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Introducing Reflective Practice Groups for Frontline Staff in Services for Adults with Disabilities

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Introducing Reflective Practice Groups for Frontline Staff in Services for Adults with Disabilities

Corinne Pearson

A Dissertation submitted in part fulfilment of the degree of MSc Leadership, Institute of Leadership, Royal College of Surgeons in Ireland

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Table of Contents

		Page Number
Acknowledgements		4
Abstract		5
Chapter One	Introduction	
1.1	Introduction	6
1.2	Nature of Change	6
1.3	Rationale for Change	8
1.4	Context of the Change	9
1.5	Aims & Objectives	10
1.5.1	Evaluation	11
1.5.2	Role of Author	11
Chapter Two	Literature Review	13
2.1	Introduction	13
2.2	Search Strategy	14
2.3	Challenging Behaviour within Residential Services	14
2.4	Impact of Challenging Behaviour	15
2.5	Theories of Stress, Coping & Burnout	20
2.6	Implication for Interventions	23
2.7	Implications for the Organisation	26
2.8	Conclusions	27
Chapter Three	Methodology	29
3.1	Introduction	29
3.2	Process of Implementation	30
3.2.1	Preparing to Lead the Change	31

3.2.2	Building Commitment	34
3.2.3	Determining the Detail of the Change	35
3.2.4	Developing the Implementation Plan	37
3.2.5	Implementing the Change	39
3.2.6	Making it “the way we do business”	41
3.2.7	Evaluating& Learning	43
3.3	Conclusion	45
Chapter Four	Evaluation	46
4.1	Introduction	46
4.2	Outcome Review	47
4.3	Conclusion	51
Chapter Five	Discussion & Conclusion	52
5.1	Introduction	52
5.2	Discussion	52
5.2.1	Initiation	53
5.2.2	Planning	56
5.2.3	Implementation	58
5.2.4	Mainstreaming	60
5.3	Impact/Evaluation	62
5.4	Recommendations	65
5.5	Conclusion	67
References		68
Figures		
Figure 1	The Job Demands-Resources Model	21
Figure 2	HSE Change Model	30
Figure 3	Force-field Analysis	32

Figure 4 Stakeholder Analysis 33

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Abstract

This project focussed on the experiences of the Author through the process of introducing facilitated reflective practice sessions for front line staff working within a challenging behaviour unit. Staff supporting individuals who display challenging behaviour may be at risk of increased work related stress (Jennings, 2004) and can inadvertently interact in ways that can contribute to the presentation of challenging behaviour (Mitchell & Hastings, 2001; Noone, 2013; Phillips & Rose, 2010). Yet frontline staff working with individuals living in residential services are the key to promoting and facilitating participation with a focus on rights and equality as highlighted throughout the Disability Standards (Health Information and Quality Authority, 2013) following the recent introduction of regulation within this sector (Health Act, 2013). To support the Author in their role of leading the change initiative, the HSE model for change (HSE, 2008) was used as a framework to guide the process and the outcome of the project was evaluated through the identified SMART objectives, achieving each objective within the range of 60 – 75%. Alongside the identified objectives the Author identifies other potential benefits from introducing the reflective groups. The groups were shown to provide a positive impact for staff attending as they were able to have a safe space to discuss the challenges they faced and a forum to share ideas. Through a reflective process, the author provides a critical review of the project and also highlights recommendations for future progression of the project and ideas for actions that may have improved the outcome for the original project.

Chapter One: Introduction

1.1 Introduction

The purpose of this paper is to guide the reader through the process that the Author completed whilst introducing reflective practice groups for frontline staff in a service supporting adults with disabilities.

Working in a service supporting individuals who display significant levels of challenging behaviour creates a number of issues for a service provider whether they are within the state, voluntary or private sector. Any service providing healthcare is influenced by both internal and external factors, currently within Ireland there have been a number of social, cultural and economic pressures that have impacted on services across the sectors

With the recent economic situation, services have been under greater pressure to demonstrate value for money. This is reflected through national policy (Department of Health, 2012b) and the service plan for the Health Service Executive (HSE). It has also occurred at a time where there has been a cultural shift in the way in which services are viewed as being best provided, a closing down of the "old institutions" and a move to community integration and participation. All of which is supported by the introduction of regulation of all disability services (Health Information and Quality Authority, 2013) and the promise of the money follows the patient as part of a strategic plan to reform the HSE (Department of Health, 2012a).

Services need to find ways to ensure that they are managing their costs, whilst providing safe, efficient and quality services that promote quality of life, equality and rights for those requiring residential services (Department of Health, 2012a; Health Information and Quality Authority, 2013). Staff turnover can be a significant burden to services supporting individuals with challenging behaviour economically through the recruitment/training process of procuring staff. In addition, there is the impact through loss of corporate knowledge and the time required to redevelop that knowledge, as well as ensure that any appropriate training is completed prior to and following a new starter in the organisation.

Alongside this, there is the impact on staff when numbers are reduced following any turnover. This can create a sense of an unsafe environment and may create responses within the frontline staff that may inadvertently exacerbate incidents of challenging behaviour (Mitchell & Hastings, 2001; Noone, 2013; Phillips & Rose, 2010). This can lead to a risky cycle and ultimately a breakdown in service provision and reputation as well as potential risks of litigation against the service provider from disgruntled staff experiencing high levels of stress who consider that they were placed in an unsafe position through their job duties. The Health and Safety Authority highlights that it is an organisations responsibility to ensure that they have taken appropriate means to identify and mitigate against risks that are present in the work environment to protect workers from work related injuries (Health and Safety Authority, 2015). One of the risks for staff working and responding to significant challenging behaviour is stress and the impact of chronic exposure to potentially

traumatic events and there is acknowledgement of the need to integrate trauma informed knowledge not only into care delivery but also in terms of supporting staff (Jennings, 2004).

1.2 Nature of Change

The author of this project has a strong interest in mechanisms for staff support and has anecdotal evidence of the benefit of the provision of protected time to reflect on recent experiences, as well as first-hand experience of the benefits of clinical supervision. In consultation with the Senior Management Team and in line with feedback from a recent staff survey, it was agreed that there was a need to formalise a structure for providing staff support to frontline staff. This change initiative was focussed on the introduction of facilitated reflective practice groups, within unit based groups for all frontline staff within a service supporting individuals who display high levels of challenging behaviour.

To support this change initiative, the HSE change model will be employed as the framework to guide the author in developing and implementing the planned change. The HSE model has been selected as an appropriate model for this change initiative given the application to a healthcare setting and the recognition that whilst there are steps within the model it also accepts that change can be a continuous process, where steps can be interrelated and influence each other (HSE, 2008).

1.3 Rationale for the Change

Working with challenging behaviour can present a number of issues for staff with multiple exposures to trauma, at times there may be a sense of threat to an individual's life. There is evidence within the literature to highlight an association between challenging behaviour, staff stress and burnout (Hatton et al., 1999; Howard, Rose, & Levenson, 2009; Lambrechts, Kuppens, & Maes, 2009; Maslach, 2003; Mills, 2010; Raczka, 2005) therefore it is important for any service supporting individuals who display challenging behaviour to also explore means of supporting the frontline staff. There is growing evidence from a number of different disciplines including nursing, teaching, occupational therapy and psychology that reflective practice and supervision can mediate the emotional burden associated with the job (Dawber, 2013; Sendall & Domocol, 2009). However, for many of those working in the frontline, exposed to the higher levels of challenging behaviour, there is limited time provided for reflective practice and supervision in comparison to their professionally qualified colleagues. Given that challenging behaviour is known to increase staff stress and potentially lead to 'burnout', which, in turns leads to a greater level of risk for the service. This is seen in terms of higher levels of staff absenteeism or the presence of staff who "no longer care" and therefore a risk of staff acting outside of expected protocols. The Author believes that this is an important issue to address.

1.4 Context of the Change

The organisation is a private company that provides residential and day support for adults who display challenging behaviour in the context of intellectual disability, mental health difficulties and/or acquired brain injury. The organisation supports adults in a variety of settings from community houses through to a unit for complex behavioural presentations that accepts referrals on a nationwide basis. The majority of referrals are funded through the HSE, with a small number being funded privately through compensation awards or through the Ward of Court system. The services are supported by an extensive Multi-Disciplinary Team (MDT) incorporating both qualified professional therapists and frontline staff from Nursing, Social Care and Fetac level 5 backgrounds.

1.5 Aims and Objectives

Aim:

To promote reflective practice skills within all frontline staff working within an intensive challenging behaviour unit by having reflective groups for all units.

Objectives:

1. Each of the 4 units within an intensive challenging behaviour unit will have access to a scheduled reflective group session at least once a month, facilitated by a member from the Clinical Psychology Department by 30th April 2015.

2. Each group will be attended by 75% of the staff on shift by 30th April 2015.

3. A feedback system will be created to provide feedback to the senior management team of any relevant, identified and agreed issues that are important for frontline staff by 30th April 2015.

1.5.1 Evaluation

In order to evaluate the impact of this organisational development, the author will examine the progression or otherwise made in relation to the identified aim and objectives. Evaluation will also be considered within the context of national standards and regulation for Disability services (Health Act, 2013; Health Information and Quality Authority, 2013) and in conjunction with qualitative feedback from those participating in the groups and the Clinical Director and Person in Charge of the Unit. The final evaluation will explore the impact and role that the reflective groups have with the implementation of recommendations made following two external expert reviews of the service within the challenging behaviour unit.

1.5.2 Role of the Author

The author will facilitate the monthly reflective groups that the frontline staff will attend, they will ensure that attendance is recorded and an aide memoir record of each group maintained. Whilst the author works within the company, their minimal role in the unit where the groups are run allowed an opportunity to promote a separation between the group and line management issues.

The Author completed a literature review to help guide and support the plans for implementing the change, and will liaise with all relevant team members to promote an understanding of the project, the rationale and the hoped for outcomes from the successful implementation of the change initiative.

