PERSON-CENTRED NURSING

AUTHORS:

Professor Tanya McCance,
Co-Director Nursing R&D/Mona Grey Professor of Nursing R&D
Belfast HSC Trust/University of Ulster
Email: Tanya.mccance@belfasttrust.hscni.net

Professor Brendan McCormack
Director, Institute of Nursing Research and Head of Person-centred Practice Research Centre,
Institute of Nursing Research/School of Nursing, University of Ulster
Email: bg.mccormack@ulster.ac.uk
Introduction

This chapter will explore the theory and practice of person-centred nursing. An overview of person-centred nursing will be provided, incorporating an analysis of its evolution into contemporary nursing practice, policy and strategy. A framework for person-centred nursing will then be outlined, with each of the constructs and concepts underpinning the framework described. Practical examples of the constructs and related concepts will be provided. We will also underpin the discussion of the constructs and concepts with relevant contemporary research in nursing and healthcare. Finally we will present a discussion of key considerations in the development of person-centred ways of working for individuals, teams and organisations.

A case study of person-centred development will be offered. This project shows how a team in an acute hospital setting attempted to change the culture of their workplace towards one that was more person-centred. The chapter will conclude with key lessons to be considered in the adoption of a person-centred approach to nursing.

The Evolution of Person-centredness

'Person-centredness' is a term that has become increasingly familiar within health and social care at a global level and has been used to describe a standard of care that ensures the patient/client is at the centre of care delivery. It is therefore not surprising that the body of literature relating to person-centred care is growing, and with it increasing academic debate and critical dialogue regarding developments in this field. McCormack (2004) undertook one of the first literature reviews of person-centredness in the context of gerontological nursing and identified a number of common dimensions of personhood that transcend the variety of models and frameworks that exist. However, more importantly, the review along with others by McCormack et al (2010a) and McCance et al (2011) highlight the limitations of the research into person-centredness thus far: it mostly focuses on attempts to clarify the
meaning of the terms personhood and person-centredness (Slater 2006, Edvardsson et al 2010); explores the implications of the terms in practice (Dewing 2004); and determines the cultural and contextual challenges to implementing a person-centred approach (McMillan et al 2010; McCormack et al 2008, McCormack & McCance 2010b). There has also been significant conceptual and theoretical advancements in the area of person-centredness with the development of frameworks such as the Authentic Consciousness Framework (McCormack 2001), the Senses Framework (Nolan et al 2004) and the Person-Centred Nursing Framework (McCormack & McCance 2006, 2010) alongside the application and testing of these frameworks in practice (McCormack et al 2010b, McCance et al 2010, Ryan et al 2008).

These conceptual and theoretical developments have gone some way to enhancing our understanding of how we can effectively operationalise person-centredness in practice and indeed have helped pave the way towards a greater focus on the development of frameworks and tools for outcome evaluation arising from person-centred approaches (Slater et al 2009, McCormack et al 2010c, Smith et al 2010; Edvardsson & Innes 2010). However the work on outcome evaluation is at an early stage of development and considerable work is needed to develop inclusive methodological approaches that can capture the complexities of person-centred nursing in practice (McCormack & Heath 2010, p.81).

The Concept of Person-centredness and Person-centred Nursing

Much of the literature about person-centredness and person-centred practice is currently found within the field of gerontology, initially due to the influences of early writers/researchers such as Tom Kitwood (who focused on person-centred dementia care) (McCormack & McCance 2010). A further focus is that of the origins of person-centredness predominantly from a humanistic psychology perspective (Rogers 1980; Heron 1992).
However, the term ‘person-centredness’ is being used more freely within health and social care strategy, policy and practice and there is a danger that the term is being used in a tokenistic way and without any deep sense of what it means for practice and decision-making.

Within nursing, the concept of person-centredness has had a long association with nursing theory. Many of the early nurse theorists (such as Dorothy Orem, Sr Callista Roy, Madeleine Leininger, Jean Watson [to name but a few]) whilst not explicitly using the term ‘person-centred’, built their theories on concepts of ‘the person’, ‘the environment’, ‘the nurse’ and ‘health’. Each of these concepts were articulated from particular philosophical perspectives and from these theories, models of nursing were developed. Whilst these models provided useful frameworks for nurses to focus their practice, in reality many nurses struggled to make sense of them beyond superficial understanding of particular care processes (such as Activities of Daily Living, Self-Care etc). However, building on this strong nursing tradition of basing care practices on theoretical perspectives, it is no surprise then that person-centred nursing has evolved a similar tradition, but without allegiance to a particular world-view. Instead, person-centred nursing is an adaptation and application of concepts of personhood, person-centredness and person-centred care in a nursing context.

