European Society of Human Reproduction and Embryology

COURSE 1

Training workshop for nurses and allied professionals

18 June 2006
Prague - Czech Republic

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Course 1 - Training workshop for nurses and allied professionals

Course co-ordinators: E Corrigan, H Birch, M Hammar and D Molero

Course description: This course is particularly suited to those who wish to be involved with improving quality of care and evidence based practice. By the end of the morning session the delegates will have an understanding of risk management and managing change. At the end of the afternoon session the delegates will have an understanding of the principles of research/audit and how to make it easy.

Morning sessions - Chairmen: M Hammar and D Molero

09.00 – 09.10 Introduction - **M. Hammar (S)**

09.10 – 09.30 Role of the Nurse in the Czech Republic - **L. Sachova (CZ)**

Putting Risk into Context – Setting the Scene

09.30 – 10.30 Checking practice against protocol - **E. Corrigan (UK)**

10.30 – 11.00 *Coffee break*

11.00 – 12.00 Managing change – putting it right - **H. Birch (UK)**

12.00 – 12.30 Discussion - **E. Corrigan (UK) and H. Birch (UK)**

12.30 – 13.30 *Lunch*

Afternoon sessions - Chairmen: E Corrigan and H Birch

13.30 – 17.00 Research/Audit Made Easy - **C. Wilson (UK) & D. Barber (UK)**

This session will be interactive and includes:

- What is research?
- Where do we start?
- Research design
- Gathering data
- Working with data
- Presenting findings

Role of the Nurse in Prague

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Introduction:

A Nurse from the Institut of the Care of Mother and Child

Topics:

A Nurse at the Department
- coordination of the tasks and smooth runing of the department

A Nurse and the Doctor
- the doctor's third hand, who brings, takes, holds and arranges

A Nurse as follow up help for the Patients
- teacher, psychologist, informent

The End:

What Florence Nightingale wrote about Nurses

Checking Practice against Protocol

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Introduction

Checking practice against protocol (audit) seeks to improve the quality of patient care through structured review. Professionals examine their practice against agreed standards and modify practice where appropriate. They are asking, what is best practice and where is the evidence?

Audit is part of Clinical Governance which is described as "A framework through which medical organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care creating an environment in which excellence in clinical care will flourish" (Quality in the New NHS, 1999).

Audit is not a new concept, Florence Nightingale said:

"For us who nurse, our nursing is a thing which unless we are making progress every, month, every week, take my word for it we are going back" (Nightingale F 1872).

What is Audit and how do we do it?

Audit is using knowledge and ensuring that the right thing is done. It is similar to, but not the same as research (which is finding the right thing to do [Smith 1992]). It is important to remember that the results of audit can be clinically significant without necessarily being statistically significant.

Audit involves:

- finding and analysing data
- developing standards
- implementing change
- repeating audit
- improving care

Nurses constantly either consciously or unconsciously audit practice in their every day work. There are two areas of skills which they assess; the tangible and intangible – the tangible is easier to assess and see results as it relates to practical procedures; for example embryo transfer. The intangible is less obvious; for example the patients' perception of care given. Cheaten and Keane reported that many audit groups remain medically dominated with nurses playing the role of "enthusiastic supporter". Obstacles such as equality make it difficult for nurses to contribute and must be overcome.

The end point benefits both the practitioner and the patient by demonstrating excellence and finding deficiencies in patient care whether in the clinical, laboratory or administrative areas. When changes are made the result raises awareness, gives better patient care with improved outcomes and also benefits staff through education and job satisfaction. It closes the gap between patient's needs and expectations and delivery of care.

Summary

Audit is checking protocol against practice. In the past it has been resented as it was seen to be time consuming with little benefit. However, it is now widely accepted that good audit raises awareness and provides standards to work to (often national standards) to improve practice. The value of audit should not be underestimated. If it can be shown that there is a need to make changes to improve patient care, enthusiasm to make the change will follow.

A short practical session will be included in the talk.

