How to reveal and encourage brilliant feeding care

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Introduction

The challenging and sometimes frenetic context of a health service can leave clinicians and their managers with limited time to engage with each other and the patients and family members they support, for meaningful dialogue and shared learning. They seldom have the space to consider and critique: what they do; how they do it; why they do it; what influences their thoughts, emotions, and practices; as well as the associated effects. Although is relevant to most (if not all) public health services, it is particularly germane to those that are atypical within health systems. Consider the services that support patients with relatively rare conditions or who require the expertise of a niche speciality, and their family members who are also likely to require specialised support. The limited availability of these services can mean extended waiting times for those who need them. It can also mean few developmental opportunities for the specialists within these services, irrespective of the discipline they represent. Clinicians and managers might have access to conventional avenues to reflect on practice, including (but not limited to): formalised (and typically didactic) continuing professional development; staff appraisal processes (which can be perceived as punitive); and incidental guidance from (typically senior or experienced) clinicians (to typically junior or inexperienced clinicians). However, these are seldom complemented by opportunities to reflect in practice.

The limited complementarity between reflecting on and in practice is problematic for (at least) four reasons. First, purely reflecting on practice suggests the insignificance and triviality of in situ practices, which occur within a rich soup of ingredients, many of which cannot be disentangled, let alone isolated. These include (but are not limited to): clinician expertise; patient (and potentially
Second, simply reflecting on practice can diminish psychological safety, where perceptions of a distrusting team and/or organisation (perceived or otherwise) are fuelled. Akin to critiques about anonymous employee surveys (Lew 2017), it can suggest there are few (or no) safe spaces in which to respectfully consider and critique practice and all that accompanies it, as a collective. This can incite insecurities or rumours about micro managerialism – or worse still, feed micro managerial practices among senior personnel.

Third, mere reflection on practice can disregard the evidence that suggests the value of reflexivity, as well as participatory methodologies (Alvesson and Sköldberg 2018, Iedema, Carroll et al. in press). Unlike reflection, which is, ‘personal, focused and purposive’, ‘reflexivity is collaborative in nature, diffuse in focus, open-ended in purpose and immediate in effect’ (Iedema 2011). While the former, ‘enable[s] individuals to intervene in specific aspects of their own conduct’, the latter, ‘is a fully internalised and socially distributed monitoring and adjusting of the safety gradient of practice’. Participatory methodologies can help to spur reflexivity by democratising scholarship. They encourage individuals who are typically relegated to the somewhat passive role of ‘subject’ to that of active contributor, or better still, co-researcher. Despite the methodological plurality represented by this encompassing term, participatory methodologies aim to involve because of the associated benefits – be they epistemological, theoretical, methodological, or practical. More specifically, participatory methodologies can respectively help to: demonstrate coherence between one’s values and one’s scholarship; advance theory through problematisation and relatedly, the use of the novel approaches (Alvesson and Sandberg 2011); and address wicked problems (Churchman 1967, Rittel and Webber 1973), particularly where conventional approaches have achieved limited success (Leung, Yen et al. 2004).

Fourth, it can reinforce the longstanding and oft-cited chasm between research and practice (Institute of Medicine 2001). This is because the development of helpful theory and relatedly, the suite of models of care and interventions that typically follow, require different approaches.

Given the aforesaid (and potentially other) implications, this methodological article demonstrates how reflexive and participatory methodologies – namely, positive organisational scholarship in healthcare (POSH) combined with video reflexive ethnography (VRE, Dadich, Collier et al. 2018) – can help to reveal and encourage brilliant healthcare. This is demonstrated with reference to a feeding clinic, which represents one of the aforesaid atypical services within a public health system. To demonstrate the potential of POSH-VRE within niche specialities, this article
commences with a brief overview feeding clinics. It then presents the reflections of clinicians who assumed the role of co-researcher for the purpose of a study to examine, understand, and ultimately promote brilliant feeding care using POSH-VRE. The article then concludes with a discussion of the associated implications for scholars, practitioners, and policymakers.

