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Practice Change and Bricolage in Nursing: A Literature Review

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Abstract This paper aimed to define and describe the concepts of practice change and bricolage in nursing. The ontology, epistemology and axiology of practice change in nursing will be clarified as it related to the experiences of the nurse and patients. This paper proposes that the most significant changes in a nurse-nursed relationship are the self-initiated incremental changes that result in improved patient care, arising from a need to cope with difficult situations, adjust and make sense of the experiences that they were having. It is also within this context that the case is argued for considering that changes in nursing practice involve bricolage activity. Bricolage is the construction or creation of a work from a diverse range of things that happen to be available, or a work created by such a process (Gobbi, 2005). The idea of using patient's environment and available resources which are at hand is the main goal in the bricolage activity (Reed and Shearer, 2011). This stance, which is derived from the work of Levi-Strauss, conceives elements of nursing practice as an embodied, bricolage practice where nurses draw on the 'shards and fragments' of the situation-at-hand to resolve the needs of the individual patient for whom they care. This conceptualization of practice change in nursing could be analyzed with a particular emphasis on its implication for nursing epistemology, pedagogy and praxis.

Keywords Axiology, Bricolage, Epistemology, Nursing, Practice change

1. Introduction

Nursing can be seen as a process of change for both nurses and patients. This meets the description of nursing identified in the literature review: promoting an ongoing process of change for the patients and their relatives (Hussey, 2002). This suggests that change is inherent in nursing and happens continually. The nurse who is supporting and caring for the patient, therefore, must also be experiencing continuous change. This notion of continual change is reflected in the classic definition of the unique function of the nurse (Henderson, 1966): "To assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he (sic) would perform unaided if he had the necessary strength, will or knowledge and to do this in such a way as to help him gain independence as rapidly as possible (page 15)." If patients are in a continuous state of change they either recover, learn to live with their condition or move towards the end of life, and the nurse who is supporting them and providing their care must also be experiencing a process of continuous change. The most significant changes in patient care are the self-initiated incremental changes of nurses that result in improved patient care, arising from a need to cope with difficult situations, adjust and make sense of the experiences that they were having. Sometimes this results in a permanent change and at other times in a temporary adjustment that would then revert to the original state of care.

Despite of the evidence in practice change in nursing, there is a paucity in the body of literature that introduces the art of bricolage in nursing and describe how bricolage influences practice change in nursing. The purpose of this study was to present a literature review of the existing literature to describe practice change and bricolage in nursing. The goal of this literature was to gain deeper insights, contribute to the repository of knowledge and propose a pragmatic future investigation.

2. Methodology

In order to focus the search strategy on nursing, the databases employed in the literature search were CINHAL® and MEDLINE®. Key words used were 'practice change' and 'bricolage'. In addition to articles retrieved from the databases, other sources were acquired by hand-searching current journals and following up references listed in the papers reviewed. Inclusion of papers for the review was based on those judged to provide a theoretical perspective relating to the practice change and bricolage in nursing. A

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literature review uses transparent procedures to find, evaluate and synthesize the results of relevant research. To minimize the bias, procedures are explicitly defined in advance, in order to ensure that the exercise is transparent and can be replicated. Studies included in the review are screened for quality, so that the findings of a large number of studies can be combined. Peer review is a key part of the process; qualified independent researchers control the author's methods and results. To ensure the review is fit for purpose, the following criteria were considered in the peer review process: clarity and basis of research question or hypotheses; appropriateness of sample selection; known reliability and validity of measures used and reliability and validity of measures as used in current study; appropriateness of design to research question and appropriateness of data analysis and inferences made.

3. Results

From the peer reviewed journals and articles retrieved from multiple database search including CINHAL® and MEDLINE®. There were 128 articles initially reviewed and 20 articles were retained that met the inclusion and exclusion criteria. These articles were originally published in English, peer reviewed in international journals of nursing, focused on practice change and bricolage in nursing context, written by nurses in various settings. Based on the current literature review of the articles that described the concepts of practice change and bricolage in nursing, two themes emerged namely: (a) the silent role of nurses as bricoleurs, and (b) a continuous developing art of bricolage in nursing practice.

