Article

Appreciative Inquiry: Bridging Research and Practice in a Hospital Setting

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Abstract

Purpose: In this action study, researchers worked with a team of interdisciplinary practitioners to co-develop knowledge and practice in a medical unit of a large urban hospital in Canada. An appreciative inquiry approach was utilized to guide the project. This article specifically focuses on examining the research experiences of practitioners and their accounts on how the research influenced their practice development to enact person-centered care. **Method:** The project took place in the hospital's medical unit. A total of 50 staff participants attended focus groups including nursing staff, allied health practitioners, unit leaders, and physicians. One senior hospital administrator was interviewed individually. In total, 36 focus groups were conducted to bring participants together to co-vision and co-develop person-centered care. **Results:** Analysis of the data produced three themes: (a) appreciating the power of co-inquiry, (b) building team capacity, and (c) continuous development. Furthermore, 10 key enablers for engaging staff in the research process were developed from the data. A conceptual tool, "team Engagement Action Making" (TEAM) has been created to support others to do similar work in practice development. **Conclusion:** An appreciative inquiry approach has the potential to address gaps in knowledge by revealing ways to take action. Future research should further investigate how the appreciative inquiry approach may be used to support bridging research and practice.

Keywords

action research, focus groups, methods in qualitative inquiry, qualitative evaluation, critical theory, person-centered care

What is Already Known?

A problem-focused approach in the past had little success in improving dementia care and sustaining change in hospital settings. There is a need to shift the mindset and practice to a positive and strength-based approach to motivate collective commitment and actions for change.

What This Paper Adds?

Our findings demonstrated that an appreciative inquiry approach could offer a bridge to address the gaps in knowledge to action by supporting practitioners to co-produce knowledge and advance practice. This paper provides a new conceptual tool, 'Team Engagement Action Making' (TEAM) as a heuristic guide to support practitioners to work together in practice development.

Introduction

The growing population of patients with dementia in hospital medical units is driving the need to focus on dementia education

for hospital staff; this claim is endorsed by evidence showing a lack of dementia knowledge among staff (Elvish et al., 2018). Researchers and practitioners are challenged to find ways to operationalize person-centered care to address this gap. Learning general theory about dementia is not good enough (Handley, Bunn, & Goodman, 2017). Hospital staff reported that they need knowledge that is relevant, practical, and applicable (Charter & Hughes, 2012). Involving staff in the development of practice may serve as a useful strategy for producing relevant knowledge. Few studies have looked in detail at the role of research in practice development; therefore, research is needed to identify

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what works (Surr & Gates, 2017) and what can motivate staff to make positive change (Scerri, Innes, & Scerri, 2017).

Traditional efforts that focused on problems led to discouragement and tended to take away the energy for change (Cooperrider, 1986). This study was designed to bring about change by attending to the social process of meaning-making and human interactions (Bushe, 2011). Bringing people together to co-inquire and reflect on workplace issues is often neglected due to the pressures of day-to-day work, yet the need exists to move away from looking for deficits to facilitating a positive approach (Reed, 2008).

Appreciative Inquiry

Appreciative inquiry offers a positive way to explore, discover possibilities, and transform systems and teams in the organization toward a shared vision (Cooperrider & Whitney, 2001). Adopting a social constructionist view and based on the principles of positive dialogue and collaboration, appreciative inquiry has been reported to be useful in supporting change in nursing practice (Scerri, Innes, & Scerri, 2016). Tapping into the motivations for change by using a positive approach can unlock the collective intelligence and build team capacity (Hung, Lee, Au-Yeung, Kucherova, & Harrigan, 2016).

Aligned with critical social theory, appreciative inquiry supports an egalitarian form of open dialogue. By challenging the dominant hierarchical power relation, appreciative inquiry empowers practitioners to become change agents and to explore innovative practice. People at the point of care are encouraged to engage in practice development project to improve the work situation and move toward shared visions for a better future (Trajkovski, Schmied, Vickers, & Jackson, 2015). Bringing staff together to cocreate change not only creates means for socially reinforcing change but also increases the potential for a larger impact (Willis et al., 2016). Unlike the punitive style of performance management, appreciative inquiry supports learning and reflection in a positive way (Curtis et al., 2017; Dewar & Nolan, 2013).

Appreciative inquiry has been criticized for focusing on the positive experiences while failing to address the negative problems (Reason & Bradbury, 2008). It is important to point out that using a "positive approach" does not mean ignoring problems (Bushe, 2011). A positive approach appreciates the negative experience and reframes it constructively into an opportunity to make improvement. Instead of remaining stuck in a dual between positive and negative, Bushe (2011) argued that the power of appreciative inquiry as a change method depends on allowing for ongoing generative conversation between practitioners and researchers. For Bushe (2013), generative conversation refers to the inquiry that challenges the status quo, so that new thinking "become compelling images . . . generat[ing] change because people like the new options in front of them and want to use them" (p. 12).