**Feeding Care**

Feeding care enables individuals – many of who are infants, toddlers, or children – to manage feeding difficulties. These encompass eating behaviours that have, ‘an adverse effect on health or psychological well-being’ (Luekens and Silverman 2014). Feeding difficulties are common, affecting approximately 25 to 45 percent of typically developing children. Although most of these difficulties are transient, many incite considerable parental distress and anxiety (Pedersen, Parsons et al. 2004).

Despite the potential seriousness of feeding difficulties for patients and their families, there is limited clarity on what constitutes optimal feeding care. Notwithstanding profession-specific guidelines (NSW Health 2016) and commonplace references to multi- or interdisciplinary care (Silverman 2010, Sharp, Valerie et al. 2017), to the authors’ knowledge, there are no frameworks or guiding principles to inform how clinicians, of different professions, support patients with feeding difficulties and their families. Although it is beyond the scope of this article to hypothesise reasons for this, they might include: the complexity of feeding difficulties, which are shaped by internal and external factors, including (but not limited to) physiology, mental health, family composition and the relationships therein, and culture (Bernard-Bonnin 2006, Bryant-Waugh, Markham et al. 2010); (relatedly) the complexity of feeding care, which takes many forms and can be delivered within inpatient and community settings; limited government recognition of the importance of feeding care, as suggested by key performance indicators and metrics that direct (and sustain) attention to acute, hospital-based care; as well as the absence of national and international datasets for benchmarking purposes.

Limited clarity on what constitutes optimal feeding care is problematic for (at least) three reasons. First, clinicians with an interest in feeding care have limited direction on the practices that reflect the tenets of safe and quality care – specifically, that which is: consumer centred, driven by information, and organised for safety (Australian Commission on Safety and Quality in Health Care 2010). Second, patients and their families who require feeding care have access to inconsistent, if not inadequate information on what they should expect from feeding clinics. Third, not knowing what constitutes optimal feeding care risks directing limited resources (including clinician time) to substandard practices.

Given the aforesaid reasons, a study was completed to clarify optimal feeding care practices.
Towards this aim, POSH-VRE was used to analyse and critique brilliant practices within a feeding clinic in south western Sydney, as determined by the clinicians affiliated with this clinic. The rationale for POSH-VRE is fivefold. First, the methodology can encourage individuals to reflect in practice (Iedema, Carroll et al. in press). Second, it can promote reflexivity (Iedema 2011). Third, as a participatory methodology, it embraces different forms and sources of knowledge – not solely that from academe or agencies responsible for clinical practice guidelines. Fourth, a purposeful focus on positive organisational scholarship in healthcare would help to reveal brilliant feeding practices, as perceived and/or experienced by the clinicians. Finally, to the authors’ knowledge, POSH-VRE is yet to be used within a feeding clinic. To demonstrate the value of POSH-VRE within this study and how it was adapted to accommodate a complex feeding clinic, the following section presents co-researcher reflections. These were collectively crafted by a Clinical Dietitian and a Senior Speech Pathologist who chose to contribute to the study as co-researchers by: preparing for and co-facilitating reflexive sessions with clinical colleagues to analyse video-recordings of feeding care delivered at the clinic; critiquing video-recordings of theses reflexive sessions; and reporting on the associated findings to different audiences.

Co-Researcher Reflections
The feeding clinic at which this study was conducted offered outpatient appointments each Thursday, from 8:30 am to approximately 2:00 pm (see Figure 1). During this time, a team comprised of a speech pathologist, a dietician, a physiotherapist, an occupational therapist, and (when available) a paediatrician assessed approximately four paediatric patients and consulted their adult companions. These appointments typically transpired for approximately sixty minutes, and were interspersed with: the documentation of clinical notes; telephone calls to other health and social services; as well as patient no-shows (despite the reminder telephone call before the appointment date). Given the limited availability of some clinicians, notably the dietician and paediatrician, the team collectively consulted patients and their adult companions across two rooms, enabling the dietician and paediatrician to contribute to consultations, as required.

