Checking the evidence for Appreciative Inquiry

Even the smallest changes in dementia care delivery can be challenging to implement. Appreciative Inquiry is one practice-change approach that’s gaining popularity in Australian organisations. Belinda Goodenough, Ruby Tsang and Michael Young investigate how it’s been used in dementia care settings and with what outcomes.

“We support progress – it’s the change we don’t like” (Anonymous)

Do you struggle with breaking a habit? Feel stuck in a thought pattern? Can’t make a new routine ‘stick’? People can find change hard – even when the case for change is based on proven facts. Organisations can also find change difficult. Whether it be implementing new processes, procedures, positions, or policies, many change initiatives do not deliver adequately on their change objectives and goals. This so-called ‘failure rate’ has been estimated to be as high as 70%, with research suggesting it is due partly to the ways organisations address people management issues and individual differences (Probst & Raisch 2005; Caldwell & Liu 2011).

An essential factor in effective change management is the ability of managers and change agents to create an appropriate mindset of ‘change readiness’.

We can think of this mindset as the degree to which people involved in or affected by a change are individually and collectively primed, motivated, and capable of executing the change (Holt et al 2010).

Team leaders and managers know that even the smallest changes in dementia care delivery can be challenging to implement. Yet, because research-derived knowledge is continually being tested and updated, change is a constant expectation of good practice.

According to the Dementia Training Study Centres’ (DTSC’s) Knowledge Translation (KT) framework, the practice change journey involves at least four steps for new knowledge to make a difference to care (see Figure 1): people need to become aware of new methods, to agree this knowledge is relevant, to adopt these new methods, and then find ways to adhere to (sustain) implementation. This sequence can take a long time, and also not be as linear as it sounds!

The DTSC’s KT program worked with the DTSCs to identify the best ways to support the KT journey, and the methods for creating and leading a ‘change’ mindset. One approach gaining popularity in Australian organisations is ‘Appreciative Inquiry’. This article checks the evidence for the application of this method in dementia care.

What is Appreciative Inquiry?
With roots in positive psychology and business management, Appreciative Inquiry (AI) is a strengths-based philosophy of change management. AI aims to guide practice change efforts around what is working, rather than trying to fix what isn’t (the problem solving approach, see box p51).

A basic tenet of AI is that organisational culture (‘the way we do things around here’) reflects the direction that employees orient their attention. An appreciative approach is a deliberate choice to focus inquiry (attention) on success, rather than organisational failures.

This inquiry method is collaborative. It involves people sharing their views to reach a common understanding about the best ‘of what is’, and develop a vision for future featuring more of that best. The AI process has been described as a continuous cycles of the ‘4Ds’: discovery, dreaming, designing and destiny (Cooperrider & Whitney 1999).

Why is it popular?
AI has a positive lens. It can feel good! AI methods encourage interactive teamwork, are achievement oriented, with...
participants adopting a different perspective to solving blame questions – some of which might lead to solutions that may cause other problems (see box p51).

Effective knowledge translation in dementia care depends on organisational agility and appetite for innovative thinking at all levels. Many policy reforms demand fast change responses and the operational and commercial stakes may be high, eg consumer directed care (Gill & Cameron 2015). AI has been described as a rapid and positive revolution for change weary organisations. For managers and team leaders seeking innovative participatory approaches to facilitate workforce engagement, AI has been promoted as offering hope for lasting change in organisational culture, learning, and healthcare delivery.

Popular is not the same as effective, however. A team from the DCRCs led by Associate Professor Belinda Goodenough asked the question: ‘how has AI been used in dementia care settings, and with what types of outcomes?’

Is AI useful?
In 2010, a review conducted on AI in aged care identified 21 studies (Reed 2010). The majority of these reports described methods or proposals; none had reached the stage of delivery. The review concluded that, despite several papers recommending and describing AI, more research was required that reported outcomes data. The DCRC team conducted a scoping conceptual review update of this 2010 review with a focus on dementia care.

Using keyword combinations including ‘appraisal inquiry’, ‘care’, ‘dementia’, and ‘aged’, the team searched for literature using indexed databases (PsycINFO, MEDLINE), Google Scholar and manually checking reports. They found eight more papers has been published since the 2010 review – only four addressed dementia care (Seeböhm et al 2010; Amador et al 2014; Fortune et al 2015; Scerri et al 2015).

Apart from case reports of processes for creating ‘team vision’, none of the reports had compelling evaluations of KT or sustainable change outcomes in dementia care. One study reported that dementia care staff enjoyed the imaginative narrative approach, despite AI being initially deemed ‘woolly thinking’ by a few initially sceptical clinicians.

AI was also used in one report with consumers as part of a participatory action research project to learn what older people want from care. In perhaps the only study using quantitative outcomes analysis (cost-effectiveness in end-of-life care), there was some evidence of positive changes in working relationships and resident outcomes for use of AI processes in a multisite study of residential care (Amador et al 2014).

In summary, AI has been used to broker vision-setting conversations with staff or consumers about the features of good dementia care (Scerri et al 2015). Since the 2010 review, there remains a dearth of outcomes evidence in adequately controlled designs. It was also not possible from our review to confidently conclude that the positive reports for engagement with the AI processes were independent; that is, whether the case report authors included paid consultants.

