

## CHNC Educational Package

### Developing Leadership Skills for a Community of Practice: Examples include Chronic Disease Prevention and Self-Management

#### Module 3: Learning to Work Together

This module is the fourth in a series of five on developing leadership skills for forming and maintaining a CoP. Communities of practice are made up of people who share a concern or a passion for what they do and want to learn how to do it better. Following the launch of a community of practice, members meet regularly to exchange ideas and refine their agenda. In this phase of development, CoP members must learn to work together and build a strong foundation for future collaboration. Module 3 focuses on the leadership skills required to assist CoP members to do this.

#### Learning Objectives

By the end of this module, you will be able to:

1. Identify strategies to enable the CoP to focus enquiry, build relationships and begin to create a shared body of knowledge
2. Compare problem solving processes for knowledge development in a CoP
3. Discuss strategies for gathering, sharing and storing information/evidence
4. Reflect on the links between activities of the community of practice and the CCHN Standards

#### Possible Agenda for a Focused Discussion on Module 3 (1.5 hours)

- 1) Introductions and Check-in (15 minutes)
- 2) Module Work (60 minutes)
  - a) Learning objectives and preliminary material
  - b) Discussion of questions
- 3) Preparation for module 4, round table and wrap-up (15 minutes)

#### Discussion Question (to guide preparation)

1. ***Describe the most positive experience you have had when working in a group. How long did it take for you to feel positive about the experience?***
2. ***With this experience in mind, discuss how fundamental personal rights were addressed in the group. These rights are: to have opinions, to be respected, to have and express feelings, to make mistakes (and be forgiven) and to accept these rights in others (Woods, 1994, 5-3).***

## **Manage the structures and processes that will enable the community of practice to focus enquiry, build relationships and create a shared body of knowledge**

A community of practice approach has been used to initiate practice change around a wide range of health issues. Although a community of practice is launched with a common focus, it needs to develop a more specific agenda in order to progress. The early meetings are crucial to creating that agenda. During these meetings, participants get to know each other, learn what others do, and find out their interests and areas of expertise. This happens through the usual social mechanisms of talking to each other and exchanging information. Community members need to find value in being part of the community of practice. Equally, CoP leaders need to check that this is happening. Evaluating the launch of one community of practice, participants were asked to select the two main things they had gained from the launch from a list of five items, or they could add other items. As shown in Table 1, the gains most frequently selected were knowledge of working together; links with nurses in other types of practice, and knowledge about the overlap in practice issues. Overall, the feedback reinforces the importance of keeping a balance between sharing knowledge about practice and facilitating linkages; both aspects were deemed important by participants.

**Table 1: Two Main Things Gained from the Workshop Launch**

	Number of participants selecting item n=38
1. Knowledge of working together in a community of practice	26
2. Links with other nurses working in other types of community practice	19
3. Knowledge about how practice issues overlap in the community	14
4. Energy/enthusiasm/motivation	7
5. Ideas that will be useful to my organization	7
6. Other: togetherness, fellowship	1

Through the process of meeting on a regular basis, talking with colleagues about problems and solutions, sharing insights from academia and practice, the community begins to accumulate knowledge. According to Knight (2002), gaining procedural knowledge, that is, skills, information and rules, expectations and dispositions concerning the field of practice, are emergent properties of a community of practice. Having a range of disciplines from more than one

organization, comparing and contrasting practice facilitates this process. Though, as complexity increases, it is more important than ever that members of the community learn how to work effectively together to focus their enquiry and achieve a common goal.

### **Defining/Refining the focus —Talking about practice**

Read the following case study, which provides a context for today's discussion. Building on material presented in module 2, it provides some starting points, and/or questions about Chronic Disease Self-Management.

#### **Case Study:**

Regional planners / Local Health Integration Network (LHIN) have issued a call for proposals for projects to improve Chronic Disease Self Management (CDSM) in community programs. Nurses in the community of practice talk about their role in CDSM.

#### **Community health centre nurse:**

“We pride ourselves on meeting the needs of our communities. Yet an environmental scan of health centres in the region found too little emphasis on CDSM in programs and services. We need to make changes but do not know where to start.”

#### **Home Care nurse:**

“The majority of our clients have at least one chronic disease. We try to encourage self-management and healthy lifestyles but are not funded to do health promotion.”

