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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Examining the engagement of health services staff in change management: modifying the SCARF assessment model

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Abstract

Background: SCARF (Status, Certainty, Autonomy, Relatedness and Fairness) is a neuroscience model based on reward and threat that has been used in a number of areas, such as coaching and group facilitation including practice development, performance management and leadership development.

Aim: The aim of this article is to understand readiness for transformation in the workplace by considering the impact of a new philosophy of care called 'reablement' on behaviour change in health services staff, using a modified SCARF questionnaire.

Methods: The quantitative survey was nested in a larger health services project to introduce the philosophy of reablement to 166 staff members of a regional community care organisation. The data collection instrument was modified to combine the five SCARF domains into statements related to reablement. Data were collected from participants at six timepoints before and after project staff training.

Results: The results show that for each SCARF domain, staff responses remain relatively stable. Results indicate a consistently positive response to the philosophy of reablement, reflecting a high level of comfort and engagement with the change-management process.

Conclusion: Evaluating reflection and change over time using SCARF can support training and other methods of change management in the context of a community care organisation. Further development is needed with different groups, and different change-management projects within health services.

Implications for practice:

- The SCARF model can be applied to organisational change in health and community care with benefits for clients, staff, stakeholders and the organisation as a whole
- This model has previously been used to improve organisational communication and collaboration but this article suggests it also has a positive impact on overall change management, with a particular focus on understanding the factors related to behaviour in health and community care

Keywords: Reablement, person-centred, organisational change, health and community care, health service improvement, practice development

Introduction

The context for this article is a health services change-management project in the north-west region of Tasmania, in a health and social care organisation that offers a range of community care services for older people, people with disabilities and their carers (Campbell et al., 2019; Maxwell et al., 2021). The actual change was a shift in philosophy within the organisation, moving to a 'reablement' approach (Hjelle et al., 2016). It encompassed a whole-workforce process, with 166 staff involved (Prior et al., 2020).

Reablement as a person-centred approach

Internationally, reablement has been developed to support integrated frameworks aiming to achieve person-centred long-term care and assistance across community settings (Bramble et al., 2021). Core to reablement's commitment is applying the Person-centred Practice Framework (McCormack and McCance, 2017), which requires all staff across the organisation to understand the importance of personhood, client, family and carer input, and a collaborative approach to enhancing individual care (Gyllensten et al., 2020; Jobe et al., 2020; Bramble et al., 2021). Underpinning the philosophy and practice of reablement, therefore, is this centrality of staff engagement in the coordination and delivery of care to meet the needs of clients and families, considering the relationship between health and social care alongside an associated collaborative plan (Jobe et al., 2020). This approach enables all employees to work together to provide services that are responsive, person-centred and respectful. These services include support for persons requiring home maintenance, domestic assistance and the provision of personal care, respite care and social support (Maxwell et al., 2021). The benefit to clients, their carers and their families can be seen through change in staff behaviour towards a reablement-focused approach to service delivery and care.

However, there is some notable critique of the practical application of reablement that needs to be reflected on when considering operationalising reablement approaches. When programmes are implemented, the emphasis is often on improving older persons' physical ability/function and activities of daily living (ADLs) within their home to reduce the costs related to homecare and other eldercare services. Without an emphasis on the philosophy of personhood, which includes individualised goal setting and supported social engagement, reablement that aims to help older people do things for themselves rather than having things done with them is simply a home-based form of physical rehabilitation. As such, its foundational intention to involve older people in setting their own self-identified outcomes and goals continue to be more of a theory than a practice (Clotworthy et al., 2021).

Frameworks aligned to person-centred practice

A number of person-centred health models and frameworks for implementing change in health services have been developed and operationalised over the past 25 years (Kitson et al., 1998; Santana et al., 2018; Hølge-Hazelton et al., 2019; Jobe et al., 2019; McCormack and McCance, 2021). Of particular note is the PARiHS (Promoting Action on Research Implementation in Health Services) model (Kitson et al., 1998), which involves important organisational and individual components such as culture, leadership and evaluation. The PARiHS framework has been applied across healthcare settings and is used to implement research evidence. It involves interaction between three key factors for knowledge translation: evidence, context and facilitation (Kitson and Harvey, 2016). Its main features include knowledge sources (research evidence, practitioner experience, community preferences and experiences), implementing evidence in practice, and contexts conducive to successful implementation, such as organisational cultures with transformational leaders and a learning focus with evaluation mechanisms and appropriate skilled facilitators (Hølge-Hazelton et al., 2019).