Chapter Two: Literature Review

2.1 Introduction

There is a long history of full residential service provision for people with intellectual disability, in particular for those who display challenging behaviour. The type of residential service available is very much influenced by the culture of service provision and in recent years in Ireland there has been a notable shift in ideology with a move away from older "institutions" and the promotion of community living with a strong focus on participation and equality of rights (European Commisson, 2000; Health Act, 2013; Health Information and Quality Authority, 2013; United Nations, 2006). In order to try and meet the needs of those requiring residential services there is an onus on the role of support staff to facilitate participation and promote rights and equality for those in services. Therefore, it is easy to argue that there is a need to have competent and engaged staff who can demonstrate a good understanding of the ongoing challenges faced by individuals living within disability services. This is more important considering that frequently the relationships that have the greatest influence on those living in services, is with the frontline staff who support them. Therefore, whilst services rightly focus on meeting the needs of those living within the service there is also a need to ensure adequate supports/ governance for the frontline staff given the influence that they can have on those living within the service (Hall, Oliver, & Murphy, 2001; Health Act, 2013; Health Information and Quality Authority, 2013).

2.2 Search Strategy

In order to complete an appropriate literature review to explore the issues relating to this project area the author accessed databases for social science, psychology and organisational journals using Emerald and PsychInfo. In addition, manual Google Scholar searches were completed. Keywords were identified to support the focus of the search and were: Challenging Behaviour; Stress Intervention; Coping; Burnout; Support Staff; Reflective Practice; Staff Support; Stress. The search was initially limited within the parameters of 1998 – current date, however, when exploring theories of stress and coping it was identified that there was a need to include some work presented in the 1980's which introduced a strong concept relating to the process of work stress. This is presented within the literature review as it has been used as a basis for the development of interventions aimed to reduce work related stress.

2.3 Challenging Behaviour within Residential Services

When thinking about challenging behaviour it is important to have a sense or definition of what is inferred by the term. Eric Emerson is often cited for his definition of challenging behaviour, he defines it as:

"culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (Emerson & Einfield, 2011)

It has long been accepted that individuals with intellectual disability often engage in behaviours that may put themselves or others at risk, or are considered to be socially unacceptable or aversive often leading to an exclusion from activities or accommodation. These behaviours can include (but are not exclusive to) physical aggression towards others or property, self-injurious behaviours, spitting, smearing, stereotypical or repetitive behaviours and have implications for the safety and well-being of the individual as well as those who are exposed to the behaviours. This is both in terms of direct physical implications as well as psychological and emotional effects (Noone, 2013)

2.4 Impact of Challenging Behaviour

Providing services to support individuals who display significant levels of challenging behaviour immediately creates a number of issues that can ultimately impact on the ability to effectively provide an effective, quality service that is value for money, including: staff turnover, staff stress, staff burnout, absenteeism and staff occupational injury (Hastings, 2002; Howard et al., 2009; Rose, Horne, Rose, & Hastings, 2004). There is a number of organisational impacts that relate to these issues including the potential negative impact for those within the service. These include changing staff leading to unfamiliar staff providing support, the financial costs with paying staff whilst absent with Occupational Injury or sickness and paying for any additional staff to ensure a full complement of staff on shift. In a review exploring health and well-being in staff in the NHS it was identified that were sick leave/absenteeism managed there would be an additional 14,900 whole time equivalent posts available whilst data from the HSE indicates that there would be a

€36million reduction in agency costs if absenteeism is managed (Health and Well Being Review Team, 2009; Redmond, 2013). There is an indication that for every 1% of absenteeism there is an associated 1.47% increase in agency costs (Redmond, 2013). It is easy to argue that if you can manage stress levels then you will also manage aspects of absenteeism, as perceived stress is known to be associated with physical and emotional health, cognitive functioning and general levels of well-being (Chandola et al., 2008; Mikels, Reuter-Lorenz, Beyer, & Fredrickson, 2008; Salmond & Ropis, 2005).

Added to this, there is the potential impact associated with services when there is a known negative reputation, a recognised vulnerability for services supporting individuals who display challenging behaviours. It can create a particular challenge especially when there is known to be high staff turnover or low staff morale, making it difficult to attract and recruit good quality staff. This creates a vicious cycle and ultimately impacts on the quality of service provided as well as creating additional risks, such as an increase in incidents of challenging behaviour. This can occur as care staff behaviour has been shown to be involved not only in the development of but also the maintenance of challenging behaviour (Hall et al., 2001). Alongside this, where there are the impacts for those being supporting within the service such as loss, perceived satisfaction with the service and in the development of appropriate social skills (Health Information and Quality Authority, 2013; National Development Team for Inclusion & Skills for Care, 2013). Therefore, it is important to explore means to promote staff retention and reduce the impact of factors that are

associated with staff turnover such as stress (Hatton & Emerson, 1998), support and supervision.

Supervision, and in particular reflective practice have long been a recognised part of practice within a number of disciplines e.g. Clinical Psychology, Occupational Therapy and is becoming more integrated into professions including Nursing and Teaching as well as in Management/Leadership training (Dawber, 2013a; Loo & Thorpe, 1999; Pearce, Phillips, Dawson, & Leggat, 2013; Sen, 2010; Sendall & Domocol, 2009). However, within many services supporting people who display challenging behaviour there is often a greater number of support staff (who may not have a professional requirement to engage in supervision) who act as the lynch pin for the service and have the greatest influence on the seen quality of the service as well as having an influence on the quality of social interaction for those supported through the service (Hatton, Emerson, et al., 1999; Hatton, Rivers, Mason, Mason, Emerson, et al., 1999).

It is these support staff who are the ones required to manage any incidents of challenging behaviour. They often work long shifts and antisocial hours with nights and weekends on duty and in many services they may not have immediate or quick access to the appropriate supports from their professional colleagues within the services. Therefore, it is unsurprising that surveys of staff have found reports of significant stress in the “frontline” staff to range from 25% to 32% (Hatton, Emerson, et al., 1999; Robertson et al., 2005) and unsurprising that there has been research

looking at approaches to address the potential stress and negative emotional reactions in care staff. It has been consistently reported that staff find challenging behaviour aversive and that repeated exposure to severe challenging behaviour can lead to emotional exhaustion and other symptoms of burnout such as depersonalisation and reported high levels of stress (Howard et al., 2009; Lambrechts et al., 2009; Maslach, 2003; Mills, 2010; Raczka, 2005; Rose et al., 2004; P Skirrow & Hatton, 2007).

With the introduction of regulation of disability services in Ireland (Health Information and Quality Authority, 2013) there has also been an increased demand on service providers demonstrating appropriate governance of services, this includes having appropriately trained staff with appropriate supervision in place. However, there is no specification regarding the process of supervision or the frequency of supervision within the regulatory system, those working within services will have guidance from their professional body regarding any supervision/development needs but as mentioned earlier often in services the majority of the direct care staff are not affiliated to a professional group. There is often a significant discrepancy in terms of representation, with there being greater numbers of direct care staff than those who are professionally bound to engage in supervision. Creating a challenge for services when at a time there is a drive for value for money within health care services (Department of Health, 2012b). Despite this challenge there remains the need to ensure that appropriate service provision and governance of that service provision also needs to be ensured, this is true for all residential services within the disability sector.

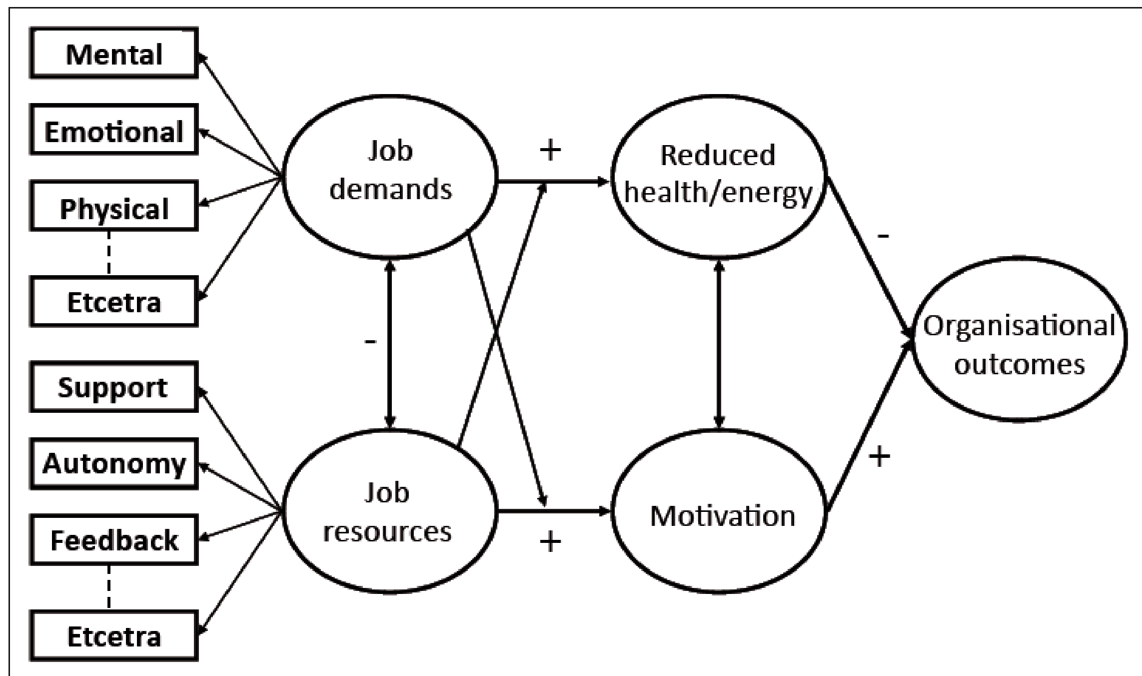
In recent years there has been an emerging trend exploring the concepts of resilience (the ability to adapt to changes and to recover from stressors/potential stressors) and agility (the ability to do this quickly and across situations), supported by findings within positive psychology and trends with mindfulness, acceptance and commitment (Noone, 2013; Pipe et al., 2012; Tugade, Fredrickson, & Barrett, 2004; Tugade & Fredrickson, 2004). The issue facing services supporting people with challenging behaviour is to find a means to help reduce perceived stress or a means to support staff in their management of perceived stress, thereby reducing the potential negative impact of the stress. As highlighted by Flaxman and Bond, there are only really two means to promote stress reduction, either through the reducing the exposure to the source of stress or to create a change within each staff member (Flaxman & Bond, 2006). When working with individuals who can be unpredictable and aggressive it is clearly not possible to easily reduce or remove this potential source of stress. Therefore the most common focus of intervention for staff within healthcare settings is to look at the individual themselves and how to adequately resource them, whether this is through their coping style or through the provision of training in specific types of coping or increasing awareness of the factors that influence attribution and coping associated with that (Bond & Flaxman, 2006; Flaxman & Bond, 2006; Gardner, Rose, Mason, Tyler, & Cushway, 2005; Pipe et al., 2012)