Bridging Research and Practice

Research tells us patients with dementia are overtreated by antipsychotics and can benefit from nonpharmacological approaches (Corbett, Burns, & Ballard, 2014). Yet knowing the evidence is insufficient to drive change (Goodenough et al., 2017). As Bowen and Graham (2013) explained, the knowledge to action gap results from a lack of meaningful engagement of practitioners in knowledge production. What we need is an integrated approach to promote partnership in knowledge co-production and utilization—an effective strategy that enables practitioners to work together to make knowledge actionable in practice.

Appreciative inquiry has been successfully used as a research strategy to facilitate practice change in a number of studies. For example, Dewar and Nolan (2013) used appreciative inquiry to develop the 7Cs of caring conversations to support integrating relationship-centered care in practice. Kavanagh, Stevens, Seers, Sidani, and Watt-Watson (2010) also used appreciative inquiry in their research about pain management. Appreciative inquiry has been reported to be a catalyst for practice change, emphasizing collaboration in research and practice development (Watkins, Dewar, & Kennedy, 2016).

Despite the evidence showing promise for using appreciative inquiry to bridge research and practice, researchers have not systematically analyzed how appreciative inquiry might play out as a strategy for mobilizing change in practice in the acute hospital setting (Watkins et al., 2016). As Greenhalgh (2017) emphasizes, one crucial aspect of knowledge translation is the extent to which staff in the organization are supported to come together to hear about new ideas and discuss their interpretation. The purpose of this article is to discuss and theorize how research may help to engage staff in practice development. We focused on examining the research experiences of practitioners and their accounts on how the research influenced practice development. The results of patient engagement have been published in another article (Hung et al., 2017).

Ethical Considerations

The University of British Columbia Ethics Board (H15-03036) and the Vancouver Coastal Health Research Institute (V15-03036) approved the research. This was the doctoral research of the first author. The inclusive approach in action research can raise questions about ownership and responsibility for the research (Reed, 2008). In this study, co-ownership of the project was encouraged with practitioners being involved to drive sustaining efforts for actions in practice development. The first author assumed full responsibility for the entire research project. The level of involvement for each researcher was kept flexible. For instance, J.T. took notes at each focus group while D.B. helped to bring staff into the focus groups. Other participants led action activities such as peer teaching and video production. Careful attention was paid to ensure that ethical principles of mutual respect and fairness were applied. All participants were also given an option to waive their confidentiality and be identified to acknowledge their contribution. For those who signed the waiver, their real names are used. For those who chose to remain anonymous, pseudonyms are used.

Table 1. Inquiry Questions.

Research Phases	Goals	Question Examples
Phase 1 (engage and look)	Vision, goals and team agreement, current state, and priority needs	What possibilities do you see for this research? What are we doing well and what are the opportunities? What might our future look like?
Phase 2 (think and act)	Video reflexive group, codesign of actions, and reflections and evaluation of actions taken	What do you like to have in the staff education? What can we do better to generate more excitement for shared learning?
Phase 3 (evaluate and modify)	Reflection on experiences of participation in research and practice development, changes; identify lessons learned and future plan	What is your experience in participating in the research? What do you need to sustain the development?

Setting and Participants

One 31-bed medical unit in a large urban hospital was purposively selected for the study. Before the project, patients with dementia, families, and staff in the medical units of the hospital voiced a need for improvement in the local physical environment and staff education in dementia care. Convenience sampling was used to recruit leaders and staff participants (nursing and allied health practitioners). The staff attended one or more focus groups during protected work time at 2:30–3:30 p.m. in a conference room at the unit. Participants included a total of 50 staff members (nursing staff, allied health practitioners, unit leaders, and physicians) and one senior administrator in hospital management. All participants signed written informed consent.

Method

This research was informed by an appreciative inquiry and action research approach, both based on the principles of collaboration and critical reflective practice (Cooperrider & Whitney, 2001; Reed, 2008).

Data Generation

Qualitative methods, including focus groups ($n = 36$) and interviews ($n = 1$), and observations were used to generate data for the research. The first author facilitated focus group sessions every second Wednesday afternoon during 2016. All conversations in the focus groups were audio-recorded and transcribed verbatim. The first author also conducted 20 hours of ethnographic observations (Emerson, Fretz, & Shaw, 2011). One 30-minute interview was conducted with a senior hospital administrator at her office.