The SCARF model

SCARF is an acronym for the five domains of human social experience that, according to the originator of the model, David Rock, activate the threat or reward circuitry of the brain and thus influence human

behaviour (Rock and Cox, 2012). SCARF stands for Status, Certainty, Autonomy, Relatedness and Fairness. Status is about our relative importance or where we are in the social pecking order. Certainty relates to the need for clarity and the degree to which we can predict the future. Autonomy is about a sense of control of events, having choices and being able to make choices. Relatedness concerns the degree to which we feel safe and connected with others, and Fairness is about making fair connections and exchanges between people (Rock, 2008; Rock and Cox, 2012).

The model states that perceived threats to these domains in social situations will trigger the threat circuitry of the brain and lead to a fight-or-flight response and disengagement, as the person experiences a psychological 'away' state. A reward to any of these domains will trigger the reward circuitry of the brain and a subsequent psychological 'towards' state. According to Rock (2009), awareness of how these five domains operate in social situations will assist in understanding individuals' reactions. It will also help people build collaborations and engagement through consciously behaving towards others in ways that are more likely to reward these domains than threaten them.

The SCARF model is based on social neuroscience, exploring the biological foundations of the way humans relate to each other and themselves (Rosted et al., 2021). A person-centred approach in health and community services often starts with a meaningful experience of engaging in activities that draw on a person's unique skills and/or values, and opportunities to adapt to new situations. Implementing change in health and community services can be challenging but a number of factors can enable implementation of evidence-based care and service delivery, including a commitment to a shared purpose, openness, sharing of ideas and relationship building (Walsh et al., 2015). Central to person-centredness in health and community services, and to SCARF, is the importance of a sense of belonging.

This article gives an overview of the meaning and use of SCARF in general, the process used to develop the SCARF questionnaire, and its evaluation in terms of reablement approaches to person-centred care. The article concludes with ideas about potential future uses of the SCARF questionnaire in health services involving reablement and person-centred approaches, and of further psychometric testing and use of such instruments in other change-management projects.

Background and origins of SCARF

The past two decades have seen a rise in the study of how the brain works at a functional level. Advances in neuroscience have been aided by the advent of functional magnetic resonance imaging (fMRI), and new theories of brain functioning and human behaviour, such as neuroplasticity, have followed (Doidge, 2015). Such has been the explosion of ideas from neuroscience that they are becoming mainstream in popular culture. Other authors, such as the biologist Tallis (2014, p 1), have been less kind and have referred to 'neuromania', contending that some of the claims have been exaggerated and some are simply sloppy science. It was within this broad context that David Rock developed SCARF (Rock, 2008).

Rock has a background in business management and coaching, and is co-editor of *NeuroLeadership Journal*. According to his website, he '…coined the term 'Neuroleadership' and is director of the NeuroLeadership Institute, a global initiative bringing neuroscientists and leadership experts together to build a new science for leadership development' (Rock, 2022, p 1). In previous work (Rock, 2008; 2009), he lays out a neuroscience foundation for SCARF, which is outlined below. The authors of this article are not neuroscientists, and it is outside the scope of this article to assess the neuroscience claims Rock makes in relation to SCARF. However, the research team members have had positive experiences of using SCARF as a simple heuristic framework to enhance engagement and collaboration in practice change in clinical environments.

SCARF in greater detail

According to Rock, SCARF is based on two themes emerging from social neuroscience. First is the overarching principle of minimising threat and maximising reward, which drives much of the motivation for social behaviour. Second, several of the same brain networks used for primary survival needs are also drawn upon in social settings. 'In other words, social needs are treated in much the same way in the brain as the need for food and water' (Rock, 2008, p 1). The five social domains of SCARF activate either the primary reward or primary threat circuitry of the brain, depending on the circumstances. Threat and reward responses are easy to trigger; by understanding what social drivers are involved in social situations, people can modify their interactions to lower the threat or maximise the rewards.

Status

In his 2004 paper *Status Syndrome*, Sir Michael Marmot, professor of epidemiology and public health at University College London, proposed that health and longevity are intimately related to a person's position in the social hierarchy. Rock (2009), citing Marmot and others, agreed that status matters, arguing that people are inherently sensitive to any potential or real reduction in status. Such a perception can trigger a strong threat response. Rock asserted that it is relatively easy to trigger a status threat inadvertently by, for example, suggesting someone has been ineffective at a task. 'In most people, asking "can I offer you some feedback?" generates a similar [physiological] response to hearing fast footsteps behind you at night' (Rock, 2008, p 6). While it is easy to trigger a status threat in social situations, Rock (2008) points out it is also easy to trigger a status reward by, for example, giving positive public feedback. Threats to and perceptions of status influence the way people perceive others and interact socially (Rock and Cox, 2012).