Taking account of these developments and a review of the person-centred literature (McCormack 2004), McCormack et al (2010b) offer a definition of person-centredness, which is consistent with understandings of person-centredness in a nursing context:

“Person-centredness is an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, patients and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self determination, mutual respect and
understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development (McCormack et al 2010b, P13)

Further, McCormack (2004) argues that there are four core concepts at the heart of person-centred nursing: being in relation, being in a social world, being in place and being with self.

*Being in relation* emphasises the importance of relationships and the interpersonal processes that enable the development of relationships that have therapeutic benefit. *Being in a social world* considers persons to be interconnected with their social world, creating and recreating meaning through their being in the world (Merleau-Ponty 1989). It focuses on what is important in our lives, represented through our values and how these are articulated through biography (i.e. who we are as a person). Closely linked to being in a social world is *being with self*, which places a responsibility on the nurse to develop a clear picture of what the patient values about their life and how they make sense of what is happening to them (McCormack & McCance 2010). This, however, is not just applicable to the patient in the care situation, but also applies to nurses involved in care delivery who need to be aware of ‘self’ and how their own values and beliefs can impact on decisions made about a patient’s care and treatment. This reinforces the centrality of shared decision-making in health care and the need for a ‘negotiated’ approach between practitioner and patient. *Being in place* encourages us to pay attention to ‘place’ and its impact on care experiences.

**The Person-Centred Nursing Framework**

The Person-Centred Nursing Framework was developed for use in the intervention stage of a large quasi-experimental project that focused on measuring the effectiveness of the implementation of person-centred nursing in a tertiary hospital setting (McCormack & McCance 2006, McCormack et al 2008). The Framework was derived from McCormack’s conceptual framework (2001 and 2003) focusing on person-centred practice with older people, and McCance et al’s framework (2003) focusing on patients and nurses experience of caring in nursing.
Figure 1: The Person-centred Nursing Framework

Overview of the framework

The Framework comprises four constructs:

- **prerequisites** which focus on the attributes of the nurse
- **the care environment** which focuses on the context in which care is delivered
- **person-centred processes** which focus on delivering care through a range of activities
- **expected outcomes** which are the results of effective person-centred nursing

The relationship between the constructs of the framework is indicated by the pictorial representation (Figure 1) i.e. to reach the centre of the framework, the prerequisites must first be considered, then the care environment, which are necessary in providing effective care through the care processes. This ordering, ultimately leads to the achievement of the outcomes – the central component of the framework. It is also acknowledges that there are
relationships within, and across constructs, some of which are currently being tested through further research.

The **prerequisites** focus on the attributes of the nurse and include being professionally competent, having developed interpersonal skills, being committed to the job, being able to demonstrate clarity of beliefs and values, and knowing self. Professional competence focuses on the knowledge and skills of the nurse to make decisions and prioritise care, and includes competence in relation to physical or technical aspects of care. Having highly developed interpersonal skills reflects the ability of the nurse to communicate at a variety of levels. Commitment to the job is indicative of dedication and a sense that the nurse wants to provide care that is best for the patient. Clarity of beliefs and values highlights the importance of the nurse knowing his/her own views and being aware of how these can impact on decisions made by the patient. This is closely linked to knowing self and the assumption that before we can help others we need to have insight into how we function as a person.