The Silent Role of Nurses as Bricoleurs

It is within this context of change in nursing, wherein the practice of bricolage activity was involved, a relatively new way to describe nursing, with the nurse as the bricoleur (the bricoleur nurse) and the practice as bricolage (Gobbi, 2005; Warne & McAndrew, 2008, 2009). The definition of Henderson regarding the unique function of a nurse also addresses the function of a nurse as a bricoleur. Bricoleur nurses draw on the 'shards and fragments' of the situation-at-hand to resolve the needs of the individual patient for whom they care. They make use of the environment and utilize available resources to give a better change in the patient's health status. A bricoleur nurse is said to be resourceful, self-driven, innovative and client advocate. On the other hand, bricolage practice is the construction or creation of a work from a diverse range of things that happen to be available, or a work created by such a process (Gobbi, 2005). The idea of using patient's environment and available resources which are at hand is the main goal in the bricolage activity (Reed and Shearer, 2011).

How nursing practice changes can be explained by referencing Levi-Strauss (1966), an anthropologist who first defined the terms bricoleur and bricolage. However, there is limited literature on Levi-Strauss and the concept of bricolage as it relates to nursing practice. Existing research studies cited in the literature that insinuate this concept discuss the learning and development of nursing in practice with particular reference to nurses' use of intuition/reflection/ thinking in action (Gobbi, 2005); One study addresses nursing as a bricoleur activity- as a way of better understanding the inter-related connections between theory, nursing practice and the felt experience of service users (Warne & McAndrew, 2009). Research with patients, using the concept of bricoleur, was described in study in which cancer patients juggle with understanding and treatment compliance within the plethora of models of disease and therapeutic practices (Broom, 2009). In this context, bricoleur nurses move into the domain of complexity. The bricolage practice exists out of respect for the complexity of the lived world. Indeed, it is grounded on an epistemology of complexity. One dimension of this complexity can be illustrated by the relationship between research and the domain of social theory. All observations of the world are shaped either consciously or unconsciously by social theory- such theory provides the framework that highlights or erases what might be observed in a nursing situation. Another study describes a situation in which a consumer accounts for responses to the third generation oral contraceptive controversy and its relationship to bricolage and bodies of knowledge (Hester, 2005). These studies seem to support the notion of nurses as bricoleurs and the practice of nursing as bricolage.

Nursing takes place within a complex context: a mental health nurse might have to practice within a context that is often uncertain, perhaps hazardous at times and distressing, for example with clients who commit suicide without any warning. Likewise, the nurse working on the acute ward may have to face lack of resources and shortage of staff, as well as distressing situations that are a feature of death and dying. Bricoleur nurses, or one who engages in bricolage (Meriam-Webster), are regularly faced with the individual in their situated and concrete context of care, and require a wide range of knowledge and skills to provide effective care. This knowledge includes the universal features of care, health, ill health and disease, as well as a specific knowledge of the individual (Gobbi, 2005). Warne and McAndrew (2009) identify the nurse as a post-formal, or postmodern, bricoleur. The term postmodern is used as the nurse functions within contexts where truth and reality are individually shaped by the nurse's own personal and professional history, social class, gender, culture, and religion. These factors, according to postmodern thinking, combine to shape the narratives and meanings of our lives as culturally embedded, localized social constructions without any universal application (Edgar, 2006). Thus the nurse can be identified as a modern bricoleur, as one who 'draws upon a heterogeneous collection of fragments from multifarious sources which are then deconstructed and reconstructed in the context of working with the individual patient nursing' (Warne & McAndrew, 2009, p. 856). This is very apparent in the role of the mental health nurse who works within a wide range of disciplines. The early intervention team, as an example,

work within several frameworks, such as cognitive behavioral therapy, psychosocial intervention, family therapy, as well as having a working knowledge of housing and client benefits. As nurses working in the acute healthcare provider organization, they have to develop these skills within their workplace which can be a ward environment, outpatient clinic or the client's own home, and they have to be resourceful. The role of the early intervention nurse can involve aspects of the roles of other professionals such as social workers – for example dealing with housing benefit – and they are expected to be teachers/health educators for which there might be minimal or no preparation other than learning on the job. Nursing practice has become an eclectic activity which is influenced by a wide range of factors. These factors made up the individuals' story or narrative of nursing, and though each nurse had their own story there are commonalities across the profession. Their story has developed over time and is made up of personal, cultural and professional influences brought forward from the nurse's personal and professional history. These changes to their personal story of nursing are influenced by the experiences on a day-to-day basis, influences within the context in which they work, and their own personal identity and self-awareness.