Certainty

In his 2009 paper *Managing with the Brain in Mind,* Rock states that when people encounter familiar situations their brains conserve energy by going into autopilot mode, relying on well-established neural pathways. This can allow the person to do two things at once, such as carry on a conversation while driving a car. However, if the brain registers any ambiguity or confusion, such as the car in front suddenly braking, it must shift its full attention to that situation (Rock, 2009). This requires extra neural energy. Mild levels of uncertainly can stimulate interest and curiosity. However, the threat response associated with high and continuing levels of uncertainty or not knowing what will happen next can be debilitating and impede concentration, engagement, memory and decision making.

The workplace can be full of uncertainty and workers can expend a lot of energy scanning the environment for threats. A new manager with a different leadership style, workplace redesign or restructuring, or economic difficulties can all trigger threat responses. However, just as uncertainty can trigger a threat response, certainty can be intrinsically rewarding. Certainty can be enhanced by open and transparent management practices, predictable and fair policies and procedures, following through with promises and agreements, breaking down complex projects into smaller parts, and clear communication (Schmidt et al., 2014).

Autonomy

Autonomy is about choice and the perception of control over events and the environment. People can tolerate high degrees of stress if they believe they have control over it. However, the same degree of stress perceived as inescapable can be destructive to a person's mental and physical wellbeing (Rock, 2008).

Autonomy is in itself rewarding; people may leave a well-paid job for one that pays less but offers more autonomy. Low levels of autonomy in the workplace, through mechanisms such as micromanagement, have a negative effect on workers' perceptions of dignity and lead to disengagement and worker resistance activities (Hodson, 2010). Higher levels of autonomy have been found to be related to greater creativity, innovation, engagement and worker agency (Hodson, 2010; Tillott et al., 2013). However, higher levels of autonomy are also linked to higher levels of responsibility (Tillott et al.,

2013). Higher levels of responsibility can also be threatening but can be balanced through rewards in the other domains of status, certainty, relatedness and fairness. This interaction between domains is a key feature of SCARF; threats to one domain may be ameliorated or countered by rewards in others.

Relatedness

Humans are social animals and quickly form tribes. For hundreds of thousands of years, humans have lived together in small groups and relied on each other in order to survive and thrive. Relatedness involves being able to decide quickly whether someone is in or out of our social group (Rock, 2008). After all, strangers could cause trouble and it may be best to avoid them.

Relatedness is therefore linked to a sense of connection with others and how safe or threatened people feel in social situations (Rock and Cox, 2012). Today people still live and work in small groups and still quickly scan the social environment for relatedness threats. A threat response can be triggered by something as simple as a facial expression or tone of voice.

In the workplace, a sense of relatedness is important. Effective and safe workplaces rely on collaboration between people and groups, which in turn relies on high levels of interpersonal trust and empathy (Rock, 2009). However, the tendency to judge others quickly as friend or foe, along with the phenomenon of 'in group preference' and 'out group bias' may mitigate against groups working together in productive ways (Rock and Cox, 2012, p 6).

In the workplace and other social situations, simple measures can be taken to enhance a sense of relatedness and avoid relatedness threats. Essentially this involves providing opportunities for people to see each other as more similar than different and possessed of a shared humanity. These measures may take the form of opportunities for social interactions between groups and the sharing of some personal information between group members. Mentoring and coaching programmes or action learning groups may also be effective. Empathy is enhanced when we perceive others as more similar to us than different (Rock, 2009).

Fairness

The perception of unfairness generates strong emotions and strong threat responses (Rock, 2008; Rock and Cox, 2012). Wilkinson and Pickett (2010, p 24) point to '…evidence that we can feel sufficiently infuriated by unfairness that we are willing to punish, even at some personal cost to ourselves'. However, it appears that a shared conception and valuing of fairness makes it easier for people to reach agreement without conflict (Wilkinson and Pickett, 2010). There is also evidence to suggest, that while unfair exchanges trigger a threat response in the brain, receiving or making fair offers can activate reward areas of the brain (Rock and Cox, 2012). Workplaces are a rich source of perceptions of unfairness, such as different rules for different groups, inconsistent disciplinary procedures, or someone not 'walking the talk' (Schmidt et al., 2014).

However, in keeping with other domains of SCARF, while it is easy to trigger fairness threats, it is also easy to trigger fairness rewards. Strategies to reduce perceptions of unfairness may include increasing transparency, improving communication, involving workers in decision making, and having clear and consistent expectations and ground rules (Rock, 2008). All these strategies need to be genuine and authentic, or they risk breeding cynicism and eventually disengagement.

SCARF and the individual

All five domains are important to people in social situations but individuals' sensitivity to one or more domains will vary. For example, a person who is most sensitive to certainty threats will likely need more clarity and instruction in uncertain or new situations than a person who is more tolerant of uncertainty (Rock and Cox, 2012). A person for whom fairness is a major driver of behaviour may, for example, base their choice of career on that.