This research involved three phases: Phase 1 (engage and look) to examine the baseline and explore the physical and social environments before actions, Phase 2 (think and act) as action learning that took place through changes in the environments, and Phase 3 (evaluate and modify) to evaluate what worked and what did not work. Table 1 shows the examples of the questions asked in the three phases of the action research cycles.

Data Analysis

The data analysis involved a participative approach based on appreciative inquiry strategies (Reed, 2008). The appreciative inquiry literature provided sensitizing concepts (e.g., coinquiry and build capacity) for deductive coding, while an inductive approach was also used to allow concepts to emerge from the data (e.g., make it easy and fun). The first author held biweekly data analysis meetings with two practitioners (J.T. and D.B.) to go through data, make sense of possible meanings, and identify the key themes. Highlights and summaries were brought back to the team members of the studied unit for group discussion. In the group discussion, conversations focused on finding whether or not individual team members had other interpretations or new points. From the results of the analysis, we then went on to develop action activities. For example, our group analysis revealed that not knowing the patient's biography and individual routine was a significant gap in practice. A tool "This Is Me" from the Alzheimer's Society was brought in. We discussed the need to simplify the tool and make it fit the format of the existing care plan. Then, we worked together to customize the document.

Following action such as this, we gathered as a group to analyze the method and effects. Regular meetings were held with three academic supervisors to discuss data generation and the analysis. We worked diligently to ensure that the analysis was systematic. Rigorous thinking was embedded in a full range of activities including member checking with participants, a continual back-and-forth between parts and the whole data set in the analysis, and working together with various groups for meaning-making of the findings. The first author kept a research journal to record personal reflections. Biweekly research meetings with coinvestigators were held to keep up-to-date with the data analysis and to challenge individual assumptions.

Findings

Three key interactive themes that captured the dynamics of the engagement process for change and the experience of staff in research for practice development are (a) appreciating the power of coinquiry, (b) building team capacity, and (c) continuous development. Embedded in the three interactive steps, there are 10 enablers as key components of the processes: (1) insist on inclusion, (2) focus on what works, (3) embrace complexity, (4) connect the heart, (5) connect the head, (6) adapt to needs, (7) build a big tent, (8) make it easy, (9) real-time testing, and (10) keep pace. Figure 1 shows the three interactive steps and 10 enablers we put together as a conceptual tool, Team Engagement Action Making (TEAM).
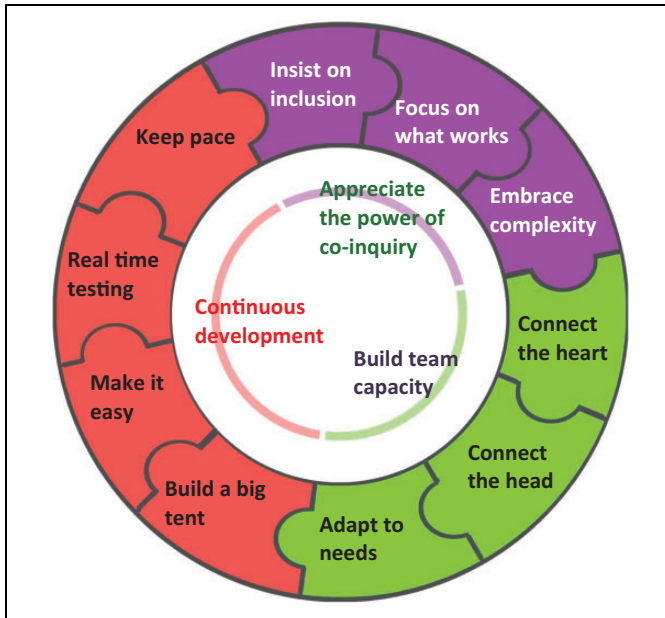
Figure 1. The conceptual tool: Team Engagement Action Making (TEAM).

A - Appreciating the Power of Coinquiry

The positive coinquiry is not only a process to find shared solutions, but it is also a way to deepen shared understanding and clarify collective visions. In this research, the team held biweekly meetings for exploring their ways of thinking and for interpreting the meaning of particular issues or events. Through the shared process of reflection, the practitioners' personal, professional, and cultural beliefs were open to review. The participants' curiosity about this novel approach of co-inquiring in research and their recognition of the need to codevelop practices motivated their participation in the research. Three components were embedded in this first theme: (1) insist on inclusion, (2) focus on what works, and (3) embrace complexity.