#### **Public Health Nurse:**

“We work with populations, including those at risk, to increase access to health resources and promote healthy lifestyles, thereby preventing chronic disease. What is our role in CDSM?”

Members of the group find it useful to hear what other health providers in community programs are doing and decide to find out more about models and best practices in CDSM.

### **Discussion Questions**

- 3. Compare top down and bottom up approaches to setting an agenda for learning more about CDSM.***

**4. Suggest two or three questions that might guide members of the community of practice in their initial search for information on CDSM.**

The CoP facilitator plays a key role in creating a forum for sharing practice knowledge and facilitating effective processes of information gathering, debate and decision making; however, community leaders, subject matter experts and members of the community all have a role to play in making the CoP work well.

**Learning to work together — Blending knowledge and experience.** Nursing Standards of Practice tell us we should base our practice on the best available evidence; taking account of the different ways of knowing. Two important distinctions are: knowing what and knowing how, sometimes referred to as explicit knowledge and tacit knowledge. Nursing draws on both types of knowledge and draws evidence from a variety of sources: the research literature, best practice guidelines, and from a wealth of experience.

Explicit knowledge (also known as propositional knowledge) is stored in written or electronic form (Sandars & Heller, 2006). However, it is estimated that only 80% of knowledge used every day in the workplace is available in written form. Much knowledge that is important for effective practice is stored in the minds of practitioners. For example: understanding about what is likely to work or not work in certain situations; how to put families at ease in a home visit, knowing who to go to in an organization and how to draw on past experience when facing an emerging problem. Dealing with such situations in practice requires the nurse to bring together book learning and best practices with experiential or tacit knowledge about what works.

**Compare problem solving processes for knowledge development**

There are several methods of enquiry that have been used to develop knowledge for practice. Three are discussed here.

- Problem-based Learning
- Appreciative Inquiry
- Action Research

**Problem-based Learning.** Problem based learning uses a problem situation to drive learning. It seeks to develop a process and set of problem solving skills that might be applied to many different situations. The key steps are listed below.

- Use the problem situation to identify issues. Elaborate.
- Try to solve the problem with what you currently know. From this will come a clearer idea of what you know already that is pertinent.
- Identify what you do not know and therefore what you need to know because your lack of that knowledge is impeding the solution of the problem.
- Prioritize the learning needs, set learning goals and objectives, and allocate resources so that you know what is expected of you by when. For a group, members can identify which tasks each will do.
- Self-study and preparation.
- For a group, share the new knowledge effectively so that all the group learn the information.
- Apply the knowledge to solve the problem.
- Give yourself feedback by assessing the new knowledge, the problem solution and the effectiveness of the process used. Reflect on the process. (Woods, 1994: 2-2)

**Appreciative Inquiry.** This approach is used to achieve organizational change. Rather than focus on problems as the starting point, Appreciative Inquiry focuses on strengths. ('Inquiry', the American spelling, is interchangeable with 'enquiry'.)

There are four steps to the approach — “the 4D cycle”.

- Discovery: Appreciate “the best of what is”.
  - Dream: Imagine “what could be”.
  - Design: Determine “what should be”.
  - Destiny: Create “what will be”.
- (Ludema, Whitney, Mohr & Griffin, 2003: 10).

The process is intensive and requires organizational commitment and the support of trained facilitators. An example follows. Building on the scenario described above, nurses and managers would come together for an intensive two-day meeting. After setting the stage for the two days, participants would break into small groups to discuss the importance of CDSM to elicit perceptions of the what they were doing well and the value of work in this area, to themselves, their organization, their clients. In a full group discussion, the facilitators would help to identify the core positive themes. Topics that might arise are the importance of teamwork; organizational support; providing excellent services, for instance. These core topics would then be translated into a few questions, which would be explored in paired interviews, each person interviewing the other, to gain what Ludema and colleagues describe as the ‘positive core’ of the work. This discovery phase provides graphic stories of the individual and organizational strengths in this area and builds energy for developing and designing the future. A similar positive energy has been

consistently witnessed when nurses come together to describe their practice in terms of the CCHN Standards.

