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Editorial

Just over a year ago I returned to clinical nursing practice 2 days per week on an acute surgical ward in the University Hospital of Wales. Like all hospitals there have been changes there to the way wards are organized and to the use of beds. The policy is to place a patient in an available bed, resulting in the ward having a number of trauma, renal and medical patients often referred to as outliers.

On a busy morning shift I was caring for a man who had severely fractured his left wrist. He had been for surgery the night before and the arm was in plaster of Paris. At the start of the shift he was fine, with good colour, movement and sensation and described his discomfort as minimal. Within 20 min he complained of pain, and after analgesia he complained of severe pain. By now his fingers had begun to swell and clearly he needed urgent relief from a very tight plaster. It took some time but eventually the plaster was split and he immediately calmed and his pain became negligible again. As I reflected with the orthopaedic surgeons about this they commented, 'It's to be expected when you have trauma patients placed outside the unit.' They seemed to me to be simply resigned to this situation but for me the incident raised a more serious issue about knowledge management.

It is increasingly clear to all concerned that we need to be much smarter, able to work faster, more innovative and more agile. The complexity of the 21st century healthcare organization has speeded up the pace of change, and those who cannot learn, adapt and change will not survive. We all know that learning is what saves us. Knowledge management is a concept that all our leaders should find easy to support and sell. My experience, however, suggests that many healthcare organizations are battered and bruised by decades of fads, and by organizational change that has failed to deliver the promised benefits. Many health care professionals find themselves exhausted and feeling cynical, and for some there is concern that we may never learn how to create healthcare organizations that can meet the challenges of the 21st century.

For some time now I have been pondering why changes for the better fail or succeed. Wheatley (1999) argues that the following seriously impede the functioning of our organizations:

- Organizations are seen as machines. We create separate parts – tasks, roles, functions and engineer (and re-engineer) them to achieve pre-determined performance levels. It is then the role of managers to recombine the parts to achieve outcomes. Strangely, we also seem to be believe that people can be treated like machines.
- Only material things are real. We work hard to try and make invisible 'things' (like knowledge) assume a material form. We accomplish this by assigning numbers to them. This combines with the idea that:
- Only numbers are real (This belief is ancient, dating back to the 6th century BC). These two beliefs lead to another, that:
- You can only manage what you can measure. And this need for measurement has led to a new deity to worship, which is:
- Technology saves.

Healthcare has by now truly entered the 21st century and we can look back at its many changes at the latter end of the 20th century – no matter where we are in the world nor how long we have been working as nurses. With change has come much more need to provide evidence of the effectiveness of what we are

doing and the need to start saying what we can and cannot do well. And this is where we meet problems!

How can we possibly consider the effectiveness of our care without having effective ways of recording what we do, to whom, when, for how long and what the outcome was? And captured in such a way that we can both use the information and share it with fellow clinicians and the people we are caring for? It is essential that we make the links between what a patient's concerns are, what we do about them and what the resulting outcome is. This allows decisions to be made about the effectiveness of care provided, resources required and staff skills and training needs.

Wheatley cites David Skyrme, who writes that in Britain and the US, a common image of knowledge management is of 'decanting the human capital into the structural capital of an organization. I don't know how this imagery affects you, but I personally don't want to have my head opened, my cork popped, and emptied of what I know by having it poured into an organizational vat. This prospect is not what motivates me to notice what I know, or to share it.'

Study after study reports that nurses want their work to provide growth, recognition, meaning and good relationships. We want to care for others, we want to learn and we want to work together. Imagine what it would be like if we believed these studies. We could trust and respect one another, we could collaborate towards truly achieving patient-focused outcomes. New knowledge is created in chaotic processes that take time. Insights and innovations are a result of nurturing; they cannot be made to appear instantly. Until we truly embrace reflective practice and until we make space for thinking, our knowledge will simply grind to a shuddering halt. We can no longer ignore the fact that knowledge emerges from inside human relationships.

One final reflection: knowledge, unlike information, is about commitment and beliefs; it is a function of a particular stance, perspective or intention. Those who are responsible for knowledge management in our healthcare organizations need to understand that we are working with 'ideals'. Nurses want to learn and grow, and we want to work for purposes we believe in. Working for a healthcare organization that is committed to creating knowledge is an exciting personal motivator because it makes me feel more worthwhile. Creating knowledge about patient focused care is what I find the most promising.

BRIAN MILLAR

Reference

Wheatley M. (1999) *Management of change*. Berkana Institute, San Francisco, CA.