Life circumstances may also influence an individual's sensitivity to particular domains at particular times. Someone coming from a restrictive, micromanaged workplace may seek out a new job that offers a higher degree of autonomy. The NeuroLeadership Institute has devised a self-assessment survey to gauge the differences in an individual's motivations, based on the SCARF model (Rock, 2022). The intention is to assess the differences in people's social motivation. The institute's thesis is that some people are more sensitive to status threat and rewards, others to certainty and relatedness, and that having SCARF needs satisfied may, for example, improve engagement and retention in an organisation. The thesis of this article is that the same or similar analysis can be applied to a much more focused context, such as the reaction of individuals to a particular project.

How SCARF has been used

SCARF has been used in a number of areas such as coaching, and group facilitation including practice development, performance management and leadership development. According to Rock and Cox (2012) SCARF has three basic functions that can operate in almost all situations. These are prediction, regulation and explanation. Prior to an organisational event where staff will be exposed to change, an understanding of the SCARF domains can help predict the likely threats in a social situation and assist in modifying activities and approaches to minimise the threats and maximise rewards. During an event, the language of SCARF may help with the identification of a threat and with the regulation of the emotion. There is evidence to suggest that labelling and reappraising emotions can help in their management (Rock and Cox, 2012). Finally, following an event, SCARF may be used to help explain and understand what went wrong and why, and encourage actions to avoid triggering related threats in the future. Equally, SCARF may help to understand what went well and why, and to build on this knowledge.

The person-centred nature of the SCARF model stems from social need and desire, and has been applied to many professional settings. Freedman (2019) used it to explore how nursing leadership may predict future interpersonal workplace conflict, and so be able to influence the rate of emotional exhaustion, professional burnout and staff turnover. Similarly, in a qualitative study of Danish healthcare professionals (Rosted et al., 2021, p 3453), staff reported feelings of 'approach and avoid' when caring for patients who were Covid-19 positive, a concept aligned with SCARF. The physiological responses of the participants in the Rosted study highlight the dramatic effect the change between these responses may have on perception and problem solving, and the implications of this for decision making, stress management, collaboration and motivation. The SCARF model illustrates, from a neuroscientific perspective, how interpersonal experiences can activate an approach-avoid response, a conflicting emotional reaction. This potentially creates an ability to problem solve, suggesting that health professionals may swing between a meaningful experience and an experience of overload in this type of situation. The SCARF model has also been identified as a tool with the potential to help healthcare services identify strategies that are conducive to changing organisational culture, thereby improving quality of care and patient outcomes (Adams, 2017). In education, SCARF has been used to guide strategic planning and create an inclusive ethos of belonging, as well as informing care and wellbeing policies for school communities (Sellars, 2021). As a broad management tool, SCARF has been successfully incorporated into management stances designed to address patterns in organisational structures and interactions (Epping, 2017). SCARF has been shown to be a versatile tool, with the wellbeing of persons at its core, which can be used in many professional situations and with many different types of structure and change-management strategies.

The unasked question about SCARF

SCARF has been used broadly in change projects, as part of a process to maximise the likelihood of the project's success. Facilitators of change use its domains to assess levels of enthusiasm for their project. However, there is limited evidence about how much stakeholders value its use, or whether it is simply a respectful process to consider participants' reactions and mitigate against negative reactions. Group facilitators might share views in preparation of group work and debrief using SCARF informally as a framework for group discussion of the processes. They are again sharing their impressions of the reactions of the group members, rather than having empirical evidence of the actual reactions. So the

unasked question concerns empirical evidence of reaction to each of the five domains of SCARF. The research team therefore developed a data collection tool (questionnaire) based on the SCARF domains to measure participants' reactions to the project that the research team undertook.

The aim of this study is to use the SCARF model and the subsequent questionnaire to examine the impact of a move to reablement practices within a social and community care organisation in north-west Tasmania.

Methods

Setting and participants

A reablement training programme was developed between the community organisation and the university as a way to build reablement skills and understanding within the staff base, with the aim of improving care and support for clients and their families. The programme was undertaken by 166 staff members at the organisation. Staff attended two 120-minute reablement training sessions (approximately two months apart, starting in March 2018) at the premises of the organisation. The two sessions were designed by the authors and approved in advance by the leadership team of the community-based organisation. Each session contained two case study videos of reablement in practice supplied by colleagues within the organisation. These videos prompted in-depth discussion around reablement among the participants. Each session was conducted by members of the research team (SP, SC, AM), with two present at each session. The materials used in the training were based on identified ADLs, with examples developed and used in consultation with staff at the organisation to ensure the chosen case studies were appropriate, relevant and relatable (Maxwell et al., 2021).