**Action Research.** Action research is the design and modification of social change by the people who are part of the change process through cycles of data collection and decision making (Lewin, 1946). Action research is advocated as a means of incorporating humanistic and naturalistic forms of enquiry into the examination of practice (Holter & Schwartz-Barcott, 1993). Action researchers (Bradbury & Reason, 2003; Grundy, 1982; Holter & Schwartz-Barcott; Murphy, 2000) consistently identify three to five key characteristics of action research:

- The subject matter is the need for change in social practice.
- The purpose is to solve a practical problem and develop new forms of understanding.
- The action is to contribute broadly to human emancipation.
- The project is a spiral of cycles of planning, acting, observing, and reflecting that are implemented and interrelated systematically and self-critically.
- The project involves the collaboration of the researcher and practitioners in all cycles.

Again, using the scenario described earlier, researcher and practitioners would together agree on common values underlying the enquiry, for example one might be the desire to improve client outcomes. Together the team expresses the nature of the problem, as they now see it, and identify what data would be required to solve the problem. For example, the community health centres might start with the results of the environmental scan to examine the criteria used to rate CDSM activities and the findings. This would provide a common understanding of the nature of the gaps and provide information to guide further enquiry and data collection. For example, the team might find that one of the services scored better than others in the scan and decide to explore the reasons for this. This cyclical process serves to redefine the nature of the problem based on empirical data and focuses enquiry.

There are common elements to the three approaches: the process of asking questions; identifying what is known; seeking out information. This iterative process can be used to guide the early phase of a community of practice, together with a consensus building approach to ensure community engagement.

Lave and Wenger's (1991) theory of situated learning (Legitimate Peripheral Participation [LPP]) provides a theoretical explanation of how a community of practice works. The theory proposes that skills, knowledge, and identity are developed through participation in day-to-day work activities and interactions with others. The community of practice guides development and in turn group

members identify with the group's expertise and create shared practices. Many argue that this combining of experiential knowledge and evidence is required to provide a rigorous understanding of best practices.

(Andrew, Tolson & Ferguson, 2008; Dicenso, Guyatt, & Ciliska, 2005; Tsui, Chapman, Schnirer & Stewart, 2006).

In part, the repertoire, or shared body of resources rests within the minds of participants as tacit knowledge. The other part can be stored as explicit knowledge in journal articles, clinical guidelines, in libraries or electronic databases (Sandars & Heller, 2006). This requires human and information systems to store information and make it available and to help community members think together (Tsui et al., 2006).

### **Discuss strategies for gathering, sharing and storing information / evidence**

As information begins to accumulate, it needs to be managed. Technology is one of the three key elements that needs to be managed to create a healthy infrastructure for the CoP (Garcia & Dorohovich, 2005).

Resource inventories are a way of keeping tabs on the information gathered by the community. Appendix B shows a resource inventory of documents pertaining to CDSM.

**Example of Working Together:** Members of the community of practice in the scenario described earlier, mapped the assets in their community to identify common interests, resources and opportunities for collaboration. They interpreted the results against the provincial framework of chronic disease prevention and management.

From this, came the realization that members of the community of practice were addressing CDSM from many different angles in the workplace at different levels of the system. Seeking a practical application, the community of practice decided to produce a workshop package that introduced the principles of self-care prevention and management to front line workers, including personal support workers. A key objective was that the workshop could be adapted to the needs of the different organizations in the community of practice. The initial plan for the workshop follows.

**Plan for a half-day workshop and learning package on chronic disease self-management.**

**Draft Agenda:**

<b>Objective</b>	<b>Time</b>	<b>Activity</b>
Engage participants in a dialogue on self management	20 mins	Small group activity: Working in pairs, describe a situation where you felt you made a difference in a) helping a client or group manage a chronic illness, or, b) engage in healthy lifestyle.
Differentiate between staying healthy and managing acute and chronic illness	20 mins	PowerPoint presentation of differences between efforts to stay healthy, manage chronic illness and manage an acute illness.
Identify challenges and opportunities	20 mins	Full group brainstorming on key challenges, drawing on earlier discussion & Powerpoint summary.
Differentiate traditional education and self-management education	10 mins	Powerpoint slides compare & contrast.  So what is the health provider role?
Definition of self-health and self-care management		Powerpoint slide & discussion of implications for health providers.
Skills to support self-management	1 hour	Presentation & demonstration: Mastery learning, problem solving, developing an action plan, information giving, readiness to change (use examples from introductory discussion).
		Small group activities using CDSM tools.
Evaluation and Wrap-up	15 mins	