(1) Insist on inclusion. Inclusion was highly valued throughout the project. Staff members in all disciplines were invited to be part of the change in design and process of inquiry. The level of involvement was flexible, ranging from being informed to being a coresearcher. To enact the participatory approach, a strong emphasis was on involving staff in all disciplines to co-develop educational activities to enhance learning in the unit. During the first few months, the first author and J.T. taught a dementia care training program, Gentle Persuasive Approaches (GPAs) to stimulate a passion for developing person-centered care (Speziale, Black, Coatsworth-Puspoky, Ross, & O'Regan, 2009). The GPA was a 1-day workshop. After 6 months, almost all of the staff in the medical unit had attended training. A staff member reflected on why GPA was successful in this unit:

> Inclusion. It engaged everyone. The fact that this project has involved all the staff so people feel that they have ownership. They

are contributing at every step in the way; people feel involved and heard—I think a sense of ownership is the key. (Darryl, physiotherapist)

This comment illustrates that an engaged team is more likely to be ready for making practice change than an unengaged team because of the sense of ownership about their practice. The term ownership can be interpreted as an individual feeling of being part of the research, with an opportunity to shape change through expressing their opinions. Ownership can also imply a joint accountability, which is closely linked to sustainability. Other team members explained how inquiring together and hearing stories of others inspire commitment and evoke team emotion, which then becomes a source of commitment.

(2) Focus on what works. Inquiring about what is useful and effective in solving real practice issues and what people highly value can lead to new transformative results. Staff members considered the research to be contextually relevant and effective because it provided them with practical and applicable knowledge:

> When we encounter a difficult situation, someone would say, have you tried the GPA? For example, when a patient is upset, if you leave him alone, try to go back later. It's called—Stop and Go. I think we have the GPA into people's mind now. (Nancy, care worker)

In this account, we can see how new story lines were created as people found positive experiences and talked about them. The story lines made up a new narrative through telling and retelling, which allowed building a new prevailing culture to replace the old. The stories people told each other every day created a new social reality so what people choose to say can have an influence on the outcomes. Wanting to contribute to improve patient care was a reason for people to participate in the inquiry. Telling successful stories in focus group sessions made team members feel proud, which fostered a team spirit.

Playing with possibilities, the team found new effective ways to transform their work. For example, in the Comfort Mitts project, nurses and other staff knitted brightly colored mitts for patients with dementia to cover intravenous lines. The comfort mitts benefited the patients by reducing anxiety and the use of restraints. Several staff involved in the project were invited to speak at local conferences. The Comfort Mitt project created a "buzz" with more people talking about it. The buzz quickly fostered more energy to get more people involved.

(3) Embrace complexity. Staff members emphasized the importance of embracing people's complex experiences in the inquiry. One nurse elaborated:

> This project concentrated on people. It's not so categorized. Like, I am in a research program. It's all the same questions. "How do you feel? Satisfied? Very satisfied?" It doesn't capture much about my experience. People aren't just numbers. People experiences are much more complex. (John, nurse)

In the focus group, the staff spoke at length about how each situation was unique and complex. The learning by doing was a constantly adjusting process in the application of knowledge. Storytelling was a good way to give a more realistic view of how the contextual factors influence a given situation. By combining the stories from the team members, a deeper level of understanding could be reached. For example, the staff spoke about working with patients with dementia, as it tends to require a deliberate effort to slow down, pause, and reflect, and a willingness to look beneath the surface to explore one's own assumptions and the assumptions of others. A nurse explained:

> If you don't try to look behind the behavior and try to explore what might be going on with the patient, you can easily fall into the quick solution, he is agitated, and he needs a PRN or restraint. Remembering the techniques are not good enough; knowing how to use them appropriately in different situations to produce the effect is the key. (Sheila, nurse)

Developing practical knowledge requires a high level of understanding of patients' experiences. The staff appreciated the power of coinquiry and learning different perspectives from each other. A nurse leader said, "Before [the research] we didn't know what to do, everybody was just kind of floundering." The learning together helped staff gained knowledge and confidence.

B - Building Team Capacity

Team capacity building is a collective social process of developing skills in the affective and cognitive domains. This is not about just providing education to the staff. It requires connecting the heart and the head of people in the team to learn together and to turn knowledge into collective action. Environmental and cultural factors influence how well the team can adapt, learn, problem-solve, and take up innovations. Relationship building in a well-connected and supported climate is a key to building team capacity.

(4) Connect the heart. The participants needed to feel connected emotionally and they wanted to contribute to having an excellent team. Instead of being passive recipients of change, the staff wanted to be active contributors:

> When you get into this kind of discussion, and then you know that it will be implemented, you would want to join in. We are doing this because we want to be able to create a better environment and give better care for the patients. It's like a game changer when people see that there's something happening from this. (Isaac, nurse)

Story sharing was an effective way to engage the staff emotionally and the narratives that were produced in the group sessions. Action projects (e.g., peer-teaching videos and the fun fair) allowed people to feel that they belonged and were helping to foster a team spirit:

> We each have a different view about something. I think it's helpful that we come together and talk about it. I think this is very "teamness." These meetings drive a lot of team spirit, most of all, of course it is the contribution part, and we are all in this together. We have a sense of unity. I sense that. Coming to these meetings, we can share our opinions. Sheila may have her opinion, I may have mine, hearing each other's, we can come together. (Georgina, unit clerk)

Tapping into the core motivation of the staff members who wanted to contribute to the team seemed to provide an impetus for change. The participatory approach helped the team connect their hearts through building trust and having team dialogue.