Levi-Strauss (1966) identified these stories as myths which he says provide basic structures for the understanding of cultures. Myths are illustrated through language and reflect cultural values and sense of being, and they all include stories that provide meaning in order to make sense of the world and resolve cultural dilemmas (Doniger, 2009b; Kambouchner, 2009). Levi-Strauss suggests that myths are made up of multiple codes of which the original meaning or foundation has been lost (Wiseman, 2009). In nursing the elements or codes of the myth include skills, knowledge and beliefs that were learnt during their pre-qualifying period, as well as the rituals that are inherent throughout nursing.

One example was the nursing skill of aseptic technique. Initially the aim of the student nurse was to undertake the skill competently and safely, without knowing the underpinning theory. The nurse, after repeated practice and becoming more experienced, the need to know more than 'just how to do' the skill developed. When the time was right for the individual, they sought out the background knowledge from other specialists in practice, courses or programs, or evidence embedded in policies or procedures. As time progressed, external influences added other layers of learning and a definitive policy was produced for this activity. The skill was then further influenced by the healthcare provider organization which had controls in place to ensure compliance. Thus, the story of the development of this skill, aseptic technique, has changed over time.

The narrative that develops does not always result in improved nursing practice. A further example is of a qualified nurse who used one glove when administering an injection. The original skill would have been learnt as a student nurse and would not have included the need to wear gloves, unless there was a risk of a blood borne infection. The qualified nurse who was a role model wore one glove to administer the injection and he based his rationale on a Levi-Strauss 'myth' that he heard. This myth took the form of 'If you had a sharps accident and it was your fault, then the healthcare provider organization would not support you.' This myth then became part of the nurse's story even though he acknowledged that it was not an example of best practice. The nurse developed the story further, despite knowing that the practice was unacceptable, by wearing a thinner glove so that the technique for injection giving was easier for him, and so demonstrated a behavior which he knew was almost irrational.

Doniger (2009) uses the metaphor of recycling to illustrate how myths change and develop according to the Levi-Stauss model. Myths are made up of units called mythemes, or codes reflected in language that over time get broken, put together again or recycled. It is the bricoleur, or handyman, who puts these mythemes back together to create a new story. This new story is termed the bricolage. Examples of mythemes from within the data include the expectation of nurses and doctors to provide patients with enough information to be able to make an informed choice in their treatment and care. This leads to the provision of information to patients that is sometimes counterproductive: for example, in the ophthalmology clinic this led to very anxious patients and nurses having to amend their care in order to spend time calming patients down before they could perform the necessary procedure.

A further example of a mytheme relates to nursing rituals. Nursing rituals can be distinguished from traditional rituals, though both exist in nursing. Nursing rituals are nursing practices that are routinized and have no underpinning theoretical basis (Strange, 2001). Traditional rituals, however, have several purposes including reducing anxiety and distress, responding to death and dying, and promoting values within the society of nursing (Lee, 2001). Nursing ritual is an example of a mytheme that make up the bricolage of nursing. In reality, however, several examples of nursing rituals were given, all linked to practice that involved task allocation and without obvious awareness of the implications. The method of application of compression bandages was cited as one ritual that had been consciously discontinued from nursing care. Previously, during the procedure the nurse would go round the ward, bed by bed, using the same trolley and applying the bandages to the patients. Nowadays, the more acceptable practice cited is to maintain the task allocation aspects, but to wash the trolley down between patients. This mytheme has been discontinued in the eyes of the nurse who described the practice, but in reality the mytheme of the task allocation ritual is too strong to be totally eradicated, resists change in practice and exists within practice in an amended form. Knowledge that underpinned practice for the bricoleur nurse came from a range of sources. The least referred to was the empirical or evidence based knowledge. For the bricoleur nurse, this disciplinary knowledge becomes one of the tools available when needing to make clinical decisions. Nurses as part of their everyday