**Discussion Question**

- 5. Reflect on how the knowledge development activities in the community of practice described above — asset mapping, interpreting data against provincial standards, identifying service gaps; collaboratively developing solutions — exemplify the CCHN Standards?**



## **Summary**

Bringing together nurses from academia and practice settings in a deliberative process to form communities of practice within a health region has the potential to provide community nurses with an opportunity to share experiential learning, identify common problems, and transfer knowledge across community settings. In the long term, this can increase the capacity of community health nurses to base practice on information about what works. In addition to improving practice, enabling nurses to learn and solve problems together has the potential to break down silos across health sectors in the community, and potentially, to increase access to effective health promotion and disease prevention nursing services.

## **Preparation for Module 4**

1. Review the discussions from this module within your organization or team. Document questions or comments that you can bring up at next teleconference.
2. Review materials and discussion questions for Module 4, including discussing questions with others. Post responses on website two days before Module 4 workshop.

## References and resources

- Andrew, N., Tolson, D., & Ferguson, D. (2008). Building on Wenger: Communities of practice in nursing. *Nurse Education Today*, 28, 246-252.
- Bradbury, H., & Reason, P. (2003). Issues and choice points for improving the quality of action research. In M. Minkler & N. Wallerstein (Eds.), *Community-based Participatory Research for Health* (pp. 201-220). San Francisco, CA: Jossey-Bass.
- Dicenso, A., Guyatt, G., & Ciliska, D. (2005) Evidence-based nursing: A guide to clinical practice. St. Louis, MO.: Elsevier Mosby, 2005.
- Grundy, S. (1982). Three models of action research. *Curriculum Perspectives*, 2, 23-34.
- Holter, I., & Schwartz-Barcott, D. (1993). Action research: what is it? How has it been used and how can it be used in nursing? *Journal of Advanced Nursing*, 18, 298-304.
- Knight, P. (2002). A systemic approach to professional development: Learning to practice. *Teaching and Teacher Education*, 18, 229-241.
- Lave, J. & Wenger, E. (1991) *Situated Learning. Legitimate peripheral participation*, Cambridge: University of Cambridge Press.
- Lewin, K. (1946). Action research and minority problems. *Journal of Social Issues*, 2, 34-36.
- Ludema, J. D., Whitney, D., Mohr, B. J., & Griffin, T. J. (2003). *The Appreciative Inquiry Summit: A Practitioner Guide for Leading Large-Group Change*. San Francisco, CA: Bennett-Koehler Publishers, Inc.
- Murphy, F. A. (2000). Collaborating with practitioners in teaching and research: a model for developing the role of the nurse lecturer in practice areas. *Journal of Advanced Nursing*, 31(3), 704-714.
- Sandars, JE & Heller, R (2006) Improving the implementation of evidence-based practice: a knowledge management perspective, *Journal of Evaluation in Clinical Practice*, pp341-346, 12(3).
- Tsui, L., Chapman, S. A., Schnirer, L., & Stewart, S. (2006). *A handbook on knowledge sharing: Strategies and recommendations for researchers, policymakers, and service providers*. Edmonton, Alberta: Community-University Partnership for the Study of Children, Youth, and Families.
- Woods, D. R. (1994). *Problem-based learning: How to gain the most from PBL*. Waterdown, Ontario: D.R. Woods.

## Appendix A - List of Discussion Questions

1. *Describe the most positive experience you have had when working in a group. How long did it take for you to feel positive about the experience?*
2. *With this experience in mind, discuss how fundamental personal rights were addressed in the group. These rights are: to have opinions, to be respected, to have and express feelings, to make mistakes (and be forgiven) and to accept these rights in others (Woods, 1994, 5-3).*
3. *Compare top down and bottom up approaches to setting an agenda for learning more about CDSM.*
4. *Suggest two or three questions that might guide members of the community of practice in their initial search for information on CDSM.*
5. *Reflect on how the knowledge development activities in the community of practice described above — asset mapping, interpreting data against provincial standards, identifying service gaps; collaboratively developing solutions — exemplify the CCHN Standards?*