(5) Connect the head. The goal of "connecting the head" (Giles & Alderson, 2008) was to grow the collective intelligence by learning together. It requires team members to listen to each other instead of talking at each other. It also requires the team to let go of the comfort and power associated with "knowing." The openness helped to create an environment that allowed critical thinking and growth in team capacity. People tend to support what they help to create.

> When you are asked to problem solve and contribute, you are taking a risk. You don't know how others may react to your idea. But when you actually took the risk in providing opinion, the project takes roots better with people being together. (Darryl, physiotherapist)

Working together on the team challenges each member on their guiding assumptions that they may have formed for their current perspective or way of thinking. In team dialogue, an opening can be created with new ideas and interpretations. For example, a staff member Sharnjit spoke about how she discovered a lot about a patient who seemed to be intimidating and physically aggressive.

> When I was helping this patient, I was really scared. Because he is tall, and he's got some built up, right. He said he knows Kung Fu, and I think someone said he is a black belt in martial arts. Once he said to me, that's bullshit, I am going to hit you. I felt he is just an aggressive man. Now hearing from you guys, I come to understand that he is scared, too.

The staff spoke about the work they do as requiring constant learning and support from each other. "Every day is a learning experience; you got to listen to those who say no, why this is not going to work, ask them what will make it work." The staff maintained that their work must tap into the accumulated wisdom of the whole team.

(6) Adapt to local needs. Responding to the needs voiced by practitioners was important. The staff said that their most pressing concern was safety. In the beginning, many staff members reported feeling scared and underequipped in terms of their knowledge and skills in dementia care. Through education, the staff increasingly became aware of many effective ways for

interacting with patients with dementia. Staff spoke about how some of the practical tools like peer teaching videos can be used to support their work.

> I haven't seen anything like this before. It is so exciting to see the people in the video, who are actually the staff on the unit, and it was filmed right at our own place. I have watched them so many times, again and again. (Bernard, nurse)

Many benefits were found from customizing education to meet the needs of the local context. One nurse, John said, "watching the videos is so much fun." Another staff added, "The video was kind of a really bite-size thing—right to the point. Here you go, one message at a time, pretty cool." The staff pointed out that any tool that was made in the unit felt like it was "home built." "Like it gives you a feeling of, it's ours. If it's done in other places, there is a hesitant in between. When it is made in our unit, by our team, our colleagues, we can trust it." The customization not only provided more relevant information and credibility, but it gave a sense of pride, agency, and identity. Although staff reported earlier that learning new knowledge from outside is important, they clearly indicated that tailoring knowledge to make it fit to use in their particular context is imperative. Another important point that was brought up by the educator was the specific need in the acute context: "I think that dementia care in an acute care setting is unique. It is important to attend to the urgent medical needs and at the same time be creative in meeting the emotional and psychological needs of dementia" (Doris, educator).

C - Continuous Development

Practice development is a continuous process of improvement toward a culture of person-centered care. The goal of the project was to help the team develop knowledge and skills, so the team would be engaged and empowered to come up with innovative ideas for change. In considering the continuous nature of development, four factors emerged as being substantial for enabling the process of becoming. The four key factors are: building a big tent, making it easy and fun, real-time testing, and keep pace.

(7) Building a big tent. Our shared goals to improve dementia care aligned with the vision of the staff and leaders at multiple levels. To achieve ongoing development and sustainability, participants emphasized the connection between the unit and the larger context outside the unit—building a bigger tent. Building a big tent is about collaborating with other units and communities and combining strengths for making larger and long-lasting impacts. To do this, we need to zoom out and look at the big picture and align the project with other initiatives and wider responsibilities of the organization. We worked with staff and leaders of other teams in some of the actions (e.g., inviting them into the education and sharing the tools we developed) to create more opportunities for extending the significance and achieving a larger impact. The program director Leighanne said:

> I honestly believe that patients with dementia are living in our surgical units because they also need surgeries. So, I am interested in how we take the learning from this work and put them into practice widely. How do we do that across the board?