Interestingly, the language of the articles frequently suggested practice change implications: the DCRC team inserted the text of the four articles into a word cloud generator and noted that phrases like ‘change’, ‘process’, and ‘culture’ featured heavily, despite little data about outcomes (see Figure 2).

Figure 2: A word cloud generated on the frequency of phrases used in four published articles about Appraisal Inquiry in dementia care

Where to from here?
Absence of evidence is not the same as proving AI is not effective in dementia care. The research is simply yet to be conducted using reliable measures of change to determine ‘what works’ (Trajikovski et al 2013). Likewise, there is no evidence for adverse outcomes.

Overall, the majority of research into strength-based approaches like AI has been done with community-dwelling populations who can communicate well. Studies recruiting older people with dementia in residential care are generally uncontrolled case reports (Hirst et al 2013).

It has been suggested that the AI approach to crafting organisational culture complements philosophies of care that emphasise what a person retains and has capacity to do. This contrasts with a deficit model which starts with failure (eg communication breakdown, knowledge deficits, uncontrolled symptoms) (Lilfee et al 2015).

Against the current state of knowledge, perhaps the more proper question is: what are the risks for using AI? Here are some considerations:
- Cost – as a change philosophy, AI is marketed as a specialist skill set: some Australian service providers engage paid external consultants, and this outlay may be expensive.
- Criterion shift – AI aims to explore what is working well and how to ‘do more’; if ‘working well’ does not include a criterion of ‘evidence based’ as a practice yardstick, then there is the risk of promoting bad practice.

While awaiting relevant research, we suggest that AI might be a useful strategy to consider when leading change with teams who lack cohesion. Applying the DTSC Knowledge Translation Framework (Figure 1), AI might assist first steps for achieving consensus decision-making about dementia care innovation adoption for teams yet to reach the ‘agreement’ stage, such as:
- Innovations that touch on personal values and philosophies of care (eg palliative/end-of-life care, sexuality assessment etc);
- Previous change experience has been negative and a ‘circuit breaker’ is needed;
- Interdisciplinary conversation (including consumers) needing a new ‘common language to describe the vision for a ‘good outcome’;
- Promoting conversations which move away from ‘blame’ for outcomes towards ‘caring about caring’.

AI will likely remain a popular consideration for supporting ‘team think outside the square’. For organisations facing change in dementia care delivery and policy, “inquiry in order to appreciate is a powerful start for a conversation” (Scerri et al 2015).

The ‘Cycle of 4Ds’ approach of Appreciative Inquiry compared with a ‘problem solving’ method

Scenario: In a high-care secure dementia unit, resident hydration is inadequate on hot days during summer. Drinks are typically served pre-poured into opaque plastic tumblers. Morning and afternoon staff disagree on which shift has responsibility.

Problem solving method

**WHAT’S WRONG?**
Define problem(s) and practice gaps:
Example: some residents are not consuming enough drinks after lunch; morning and afternoon staff blame the other shift as having responsibility.

**WHO/WHAT IS TO BLAME?**
Analyze cause(s) of a problem:
Example: no extra drinks break scheduled in care plan for afternoon; staff resistant to taking on what they perceive to be an extra task at the same time as shift handover.

**HOW TO FIX?**
Scope possible solutions to problem:
Example: purchase and install a thermometer in main lounge area; draft new policy to cover hot days (>25°C); designate staff member at shift handover to deliver extra drink at a fixed time (eg 3pm), with delivery to be recorded in file notes.

**IMPLEMENT/MONITOR A FIX**
Action planning (treatment):
Example: managers to educate staff via in-service training on new policy, how to read the thermometer, and action pathway to alert designated “drinks staff” to serve water.

**POSSIBLE OUTCOMES**
Staff view hydration solution as task-oriented; potential persistent; irritation about “extra jobs”; initiation of solutions become thermometer-driven and not “tuned in” to resident needs.

Appreciative Inquiry

**DISCOVER ‘best of what is’**
Identify, appreciate, value practices that are working well:
Example: most residents are comfortably hydrated; some enjoy a drink when staff sit with them; one resident likes watching her drink poured from a jug into a clear glass (which was a birthday present).

**DREAM ‘what might be’**
Envision future practices that might work well:
Example: could staff and residents take an afternoon drink break together; could personalised clear drink containers be used; serve drinks that have colour?

**DESIGN ‘what should be’**
Engage in dialogue and plan practices that should work well:
Example: discussion led by lifestyle officers on activity/socialising ideas; attention to other factors, eg music; personalised glasses; coloured ice-cubes as a scheduled staff-resident activity.

**DESTINY/DEPLOY ‘what will be’**
Innovate and implement the proposed practices:
Example: community (staff and residents) drinks activity with a “butter” service (staff volunteer on roster), offering: straws, personalised clear glasses, coloured ice-cubes.

POSSIBLE OUTCOMES
Community well-being response to hydration and comfort for both staff and residents; sustainable activity not just ‘care’, connect several lifestyle elements; staff enjoy owning program.