Following each training session, and over a 12-month period, staff were asked to complete two questionnaires – the SCARF questionnaire and the Reablement Readiness questionnaire (Prior et al., 2020) to measure changes in thought and behaviour around reablement approaches to care and service delivery. The Reablement Readiness questionnaire can be tailored for the context and the statements included were developed based on areas staff believed were most closely aligned with their own practice and their own clients within the organisation. This framework allowed for evaluation of staff not only from a readiness for practice perspective but also from a practice change perspective.

Development

A five-item Likert scale study questionnaire was developed based on SCARF (Rock, 2008) and aligning with each domain: status, certainty, autonomy, relatedness and fairness. To capture the relevance of reablement as a new area of person-centred practice specifically within this organisation, the wording of the statements was important in order to ask the right question about each domain. The following statements were developed based on previous staff experience, feedback from staff in pre-training sessions (Maxwell et al., 2021) and organisational need:

1. I think my status and experience in the organisation is respected when I think about reablement development
2. I have no idea about what the future looks like in this organisation when I think about reablement development
3. The reablement developments show that I have control over what I do for the organisation
4. When it comes to reablement development, I do not feel safe when discussing my views with my colleagues
5. When I think about reablement developments, I am treated fairly within the organisation

Statements were classified as positive (statements 1, 3 and 5) or negative (statements 2 and 4) and were scored and analysed accordingly. The statements were designed to explore and understand how the staff perceived their relationship with reablement within the organisation, with staff rating their level of agreement with the statements at six timepoints. In turn, this provided an understanding of how staff used the reablement philosophy in their own practice with clients and their families, and therefore the person-centred nature of their care delivery.

There is no guidance in the literature on how to develop these statements. However, an attempt was made in each case to come up with a statement (whether positive or negative) to try to summarise a position in relation to each domain, and in keeping with the definition of each domain, while maintaining organisational relevance. There is the potential for participants to think about how they are respected for each domain, within the organisation itself, rather than specifically in relation to the change project.

Data collection and analysis

Data from the SCARF questionnaire were collected at the same timepoints as from the Reablement Readiness questionnaire across a 12-month period (Table 1).

Table 1: Timepoints for data collection

Timepoint	Abbreviation
Baseline	T1B
Post first change-management training session	T1E
Post second change-management training session	T2E
Three months post first change-management training session	3M
Six months post first change-management training session	6M
Twelve months post first change-management training session	12M

Scores were collated using SPSS (v24.0) and mean scores calculated for each statement across each timepoint. Paired sample t-tests were used to explore relationships between timepoints.

Ethical approval was obtained from the University of Tasmania human research ethics committee.

Results

A total of 166 staff participants from the organisation completed the baseline data collection tool (T1B), with 18 participants completing the tool across all six timepoints. Staff participants included direct support workers, care coordinators and administration staff working within the organisation. Each of these staff members have direct contact with clients and/or their families and participated in two education days aimed at improving knowledge and skills around developing and implementing reablement-based, person-centred practices. Internal consistency was measured with Cronbach's alpha (Table 2) using the responses from these 18 participants, which suggested the tool is a reliable measure of the participants' relationship with organisational change management.

The remarkable aspect of the results in Table 2 for Cronbach's alpha is the high level of internal consistency, which some regard as equivalent to reliability. A value of 0.6/0.7 is regarded as indicative of a robust measurement instrument in the social sciences (Mohamad et al., 2015); 0.8 is the equivalent figure in health and medicine (Namedo and Rout, 2016). In the case of these results, all the domains of SCARF measure as robust, some well above the required level.

Table 2: Cronbach's alpha for each of the timepoints

	T1B	T1E	T2E	3M	6M	12M
Chronbach's alpha (n=18)	0.735	0.909	0.799	0.744	0.772	0.696

The results show that for each domain, staff responses remain relatively stable (Table 3). Staff rated their experience in the project within the organisation as generally positive across the 12-month period. A paired samples t-test indicated a significant difference in the mean scores in *Status* for T1B

and T1E (t[109] = 2.357, p = 0.020), T1B and T2E (t[74] = 2.637, p = 0.010), T1B and 3M (t[49] = 2.436, p = 0.019) and *Autonomy* for T1B and T1E (t[108] = 3.536, p = 0.001). These results suggest that staff may have changed their views on their behaviour (Autonomy) and experience (Status) within the organisation across the period of the two training sessions.