As previously mentioned, changing practice is a social process, and shared ownership is needed to support mutuality and to drive the actions. In the project, people used terms like our unit, our patients, our future, and so on. In addition, many staff members spoke about wanting to use their learning to help others beyond the unit. The physicians, in particular, emphasized that many patients with dementia were on other units and they expected this project to spread the practice development to other units across the system: "We have to think about keeping our eyes on the prize of the success, and you need to think about 100 patients or more, that we have to serve a very similar need in other units" (John, physician).

(8) Making it easy and fun. Focus group sessions were booked every second Wednesday afternoon, and the meetings were integrated into existing routines to build a regular process. We learned that the biweekly meetings made the project easier to manage since short frequent meetings provided opportunities for the team to contribute ideas on what otherwise might be forgotten or simply in need of some adjustment. Meeting at the same place at the same time was effective for building a habit. We also kept the action activities at a small scale, so they would be easy to execute. The benefit of seeing the success in early phases helped to build high motivation and collective commitment. For example, we used gamification in one of the learning events. We turned the rehabilitation gym on the unit into a vibrant environment for learning about dementia through games. The event was a big success because it was fun, challenging, and competitive. Over 50 staff members attended the event. In the fun fair event, the room was filled with laughter, excitement, and mutual learning. Fun was a significant driving force behind the educational activities, which was important to the group from the very beginning. A nurse commented about the fun fair: "I like this because it challenges me. I learn something new each time when I can't answer a question. It's so nice to see everyone is having so much fun. We should have more of this kind of event" (Bernard, nurse).

(9) Real-time testing. An important lesson from the project was to build in time to share stories about how the work was actually having an impact on the lives of patients and staff. After hearing compelling stories about how something had worked, the staff applied their knowledge to quickly test it, which accelerated the learning. For example, an occupational therapist, Carola was excited to share her successful experience of using a hand grab release technique that she learned in GPA. Positive stories like Carola's helped to engage other team members to use or to test out the new knowledge. For clinicians in the applied world, the usefulness of new knowledge can be validated in action. One nurse commented that "this project is beneficial because it can take effect right away." Another staff member echoed the idea

and was surprised that simple activities like painting classes could have significant impact on some patients:

> Yeah, like it surprises us too. I know some of the patients really look forward to it and are excited to do it. They look forward to it because it feels good to paint with a group, the social atmosphere.

The staff spoke about the need for learned knowledge to be applied to see how it works and under which conditions it could work better. A lot of experimentation with the specifics had to take place right away in real time, and quick corrections or adjustments were occasionally needed to make new knowledge work. For example, we tried painting at the bedside at first but quickly learned that the patients actually wanted the social processes—painting and chatting in a group. In our study, we noticed that new knowledge gained significance through its utility and whether or not people found it useful in routine practice. Because the inquiry and actions were joined in the project, the uptake of knowledge was quick. Adaptations and modifications could also happen at the same time, which made practice changes efficient and effective.

(10) Keep pace. Although the 1-year project demonstrated positive changes in the social environment, we have not achieved outcomes in physical environment changes. When the program director left her position, we were less certain that the promises would materialize. The delay in the physical renovations also caused some doubts among the staff. At the end of the study, the participants wanted to have a longer study for sustainability. A strong desire was expressed to keep pace with the momentum of action activities and evaluate long-term impacts. Some individuals asked whether we would continue the research. Others asked for ongoing facilitation and support. One staff member commented about his concerns for the physical renovations:

> Pardon me for being a cynic. But I have worked in the system for 25 years. Until you see the dream realized in concrete form, having that space to work in, and work with that space for a while, then you potentially see ways to make that space more malleable and changing it. (Darryl, physiotherapist)

Despite the participants facing frustrations and uncertainties about the delay of physical renovation, we took time to celebrate successes to keep up the positive appreciative spirit and continued moving forward. A summary report for the action activities was created in a sketch (Figure 2), which showed our accomplishments. Social connection, a shared positive memory, and collective joy helped to fuel our desire for continuous development.

Discussion and Implications

This study supports that appreciative inquiry is a useful strategy for bringing the practitioners together to develop knowledge and take action for practice change. Our results show successful staff engagement for practice change in the hospital setting requires a collaborative and positive inquiry approach, a commitment to research for practice, and overcoming barriers and challenges to engage staff in practice development.