2.5 Theories of Stress, Coping and Burnout

In order to identify appropriate means of providing support for staff it is important to have an understanding of how work stress can develop and is maintained. A number of theories have been presented to explore staff stress and burnout across a variety of settings (Devereux, Hastings, & Noone, 2009; Hatton et al., 1999; Maslach, 2003; Noone, 2013; Paul Skirrow & Hatto, 2007). Maslach and colleagues identified burnout as a multidimensional construct in response to chronic interpersonal stressors associated with the job leading to overwhelming exhaustion, cynicism and detachment from the job along with a reduction in personal accomplishment and effectiveness within the job (Maslach, Schaufeli, & Leiter, 2001). Working in a job role supporting other people, particularly those who engage in behaviours that challenge is considered to create interpersonal demands on the staff and that these demands erode the individual staff member's emotional resources creating stress and ultimately burnout is a symptom of the stress experienced (Devereux, Hastings, & Noone, 2009; Maslach et al., 2001; Noone, 2013; Peterson, Bergstrom, Samuelsson, Asberg, & Nygren, 2008).

Initially early work looking at stress and burnout tended to focus on workers within Healthcare fields, however, over time there has been a growing recognition that stress and burnout can occur across job settings and the Job Demands-Resources model (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Demerouti & Bakker, 2011b) was developed to help explain how stress and burnout can be developed regardless of where the person works (see Figure 1).

Figure 1: The Job Demands-Resources Model (Demerouti et al., 2001; Demerouti & Bakker, 2011a, 2011b)



This model identifies that there are two elements central to work that can contribute to perceived stress and impact physiologically or psychologically on the individual. These are the demands of the job (e.g. workload, hours, competencies, physical environment) and the resources available (e.g. pay, career opportunities, supervision, support, autonomy, involvement, feedback). It has been highlighted that there is relationship between perceived job demands and levels of exhaustion (Peterson et al., 2008), known to be associated with reported stress levels. Whilst

there is also a link between job resources and levels of engagement from staff (Peterson et al., 2008).

Preceding the Job Demands-Resource Model for Stress, Lazarus and Folkman (Lazarus, Folkman, Dunkel-Schetter, DeLongis, & Gruen, 1986; Lazarus & Folkman, 1984) presented the idea that stress is developed through a transactional process. The model indicates that stress will occur in any situation when the situation demands exceed the ability or resources available to cope. Once in a situation there are two processes evoked, firstly the individual makes an appraisal of the situation to identify whether it is a potential threat or stressor. Following this there is a judgement made regarding the available coping resources and their likely impact on managing the situation, i.e. whether the cognitive and behavioural resources will reduce the threat of the situation (Devereux, Hastings, Noone, Firth, & Totsika, 2009).

Lazarus suggests that coping mediates the emotional outcome within a stressful situation and that coping will either be practical based (problem focussed on how to change the situation) or emotion based (focussed on the needs to manage the emotional distress associated with the situation). Strategies associated with practical based coping are information seeking, manipulation of the environment whilst those that operate more at the emotion based coping can include avoidance, denial, wishful thinking etc (Devereux, Hastings, Noone, et al., 2009; Noone, 2013).

The evidence supporting this model has found that staff using strategies that are emotion focussed can report higher levels of stress, e.g. those that start to disengage from individuals with intellectual disability that they are working to support. This way of coping was a positive predictor of emotional exhaustion and burnout as well as negatively associated with a sense of personal achievement (Devereux et al., 2009; Mitchell & Hastings, 2001). However, practical based coping appeared to lead to a sense of accomplishment for staff (Mitchell & Hastings, 2001). There was a discernible difference reported in the outcomes for those that used adaptive versus maladaptive coping, which suggests that any intervention needs to focus on supporting staff to develop adaptive coping skills to support the management of identified stressors.

2.6 Implications for interventions

Having a good theoretical understanding, with supporting evidence of the development and maintenance of stress, it is expected that the theories will help to guide and develop methods for intervention. Interventions have been explored looking at both the individual and organisational level with limited efficacy for either approach. The evidence is inconsistent, and the studies are quite varied both in terms of the methodology that they employ as well as the work area in which they were conducted (Noone, 2013; Peterson et al., 2008).

Starting with the work from Lazarus and Folkman in which the importance of appraisal is highlighted, there are clear suggestions that if an individual is supported

in developing an understanding of how appraisals are made and how they might challenge or alter these appraisals, using techniques associated with Cognitive Behaviour Therapy, that it may influence the ultimate outcome of the situation. Gardner and colleges found that using a cognitive behavioural intervention as part of a stress reduction program for staff working in an intellectual disability service created a positive outcome for the staff involved (Gardner et al., 2005) and reduce burnout symptoms (Schaufeli & Enzmann, 1998). However, there are naturally going to be limitations to this approach such as when different staff members have conflicting appraisals of the same situation which will lead them to react in different ways resulting in potentially different outcomes, especially when working with behaviours that challenge. Thinking about how this is seen in practical terms is that there is a vulnerability to splitting within the team due to different members attributing the behaviour to different causes, which in turn can influence the support that staff perceive they are getting or alter the response they provide to the resident.

Using the Job Demands-Resources model as a basis to guide intervention, there is the possibility that exploring support for the staff will alter the resources available for meeting the demands. From reviewing the available literature, many of the interventions that have been identified as creating a positive outcome with regard stress symptoms have been group based, although few of those have looked at the group itself in terms of support rather the activity that the group were engaged with during the course of the intervention. Yet a number of the factors identified as contributing to symptoms of stress include lack of social support or lack of support from the organisation (Devereux, Hastings, Noone, et al., 2009; Devereux, Hastings,

& Noone, 2009) so creating a logical argument that interventions targeting support will have an impact on reported symptoms of stress. Pipe and colleagues found that using principles of positive psychology within a group setting produced a greater positive impact when the group was from within a team that worked closely on a day to day basis. They found that this day to day support allowed the group to practice and cement ideas that were introduced within the group as well as enhancing the social support within the team. It was clear that this occurred due to the fact that nurse manager of this team identified the program as importance and continued to promote the need for a healthy work environment after the group was completed (Pipe et al., 2012).

Peterson et al (Peterson et al., 2008), explored directly the impact of participation in a reflecting peer support group and found that whilst there was a trend seen for an improvement in participation at work and support at work. It is unsurprising that peer support groups can be effective in reducing staff stress levels as they provide a number of different types of support (Schaufeli & Enzmann, 1998). However, it is interesting that the evidence available is inconsistent. From a systematic review of work aimed at reducing work stress, Michie and Williams identified that there were three elements that are required to make an intervention successful: the organisation must support training and other approaches that will increase staff participation decision making, that there is increased support and feedback for the staff and that there is improved communication within the organisation (Michie & Williams, 2003).

More recently, in line with developments in psychological therapy, there has been a focus on how interventions can support the development of resilience. This is supported from work looking at the role of mindfulness, meditation and acceptance so rather than trying to change and alter the situation through challenging and changing our interpretation there is an element of accepting the situation. This allows the concept of Fredrickson's "broaden and build" philosophy to be used, thus allowing the individual to build and develop personal resources through seeing possibilities (Fredrickson, 1998; Tugade & Fredrickson, 2004). This can help reduce the time that is often spent worrying and regretting, a significant mental effort (Hayes, Luoma, Bond, Masuda, & Lillis, 2006) and often fails to find a resolution to the problem, which ultimately creates a greater sense of distress and failure. This means that less time is available to review the actual events that have occurred and to take from that experience to help broaden the opportunities.

2.7 Implications for the Organisation

Supporting adults with an intellectual disability is a challenge as there are often limited resources available to meet the identified needs of each person. Often services (especially community houses) can be quite isolated with at times just one staff member on shift. Resources and support have been identified as factors that can mediate coping and therefore the impact of stress. If you add to this the knowledge that staff perceptions (or attributions) regarding an individual's behaviour will influence their interactions and this has been shown to be a factor that is important for the success or failure of a placement in the service (Phillips & Rose, 2010). Therefore a number of factors become important for an organisation when

looking at the frontline staff within these services. Firstly, there is a need for successful placements in order to maintain current service provision and support the service continue to receive referrals based on the reputation of having successful placements. This allows the service to continue to operate or to grow, which in turn provides some job security for staff (a factor identified as contributing to stress within services). Secondly the manner in which staff interact with those being supported by the service can add to or support in managing any incidents of challenging behaviour, which in turn feeds back to whether a placement is successful or not. Intellectual disability services face a challenge within the local community as there can be suspicion, and a lack of understanding about the service. Therefore, the staff act as a promotion for the service and it is really important that the interactions are perceived in a helpful way to foster support from the local community. It is easy to suggest that if time and effort from an organisation is spent developing systems to support staff it will be of benefit to not only the organisation but those being supported through the services.

2.8 Conclusions

It is clear that individuals' with intellectual disability can often display behaviours that would be considered as challenging and that there are a number of effects created through this display of challenging behaviour (Devereux, Hastings, & Noone, 2009; Noone, 2013). These effects can impact on the individual in terms of reducing their opportunities which is considered to lead to a lower level quality of life, can increase the likelihood of the placement breaking down (Phillips & Rose, 2010) which in turn can lead to further loss for the individual who is, often without involvement, moved to

another service. The associated stress from being a witness to aversive and frequent incidents of challenging behaviour can predict staff turnover within residential services, which, can create a sense of instable and unsafe environment for those accessing the service and the staff working to support them. Therefore, using knowledge that supervision and reflective practice can act to moderate and mediate the impact of challenging behaviour it is seen as a necessity that systems are created to promote access to these opportunities. Especially for services that provide support for individuals who display significant levels of challenging behaviour and thus the start point for this change project.

