Positive practice change using appreciative inquiry in oncology primary care nursing

By Colleen P. Campbell

Abstract
Ambulatory oncology nurses struggle to meet the increasing demands placed on them. Increased volume of patients, more complex treatments and symptom management, an older population with multiple co-morbidities combined with fiscal and human resource restraints has created job dissatisfaction and the feeling of powerlessness in the current environment. The Appreciative Inquiry process enables nurses to become engaged in planning and creating positive change based on their knowledge, experiences and clinical expertise, as oncology professionals. Through surveys and group work, nurses in this project were able to turn theory into positive practice change, inspiring a new paradigm of primary oncology nursing. Through the promotion of innovation, we have inspired hope while advocating for our profession.

Introduction
Nurses throughout Canada have experienced an increase in the number and acuity of patients diagnosed with cancer. On average, 500 Canadians are diagnosed with cancer every day with five-year survival estimated to be more than 62% (Canadian Cancer Society, 2012). Population growth, aging and rising cancer incidence have caused a doubling of new cases of cancer in Ontario from 1982 to 2006. Survival rates for all ages have improved (Cancer Care Ontario, 2007). With the growing number of patients requiring chemotherapy, the majority of treatment has moved to ambulatory departments in community hospitals or cancer centres. The complexity of treatment delivery and symptom management is increasing with chemotherapy given in neoadjuvant, adjuvant or palliative intent over a number of years. Nurses in oncology struggle to cope with these increased numbers compounded by: an aging society with multiple co-morbidities, declining experienced human resources and budget restraints for material and educational resources (Davidson, Halcomb, Hickman, Phillips, & Graham, 2006).

In Ontario, cancer care workers have demonstrated a high rate of burnout related to volume of work and a sense of diminished personal accomplishment (Grunfeld, Whelan, Zitzelsberger, Willan, Montesanto, & Evans, 2000).

The nursing model of care for oncology outpatients has become fragmented with specialization in radiation, chemotherapy administration, navigation, survivorship and outpatient clinic visits. A variety of nursing models exists within these subspecialties and include shared-care, case management, nurse-led, patient navigation and interprofessional team (Canadian Health Services Research Foundation, 2012). Lee and colleagues (2012) found a lack of empirical evidence for these models of care within the ambulatory cancer system. Current oncology nursing work is driven by patient numbers, complexity and resource constraints (Lee, Fitzgerald, Downey, & Moore, 2012). In many outpatient oncology clinics, nursing has evolved through necessity to a primary model. This model initially complemented the physician through answering phone calls, directing patients, filling out requisitions and assisting with procedures (Porter, 1995). Through education and utilizing professional ideologies, many oncology nurses have evolved the primary care nursing model linking the interdisciplinary team. Various responsibilities include: direct care, supportive care, patient education and navigation of the system, accountability for professional practice, working collaboratively and using evidence-based guidelines (Cancer Care Ontario, 2011).

Interdisciplinary team involvement of the oncology patient has become the standard of care, where available. Many patients have a social worker, a dietician, and access to community services. They may also involve their primary care physician, surgeons, possibly physiotherapy, palliative care or pain management services. These services may or may not be in one centre or community with a number of people living in rural communities throughout Canada. Communication between providers can be onerous at best. The primary care nurse often becomes the contact person for many inquiries or concerns regarding treatment effects and management.

The unremitting growth of patient volume and acuity, increased nursing sub-specialties and isolation with reactive models of care, communication demands of team members and diminishing material and human resources have put a strain on the amount of time the nurse is available for true collaborative primary care practice. Frustration, feeling powerless among competing demands and lack of job satisfaction is infecting oncology nurses in many centres.

The purpose of this paper is to describe the Appreciative Inquiry methodology and how it was used in a quality improvement project to enhance the oncology nursing model of care and improve nursing experience.
Methodology
Appreciative Inquiry (AI) is a theory of collective action that encourages change through the strengths and vision of individuals. The aim is to search for new knowledge in a cooperative and positive way, therefore directing the vision and actions of the individuals involved. There are five central principles that move the theory to practice (Cooperrider, Whitney, & Stavros, 2008; Lind & Smith, 2008).
1. Constructionist principle: Looks at the ways individuals and groups participate in the construction of their preserved social reality. In an organization, the question asked would direct the thinking and inquiry of individuals.
2. Principle of simultaneity: Recognizes that inquiry and change happen at the same time. Through discussion we generate and gather data, therefore directing change and formulating the outcomes we seek.
3. Poetic principle: Organizations are living and directed by their employees. They are composed and engaged by the experience, learnings and interpretations of the organization. As an organization, there is a choice of what to study and how to interpret our findings.
4. Anticipatory principle: The vision we have for the future directs our thoughts, actions and behaviours in the present. Organizations exist because of the collective vision for the future, such as is developed in strategic plans. Those visions drive our goals and actions in the present.
5. Positive principle: Organizational systems respond to positivity. They are empowered by inspiration and hope. If an organization engages employees in a positive nature, then a more sustainable future will exist.