Managing change – putting it right

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Learning Objectives

At the end of this session the delegate will be able to

1. Explain why change is necessary
2. Identify the triggers that cause change
3. Explain the difference between planned and emergent change
4. Identify barriers to change
5. Understand the factors required to implement change successfully

Change is defined in the Chambers Concise Dictionary as '*to alter or make different; to cause to move from one state to another'*

Why change?
In an increasingly competitive world the necessity for change is vital for survival. Without the ability to change an organisation will become stagnant and no longer meet the needs of its clients and employees.

As in the words of Charles Darwin:

'It's not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.'

Change is triggered by many different factors and these can be divided in to two groups

External	**Internal**
Technology	Product/service innovation
Customer requirements	Change in management structure
Government legislation	Low performance/moral
Competition	Restructuring (e.g. downsizing)
Supply of resources	Increasing size/complexity of an organisation

Change may be ***planned*** or ***emergent***
Planned change as its name suggests is deliberate and predetermined. The most well known model used is that of Kurk Lewin. This three-stage framework takes the organisation from the current 'known' state to the 'desired' state in a predictive process

Unfreezing **Transition** **Re-freezing**

The present level *To the new level* *At new level*

Unfreezing

The first step involves the decision that change is necessary. It is important that those who will be involved in the change process are aware why change is necessary and the consequences for the organisation if change does not occur. This is achieved through discussion and negotiation. The person driving the change must be able to clearly communicate the vision for the change i.e. clearly describes what the future will look like after the change. Good communication is essential. The key elements to communicate are: -

1. What is the Change
2. Why are we doing it
3. How are we going to go about it
4. How long will it take us to do it
5. What will be the role for each department and each individual

Transition

Once the need for change has been identified the next step is to take action. This usually involves a series of interventions. This could include restructuring, introduction of new processes, team-building sessions and retraining. The person responsible for driving the change will need to establish the support elements necessary for change. According to Cornelius and Associates there are 8 essential support elements.

1. A realistic project plan
   The leader ensures that a step-by-step plan, has been produced in the planning phase.
2. An organization structure for managing the change
   The leader must ensure the structure for implementing and managing the change is installed. The leader should establish a system that seeks involvement and ownership of key stakeholders. Typically, the organizational structure for doing so consists of a team approach
3. Internal change agents
   The leader identifies and orients a coalition of internal change agents. These agents will act as facilitators and "cheerleaders" of the change. (Getting key people on board)
4. A formal communication plan
   The leader creates a formal communications plan for the life of the change initiative. First, all key stakeholders must be identified. Then, for each stakeholder the leader develops the types of information necessary, the frequency of the information, the method of communication, and the responsible party for carrying out the communication.
5. A formal training plan
   The leader identifies the new skills or training necessary for the change to be successful and establishes a formal training program to fulfil those goals.

Often key stakeholders will need new skills in either bringing about the change or in operating in the new environment once the change is completed.

6. Barrier removal
   The leader makes a concerted effort to first identify barriers in the environment that will inhibit or prevent the change, and then develops action steps to systematically remove the barriers. Barriers can include staffing (not enough people or release time to carry out the change), lack of budget, lack of management support, competing initiatives, etc.
7. A supportive and aligned management group
   In many change efforts there is lack of alignment and support among the management group, which hinders the change process. The leader's first responsibility is to ensure that his/her management team presents a united front about the change. Often the leader will insist that successful change performance is tied to the performance management system of the organization.
8. A system of periodic audits and feedback
   In order to map progress against the change goals, as well as to help institutionalize the change, the leader must install an audit process, as she/he would for quality, customer service, or employee satisfaction purposes. Psychologically, it is important to build in a "quick win" or a "quick success" to help build momentum for the change.

(adapted from The role of leadership: the role of leading change in the organisation - Cornelius and Associates)

Re-Freezing

The final step is re-freezing. It is important that the change becomes the norm and that those involved in the change process do not revert to the pre-intervention behaviour. It is possible to monitor this through audit as part of the quality control system.