Chapter 3: Methodology

3.1 Introduction

This chapter will lead the reader through the author's selection of methods to support the development and implementation of the Organisational Development (OD) process. Due to the setting for the OD, within a health care setting, it was deemed that the HSE change model (HSE, 2008) was an appropriate model (see figure 2). This model is useful is helping to guide people through the change process and whilst there are a number of stages and steps within the model there is also the recognition that change is not always a linear process rather that it is continuous and that each step may influence subsequent as well as prior steps. As highlighted through the literature review when developing the HSE change model for change to be effective there is a need for:

- A commitment to ensuring that the needs of service users and communities are at the centre of planning and decision-making and
- A partnership approach that engages all parts of the system, including service users, their families and local communities, voluntary and community-based organisations, other statutory bodies, staff, trade unions and representative bodies

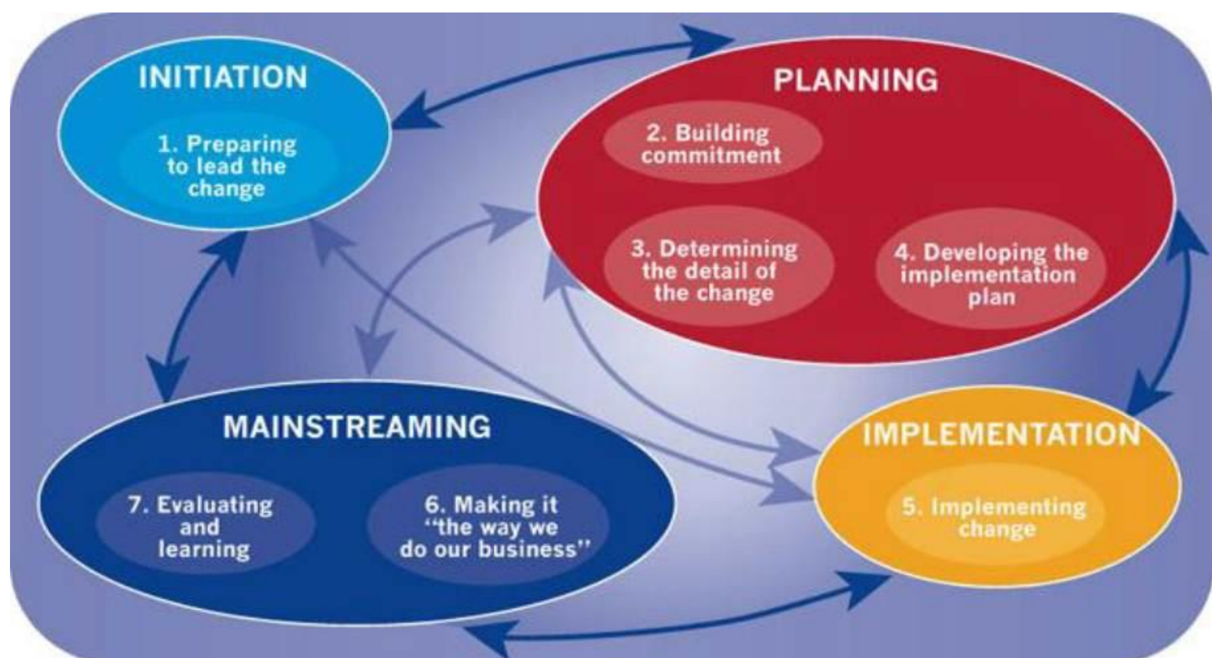
The HSE change model acknowledges these elements with clearly identified aims of:

- Improve the experience of patients and service users

- Help staff and teams play a meaningful role in working together to improve services
- Promote a consistent approach to change across the system

This provides further validation for the use of this model within this OD process given the importance of the involvement of staff within the process.

Figure 2: HSE Change Model (HSE, 2008; McAuliffe & Van Varenbergh, 2006)



3.2 Process of Implementation

To support the reader in understanding the processes involved in implementing the change initiative, the next section will detail the work completed and identify the tools used to facilitate the OD process within the steps identified by the HSE change model.

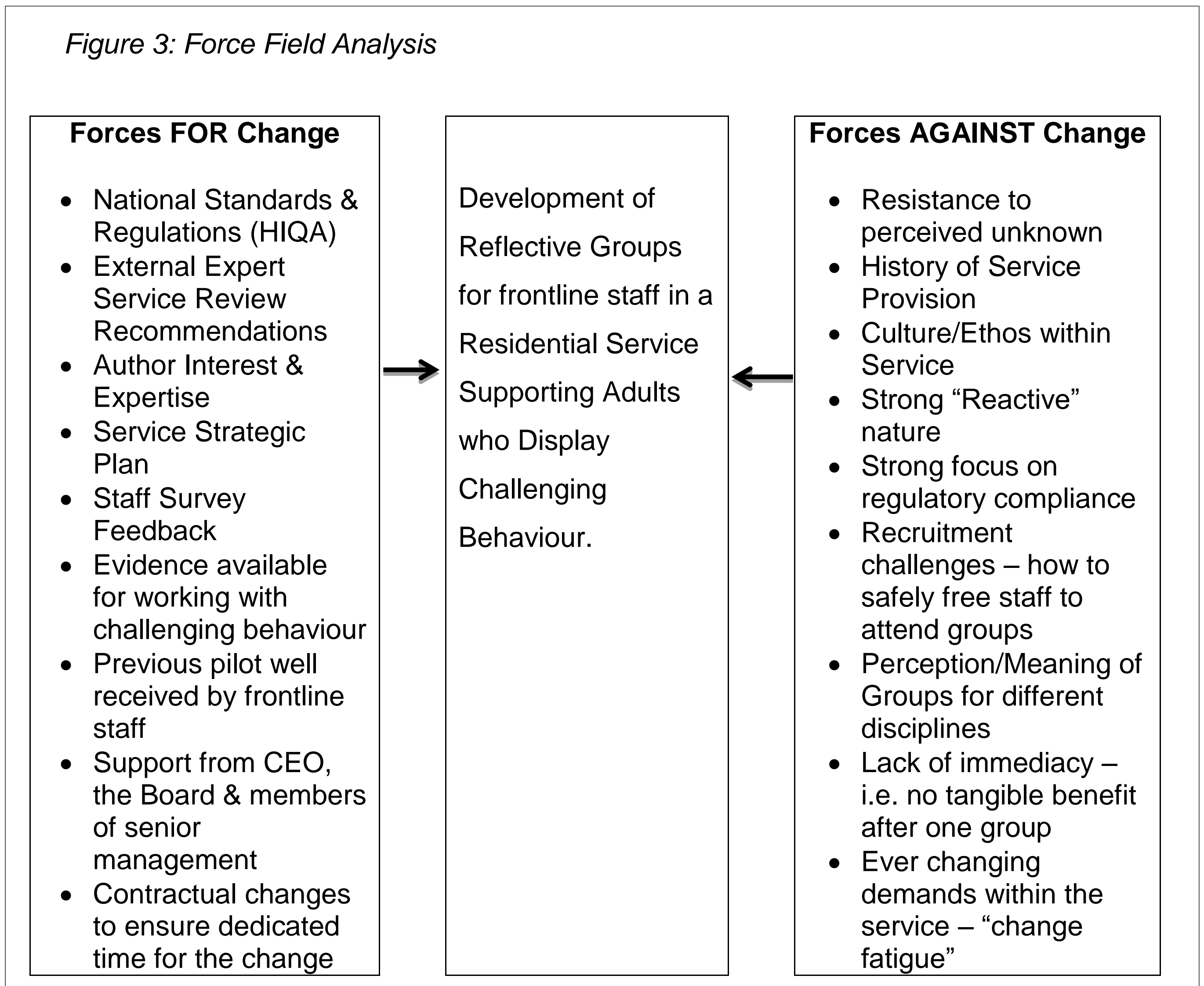
3.2.1 Preparing to lead the change

This is an important stage of any change initiative as there is an active encouragement to focus on establishing the organisation's readiness for change and where there might be resistance or support for the change. Within this process the author completed a force field analysis to help identify the drivers supporting the change and the forces that are likely to cause a resistance to the change (see figure 3).

As can be seen there are a number of factors that can act as a driving force for the change including the recommendations from external expert reviews of the service and the regulatory requirement of appropriate supervision and governance of the staff in the service (Health Act, 2013; Health Information and Quality Authority, 2013), which given the push from the service for regulation can act as a strong force for the change. However, countering these elements is the general history and culture within the service and the fact that it is difficult to see an immediate tangible effect of supporting reflective practice. When this change process was initially discussed with the service, an immediate resistance was the fact that it was an unknown process and for the staff a strange idea of having to meet with a member from the Clinical Psychology department. This is consistent with general feedback following incidents, whereby the common response from frontline staff is "I'm grand", so the provision of a space to review incidents and to be able to acknowledge

personal feelings about the incident/resident can be seen as somewhat threatening or unsafe.