Table 3: Average scores for SCARF data collection tool over time

Statement	**T1B** n=160	**T1E** n=110	**T2E** n=75	**3M** n=50	**6M** n=28	**12M** n=18
	Average score (1 = strongly agree, 5 = strongly disagree)					
Status I think my status and experience in the organisation is respected when I think about reablement development	2.21	1.93	1.89	1.92	1.89	1.94
Certainty I have no idea about what the future looks like in this organisation when I think about reablement development	3.10	3.34	3.47	3.33	3.64	3.65
Autonomy The reablement developments show that I have control over what I do for the organisation	2.62	2.14	2.27	2.46	2.57	2.65
Relatedness When it comes to reablement development, I do not feel safe when discussing my views with my colleagues	3.84	3.98	3.91	3.90	4.21	3.88
Fairness When I think about reablement developments, I am treated fairly within the organisation	2.14	1.92	1.88	2.06	1.82	1.88

The results in Table 3 show that while the number of participants decreased substantially over time, and particularly at the 12-month end of project, the results remained fairly consistent. The project team interpreted this as a high level of consistency in response to adopting the philosophy and practice of reablement. There were no major areas of lack of respect within the reablement project. In terms of developing an instrument that measures the way people respond to a change project, the participants were relatively positive in SCARF terms about the reablement philosophy, and their response changed little during the 12 months. While this was reassuring in terms of the consistency of measurement, it does not mean that the instrument can be regarded as consistent in terms of being able to measure major changes of reaction in all or any of the domains of SCARF.

Discussion

This study aimed to show that an assessment based on the SCARF model can be used to explore the impact of reablement practices within the identified social and community care organisation. The SCARF framework deployed here encompassed core elements from the PARiHS approach (Hølge-Hazelton et al., 2019), including organisational context, culture and leadership. SCARF evaluation tools have been used in a number of areas including practice development, performance management, education and leadership development (Rock, 2008; Javadizadeh et al., 2022). In particular, autonomy and embracing change, in this context, were linked to leadership and facilitation within the organisation. Status and certainty within the organisation can also be associated with culture and McCormack's use of Drennan's (1992) definition of organisational culture, as 'how things are done around here'.

In order to assess staff's readiness for integration of a reablement approach to service delivery, various evaluations were carried out during the research project, including the questionnaire based

on the SCARF domains: Status, Certainty, Autonomy, Relatedness and Fairness (Prior et al., 2020). This innovative methodological approach was deployed in our study to test the success of the change-management project in quantitative terms, as opposed to an emphasis on a process using qualitative methods. The significant changes in participant scores for some domains following the training sessions are likely a reflection of the fact that staff then had more knowledge around reablement and potentially a realisation that they were already doing reablement in their role rather than its being something new and innovative. Similarly, across the 12-month period, there were slight decreases in scores for the 'positive' statements and increases for the 'negative' statements, although not significant, which may be attributed to staff realising they had existing knowledge and skill in reablement approaches which brought them little reward.

It is not suggested that this approach to the development of an instrument to measure SCARF over time during a change-management project is definitive or proven. However, there are some interesting results that may well indicate the potential for its use in future projects that focus on the development and expansion of staff knowledge around person-centred care and cultures (Jobe et al., 2020). It would be beneficial to conduct further work with different groups, and for different change-management projects that focus on integration of health and social services and the capacity of staff to focus on clients' capability to self-manage as well as their physical and psychological health status (Jobe et al., 2020). The following might be regarded as potential standard wording to be applied to any change-management project, with the addition of a Likert scale:

Status: I think my status and experience in the organisation is respected when I think about the change development project
Certainty: I have no idea about what the future looks like in this organisation when I think about the change development project
Autonomy: The change development project show(s) that I have control over what I do for the organisation
Relatedness: When it comes to the change development project, I do not feel safe when discussing my views with my colleagues
Fairness: When I think about the change development project, I am treated fairly within the organisation

Limitations of the study

The project team would welcome others trying these statements out using a Likert scale and a similar analysis of the results. Reflecting on the statements above, despite the results in this article, there is some concern about the Relatedness statement, based on staff feedback. The present study was questionnaire based, and participants self-selected to complete the survey. Although some attrition was expected, there was a substantial drop in participants across the 12 months. A number of factors contributed to this, including staff leaving the organisation, a lack of interest in continuing to complete surveys and time constraints. Despite these limitations, the present study is, to the best of our knowledge, the first in Australia to investigate staff attitudes to a reablement approach to care using a SCARF questionnaire.

Conclusion

As a person-centred, goal-directed intervention, reablement is now considered fundamental to health and social care services to enable independence for community-dwelling older persons. With this social investment in wellness must come sustainable changes in community-based organisational culture and training across all levels, including direct care staff, care coordinators, interdisciplinary health professionals and managers (Maxwell et al., 2021). The SCARF questionnaire, with its emphasis on measuring behavioural change, has the potential to support change management from a person-centred as well as an organisational perspective, particularly in areas related to service delivery, such as autonomy, status and relatedness. Enhancing staff capacity to embrace change potentially leads to improved care quality through an integrated framework of delivery across community settings (Gyllensten et al., 2020; Bramble et al., 2021).