As an entrée to POSH-VRE, the academic team member met with the feeding care clinicians, including the manager, to describe POSH-VRE, how it might be used, and opportunities to participate with varying degrees of involvement. Following these discussions, it was decided that feeding care consultations were to be video-recorded over four consecutive weeks, pending participant consent. These recordings were then to be prepared for and analysed during reflexive sessions with the team.
Our first reactions to POSH-VRE, particularly the ‘V’, was one of discomfort as we considered having our patient consultations and collegial conversations (during the study period) recorded and critiqued by colleagues. What if our interactions with families or colleagues were negatively impacted by the video-cameras; what if we found it uncomfortable to watch ourselves on the recordings? As we considered the study further, our thoughts turned to the extra work this study would involve. Given our busy clinical schedule, we doubted our capacity to manage our co-researcher roles.

Similarly, being relatively more familiar with quantitative research – as per convention within medicine and health science – we questioned the value of POSH-VRE; notably, its use of qualitative data. We questioned the truthfulness and accuracy of these data – how could we ensure that we captured and appraised brilliant feeding care? We suspected that we would be open to unfavourable critique when we attempted to communicate our findings via refereed journal articles. Although we had certainly read about the potential value of qualitative data, particularly in the context of POSH-VRE, these data were seldom used in this clinic.

During the initial weeks of the study, we saw how POSH-VRE can be operationalised and what it can mean. In this study, it meant accommodating (and re-accommodating) the changing needs and interests of: individuals – be they clinicians, the manager, children, parents, or carers; the team of clinicians; and the organisation. For instance, it meant asking and re-asking: whether the study timeframe was acceptable; and whether individuals were comfortable about the presence and use of the video-camera, and the subsequent use of the video-recordings. POSH-VRE also meant directing our focus to what we did well, individually and as a team, and what we were proud of; it meant providing a safe space to lament the challenges associated with, if not the tribulations of healthcare, notably feeding care; and it meant thinking about ways to champion feeding care to those who were unfamiliar with it, be they clinicians, policymakers, or those who (could potentially)
use health services. As we became better informed about POSH-VRE, our initial reservations dissipated, except that of the time commitment involved.

This is not to suggest the use of POSH-VRE was straightforward. For instance, given limited time during consultations and competing priorities – including patients’ clinical needs, the psychosocial needs of their adult companions, and the boredom of the patients’ siblings – parents and carers were telephoned before the child’s appointment to invite their participation in the study. Those who consented were then posted an information sheet and a consent form, which they were asked to sign and return to the clinic during their next appointment. However, they did not always receive these documents before the appointment – and those who did, did not always return their signed consent form. Consequently, precious clinic-time was sometimes used to ensure informed consent. To minimise the effects of this, it might have been preferable to seek informed consent from parents and carers as they waited for their appointment in the waiting room. While not in the presence of a team of time-poor clinicians, eager to commence the consultation, the parents and carers might have been better able to: pose queries; discuss concerns; respectfully decline the invitation; and/or explore opportunities to further their participation in the study as, for instance, a fellow co-researcher.

Another challenge was containing the video-recording period to four weeks, given limited workforce capacity. During the study, clinician availability changed due to planned and unplanned leave, as well as additional roles they were required to fulfil. This in turn meant fewer clinicians were available to seek informed consent from parents and carers, or assemble the recording equipment in a stable position, ensuring it was: unlikely to be in the clinicians’ way; beyond toddler-reach; and within reach of a power-point. Although it was necessary to extend the video-recording period, video-recording was scheduled when the clinicians deemed it feasible.