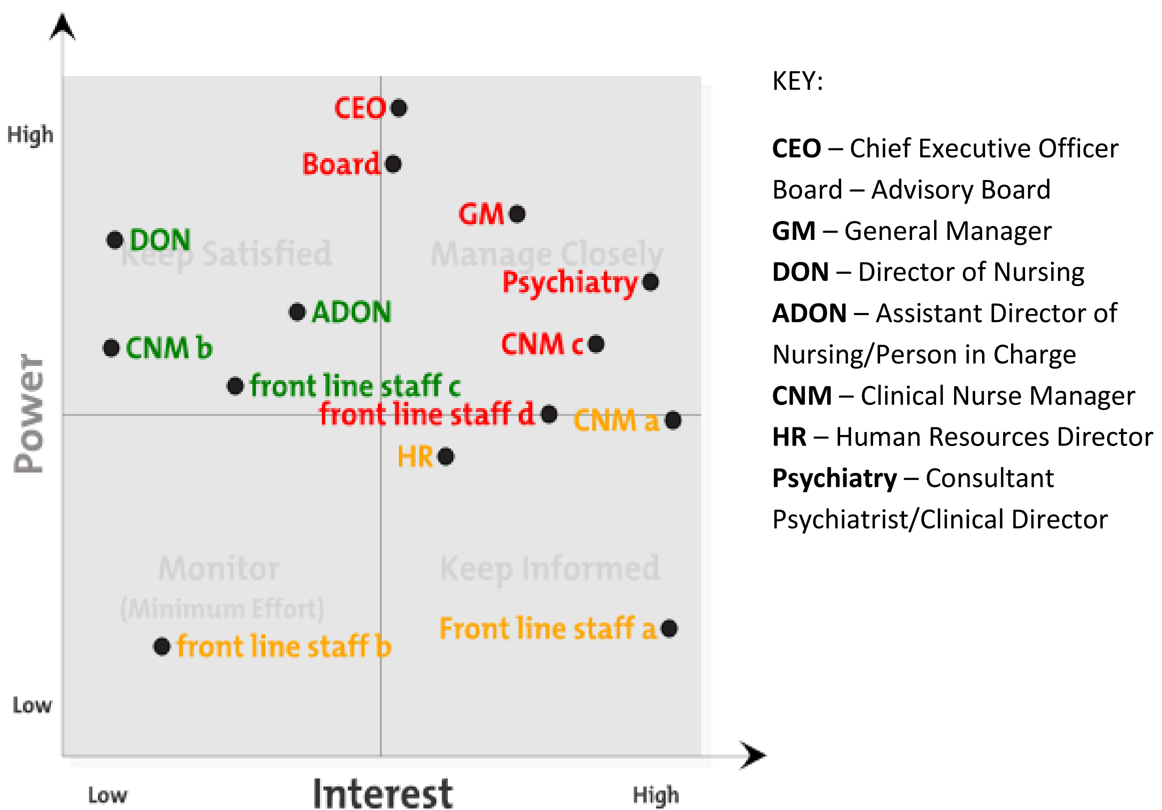
Figure 3: Force Field Analysis



A stakeholder analysis is a useful tool to direct thinking and approaches to different people associated with the change initiative. As part of the preparation phase for this OD process the author completed a stakeholder analysis as demonstrated in figure 4 below. Of interest was the finding that there are a number of positions that the frontline staff may be in and therefore a number of strategies are required to

support them through the change. There are a number of frontline staff who are "informal leaders" (Pearce, 2004) and therefore it is important that time is spent to earn their support in the project so that their influence can be directed to support attendance and prioritisation of the groups.

*Figure 4: Stakeholder Analysis (*Source Mind Tools (Mind Tools Ltd, 2014))



Additionally the stakeholder analysis found that there were some unexpected allies within the process and this allowed an opportunity to assess how to use the allies to promote the OD process and utilise the varied influence that exists within the culture due to the array of different disciplines within the service. The author recognises that there are a number of disciplines not noted within the stakeholder analysis

(Occupational Therapy, Speech & Language Therapy, Clinical Psychology & Physiotherapy), these disciplines were not disregarded for the purpose of the stakeholder analysis rather there was a focus on the disciplines that were known to have the greater involvement within the centre and with the frontline staff.

3.2.2 Building Commitment

The author and driving force for the OD project recognised from the force field analysis that some of the forces against the change needed to be explicitly addressed/acknowledged and with the information available from the stakeholder analysis identified some key figures that they needed to support to develop an understanding of the rationale for the OD project. Initially the author focussed on meetings with the senior management team, including the CEO, General Manager, HR Director, Consultant Psychiatrist/Clinical Director and DON. Within these meetings the author was able to work on building a coalition to support the OD process by presenting the rationale for the OD process and making explicit links to the corporate service plan and the timely recommendations from external reviews. The author was also able to attend the quarterly meeting with the advisory board and present information to the board regarding the project. This was well received and further enhanced the drive for the project. Following this meeting, there was the opportunity to create a change in contract and work allocation for the author, seen as a demonstration of the support from the CEO, the board and General Manager.

The Nursing Team has a strong influence both in terms of promoting the groups and proactively supporting staff to attend the groups, therefore, it was seen as a necessity to build commitment with this department as having a coalition with members who have positional power/influence is known to support the implementation of change (Lines, 2007; Self, Armenakis, & Schraeder, 2007). The force field analysis identified that resistance to change may come from a fear of the unknown and the author hypothesised that there was a perceived sense of mystic surrounding the groups and a concern about what might be shared within the group. To explicitly address any concerns a number of face to face meetings were arranged with the DON, ADON & CNMs to provide a forum to discuss what they might see as potential barriers for the groups and to develop a shared understanding of the purpose of the groups, i.e. to ensure that there was no perceived conflict in terms of line management. Within these meetings there was an opportunity to share ideas about the process and objectives as well as the identification of a needed feedback system to ensure that any significant issues identified through the groups were shared with the Nursing Team to promote governance processes.

3.2.3 Determining the detail of the change

Having initially secured support from senior staff who have the power and influence to promote the frontline to attend the planned groups, part of this stage was to identify where the service is now and where it needs to be for the OD to have been successful, i.e. a gap analysis. The clear gap being that there was a lack of support and supervision for the frontline staff. Given the introduction of regulation within the disability sector (Health Act, 2013; Health Information and Quality Authority, 2013)

there is a strong emphasis on staff supervision in order to demonstrate appropriate governance of the service, that the service is safe and effective as well as the appropriate use of resources. Therefore the service needs to ensure that there is evidence available for any support/supervision to show compliance with the regulations. Alongside this, there was a notable gap in understanding of the planned process within the frontline staff, highlighting the importance of a shared and coherent language. To help address this, the author visited the units and made links with the "Lead Health Care Assistant" for the unit to discuss the practicalities such as timing of the groups as well as the actual naming of the groups. Throughout the initiation and start of the planning the author had labelled the groups as "reflective groups" but it soon became apparent that this term created a sense of uncertainty for some of the frontline staff leading to reduced interest in the group as they were unable to see the potential benefits for them. To address this gap the author recruited staff within the unit to promote the process and encouraged each unit to take responsibility for identifying the "when" for the group.

Within the detail it was identified that an attendance record would be required for all the groups; that would serve a dual purpose – evidence that the groups are happening and a way of ensuring that all staff has the opportunity to attend. Feedback from a pilot programme of running voluntary reflective groups identified those that attended found value and benefit from the time and that once there is a dialogue about the groups it will create an urgency for all to participate. Initially there was a target, set by the senior management team, to start the process with two of the four units due to the nature of the incidents that were occurring within the unit.

3.2.4 Developing the implementation plan

In order to promote the successful outcome of proposed change it is important to have a plan for implementation, within this plan there must be clarity about what the desired outcome is following the change as well as an assessment of the impact of implementing the change and that the plan is complete. For this to occur there is a need for clear leadership/accountability within the plan, the author and driving force for the OD project holds full accountability for the project. However through the support of the identified coalition the Nursing Team were accountable for ensuring that dates were provided for each unit at a time that was suitable for the unit to enable as many staff as practicable to attend the group.

The outcome for the process will be that there is a minimum of one reflective group a month for each unit that will be part of a supervision process for frontline staff. These groups will occur at a time that is convenient for the unit, thereby minimising disruption for the residents whilst optimising attendance for the staff. The author hopes that it becomes an accepted part of the role of frontline staff that they attend and participate within reflective groups.

As highlighted within the HSE model of change there is a need to communicate relentlessly and part of the identified objectives was that a feedback system will be created to provide feedback to the senior management team of any relevant, identified and agreed issues that are pertinent to service delivery for frontline staff.

Therefore, it was agreed that the facilitator of the group would need to take “aide memoir” records from each group and reflect with each group the issues that need to be shared with senior managers within the unit. In order to promote a sense of safety and confidentiality the author identified that these records would be stored within a locked cabinet accessed only by the author. The minimum of a monthly meeting between the author, Clinical Director and Person in Charge for the unit was identified at a regular stage each month, e.g. the second Wednesday each month, making it a predictable part of the routine for the unit. Governance of this process is also important, therefore the author identified that a record and agreed actions from these meetings is also required. This will provide evidence for the regulators and the service, in particular the frontline staff which will be an important means of showing validation for the staff. Records of the agreed actions from the feedback meeting will also be shared with the senior management team.

The resourcing of the OD plan will come from the change in contractual obligations of a member of the Clinical Psychology department, the project lead and author. Within the changed contract there are explicit expectations that the author will hold the responsibility for developing staff support systems within the services. Parts of the identified support systems are regular access to a unit specific reflective group facilitated by the author. The change in contract provides the author with formal leadership for the task as well as a clear message that the company is supportive of the process in keeping with the identified strategic plan and following feedback garnered from a recent staff survey completed by an external source to promote honesty in response.

3.2.5 Implementing Change

The Author explored the identified factors from the NHS Leadership Framework (National Health Service Leadership Academy, 2011). The start point has to focus on developing networks and building/maintaining relationships so at the start of the implementation of the plan the author used the links established with the Nursing Team to identify dates for the initial groups. Once the dates and times were agreed the author ensured that the day prior to the first group and the day of the first group reminder emails were sent to members of the Nursing Team highlighting that a group was to take place. Knowing that there is a preference for face to face communication, in recognition that the people required to attend the meeting were either Generation Y or had limited IT skills, the author where practicable attended the unit the morning of any group to provide an additional reminder.

Part of implementing the plan is to also monitor the plan and identify any barriers/blocks to the plan. Using the force field analysis the author was aware that the unknown factor of the groups & the naming of the group had the potential to create resistance and so used the opening of the groups as an opportunity to review what the frontline staff perception of the group was and what concerns people might have. Each group was then encouraged to name the group as they deemed most appropriate to convey the understanding of the group. In addition, when bringing the group to an end the author endeavoured to seek some feedback on the group itself both in terms of meeting expectations and in terms of personal enjoyment/benefit

from the group. This was seen as an opportunity to help build commitment and encouraging contribution from those attending the groups as well as a time to ensure that there is clarity around the vision/expectation for the process.

