participants stressed that understanding PD principles is a prerequisite of effective facilitation and informs creation of effective relationships, service and practice quality improvement for nursing. Facilitators require training in PD and facilitation skills and these should be incorporated within nursing post-graduate workplace training programs, including opportunities for facilitation practice, reflection, coaching, observation and working with experienced facilitators.

As distinct advantages and disadvantages accrue to internal and external models of facilitation, flexible use of both approaches is required to meet local situations and needs. Both models should be available, and procedures to match availability to local situations and needs.

Solo facilitation risks burnout and loss of voice, momentum and opportunities for peer skill development. A team approach to facilitation was recommended, preferably with facilitators from a variety of backgrounds, roles and professions.

Organisational support is required to sponsor, promote and resource any form of proactive change, with widespread ownership and engagement. For effective facilitation all relevant stakeholders should be engaged, and expectations managed

so that the aims of PD programs such as EoC are feasible and resourced to be achievable.

Evaluation is an important component of practice change, so achievements are visible. Complaints about unclear relationships between processes and outcomes and lack of objective evaluation data undermine the achievement of agreed goals and hamper effective facilitation. Training is required so facilitators have the skills to negotiate multi-method evaluation to ensure effects on workplace culture and relationships between change initiatives and patient outcomes are captured.

CONCLUSIONS and IMPLICATIONS FOR PRACTICE

This study contributes new insights from clinical nurses working in facilitation roles within a PD program. Findings enhance understanding of facilitators' experiences of the role in this and perhaps similar PD programs, and contribute to better understanding of effective processes for nursing practice change in acute health services. With PD increasingly recognised for its role in knowledge translation, this study makes an important contribution to understanding how to make PD 'work'. Facilitation skills clearly play an important role and are valued within and beyond PD. Recommendations indicate policy, education and practice initiatives and processes that may enhance facilitator roles and hence PD programs and care quality in nursing. Future research should examine whether and how reports of enhanced person-centred cultures and better patient experiences and outcomes are achieved.

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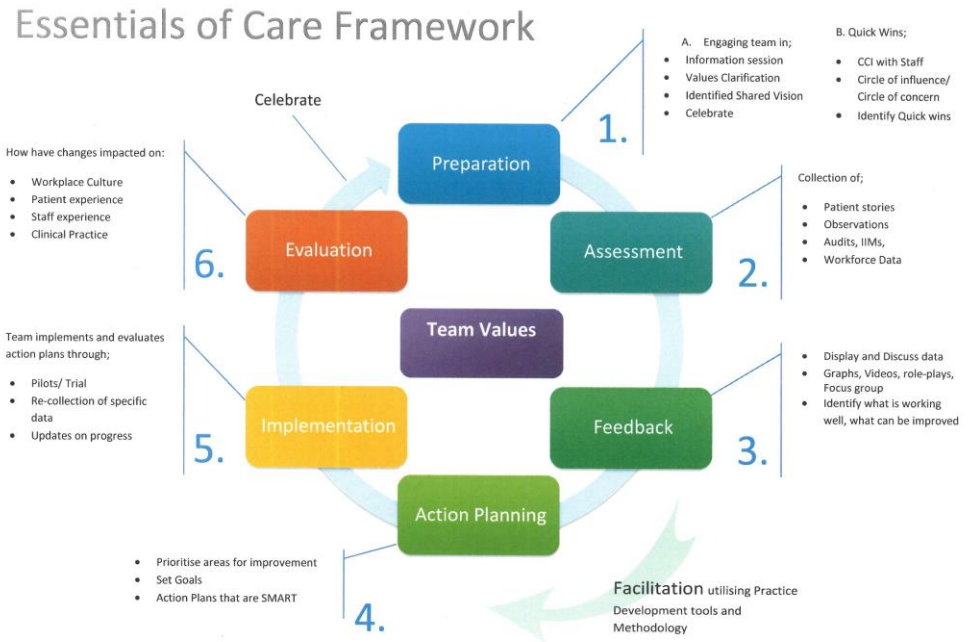

Figure 1 The model of the Essentials of Care Practice Development program

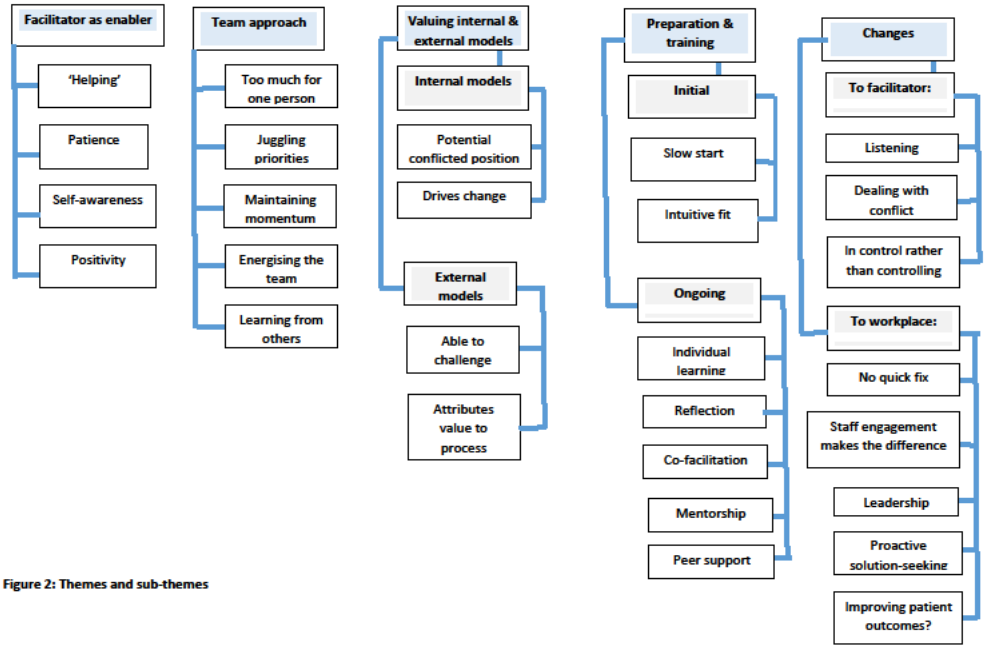

Figure 2: Themes and sub-themes