Contrary to problem-based inquiry, AI causes individuals to consider what is working well. Through focusing and gathering data on our successes, we envision a superior future, collectively inspire motivation and create excitement moving forward. This approach is unique in its ground up approach, facilitating empowerment, positive relationships and collaboration around common goals. Initially a theory of organizational development, this approach has been successful in a number of organizations and settings to facilitate change management. It has emerged this approach has been successful in a number of organizations and settings to facilitate change management. It has emerged with increased frequency in health care literature. In recent years, AI has been used to effectively facilitate knowledge translation (Yoon, Lowe, Budgell, & Steele, 2011), enhance collaborative practice (Havens, Wood, & Leeman, 2006), reorganize health care services (Richer, Ritchie, & Marchionni, 2009), improve staff retention (Challis, 2009), enhance patient safety (Shendell-Falik, Feinson, & Mohr, 2007), and improve practice and transformative change (Carter, Ruhe, Weyer, Litaker, Fry, & Stange, 2007; Lazic, Radenovic, & Mohr, 2007).

Appreciative Inquiry identifies common goals and values of individuals. From those goals, themes are developed utilizing group dynamics. There are four essential stages. Discovery is used to determine what is positive and meaningful. Dream is used to envision a new future. Design assists in planning and implementing change. Destiny is the stage of evaluation and sustaining progress.

Many oncology nurses are experts in the care they provide. AI utilizes nurses’ clinical expertise, knowledge, experience and compassion through reflection on what has worked best. Through the four-stage systematic method, nurses envision what their work could look like in the future, and then determine processes to make the vision a reality. Progressing on a continuum, nurses realize the change created, combining individual skills to create more complex care plans and focus on excellence.

Methods
The objective of the project was to explore the practices of oncology primary care nurses that gave them job satisfaction; to build on those positive practices and enhance our model of nursing care. This was done through surveys and group work.

Participants
The project was conducted in a non-academic cancer centre approximately 100 kilometres north of Toronto, Ontario. In this centre, the oncology primary care model is used in the outpatient clinics. Each of the seven medical oncologists and one general practitioner in oncology is assigned a primary nurse. The nurses cover each other for vacations, illness and other variations in staffing. All eight oncology primary nurses agreed to participate in the project. One dropped out due to extended illness.

More than half the nurses (57.2%, n=4) had greater than 16 years of oncology nursing experience, although 71% (n=5) had been in a primary care role less than six years. Canadian Nurses Association
Certification in Oncology had been obtained by 85.7% (n=6). The highest education in nursing was diploma for 66.7% (n=4), which is representative of the average age group (Figure 1).

**Design**

A survey was created to explore common themes of interest and importance. Reflective discussions occurred on a regular basis to maintain motivation and engage stakeholder input. The survey incorporated the four stage cycle of iterative phases (Table 1).

A survey exploring the experience of the participants using AI was done after 10 months.

**Data analysis**

The survey was sent in paper format to all primary care nurses. It was offered to other members of the inter-disciplinary team, and two additional surveys were completed by nurses who worked in a casual basis in the clinic. Results were put into a table reflecting the phases of AI. Statements made by more than one person were repeated in the table. Two members of our team separately reviewed the results and identified major themes in the content. Line-by-line coding was not done. Discussion regarding the content interpretation and relevant themes was held and verified with the larger group to obtain consensus.

<table>
<thead>
<tr>
<th>Table 1: The four stage cycle of iterative phases</th>
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<tbody>
<tr>
<td><strong>Discovery</strong></td>
</tr>
<tr>
<td>Appreciate what is.</td>
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<tr>
<td>What are the key steps to providing patient care in your area? Give as much detail as possible.</td>
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<tr>
<td>Reflect on your own experience. Tell me a story about a time when you experienced “exceptional patient care”. Include high points when you would have wished all patient experiences were like this. Include as much detail as possible.</td>
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<tr>
<td>Describe creative strategies you have learned that facilitate efficient, effective patient care.</td>
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<tr>
<td><strong>Dream</strong></td>
</tr>
<tr>
<td>Imagine what might be.</td>
</tr>
<tr>
<td>In your opinion, what is required from others to better support exceptional patient care? Consider resources, environment, communication, practices and roles.</td>
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<tr>
<td><strong>Design</strong></td>
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<tr>
<td>Determine what should be.</td>
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<tr>
<td>Imagine a good friend is going to be treated at our clinic. What would you ask the staff to do to provide the best possible patient care? Who do you want included in decision making? What information or documentation would you request?</td>
</tr>
<tr>
<td><strong>Delivery</strong></td>
</tr>
<tr>
<td>Create what will be.</td>
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<tr>
<td>Imagine it is three years from now and exceptional patient care is the norm. Please describe it in detail. What are you doing that is new or different? What three key changes have been made? What barriers need to be broken down to achieve the changes? What did you do to assure the changes occurred in a smooth and rapid fashion?</td>
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**Results**

Four themes with a strong vision for the future were identified.