practice both metaphorically and literally handle people and can be identified as 'embodied bricoleurs' (Gobbi, 2005). When nurses are caring for patients they are drawing upon a range of knowledge and skills which include reading the signs from the patients, their body, referring to what they know about the situation in hand, what they are hoping to achieve, and what they have available from previous situations, and then deciding how to respond through their own bodies and their own self (Gobbi, 2005; Hester, 2005). Consequently, nurses always to some degree put something of themselves into their nursing practice. This results in an embodied bricolage and the development of embodied knowledge which is a product of their overall actions. This embodied knowledge is the intuitive, subjective knowledge that they refer to in order to make sense of their practice. It is knowledge that is interpreted through their self-awareness and experiences that they have had in practice. Embodied knowledge is initiated through feelings arising from experience that something they are doing is not right, through watching others, through knowing that their approach is not the right one, and looking back on how they handled situations in the past, all of which lead to a general awareness of wanting to change. They become 'conscious, aware and informed by putting something of themselves into the activity' (Levi-Strauss, 1966, p. 21). As Benner observed 'Our embodiment is a unity that we live, therefore we do not perceive the world in pieces or meaningless sensations, but as a whole pre-given, pre-reflective world' (Benner, 2000). Nurses' embodiment is influenced by their own personal values, which can come from various sources, including religious frameworks and personal or family experience of ill health, and these can lead to an increase or decrease in empathy with patients. Other influences that may impact on embodied knowledge include gaps in knowledge, cultural and professional perspectives, significant others who act as role models, or clinical or managerial supervision.

Bricoleur nurses with their tools do not create new knowledge, as in empirical knowledge, but create new understandings or an assemblage of existing knowledge that they use in their practice (Hester, 2005). These new understandings are the knowledge that is generated in practice, or clinical expertise (Winch, et al., 2005). The nurse, who for years had been making beds by top and tailing the sheets, suddenly had a realization that her practice was unacceptable (to herself) and she needed to change. This realization was new embodied knowledge based upon her feelings on putting the part of the sheet that had been near the patient's feet up to his or her face when 'top and tailing' the bed. She put herself in the place of the patient, instantly changed her practice and shared this new understanding with her nursing colleagues.

Hester (2005) suggests that disembodied knowledge, such as evidence, statistics and scientific information are filtered through the individual's body along with embodied knowledge in order to create new understandings. Hence, the bricoleur nurse uses a wide range of knowledge – scientific, contextualized, personal knowing and patient experience knowledge – in the provision of patient care (T Warne & McAndrew, 2005). The process of creating new knowledge or new understandings has been identified within the literature as the process of reflexivity (Fook, 2007). Reflexivity is the ability to look inwards and outwards using a process of reflection, and recognizing the significance of wider social and cultural influences on the process (White, 2002). All aspects of ourselves and our contexts influence the way we create new knowledge, either through research or practice (Ruch, 2002). Knowledge creation is therefore 'reactive, embodied, social and interactional' (Fook, 2007, p. 31). This embodied knowledge is influenced by the individual, their past and current experiences, their senses and the situation at hand. Knowledge creation is reactive as it is influenced by the tools and processes that are available; an example being the differences in knowledge that will be generated by a mental health nurse who uses an assessment tool as opposed to one who has no framework to use. Knowledge according to Fook (2007) is also interactional in that it is shaped by the historical and cultural contexts within which it is generated. Clinical supervision is one of the frameworks where this process of knowledge generation is facilitated. The supervisor and supervisee share their own experiences and knowledge as applied to specific situations.