Having collected approximately 11 hours of footage, we then analysed some of the video-recordings, in preparation for the reflexive sessions. Although it would have been preferable to analyse all of the video-recordings, our capacity was largely limited by our primary clinical responsibilities. Nevertheless, in the spirit of democratised scholarship, we continued to contribute, as our workload and personal time and interest permitted. To edit the footage into video-clips that might ignite a critique of brilliant feeding care, we purposely watched for probable manifestations of such care. Specifically, we attempted to discern: explicit or implicit demonstrations of appreciation; our experiences of the ‘feel good factor’ while watching the footage; respectful dialogue, particularly when it might not be expected; and/or demonstrations of a safe space or trusting culture where, for instance, reverential dissent could be heard or a vulnerability, disclosed. These lines of inquiry helped to anchor us to POSH. We then edited the footage into video-clips of approximately two to three minutes.
To aid coherence, the aforesaid description was purposely phrased to suggest a somewhat planned process – however, it fails to capture the messiness of the analytical process. Although the hours of footage contained myriad scenes in which brilliant feeding care was represented, we relied on our senses, our values, our interests, and our attention-span to prioritise, or triage these scenes. As we sifted through the scenes, we considered: what was interesting or mundane – and why; how (a)typical was this of this particular feeding clinic; which professions and aspects of organisational politics were apparent or absent, why, and did it matter; and what could this scene teach us, or the anonymous faces of ‘management’ about feeding care? These questions reveal the political dimensions of POSH-VRE, whereby decisions about capturing and selecting particular scenes are shaped by individual and collective interests.

Once video-clips had been prepared, we co-facilitated two reflexive sessions with the academic team member, each of which transpired for approximately ninety minutes. All of the feeding care clinicians were invited to participate, and those who were available at the time, participated. The only exception was the manager. To moderate power imbalances within the team, it was suggested that the manager contribute to the study in alternative ways – this helped to ensure the clinicians would candidly contribute to the sessions and thus, democratise scholarship.

Securing a mutually convenient time for the reflexive session was difficult. In addition to aligning the calendars of the health service and university, clinician diaries also had to be synchronised. Some were scheduled to deliver feeding care at other services, or facilitate group programs for children, as well as their parents and carers. Although it is difficult to know how this challenge might be managed in studies, one approach might be to allocate times for the reflexive sessions at the initial planning stages, when all team members are present. Another approach may be to run several reflexive sessions to account for unavailability and give every team member an opportunity to attend at least one session.

With this team of feeding care clinicians, who shared warm, supportive relationships – if not friendships – it was relatively easy for us to co-facilitate the reflexive sessions. They eased into respectful conversations about their craft and the ways they melded the science and art of feeding care. They readily recognised each other’s strengths – for instance, they way that some clinicians readily took to the floor to play with children (including patients’ siblings) to inconspicuously observe and assess the child’s development; the way they politely steered parental practices by suggesting recipes and meal-time routines that they found useful as parents, rather than as clinicians; and the way they explicitly recognised the brilliance of parents and carers who typically juggled feeding care with a myriad of other responsibilities. For instance, some parents and carers cared for other children and/or ageing parents, some of who experienced disability; some were employed, fulltime; and some experienced poor mental health, particularly those who arrived in
Recognising challenges both within and beyond the clinic helped to clarify the ways in which hardship can arouse brilliant feeding care. For instance, cognisant that a parent, carer, or colleague was experiencing a ‘tough time’ elicited greater empathy and compassion as the clinicians placed themselves in another’s position.

POSH-VRE helped to elicit different understandings of feeding care, particularly that which was deemed to be brilliant. It carved out protected time from an otherwise chaotic day to reflect and reflex with critical friends who agreed and (caringly) disagreed with each other’s observations. This is not to suggest the reflexive sessions only spurred revelations. A few clinicians indicated that several of the ingredients thought to enable brilliance were expected. For them, it was hardly a surprise to acknowledge the importance of play (as a form of inconspicuous assessment), empathy, or compassion. Nevertheless, they valued the opportunity to view themselves and their colleagues, together – this was certainly a new approach to facilitate both reflectivity and reflexivity. This helped us – as a team – to recognise that the ingredients required for brilliant feeding care are not solely found among feeding care clinicians – these ingredients can be found within and beyond the team. Although it is not the purpose of this article to explicate these, suffice to say, the ingredients can be found among the patients, their adult companions and family members, as well as the networks the clinicians and family members maintain.