A Collaborative and Positive Inquiry Approach

Our study demonstrated small-scale testing and trials of new knowledge allowed for rapid responses for validation and adjustment. People were willing to come forward to codesign action and cocreate better practice. In this research, staff members provided input and decided among themselves about what their dementia education should look like. They had a lot to say about their practice and what they wanted to change. Their involvement gave a sense of liberation and empowerment, which led them to have an increased awareness about possible alternatives and a range of action learning. Instead of feeling judged for wrongdoing, the staff members developed a safe space for themselves to critically reflect and make change in their practice. As Bushe (2013) states, "momentum and sustainable change require positive affect and social bonding" (p. 2). Our results suggest that the positive approach engages people more effectively. People wanted something new and something positive. Talking about and listening to the stories connected people and built relationships. As mentioned previously, generative questions are necessary to make transformative change, and generative questions engage people to imagine new images and ideas to challenge what it is. Disengaged staff, on the other hand, often viewed change as yet another program to be tolerated until superseded (Willis et al., 2016).

Research for Practice

Greenhalgh (2017) points out that there is a substantial mismatch between what researchers produce and what clinicians want and need in practice. Ioannidis (2016) asked why most clinical research is not useful and found clinical research does not always address real practice problems and rarely reflect patient priorities. Similarly, participants in this research clearly emphasized that knowledge they value is something that helps them solve real problems (clinical utility) and improves patient care (patient benefit). Bradbury (2015) explicates that the way research translates into practice is by actionable knowledge where the inquiry is connected to the needs of those involved. Seeking knowledge is part and parcel of everyday practice in care. Knowledge is linked with action. This research contributes to the field of practice development in dementia care by problematizing the notion of knowledge as a separate thing from practice in the field, generated by researchers and used by practitioners.

In the study, the staff spoke about wanting to contribute and their hopes and wishes to do good for the patients. As Gergen (2014) indicated, research should be linked to create
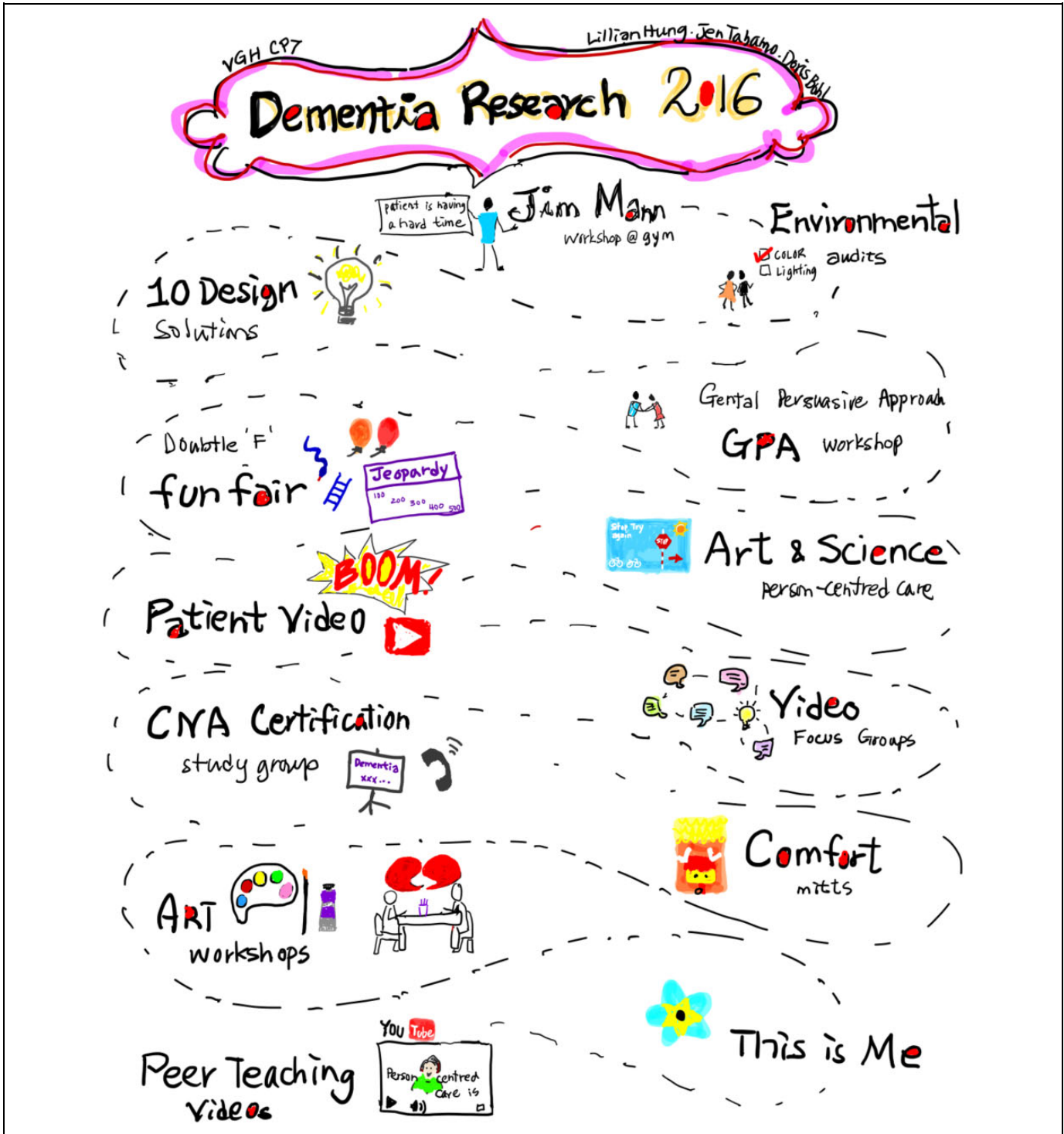
Figure 2. A summary of research activities.