**Knowing your patient**

The nurses enjoyed getting to know their patients. Spending time through assessment and being available for problem solving was important to them. Having the information they needed for completeness was imperative. They felt valued when they were included or were asked for input in the plan of care. Consistency of care provider ran through all the themes and intertwined with communication. Their vision was to have the time and documentation available to provide personalized care for their patients.

**Team approach**

Access and input into the plan of care resonated with this theme, as well. They felt good when they were part of a co-operative approach between intra-disciplinary team members. Patients were best served when the whole care team was involved. The future includes clear role definition and a comprehensible communication plan.

**Patient focused**

Best care practices involved consistency of care providers and easy access to the plan of care, facilitating clear messages to patients. Opportunities to have flexibility for drop-ins, phone calls or health teaching would be the ideal. To facilitate team-based care, they need and expect access to various team members.

**Knowledge and skill**

Treatment plans, goals of care, and advance care planning are all important to nurses. Having the knowledge and skill to contribute to these plans, along with nursing history and physical examination are important to nurses. They value leadership support in guiding them in their career development.

The four major themes were taken back to the nurses and validated.

We decided on three themes, knowing your patient, team approach and patient focused, as our centre of attention. Knowledge and skill sat in the “parking lot” to be incorporated into each of the other themes, as we went along. Nurses created projects that interested them and would contribute to improved patient care. They worked individually or in groups to come up with projects that would reflect the collective themes. Two nurses focused on the breast population to improve access and knowledge about lymphedema. Two nurses focused on palliative care referral processes and resources for patients in the community. Other nurses are working on flow sheets to standardize nursing processes and clarify their roles. In order to maintain momentum we met every two weeks to review plans, give collegial support and input.

A qualitative survey was done 10 months after the project was initiated. Two nurses completed the survey. The experience had been favourable overall. Nurses expressed frustration at not having dedicated time to complete their projects. They gained an understanding of the expertise each nurse brings to the team and the common goal of quality patient care. Nurses were encouraged that they were being listened to and were part of positive practice changes.

**Discussion**

The initial surveys were sent out to all disciplines of the cancer program. Only eight primary nurses completed and returned the survey. At that time, the cancer program was anticipating a physical move from an 8,000-square-foot space to a 75,000-square-foot cancer centre. The computer platform used was undergoing change for which all employees would have to...
be re-trained. All staff was anticipating change to where and how they worked. An Employee Experience survey done at that time demonstrated staff morale below the provincial average. Over the course of the project we had staff off for surgery, critical illness and bereavement.

The nurses pulled together and shared their visions for a better future. Due to financial restraints and competing priorities, the nurses were unable to meet in a large group to share experiences and encourage momentum. In order to facilitate a collective vision, a workshop away from the work environment may have helped create more excitement and momentum moving forward (Ruhe et al., 2011). Being committed to the process by having an AI summit, as suggested by Cooperrider et al. (2008), would have provided the opportunity to collectively spur the energy and creativity for action plans. We have met for a 45-minute meeting every second week. The need to reflect and stay solution-focused has required strong leadership, building a climate of trust (Keefe & Pesut, 2004). Persistence in communicating our vision, goals and commitment to enhance our model of care at regular intervals has been essential (Reed & Turner, 2005).

The number of nurses involved in the process was small and there were staff changes during this time. The project was done with the clinic nurses only. It may have benefited from involvement of all nursing at the centre. There may not be one solution. It is quite possible that there will be multiple models of care within oncology nursing depending on the setting and area worked. The very nature of the AI process is ideal to utilize the strengths, experiences and creative potential of oncology nurses regardless of the setting. Further nursing research is warranted.

The model of care is evolving. Nursing leaders need to utilize the experience and commitment to care inherent in all oncology nurses. Collectively, nurses have a loyalty to their specific population and the future generations of oncology nurses to create a better future.

### Conclusion

The number of patients requiring ambulatory cancer care is growing, and will continue to do so. Many oncology nurses are overwhelmed with the workload and lack of clarity in their role or model of care. The AI methodology was used to evolve the model of care utilizing a group up approach. It has provided the clinic nurses with autonomy and some control over their destiny. In focusing on positive solutions, they are gaining momentum and moving toward a more interdisciplinary model of care within disease sites. There is a feeling of empowerment and enthusiasm within the team. We haven’t got it quite right yet, but we are definitely moving in the right direction.

### REFERENCES