Discussion

In 2017, the New South Wales Ministry of Health launched the Leading Better Value Care program defining value, not only as ‘efficient and effective care (in relation to costs)’, but also as the ‘experience of care’ and in terms of the ‘outcomes that matter to patients’ (Agency for Clinical Innovation 2017). These laudable goals require a better understanding of what matters to patients, and this creates challenges in areas that have attracted limited scholarship, like feeding care.

To build the knowledge-base on feeding care, the use of POSH-VRE in this study was a deliberate attempt to better understand ‘value’ for patients, family members, and clinicians in a different way. Specifically, the aim was to discover a richer and more meaningful critique of value than can be achieved by efforts that merely quantify care. Thus, the positive frame of brilliant care was purposely chosen to juxtapose the predominately negative ‘absence of harm’ indicators, typically used to gauge quality healthcare. Additionally, the novelty of POSH-VRE within a feeding clinic was attractive – it supported an overarching aim to improve feeding care, energising scholarship in this important area.

The success of POSH-VRE in this study, in that it was felt to be a positive use of scarce clinician
time, generated and reinforced ideas useful to feeding care practitioners and stimulated research in an important and under-examined area, can be attributed to (at least) two key factors. First, it helped to address an area of significance to the clinicians and manager involved in this study, as well as the children, parents, and carers they supported. Second, it was premised on a trusting relationship between the academic and clinical members of the research team. These factors were notable at particular times in the study. For instance, before meeting with the feeding care clinicians, the academic team member attempted to familiarise with their service, their priorities, their interests, and impending changes within the Local Health District. This helped to ensure the entrée to POSH-VRE spoke to, and resonated with the clinicians. She also drew on previous experiences with POSH-VRE to helpfully illustrate the adaptability of this methodology, and how it might be used in the feeding clinic, while welcoming clinicians’ additional and alternative suggestions. As the fieldwork days commenced and progressed, the academic and clinical team members collectively decided, if, when, and how the video-recorder and the subsequent recordings were to be used. This bolstered trust within the team, reinforcing the participatory ethos of POSH-VRE. Furthermore, it helped to assuage clinician concerns about the ‘V’ of this methodology and the time required to fulfil the co-researcher role.

The reflections presented in this article regarding the use of POSH-VRE have implications for scholars, practitioners, and policymakers. For scholars, they demonstrate this methodology is a feasible way to examine and understand paediatric feeding care, particularly within an outpatient service. This is notable because paediatric healthcare is an inherently difficult research area, and might disincentivise the use of novel methodologies and research methods (Greenberg, Gamel et al. 2018). Yet, a clear focus on aspects of greatest interest to the feeding care clinicians – particularly care which is optimal, if not brilliant – helped to sustain their engagement, despite changes to their availability, due to clinical, organisational, and/or personal obligations.

For practitioners, including health service managers, the reflections reveal how POSH-VRE offers opportunities to reflect on, appreciate, and be energised by their own and colleagues’ practices. Although the benefits of reflective and reflexive practice are established (Dallos and Stedmon 2009, Ripamonti, Galuppo et al. 2016), practitioners seldom have opportunity to engage with these. POSH-VRE opens an aperture through which practitioners can view and understand what they do well, rather than what they should be reprimanded for. Furthermore, within the safe space cultivated by POSH-VRE, they might also consider how impending changes might influence the practices they are proud of, and how these might be protected.

Finally, for policymakers, the reflections illustrate the value of a positive frame to examine, understand, and ultimately promote the brilliant care that occurs within health services, devoid of a superimposed (and typically costly) ‘intervention’. This is not to suggest the futility of external
interventions; but rather, it can be difficult to sustain these ‘interventions’, given the typical need for continued funds and recurrent training for staff members.

POSH-VRE can help to reveal and encourage brilliant feeding care. By bridging academic and health systems through meaningful dialogue, the methodology offers a way to democraticise scholarship. It harnesses the expertise within (rather beyond health services) to examine, understand, and promote the type of healthcare that clinicians and managers are proud of, and that patients and their family members deserve.

References


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