Within the monitoring process, there was an ongoing need to keep various stakeholders informed and for the author to make use of some of the structured formal communication meetings to facilitate progress with the plan. An example of this occurred when there were a number of issues in getting dates/attendance for a particular unit and on review with the Clinical Director and member of the MDT this was considered to be a reflection of the difficulties that they were experiencing in implementing interventions within the unit. Having been assigned the formal leadership role within the project, the author arranged to meet with the CNM assigned to the unit and after a number of meetings and still no progress with identifying dates for the assigned unit reflective groups, the author made use of the formal leadership allocated for the project and raised the issue within the senior management team meeting. Using the Stakeholder analysis it was clear that there were people with influence and power within these meetings and so the author attempted to use this sway to promote the urgency of the groups for that unit. This process was aided by the formal minute taking within the forum that logged there was a concern around continuing the groups and an acknowledgement that the initial feedback from the staff was positive regarding the groups. Following this meeting, and with the renewed involvement of key personnel not only were dates provided but in addition the Nursing Team were conveying a message that it was a necessity for staff to attend the identified groups. Dates were allocated for the groups through

until July 2015 and within the process a further key supporter of the process was identified within the Nursing Team. Highlighting that effective leaders need to work through others to achieve their objectives (The King's Fund, 2011) and that without the involvement of others within the process change will not be effective.

3.2.6 Making it "the way we do business"

In order for any change to be sustained there is a need to focus on how the change is integrated into practice so that it becomes part of the normal process, i.e. the way we do business (HSE, 2008; McAuliffe & Van Varenbergh, 2006). In order for this to happen there is a need to recognise the value of the process, and of course value may vary dependent on the perspective (e.g. staff, the service, those using the service, the local community etc). To help with this process the HSE model highlights the need to celebrate success along the way, a factor that is acknowledged within many change models (Appelbaum, Habashy, Malo, & Shafiq, 2012; HSE, 2008; Kotter, 1995). Therefore, the author within their leadership role needed to ensure that information was available regarding the success along the way during the change process.

Regular feedback was provided to the Senior Management Team in terms of groups taking place and general themes that were arising within the groups and this enabled a chance to highlight and celebrate group attendance, with an aim of having a minimum of 75% of the staff attend each unit reflective group. Feedback was sought at the end of each group to assess the value/expectation for those in the group and

this resulted in some interesting developments. Staff within one group highlighted that they had attended a number of groups now and found them useful but they wanted to see some action following the groups, this when clarified was a need for feedback at the start of each group regarding any of the issues that were taken to the PIC and Clinical Director. Within the group it was agreed that the first five minutes would be dedicated to this feedback and this was seen as positive for the staff within the group. This sentiment highlights the identified factor of resistance that sometimes there is nothing tangible at the end of the group and therefore could be easily dismissed, an area that needs to be addressed in order to mainstream the change.

One staff member acknowledged to the group that he had not wanted to attend and had only attended as he believed that it was mandatory citing that “why would I want to reflect”, however at the end of the group, and having been an active participant in the group, he stated that he was glad that he had come and was looking forward to the next group for that unit. His statement was acknowledged and echoed within the group, this is suggestive of the power of building relationships through listening, supporting others, gaining trust and showing understanding a required competency of leadership (National Health Service Leadership Academy, 2011). In building the relationships there will be an increase in the likelihood of staff attending further meetings and the success of this process can be celebrated through word of mouth promotion between the frontline staff.

In terms of influence, the author found that another key method of ensuring that it is the way we do business was through the influence of the lead HCA or key frontline staff on shift on the day of the group. With certain key frontline staff, aligned with the position of frontline staff d in the stakeholder analysis, there was a concerted effort made to ensure that staff was available to from other units to allow staff to attend the group and an active encouragement of staff to attend. One Lead HCA took the responsibility to the extent that they attended every group for their unit, whether they were on shift or not. In these situations the author made sure to "celebrate the success" through some individual feedback to the staff member highlighting the value of their contribution in determining whether the group could take place.

3.2.7 Evaluating & Learning

The final step within the model is to ensure that there is evaluation and learning of the process, again to promote the success of the change being mainstreamed into the routine of the service. Within the groups a number of factors were identified that were seen as being necessary to improve the effectiveness of the groups. These included the introduction of a feedback loop at the start of the group, thus providing staff with a sense of something concrete and tangible occurring as a result of the group.

The reflective groups provided an opportunity to review and evaluate incidents/activities that were specific to each unit and to explore alternative means of addressing/managing them. Thus each group needed to have an element of

evaluation and a clear example of this was noted when a group discussed a current method of supporting a resident which minimised the impact for staff but might indirectly be creating additional stress to the resident and through the group reflection it was agreed to try an alternative means of support which address previously unrecognised factors by the frontline staff. The learning from the groups can directly influence the day-to-day practices within the service leading to an increase in person centredness, a key aspect of regulatory requirements (Health Act, 2013; Health Information and Quality Authority, 2013).

Identified issues raised by the staff, whilst at times creating a potential confusion with line management processes, were important to evaluate and address as required. This process allowed staff to have a sense of purpose and value as well as promoting “buy-in” to the group process. In addition, it the issues raised provided an opportunity for the service and the leaders to reflect on the process in terms of challenges that they face with supporting frontline staff, from being visible on the units as well as managing the complex needs “behind the scenes” that frontline staff may not be aware of. This has led to a review of processes such as clinical handover, documentation and how to promote greater involvement of the frontline staff and provide them with greater responsibility etc. As suggested by the HSE model, change does not happen in isolation rather change has a knock on effect with one change process often leading to and interacting with further change processes and this is clearly evident from this change project.

3.3 Conclusion

Whilst this OD project was focussed on the introduction of a support process for staff within a service supporting people who display significant levels of challenging behaviour, the HSE model was effective in supporting the development and implementation of the process. As highlighted within the HSE model there is a need for continuous communication and the author found that this was a key element within the process here. Communication in terms of getting a clear vision for the process, ensuring that the plan was followed and also within the purpose of mainstreaming to help consolidate the feedback that there was utility to the groups, which is turn will promote the future engagement of frontline staff in the reflective groups. At times there were challenges faced, both from internal and external drivers, highlighting that change is a messy process and as a leader there is a need for fluidity and review to identify where the focus for the leader needs to be within any given challenge. The next chapter will provide an evaluation of the aims and objectives of the project to help determine the overall success of this OD project.

Chapter Four: Evaluation

4.1 Introduction

In order to assess the efficacy of any change process it is a requirement to evaluate information pertaining to the change in terms of the overall aims and objectives of the project. Goal setting theory highlights that there are multiple benefits to the act of setting goals and monitoring progress towards these goals (Latham, 2004; Locke & Latham, 2006; Morisano, Hirsh, Peterson, Pihl, & Shore, 2010). Therefore an important part of the evaluation is to review the initial aims and objectives that were set by the Author for this project.

The overall aim of the project was: To promote reflective practice skills within all frontline staff working within an intensive challenging behaviour unit by having reflective groups for all units.

This was expected to be achieved through the three identified objectives listed below:

1. Each of the 4 units within an intensive challenging behaviour unit will have access to a scheduled reflective group session at least once a month starting in December 2014, facilitated by a member from the Clinical Psychology Department by 30th April 2015.

2. Each group will be attended by 75% of the staff on shift by 30th April 2015.

3. A feedback system will be created to provide feedback to the senior management team of any relevant, identified and agreed issues that are important for frontline staff by 30th April 2015.

In addition to reviewing the aim and the objectives, it was identified that evaluation will also be considered within the context of national standards and regulation for Disability services (Health Act, 2013; Health Information and Quality Authority, 2013) and in conjunction with qualitative feedback from those participating in the groups and the Clinical Director and Person in Charge of the Unit. The final evaluation will explore the impact and role that the reflective groups have with the implementation of recommendations made following two external expert reviews of the service within the challenging behaviour unit.

4.2 Outcome Review

The first objective identified that each unit would have access to a reflective group at least once a month from December 2014 to April 2015. The groups commenced for two of the units in November 2014 and they had allocated time for December. One of these units was supported by the staff member who ensured that they attended all the groups and soon after the start of 2015 this staff member identified dates for the unit groups through until August 2015, planning them to ensure that they fell onto alternate shifts. February to April saw that all four units had at least one session a month. Overall this meant that for the overall objective 75% of the planned groups took place. Implementing the plan for this objective identified a number of barriers

and actions were required to address these barriers, this will be discussed in more detail within the next chapter. Of note, dates have already been supplied to the author for groups for each unit until the end of August 2015 and that in general there are requests for the unit to be facilitated to have a group each month for both shifts rather than just the one group each month.

The next objective was built upon the initial objective and explored not just whether the group took place but the number of staff available to attend the group, identified as a potential factor of resistance in terms of staff being made available to attend the groups. Overall the attendance was positive with numbers ranging from five staff to ten staff being made available. This fluctuation is also reflective of the number of staff required to safely support each unit so the objective was identified for 75% of staff on shift be able to attend. Three of the units were able to ensure that at least 75% staff for the unit attended on each occasion that the group met and one unit met this target for three of the five groups. Therefore on 75% of occasions at least 75% of the staff was made available to attend the allocated reflective group.

The third objective was focussed on some of the governance surrounding the groups to ensure that they were not operating in a vacuum outside the service. For this to happen, it was identified that there would be a regular monthly meeting between the Clinical Director, PIC and the Author/Group Facilitator. This meeting took place on 60% of occasions, again as the project progressed it was clear that there were a number of barriers to this meeting and an evolution of the meeting itself in the

context of feedback from those participating in the groups. These barriers and evolutions will be discussed in more detail within the next chapter.