what is to become, a future-making performance. Our findings are congruent with a study conducted by McCance, Gribben, McCormack, and Laird (2013) with 10 nursing teams in a large UK organization. They found the staff engagement in their program was characterized by positive ways of working, building relationships, and maintaining momentum. They were also challenged by conflicting priorities, limited staffing and resources, and organizational restructuring in acute care. As McCormack et al. (2010) suggested, establishing a person-centered culture requires a sustained commitment to practice developments, service improvements, and ways of working that embrace continuous feedback, reflection, and engagement methods that enable all voices to be heard.

Barriers and Challenges to Engage Staff in Practice Development

Three main barriers and challenges to practice development in this study were the heavy workload, change in leadership, and competing priorities. Our results suggest that the necessary conditions for staff engagement in practice development are giving staff protected time, resources, and autonomy to innovate, take risk, and apply new and improved ways of delivering care. Having a stable and supportive leadership is more important than ever before as the current climate of health care is constantly changing and having a focus on budget and cost efficiency. Change is difficult to sustain if leaders do not stay long enough in position to provide ongoing support. As Holmes et al. (2016) noted, changes in leadership can be extremely disruptive and can take years to adjust to. The resource constraints and leadership turnover that hospitals face represent a significant risk to sustain organizational support for continuous development (Rodney et al., 2013). Top leaders and managers must value the development of workforce and focus on the quality of care. Constantly asking staff to do more with less to meet budget targets can demotivate staff and lead to disengagement and burnout. Without careful consideration of the contextual factors, it is easy to jump on the accusatory bandwagon and blame staff for the deficiency of dementia care in hospitals. As Rodney (2011) wrote, "we need to know more about how to make progress towards better ethical practice and policy, and political in the sense that we need to know more about how to foster stronger democratic dialogue within care-delivery and policy structure" (p. 9).

The Conceptual Tool—TEAM

Based on our results, we developed the conceptual tool, TEAM (Figure 1), to guide thinking and discussion in team dialogue for practice development. The tool shows three interactive steps and 10 enablers for team engagement and action making. It is important to point out that the 10 enablers in the conceptual tool are not intended to be a checklist to tick off without understanding the theoretical basis of why that particular factor is key to the engagement process and how each fit with all the other factors. Also, the steps are not linear and rigid. Substantial interactions can occur between the steps and the enabling factors. The use of the guide requires a systematic and rigorous approach to practice development, supported and valued by people at all levels in the hospital. Top leaders must see engaging staff in knowledge production and application as one of their strategic priorities. As the program director Leighanne said at the beginning of the project, "people who know the problems are the staff themselves so they give me the good ideas to solve problems, and my job is to support them to operationalize it." The results of this study lend support to the research by West, Lyubovnikova, Eckert, and Denis (2014) that leadership is vitally important in nurturing and sustaining a culture of high-quality care.

Study Limitation and Strength

This study took place in one hospital setting, so it is important to acknowledge the limitation of its scope for transferability. The setting in which we conducted this research is a particular "organizational context," where the team has their own history, attitude, relationships, and ways to relate with each other. The social and physical environments of the medical unit offer a range of supports and constraints to staff's practice and patients' experiences. Readers need to consider how the knowledge generated in this study may be applicable to their own settings and decide how they may adapt and adopt the knowledge.

An important strength of the study is it demonstrates that appreciative inquiry action research can offer a bridge to address the gaps in knowledge to action by supporting practitioners in producing knowledge and advancing practice. We offer a conceptual tool, TEAM, as a heuristic guide to support others to do similar work in practice development. A very practical use of the tool is for team discussion, as talking points to stimulate reflection on what needs to be considered to facilitate change.

Conclusion

The appreciative inquiry approach shows potential to address current gaps in knowledge to action. The conceptual tool, TEAM, shows the dynamic relationships of how complex factors interplay in the acute hospital context to enable and hinder practice change. Further investigation is required to evaluate and refine the tool in order to gain a fuller understanding of how enablers interact in change processes.

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