With these realizations, nurses face problems and question in their practice, whether they will revert to the original practice once the situation is over or make a permanent change. Three processes were related to the decision to change or not change practice: intuition, learning and reflection. Nurses identified learning as a process of change and although they did not refer directly to intuition, there were clear examples of the intuitive process as a starting point for change. Nurses also referred to reflection as part of the change process. The process of intuition was referred to as an awareness of how they engage with clients, 'something that you develop or is just part of you, just something you become', and 'feeling that something is not right, or a sense that you like an approach that is seen in the work of a colleague'.

Part of the process of intuition as applied to nursing is based upon experiential learning, perception, embodied skilled know-how and recognition (Benner, 2000). One definition that sums up the process of intuition is 'the understanding without rationale, inherent in the expert practice of operating from a deep understanding of the whole situation' (Benner, 1984). This intuition is a balance between knowledge, expertise and experience and has been applied to nursing practice as part of clinical decision making (McCutcheon & Pincombe, 2001; Traynor, et al., 2010; Welsh & Lyons, 2001). This type of decision making is cited in response to everyday practice where nurses encounter situations that require early warnings or recognition that something is not right. These include ambiguous situations when there is a need to react to situations instantly.

The main focus of all intuitive decision making models in nursing suggest that intuitive judgement distinguishes the expert from the novice, with the expert having developed

skills that mean they do not need to analyze situations before they act (Thompson, 1999). The second process referred to was learning. This aspect was highlighted as learning from experience and phrases such as 'being on a learning curve,' constantly learning', 'learning over a period of time' and 'learning on your feet'. This learning arose from experiences that were encountered within practice and often these experiences were difficult and challenging, caused uncomfortable feelings and led to the desire to change.

A Continuous Developing Art of Bricolage in Nursing Practice

Experiential learning has been defined as 'having one['s expectations refined, challenged or disconfirmed by the unfolding situation' (Benner, Hooper-Kyriakidis, & Stannard-Daphne, 1999), is based upon how individuals process experience (Boud, Cohen, & Walker, 2000; Fowler, 2008) and involves the process of reflection (Rashotte & Carnevale, 2004). Learning from experience underpins adult learning (Kolb, 1984; Miettinen, 2000; Yorks & Kasl, 2002), and is often related to promoting learning within the workplace (Dewar & Walker, 1999; Mezirow, 1998) and work based learning. Miettinen (2000) suggests that the founding fathers and developers of the concept are David Kolb, John Dewey, Kurt Lewin and Jean Piaget. The classic experiential learning process developed by Kolb (1984) constitutes a four stage learning cycle that learners undergo. The learning commences with a concrete experience, which then leads to reflection on the experience. As a result of this reflective observation, abstract concepts are devised to serve as frameworks for future actions. The frameworks are actively tested in new situations, leading to new learning that can then be applied to the next experience (Baker, Jensen, & Kolb, 2002).

This model of experiential learning hinges on the experiences that the learner has in practice and the process of reflection. For the majority this took place after the event or the experience, and could be identified as reflection on action (Schon, 1983). Although professional learning was seen to center around experience, there are also strong influences from the complex context within which practice takes place, personal, professional and cultural influences that the nurse may be unaware of and unable to verbalize and that are not accounted for within Kolb's model. Likewise, learning sometimes arises from repetition and the everyday habitual processes of life, and at other times from intuition and intuitive thought. Miettinen (2000) suggests that this non-reflective experience born out of habit was the dominant form of experience, and that reflective experience only occurred when there were contradictions of the habitual experience. This was the basis of experiential learning as identified by Dewey (1997) which Kolb does not discuss in his model. Dewey also believed that observations of reality and nature were the starting point of knowledge acquisition, whereas for Kolb the starting point was experience (Miettinen, 2000). Emotions, embodied feelings, sensory motor perceptions and skills shape rational thought and actions (Benner, et al., 1999; Lakoff, 1999). It is embodied knowledge that contributes to the overall perception and understanding of the situation, and is an integral part of experiential learning that nurses identified as the main component of the process of change. The process of practice change and development is an integration of embodied experiences, knowledge, reflexivity, reflection and experiential learning within the context of practice. The process of practice change and development was identified as developing and learning, reflection, moving on and changing.