The overall aim was to promote reflective practice within all frontline staff, this is harder to quantitatively assess. In terms of attendance, the staff sign in for each group and that allows a way of assessing whether all frontline staff have attended a group. Given that frontline staff includes the nurses as well as the HCAs and that for this initial period the focus was on encouraging the HCAs to attend and the nurses were providing support to ensure that the unit remained safe. Therefore, this aim has not yet been achieved. However, given the growing interest in the groups and the process there has been a request for a group to be established for nurses, with a request that maybe there is a group for staff nurses and a group for CNMs given the slightly different challenges that the two roles face. This idea will be discussed more within the discussion section of this report.

As highlighted earlier, it is also important to evaluate this project in the context of national policy/standards. There is a requirement within the Disability Regulations for appropriate staff supervision and governance. Within the service, as would be common to many disability services there are a greater number of frontline staff than staff who may have the confidence or experience to lead supervision of others. The service already had in place systems for performance development which was in keeping with the regulatory requirements, however, this project will add a further layer to the supervision and governance framework that supports staff in working

with people with a number of complex needs. Whilst there is a process instigated for the development of a governance body for HCAs, the feedback from those participating in the groups suggests that there is a need for formalised structures of supervision for this group of staff, currently there is no statutory requirement of the same. However, the regulations specify the requirement of adequate governance of the service, without clarifying what adequate governance means.

Feedback regarding the groups and the attendance/issues discussed has been highlighted within the Senior Management Team and has been reviewed in the context of the external review reports. Within one report there was an identified need for the frontline staff to be fully aware of the underlying model of choice for the service, one of Positive Behaviour Support (PBS), and that support should be provided to bring in other relevant theories/models to help develop an understanding of individual presentations. The reflective groups have provided an opportunity to expand knowledge of PBS and to introduce concepts such as attachment and trauma informed care (Jennings, 2004). Through these discussions there has been an identifiable shift in perception and attributions made regarding challenging behaviour that has resulted in informing practice within the unit. Suggesting that there are benefits being made beyond the initial aim and objectives in that staff is taking information that they have explicitly discussed and applying it in practice for the benefit of the resident, the service and themselves.

4.3 Conclusion

In summary, the identified objectives were met to a satisfactory degree with 60 – 75% attainment. Whilst it cannot be claimed that the overall aim of the project was met within this timeframe, it is clear that the plan is supporting the service in achieving this aim. The process of running the groups has created the desired word of mouth effect, with the author receiving further requests to run groups beyond the initially identified HCA groups and also with the fact that the units are actively requesting that there is a group each month for each shift rather than just the identified single unit group. A number of barriers and evolutions were identified during the implementation of the plan and these along with reflections of the process and where to go next will be explored in the following chapter.

Chapter Five: Discussion & Conclusion

5.1 Introduction

When leading and implementing any OD project it is important to ensure that there is a critical review not just of the process but also the experience of the process. This can add valuable information to guide and support future projects as well as an opportunity for personal growth, a key component of leadership qualities. Reflection has long been recognised as a useful tool in both professional and leadership development (Dawber, 2013a; Loo & Thorpe, 1999; Pearce, Phillips, Dawson, & Leggat, 2013; Sen, 2010; Sendall & Domocol, 2009). This review will not only explore the personal experience of the author but will also explore the immediate and predicted longer term impact of the change and make recommendations for future improvements.

5.2 Discussion

To support the critical review and discussion the author believes that there is merit in reviewing the process in the context of the HSE change model (HSE, 2008) that was used as a framework to support this OD project. So as a start point the process begins with the initiation phase.

5.2.1 Initiation

Within this phase the focus for the author was on preparing for the change itself. This involved making the case within the company to garner support for the project. Here the context of the service became important; November 2013 saw the introduction of regulation (Health Act, 2013; Health Information and Quality Authority, 2013) within the disability residential sector for the first time in Ireland and the company was already preparing for this change when there was inadvertently a sense of uncertainty regarding the regulation process and whether private service providers would fall under the remit of the Authority for regulation. As an organisation striving for best practice and keen to be assessed against indicators of the same there was a drive within the company to seek consultation with the Authority and to offer involvement within any early phases of regulatory assessment. In addition, the company sought and requested expert review of the service to seek benchmarking against best practice outside the state.

As part of the process to ensure readiness for regulatory inspections, the service was disseminating information about the standards and the regulations, within which there is a clear need for effective governance, safe services and effective use of resources (Health Act, 2013; Health Information and Quality Authority, 2013). The Author already had a personal interest in staff supervision and staff support and had a strong awareness of the potential benefits of creating a structured reflective process not only for the staff in the service but also in terms of the impact for residents within the service, supported by evidence from the available literature (Dawber, 2013a; Pearce et al., 2013; Sendall & Domocol, 2009).

Having identified a starting point with a clear rationale for the OD project, the author needed an awareness of those factors available that would support the change but also that would act in resistance to the change. There is a sense that forewarned is forearmed in the process of creating a change. It is clear that companies need to evolve to survive and the company had demonstrated through its own history the ability to evolve. However, this can create a sense of change fatigue and also uncertainty, which given the new demands of regulation where all staff need to be able to demonstrate competency there is a risk that too much change creates a dissonance between the policies and the practice. Therefore, communication was an important tool for the author not just in the initiation phase but throughout the project and within the organisation and has been identified as a central factor to successful interventions with staff (Michie & Williams, 2003).

Communication itself can present with a number of challenges, similar to those seen with the idea of support, i.e. support is only supportive when perceived as such. Communication is only effective if there is a shared understanding created through the communication rather than just having communication events. Making use of the force field analysis (figure 3) and the stakeholder analysis (figure 4) identified that there were key factors of resistance and key people to target with information to help support the development of the project.

Of interest for the author was the challenge of trying to manage the historical aspect of service delivery, which was considered central to the development of the current culture, both in relation to the "I'm grand" attitude and the reactivity of the service. It is important to acknowledge that this is vulnerability for any service supporting people who display behaviours that challenge as in general it is easier to react to a concrete situation and ensure immediate safety where there are immediate tangible results in terms of safety rather than analyse and make the necessary long term plans, where often there is limited tangible outcome in the immediacy of the plan. Part of this, as the author became increasingly aware during the project, is due to an internal pressure to be seen to be doing and that in high stress situations people will use the resources that are available to be doing, consistent with the Job Demands-Resources model ((Demerouti et al., 2001), see figure 1.

What became apparent and added to the potential resistance is that sense of the unknown, and the role of individual appraisals within the day-to-day management of situations as highlighted by Lazarus and colleagues (Lazarus et al., 1986; Lazarus & Folkman, 1984). As we try to make sense of situations, or appraise them, we then start to respond to them using our own beliefs and ideas, often influenced by our own experiences and training. Therefore, trying to support staff to be able to say that they are frustrated by the behaviour of a resident or that they might be frightened goes against the "I'm grand" ethos, yet the evidence highlights that maladaptive emotion based coping such as avoidance or denial leads to a greater risk of stress symptoms and ultimately burnout (Devereux, Hastings, Noone, et al., 2009; Noone, 2013).

In order to maximise the progress of the project the author made use of this information to guide her within the planning phase of the project.

5.2.2 Planning

Within this phase there is a need to build commitment, and with commitment there is an expectation of support for the project. To help address this, the author made use of knowledge regarding both informal and formal leaders (Pearce, 2004) to add to the information from the stakeholder analysis regarding interest and influence. Frontline staff who had engaged in a pilot programme of peer support groups had reported a benefit from these groups, consistent with the evidence base e.g. the work of Pipe (Pipe et al., 2012), therefore, the author identified that these people would be a support in communicating the rationale for the groups using their own experience of being a participant within the pilot scheme. This was useful in building commitment from frontline staff; however, resistance was faced from more senior staff and indeed the fluctuating commitment of the senior management team.

The author identified that whilst a stakeholder analysis is a useful tool at the start to help identify supporters and those against the project, people's attitudes are changeable. Attitudes can change as an effect of information given to them regarding the project, but also due to external influences such as economic, political and social influences. OD projects can be supported by the use of analysis of these factors through PEST analysis, in this project the author informally considered these

aspects through the force-field analysis and at the time considered that a PEST might have been duplicating information. However, during the course of the project recognised that the use of a PEST may have identified factors that were seen to influence the commitment of the senior management team, the foremost one that there is a the need within a private company to provide high quality services but also to ensure that they work financially and that these financial drivers will influence the commitment to the project given the resources required to support the project. This meant that whilst during the planning phase there was apparent commitment to the project, there was also periods where the project was not seen as a priority for the service and a sense of “lip service” being made to it.

Once the author was aware of this conflict, they were able to reassess and return to the ideas of the planning phase, adding support to the selection of the HSE model which stipulates that each phase is dependent on other phases and that change is not a straightforward linear process. At these times, the author made use of their own knowledge from expert reviews of the service and the support from members of the board to reignite the rationale of the groups and how they could link to the known financial drivers for the service, i.e. staff morale, staff turnover, recruitment & training costs etc. The author recommends that during any OD project the leader must revisit the stakeholder analysis to monitor and check for movement, both in terms of positive influence/interest but also to check for situations where people initially identified as supportive may become resistant to the change. Change is not a static process rather it is fluid and akin to a river flowing it is easy to underestimate the impact of small barriers to the ultimate destination of the river.

As a leader in charge of developing, implementing and evaluation an OD project, the author was required to make sure that the evaluation and learning was integrated into the project and this also required reflection on themselves and how they were interacting with other staff members. Any effective leader will take the opportunity to learn from 360 degree reviews, the challenge being to listen and use the feedback that is provided in a way that produces change not only for the current project but also for the leader. How this change is measured may vary and may result in further changes whilst implementing the identified plan.