Planned change is "*an iterative, cyclical process involving diagnosis, action and evaluation and further action/evaluation."* Burnes 2000

Emergent change acknowledges that because the very nature of change is unpredictable and evolving, change should be seen as a continuous process that unfurls as the process evolves. This method requires a radical approach. The managers/directors are not necessarily controlling the change process but are facilitating the change. They have to bring the staff together and motivate teams and groups to identify the need and achieve change. Within the process the facilitators need to create an environment that allows employees to express ideas that may be considered to be radical and different to what is accepted as traditional for the organisation. An environment where the employee is allowed to speak freely and challenge current thinking can foster ownership which in turn may trigger fresh and creative ideas that are relevant to the customer.

In reality it is likely that most successful change processes will incorporate aspects from both Planned and Emergent change models. The change process starts with a 'planned strategy' and as the process develops this is modified into the 'realised strategy' as the process is affected by changes within the internal and external

environment. This shows the necessity of a reflective approach and the value of evaluation throughout the process.

Barriers to Change

With the prospect of change comes uncertainty. Most people feel Kurt Lewin (1951) illustrated this with his 'Force Field Theory'. He states that there are two opposing forces 'driving forces' and restraining forces and that all behaviour is the result of an equilibrium between these two forces.

Forces resisting change / maintaining the status quo

Forces for change

Individuals may feel threatened when they are asked to move out of what they feel is their comfort zone. According to Fisher this is manifested in a series of emotions including anxiety, happiness, fear, threat, guilt depression disillusionment, hostility and denial.

Anxiety is made worse when the individual does not have enough information or is unable to see how the change will make thing better in the future. Communication is essential to reduce anxiety.

Happiness stems from the belief that something positive will happen and things will not continue as before. There is a danger that the individual may have unrealistic expectations of the change and may not share the same vision as other individuals.

Fear that things will not be the same and that they will be expected to act differently.

Threat, things are no longer the same and their beliefs and values may be challenged.

Guilt, they may bring in to question their previous behaviour and recognise that they may have moved away from what they recognise as their core beliefs.

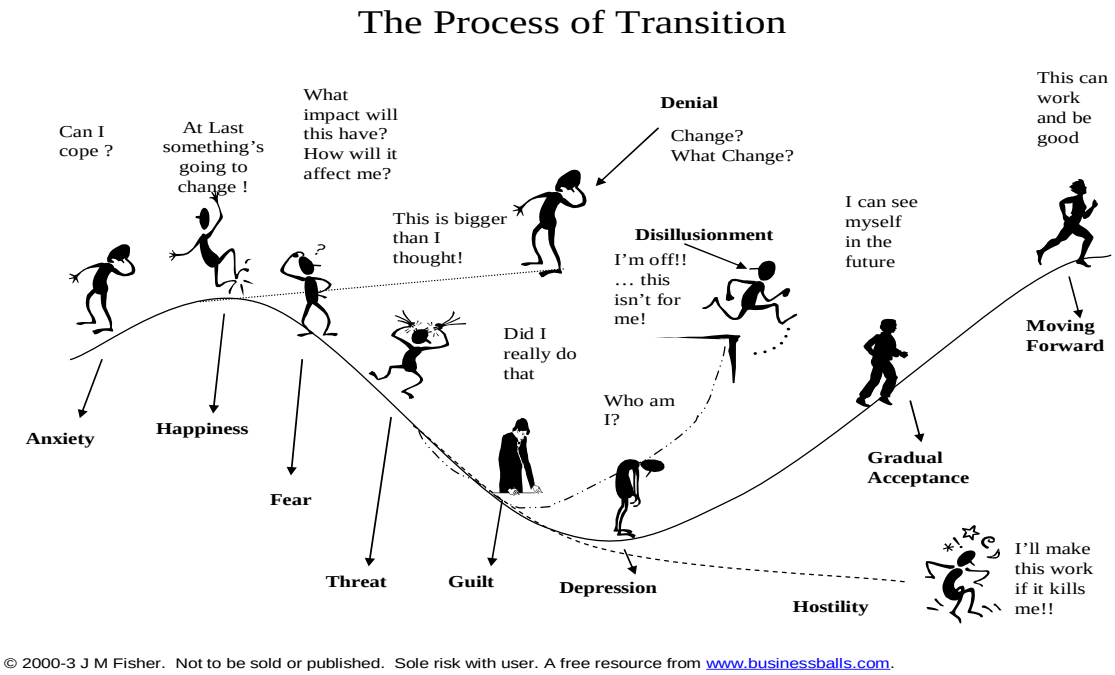
Depression is characterised by a lack of motivation. The individual may not be able to see how they will fit in once the change process has occurred and may feel inadequately prepared for a change in role.