Findings from the study imply that quantitative methods of evaluating progress using SCARF can support training and other methods of change management in the context of a community care organisation. Using an approach that is considered genuine and authentic has the potential to uncover and make explicit real concerns and issues for participants, thereby enhancing a project's chances of success. Further development of the method will be beneficial, especially with different groups, and different change-management projects.

References

Adams, C. (2017) *Assessing 'Readiness for Change' in Organisational Culture: A Descriptive Study Using Sequential Explanatory Mixed Method Design.* PhD Thesis. Sydney: University of Technology.

Bramble, M., Young, S., Prior, S., Maxwell, S., Campbell, S., Marlow, A. and Doherty, D. (2021) A scoping review exploring reablement models of training and client assessment for older people in primary health care. *Primary Health Care Research & Development*. Vol. 23. E 11. https://doi.org/10.1017/S1463423621000918.

Campbell, S., Bramble, M., Marlow, A., Maxwell, H., Prior, S., Heath, A. and Reeves, N. (2019) *Reablement Implementation and Evaluation at Family Based Care: Final Report*. Tasmania: University of Tasmania, and Family Based Care Association North West.

Clotworthy, A., Kusumastuti, S. and Westendorp, R.G. (2021) Reablement through time and space: a scoping review of how the concept of 'reablement' for older people has been defined and operationalised. *BMC Geriatrics*. Vol. 21. Article 61. pp 1-16. https://doi.org/10.1186/s12877-020-01958-1.

Doidge, N. (2015) *The Brain's Way of Healing: Remarkable Discoveries and Recoveries from the Frontiers of Neuroplasticity*. London: Scribe.

Drennan, D. (1992) *Corporate Culture and Organizational Effectiveness*. New York: Free Press.

Epping, T. (2017) Management stance patterns. *EuroPLoP '17: Proceedings of the 22nd European Conference on Pattern Languages of Programs*. Article 3. pp 1-7. https://doi.org/10.1145/3147704.3147707.

Freedman, B. (2019) Risk factors and causes of interpersonal conflict in nursing workplaces: understandings from neuroscience. *Collegian*. Vol. 26. No. 5. pp 594-604. https://doi.org/10.1016/j.colegn.2019.02.001.

Gyllensten, H., Björkman, I., Jakobsson Ung, E., Ekamn, E. and Jakobsson, E. (2020) A national research centre for the evaluation and implementation of person-centred care: content from the first interventional studies. *Health Expectations*. Vol. 23. No. 5. pp 1362-1375. https://doi.org/10.1111/hex.13120.

Hjelle, K.M., Skutle, O., Førland, O. and Alvsvåg, H. (2016) The reablement team's voice: a qualitative study of how an integrated multidisciplinary team experiences participation in reablement. *Journal of Multidisciplinary Healthcare*. Vol. 9. Article 575. https://doi.org/10.2147/JMDH.S115588.

Hodson, R. (2010) *Dignity at Work*. Cambridge, UK: Cambridge University Press.

Hølge-Hazelton, B., Brunn, L.Z., Slater, P., McCormack, B., Thomsen, T.G., Klausen, S.H. and Bucknall, T. (2019) Danish translation and adaptation of the Context Assessment Index (CAI) with implications for evidence based practice. *Worldviews on Evidence-based Nursing*. Vol. 16. No. 3. pp 221-229. https://doi.org/10.1111/wvn.12347.

Javadizadeh, B., Aplin-Houtz, M. and Casile, M. (2022) Using SCARF as a motivational tool to enhance students' class performance. *International Journal of Management Education*. Vol. 20. No. 1. Article 100594. https://doi.org/10.1016/j.ijme.2021.100594.

Jobe, I., Lindberg, B. and Engström, Å. (2020) Health and social care professionals' experiences of collaborative planning - applying the person-centred practice framework. *Nursing Open*. Vol. 7. No. 6. pp 2019-2028. https://doi.org/10.1002/nop2.597.

Kitson, A., Harvey, G. and McCormack, B. (1998) Enabling the implementation of evidence based practice: a conceptual framework. *BMJ Quality & Safety*. Vol. 7. No. 3. pp 149-158. https://doi.org/10.1136/qshc.7.3.149.

Kitson, A. and Harvey, G. (2016) Methods to succeed in effective knowledge translation in clinical practice. *Journal of Nursing Scholarship*. Vol. 48. No. 3. pp 294-302. https://doi.org/10.1111/jnu.12206.

Marmot, M. (2004) *Status Syndrome*. London: Bloomsbury.

Maxwell, H., Bramble, M., Prior, S., Heath, A., Reeves, N., Marlow, A., Campbell, S. and Doherty, D. (2021) Staff experiences of a reablement approach to care for older people in a regional Australian community: a qualitative study. *Health & Social Care in the Community*. Vol. 29. No. 3. pp 685-693. https://doi.org/10.1111/hsc.13331.