5.2.3 Implementation

The author had identified that the project required reflective unit based groups (shown to benefit team functioning when those in the group work closely on a day-to-day basis (Pipe et al., 2012)) to be run on at least a monthly basis. Initially, when the project started there was an eagerness to start the groups following the feedback from the staff survey. Feedback was requested at the end of each group relating to the value or not of attending the group. Whilst this feedback was positive, with a general sense of further groups wanted, it became apparent that having a shared responsibility for arranging the groups ultimately led to no one person taking the lead and coordinating dates for the groups. Given that the groups were run on a unit basis, the author had made an assumption that the unit teams would work to identify dates that worked for the units, however, it was clear that where dates were allocated was due to having one staff member on the unit take on the coordination

role. Using this knowledge, the author adapted the implementation plan and identified some key staff from the stakeholder analysis who could take on the role of coordination for the unit. Whilst participation in decision making is identified as a required element of staff interventions (Michie & Williams, 2003) and a common criticism within staff feedback, there is a need to have clarity about accountability/responsibility to promote effective governance as required within the regulatory framework (Health Act, 2013; Health Information and Quality Authority, 2013). So a needed change to the implementation plan was for the naming of a key person for each unit to continue to drive the project.

An ongoing challenge with the groups remains the clarity between the need for reflection on day-to-day practices and line management issues. At the suggestion within one group regarding information shared with the PIC and Clinical Director there is now a feedback loop within the unit group. This potentially reflects a strong desire for improving communication as well as the need for a tangible outcome, as identified as a resistive factor in the force field analysis. The groups made some interesting statements regarding their sense of the groups, these comments provided opportunity for the author to reflect on their role in the groups and highlight a potential challenge to mainstreaming. It was clear to the author that the groups were making good reflections allowing them to questions some of the initial responses to situations and to think about possible other ways of working with specific residents, however, there was no awareness that this was part of the reflective process. If the ultimate aim of the OD project is to develop reflective skills in frontline staff, then the author in their role as a leader of this change will need to build upon their

professional skills to help the groups identify when they are reflecting within the groups. This suggests that there may be the need for some training sessions to accompany the reflective groups to provide the staff with a practical sense of accomplishment to support generalisation from the group discussions to the day-to-day practice, which is considered to help develop coping resources and in turn foster staff engagement (Peterson et al., 2008). However, given the time frames for this project, the author believes that it would have been unrealistic to have identified a training component too. It is hoped that through developing a training component in the future this will be a means of supporting and mainstreaming as an extension to the original project.

This suggests that there are key elements to think about when reviewing the mainstreaming of the project, not just in terms of what has been done but also what might need to be further developed to support the mainstreaming. This again highlights that change will evolve and that no stage will ever operate in isolation of the other stages.

5.2.4 Mainstreaming

Through having a key person to coordinate the groups, the author found that there was an increased likelihood of the groups taking place. This is conjunction with a concerted effort to ensure that the day before the group as well as the day of the group contact was made with the service senior nursing team to check in re staffing levels and ability to free the staff for the group. The idea of relentless

communication was needed to promote the groups, especially to get them started. Once started the author with support of advocates of the process identified that there was an impetus through the open discussion of the groups. In the early phases of implementing the groups starting with two of the four units there was a dialogue in the service from the other units highlighting their desire for the groups too. This helped the author persuade senior management when is states of fluctuation of the value for the groups and to view them as an opportunity to show staff the support that is available, knowing that when staff have a greater sense of support there can be an increase in engagement, participation and a sense of team (Michie & Williams, 2003; Peterson et al., 2008; Pipe et al., 2012) as predicted within the Job Demands-Resources model (Demerouti et al., 2001) and the "broaden and build" ideas of Fredrickson (Fredrickson, 1998; Tugade et al., 2004).

A factor identified within the force field analysis was the lack of a tangible outcome and the author certainly found that both in the staff attending the groups and with some senior staff there was an unstated question regarding the value of the change given the pressures of a busy service. Indirectly this was addressed through the feedback systems identified with the PIC and Clinical Director. In addition, the author ensured that it also became an agenda item within the senior management team meeting, with the aim that by making it part of the regular conversation it will be accepted as part of the service.

As highlighted earlier there was fluctuating interest and influence from the senior management team for the project and was likely to reflect the historical cultural bias of reactivity. The service has a distinct strength in being able to respond to crisis situations, however, given the need to evidence safe services there is a need to maintain a strategic overview promoting proactive approaches. This may continue to be a barrier to mainstreaming the project and will need to be explored in terms of succession planning/training needs to ensure that if the author were to leave or be unavailable to continue the groups that they would not just stop. This is an issue that the author still needs to resolve and hopes to build upon the fact that contractual changes were made prior to the groups starting so in terms of succession planning that this obligation would remain part of the contractual requirements for an identified member of the Clinical Psychology department. In addition, it is worth exploring the cost-benefits of supporting and upskilling the Nurse Managers/Team Leaders to be able to facilitate the groups, this would allow even more flexibility for the groups and as highlighted by Pipe (Pipe et al., 2012) would further promote team functioning and build staff resilience.

5.3 Impact/Evaluation

At the start of the project the author identified three SMART objectives that would provide evidence of achieving the overall aim of promoting reflective practice within frontline staff. The outcome of these objectives was discussed in the previous chapter and this chapter provides an opportunity to review the process of evaluation and what the author’s perceptions of the impact of this project.

Once the author was able to identify a named key person to support the coordination of groups for each unit there was a clear impact in the likelihood of the group taking place. In addition, the author took responsibility for ensuring that the service was contacted the day before and the day that a group was planned, this provided an opportunity to liaise with the managers of the unit to discuss potential barriers for that group and what can be done to minimise them, for example on one day a number of staff were in mandatory training and out with residents on goal related trips/activities making it difficult to use staff from other units to free staff to attend the group during the shift. On this occasion, with discussion with members from the off-unit clinical team the author with the manager was able to redeploy the off-unit team members to cover the unit for the groups. This action was commented on within the group and created an immediate sense of value, both for the group and the efforts that the manager was making to ensure staff could attend.

Whilst these elements were not explicitly stated as an objective within the project, due to the number of difficulties in assessing the sense of being valued, it is clear to the author that the groups are creating a structure that provides a supportive forum for the frontline staff. However, the fact that these objectives were not included within the project does present a weakness. The author identified that there is a need for a tangible outcome from the groups to help show that they are beneficial and if there was information to evaluate the sense of support/value that was perceived by those attending the group this could be used to create tangible and visible data for the frontline staff, senior managers and the board. At the start of the

project the author was aware of possible change fatigue within the service and a sense of burden from the perceived recent increase in demands due to impending inspections, therefore whilst a staff survey might have added value to the project it may have come at a cost and given that survey response rates tend to be under 50% the author tried to access feedback at the end of each group. A recommendation is to ask explicit questions about the reflective groups within the next annual staff survey and that these questions become an integral part of the staff survey, highlighting that change in one area of service provision/delivery will influence changes in areas that might initially appear unconnected and a leader must have the ability to adapt as these links become apparent.

Another area where the project could be strengthened is exploring the impact for the residents in the service. At the start of thinking about the project, the author identified in the literature the role that staff influence the quality of social interactions and other elements associated with quality of life for residents (Hatton et al., 1999; Hatton, Emerson, et al., 1999; Robertson et al., 2005) and therefore, if staff are more engaged and active within their role it is understandable to expect that this will have a positive impact for the residents. Given that this is a novel project in the Irish context, a service providing dedicated working time from a Clinical Psychologist to promote reflective practice in frontline staff, it was considered by the author inappropriate at this stage to explore the impact for residents, but would be worthwhile identifying a means to evaluate from the residents perspective in the future.

5.4 Recommendations

A number of recommendations have been generated through the process of reviewing the project:

1. In the role of leading the change there is a need to check and review analysis that are completed, in particular when there is notable change in support/resistance.

This checking is often done informally but a formal process may allow the leader to identify if there are patterns of influence and to better equip them to not only respond to the fluctuations but also to potentially predict them.

2. Identify a means of extending the objectives to include a measure of the sense of support/value/benefit for the frontline staff from the groups

It was apparent that staff at all grades found the lack of an immediate tangible outcome difficult in terms of being able to continue their support for the groups, as reflected by statements from staff within the group. Whilst the author has identified why a measure of value was not used within this project, to help with mainstreaming it must be considered. One option available is to find a way to integrate feedback into the annual staff survey and the author will need to liaise with the HR Director to assess viability of this option.

3. Feedback on the impact for residents

As highlighted above the author started this project thinking about the impact of staff interaction on quality of life for residents, however, this is and will be a difficult area to assess directly. However, it is recommended that time is spent considering how to include feedback from residents within any future developments of this project.

4. Training is developed for Nurse Managers/Team Leaders to become actively involved in facilitating their unit reflective group

The Author raises the question of succession planning, an important element for any leader to think about within any project. Initially, this was considered to have been addressed through the change in contractual arrangements with explicit reference to staff support and the assumption that these terms and conditions would continue if the author were to leave. On reviewing the process and reflecting on the challenges, one big area was that sometimes having a set date and time for the group is not practical for the and the services they are providing. If the Nurse Manager/Team Leader was equipped and confident to facilitate the groups then it could become more flexible, in that a day may be identified and that the group then takes place at a time that day guided by the demands of the service. Those that are facilitating the groups could be supported through a reflective session with a member of the Clinical Psychology Department.

5. Expand the reflective groups to create a space for senior staff

The Author has already been approached by other Nurse Managers requesting that they are provided with their own forum for facilitated reflective practice given that they may face different challenges to the frontline staff and she believes that this will

be of benefit to the frontline staff, the service and the residents. If these groups are created it will help to address the resistance created through not knowing what is happening. Given the time commitments associated with the current structure of the reflective groups there is a need for the author to share some of the responsibility and this will be supported through developing skills in others to facilitate the unit groups, freeing time to facilitate a senior group and a group for those facilitating the unit groups.

5.5 Conclusion

The process of introducing reflective groups for frontline staff created a number of challenges for the author, made easier by their personal interest in staff support. In order to implement the project the author made use of both their formal leadership position as well as the network of identified informal leaders with the service. The experience highlights preparations are very much the foundation of the project and must not be underestimated, nor should the value of continued and relentless communication with stakeholders throughout the duration of the project and ensuring that there is communication on the outcome. As part of this process the author hopes to present information about this project to all the staff in the service where the groups were established and to the senior management team and the company board.

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