Disillusionment, the employee becomes unmotivated and may feel that their values, beliefs and goals are different to and therefore no longer compatible with the organisation. This can lead to mental withdrawal (going through the motions, becomes critical and obstructive) or physical withdrawal where the individual leaves the organisation.

Hostility can occur when the individual is unable or unwilling to make the change work. They can at best ignore the new systems and at worst actively undermine them.

Denial, the individual continues to act as if the change has not occurred.

If the facilitator is able to communicate effectively allowing the individual to visualise how the change can positively affect the future there will be ***Gradual Acceptance.*** This will eventually lead to the organisation ***Moving Forward.***



So how can we implement successful change?

There is no magic formula! We can learn from others and from our own past experience. Jick (1991) suggests the following though this is by no means an exhaustive list: -

- **analyze the organization and its need for change**: look at the company's history of changes (successes and failures), patterns of resistance; analyze the forces for and against change (Force field analysis)

- create a **shared vision** and common direction: this should reflect the values of the company; the vision should include the rationale, the benefits, personal ramifications
- **develop a non-threatening and preferably participative implementation process**: skilfully present plans, make information readily available; explain the benefits for end users; start small and simple; go for quick wins; publicise successes
- **separate from the past**
- create a sense of **urgency**
- support a **strong leader role**: the change advocate role is critical to create a vision, motivate employees to embrace that vision and craft a structure to reward those who strive toward realization of the vision
- line up **political sponsorship**: broad based support is important (both formal and informal support); identify target individuals and groups whose support is needed; define the critical mass of support needed; identify where each key player is on the continuum (from "no commitment", "may let it happen", "help it happen" to "make it happen"
- craft an **implementation plan**: this plan maps out the effort
- develop **enabling structures**: examples include pilot tests, off-site workshops, training programs, new reward systems, symbolic changes like redesigned work spaces
- communicate, **involve people** and be honest: not every change effort calls for full involvement, communication and disclosure but most do; where possible there should be meaningful dialogue that gives people a stake in the change
- reinforce and **institutionalize change**: it is important to reinforce the change, reward those who take risks and incorporate the new behaviours

Resources

www.corneliusassoc.com

www.businessballs.com

References

Jick, ToddD, “Implementing Change,” Harvard Business School Case N9-491-114, 1991
Lewin,K (1951), Field Theory in Social Science, Harper
Burnes, B Managing change: a strategic approach to organisational dynamics, 2000 (3rd ed.) FT Prentice Hall

Research/Audit made easy

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Aims

Health care practitioners working within a health care setting provide practice that is evidence based. This session introduces practitioners to the basics of research and audit in practice and thus giving them the opportunity to increase their knowledge base of the research process. It is hoped that this will encourage practitioners to undertake research in a safe, confident and ethically manner.

Learning objectives

By the end of the session and following a period of reflection the practitioner will be able to:

i) Demonstrate an understanding of the research process and research methodology
ii) Understand and discuss the differences between qualitative and quantitative research
iii) Demonstrate an understanding of how to review a research article
iv) Demonstrate an awareness of the ethical issues in the research process

Lecture summary

This session will be interactive and follow the format of the research process:

- Introduction
- Research design
- Gathering data
- Working with data
- Presenting findings

Introduction

This initial part of this session gives the practitioner the opportunity to reflect on why research is needed in relating the theme around evidence-based practice. Examples will be presented of nursing research undertaken within reproductive medicine. This will support the importance and requirements of health care staff working as competent practitioners within their own clinical areas.

The session will also discuss how to commence a research study considering the need for an idea, barriers to research within the clinical environment as well as the lack of experience of working with research. Consideration will also be given to the development of a research proposal and presentation to the ethics committee.