McCormack, B. and McCance, T. (2021) The person-centred nursing framework. Chp 2 *in* Dewing, J., McCormack, B. and McCance, T. (Eds.) (2021) *Person-centred Nursing Research: Methodology, Methods and Outcomes*. Cham, Switzerland: Springer. pp 13-27.

Mohamad, M.M., Sulaiman, N.L., Sern, L.C. and Salleh, K.M. (2015) Measuring the validity and reliability of research instruments. *Social and Behavioural Sciences*. Vol. 204. pp 164-171 https://doi.org/10.1016/j.sbspro.2015.08.129.

Namdeo, S.K. and Rout, S.D. (2016) Calculating and interpreting Cronbach's alpha using Rosenberg assessment scale on paediatrician's attitude and perception on self-esteem. *International Journal of Community Medicine and Public Health*. Vol. 3. No. 6. pp 1371-1374. https://doi.org/10.18203/2394-6040.ijcmph20161448.

Prior, S., Heath, A., Reeves, N., Campbell, S., Maxwell, H., Bramble, M., Marlow, A. and Doherty, D. (2020) Determining readiness for a reablement approach to care in Australia: development of a pre-employment questionnaire. *Health & Social Care in the Community*. Vol. 30. No. 2. pp 498-508. https://doi.org/10.1111/hsc.13150.

Rock, D. (2008) SCARF: a brain-based model for collaborating with and influencing others. *NeuroLeadership Journal*. Vol. 1. No. 1. pp 44-52. Retrieved from: tinyurl.com/Rock-SCARF. (Last accessed 4th May 2022).

Rock, D. (2009) Managing with the brain in mind. *Strategy+Business*. Vol. 56. Retrieved from: strategy-business.com/article/09306. (Last accessed 4th May 2022).

Rock, D. and Cox, C. (2012) SCARF in 2012: updating the social neuroscience of collaborating with others. *NeuroLeadership Journal*. Vol. 4. pp 1-14.

Rock, D. (2022) *About Dr David Rock*. Retrieved from: davidrock.net/. (Last accessed 15th January 2022).

Rosted, E., Thomsen, T.G., Krogsgaard, M., Busk, H., Geisler, A., Hansen, S.T., Kjerholt, M., Mortensen, C.B., Thomsen, T.H., Beck, M. and Petersen, M. (2021) On the frontline treating COVID-19: a pendulum experience - from meaningful to overwhelming - for Danish healthcare professionals. *Journal of Clinical Nursing*. Vol. 30. Nos. 13-14. pp 3448-3455. https://doi.org/10.1111/jocn.15821.

Rycroft-Malone, J. (2004) The PARIHS framework - a framework for guiding the implementation of evidence-based practice. *Journal of Nursing Care Quality*. Vol. 19. No. 4. pp 297-304. https://doi.org/10.1097/00001786-200410000-00002.

Santana, M., Manalili, K., Jolley, R., Zelinsky, S., Quan, H. and Lu, M. (2018) How to practice person-centred care: a conceptual framework. *Health Expectations*. Vol. 21. No. 2. pp 429-440. https://doi.org/10.1111/hex.12640.

Schmidt, S., Roesler, U., Kusserow, T. and Rau, R. (2014) Uncertainty in the workplace: examining role ambiguity and role conflict, and their link to depression - a meta-analysis. *European Journal of Work and Organizational Psychology*. Vol. 23. No. 1. pp 91-106. https://doi.org/10.1080/1359432X.2012.711523.

Sellars, M. (2021) Belonging and being: developing inclusive ethos. *International Journal of Leadership in Education*. https://doi.org/10.1080/13603124.2021.1942994.

Tallis, R. (2014) *Aping Mankind: Neuroscience, Darwinitis and the Misrepresentation of Humanity*. London: Routledge.

Tillott, S., Walsh, K. and Moxham, L. (2013) Encouraging engagement at work to improve retention. *Nursing Management*. Vol. 19. No. 10. pp 27-31. https://doi.org/10.7748/nm2013.03.19.10.27.e697.

Walsh, K., Bothe, J., Edgar, D., Beaven, G., Burgess, B., Dickson, V., Dunn, S., Horning, L., Jensen, J., Kandl, B., Nonu, M., Owen, F. and Moss, C. (2015) Investigating the role of clinical nurse consultants in one health district from multiple stakeholder perspectives: a cooperative inquiry. *Contemporary Nurse*. Vol. 51. Nos. 2-3. pp 171-187. https://doi.org/10.1080/10376178.2016.1169936.

Wilkinson, R. and Pickett, K. (2010) *The Spirit Level: Why Greater Equality Makes Societies Stronger*. London: Bloomsbury.

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