Bricoleur nurses have access to a wide range of resources within their metaphorical toolbox that they then balance against their embodied experience to make sense of nursing practice and change. The continuum identified the range and variety of resources that the nurse would most commonly use in decision making for change.

Nurses have been educated and socialized to maintain their ontological security. Resistance to self-imposed change of practice could be re-defined as reluctance to change and is a feature of ontological insecurity. Resistance to imposed, top down change, however, is perceived in the literature as something that has to be resolved as it impedes the implementation of change (Copnell, 1998), and is often discussed from the perspective of the manager or change agent implementing the change (Balogun, 2006). Likewise, resistance to change is mostly reflected within the literature as a response to imposed change (Pardo de Val & Fuentes, 2003; Waddell & Amrik, 1998).

The process of change and development of practice has been identified as a changing or developing bricolage – a piece of work that is constructed from different resources – with nurses as the bricoleurs. It is this changing bricolage that nurses are seeing as their change in practice: the bricolage changes as the situation changes, according to the patient/clients' needs, the nurses' understanding of themselves and the clients, the resources that are available and the underpinning knowledge.

Nursing can be seen as a process of change for both nurses and patients. This meets the description of nursing that is, promoting an ongoing process of change for the patients and their relatives (Hussey, 2002). Change is inherent in nursing and happens continually. The nurse who is supporting and caring for the patient, therefore, must also be experiencing continuous change.

Nursing practice has become an eclectic activity which is influenced by a wide range of factors. These factors constitute the individual's 'story' or 'narrative of nursing'. This story has developed over time and is made up of personal, cultural and professional influences brought forward from the nurse's personal and professional history. These changes to their story of nursing are influenced by their experiences on a day-to-day basis, influences within the context in which they work, and by their own their own personal identity and self-awareness. However, increasing experience does not necessarily lead to increasing expertise in response to practice change and development.

4. Conclusion

The literature defines practice development as an 'interconnected and synergistic relationship between the development of knowledge and skills, enablement strategies, facilitation and a systematic, rigorous and continuous process of emancipator change in order to achieve the ultimate purpose of evidence-based practice person-centred care' (McCormack, et al., 2004).

One of the implications from this paper is the need for the identification of effective strategies for promoting, supporting and enabling the process of practice change and development, both from the managers' perspective and that of the nurses in practice.

Challenges for healthcare organizations in promoting practice change and development are that these changes are contextually bound, found at the micro system level of care, and involve a series of interventions based upon a range of methodologies (Manley, McCormack, & Wilson, 2008). Another implication is for nursing education, the recognition that learning at work is a very effective form of learning and this needs capitalizing upon. Siebert et al. (2009) suggest that learning at work is heavily influenced by social and cultural influences. They also suggest that learning takes place within different communities, of which learning as a group within the university has value, as has learning at work.

Nurses make sense of change by incorporating it into their existing bricolage of practice, where it is made sense of in relation to other factors such as their own values, professional culture and issues in practice around them. New, imposed nursing practice was amended by the implementing nurse in order to make it fit into their existing practice. This amendment was not always good practice or cost effective: for example, the duplication of effort following the implementation of electronic record keeping, where the nurse made paper notes and then had to record them electronically at a later date.

Nursing is influenced at a national level by a range of organizations including the Philippine Nurses Association, Board of Nursing and the Department of Health. These organizations are concerned with the quality of nursing practice and influence nursing care through the setting of targets and standards of nursing practice and education. Practice change and development is heavily influenced by the self-awareness skills of the nurse such as the ability to recognize the impact of professional and personal issues. The implications for practice are the need to ensure that all nurses are encouraged to develop their own self-awareness and that these are an integral part of the standards required of a newly qualified nurse.

It would be helpful to consider further the most significant reasons for nurses being at one end or the other of the continuum and how they can be encouraged to move up it. Other queries include the extent to which personality, past experiences or the working environment influence this movement. Likewise, the impact of the workplace as a learning environment on nurses' response to change and their ability to move up the continuum would be a useful topic for further discussion.

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