The need for a literature review and critique is discussed. Consideration will be given on how to read and review research articles (Greenhalgh, 2001, Cormack, 1996).

This session will include audience participation in specific exercises to explore these areas.

Research Design

This will provide an overview of examples of research design considering the differences between qualitative and quantitative research (Clegg, 1981, Swinscow, 1990). The session will include audience participation in specific exercises to explore these areas. We will explore how studies are carried out. Consideration will be given to the ethical issues that can arise from research practice (Parahoo, 2006). The need for ethical approval, information giving and informed consent is essential within the research process as well as ensuring confidentiality of the sample group and security of data storage.

Gathering data

Examples of different tools to gather data will be discussed. This will be discussed in relation to the context of the research method. Types of the data gathering tools include: observations, questionnaire, and interviews (Lanoe, 2002) as well as measurements (Cormack, 1996).

Working with data

Consideration will be given in relation to analysis of data with reference to qualitative and quantitative research. Data is often scrutinised manually looking for concurrent themes within the qualitative research design as well as through statistical/graphics databases such as SPSS and MINITAB (Cormack, 1996) for quantitative research. Examples will be given to support the concept of working with data.

Presenting findings

Consideration will be given to the importance of checking whether the original research question has been asked as well as limitations of the research study the practitioner has undertaken.

Presentation of the result is normally for quantitative studies through tables and graphics to present the statistical findings while qualitative research is presented through rich descriptive methods (Lanoe, 2002)

Completion of the research study includes discussing the findings of your study acknowledging limitations as well as the strengths and weaknesses of the study (Lanoe, 2002). References to be presented in line with either your local university or

if you are aiming to achieve publication or presenting at a national or international conference through their recommended reference protocol eg The Harvard Reference System.

Conclusion

It is anticipated that this session on 'Research/Audit made easy' will introduce the practitioner to research within clinical practice. It is recommended and encouraged that individuals undertake further reading around the topic as well as seeking support and advice from experienced researchers prior to writing a research proposal and subsequent research study. It is envisaged that the session will encourage practitioners to reflect on the research process.

References

Cormack D (1996) *The Research Process in Nursing* (3rd Ed), Oxford: Blackwell Science

Clegg F (1981) *Simple Statistics*. Cambridge University Press.

Greenhalgh T. (2001) *How to Read a Paper; The Basics of Evidence-Based Medicine*. (2nd Ed) BMJ Publishing, London
(Although this book has been written for medical staff it does help a research to focus on critiquing research literature. Extracts from the book (first edition) have also been reproduced on the BMJ website – http://bmjjournals.com)

Lanoe N (2002) *Ogier's Reading Research, How to make research more approachable*, Edinburgh: Bailliere Tindall
(This book is very easy read giving good tips and focus for the novice researcher. Well worth a read)

Parahoo K (2006) *Nursing Research Principles, Process and Issues*, (2nd Ed) Great Britain Macmillan
(Ideal book to read prior to undertaking a research paper)

Swinscow T (1990) *Statistics at Square One*. BMJ London
(very basic and useful for practical application)

Recommended further reading

Ashcroft R. and Pfeffer N. (2001) Ethics behind Closed Doors: Do Research Ethics Committees need Secrecy ? BMJ. 322: 1294-6

Butler J. (2003) Research in the Place where you Work – some Ethical Issues. *Bulletin Medical Ethics*. Feb/Mar 21-23

Robson C. (1993) *Real World Research: A Resource for Social Scientists and Practitioner-Researchers*. Oxford: Blackwell

The following journals also publish research reports:
Human Fertility

Human Reproduction
Journal of Advanced Nursing
International Journal of Nursing Studies
Nurse Researcher

Recommended web sites

Cochran Library
http://www.cochrane.org

Centre for Reviews and Dissemination, York University
http://www.york.ac.uk/inst/crd/

National Institute for Clinical Excellence (NICE)
http://www.nice.org.uk

The Scottish Intercollegiate guideline Network (SIGN)
http://www.sign.ac.uk