The **care environment** focuses on the context in which care is delivered and includes: appropriate skill-mix (the ratio of RNs to support staff); systems that facilitate shared decision making; the sharing of power; effective staff relationships; organisational systems that are supportive; and the potential for innovation and risk taking. Appropriate skill-mix highlights the potential impact of staffing levels on the delivery of effective person-centred care, and emphasises the importance of the composition of the team in achieving positive outcomes for patients. Shared decision making is dependent on systems and processes being in place that facilitate a dialogue between those involved in the caring interaction. This can include patient, family member and/or carer or indeed nurse, doctor or another health professional. This is also closely linked to the development of effective staff relationships and to the sharing of power. It is, however, important to note that the sharing of power also relates to the power base between the patient and the nurse, which reflects one of the basic tenants of person-centredness described above. The identification of supportive organisational systems acknowledges the incredible influence organisational culture can have on the quality of care delivered and the freedom afforded to practitioners to work autonomously, reflecting the potential for innovation and risk taking. These characteristics of the care environment are consistent with the conceptual development of the concept of context undertaken by McCormack et al (2002) and Rycroft-Malone et al (2004). Key characteristics of context arising from these studies include the culture of the workplace, the
quality of nursing leadership and the commitment of the organization to the use of multiple 
sources of evidence to evaluate the quality of care delivery. As previously highlighted, the 
care environment and the components described here have a significant impact on the 
operationalisation of person-centred nursing and have the greatest potential to limit or 
 enhance the facilitation of person-centred processes (McCormack 2004).

**Person-centred processes** focus on delivering care through a range of activities that 
operationalise person-centred nursing and include: working with patient’s beliefs and values; 
engagement; having sympathetic presence; sharing decision making; and providing for 
physical needs. This is the component of the framework that specifically focuses on the 
patient, describing person-centred nursing in the context of care delivery. Working with 
patients’ beliefs and values reinforces one of the fundamental principles of person-centred 
nursing, which places importance on developing a clear picture of what the patient values 
about his/her life and how he/she makes sense of what is happening. This is closely linked 
to shared decision making. This focuses on nurses facilitating patient participation through 
providing information and integrating newly formed perspectives into established practices, 
but is dependent on systems that facilitate shared decision making (the care environment). 
This must involve a process of negotiation that takes account of individual values to form a 
legitimate basis for decision making, the success of which rests on successful processes of 
communication. McCormack (2004) illustrates the links between these processes stating 
that “knowing what is important forms a foundation for decision making that adopts a 
‘negotiated’ approach between practitioner and patient” (p35). Having sympathetic presence 
highlights an engagement that recognises the uniqueness and value of the individual and 
reflects the quality of the nurse-patient relationship. Finally, the provision of physical care by 
a nurse who is professionally competent is essential as it is a ‘way in’ to operationalise 
person-centred processes and to achieve person-centred outcomes.

**Outcomes** are the results expected from effective person-centred nursing and include: 
satisfaction with care; involvement in care; feeling of well-being; and creating a therapeutic 
environment. Patient satisfaction reflects the evaluation a patient places on their care 
experience and is arguably the most tangible outcome measure, which is well documented 
in the literature as an indicator of quality care (Edwards & Staniszewska 2000, Edwards et al 
2004). Involvement in care is the outcome expected as a result of participating in shared 
decision making processes. A feeling of well-being was clearly highlighted by McCance 
(2003) and is indicative of the patient feeling valued. Enhanced mental well-being and
improvements in patients’ physical well-being was similarly identified in the meta-synthesis of caring in nursing undertaken by Finfgeld-Connett (2007). Creating a therapeutic environment, described as one in which decision-making is shared, staff relationships are collaborative, leadership is transformational and innovative practices are supported, is the ultimate outcome for teams working to develop a workplace that is person-centred. Identifying outcomes from effective person-centred care that are measurable, however, remains a challenge. This was an essential aspect of the research study in which this Framework was being tested, and tools have been identified from the literature and some further developed to facilitate outcome measurement.

Whilst the Person-centred Nursing Framework provides a basis for understanding the dynamics of person-centred nursing, it is important to remember that being person-centred is an ongoing activity and cannot be achieved through one-off change events. The Person-centred Nursing Framework can act as a heuristic for reflecting on where a team might be at in terms of the development of their person-centredness and equally can be used to guide decisions about necessary changes in practice. To make that more ‘real’ we offer an in-depth account of a case study of one organisation’s approach to the development of person-centred nursing in practice. The case study illustrates the development processes that are helpful for developing person-centredness and also the issues that need to be addressed as the process evolves. Finally, whilst the case study is representative of an organisational approach (and therefore is large and complex), the actual processes used can be scaled down to be applicable to individual practice settings, individual teams and individual practice developments (for example changing the process for making decisions about care plans).

A Case Study of the Development of Person-centred Nursing

The context
Improving the patient experience is an explicit goal for providers of health and social care and is integral to providing a quality service (Machell et al 2010). It is, however, not solely about providing good clinical care, but as emphasised by Goodrich and Cornwell (2008) it is also about being cared for with ‘kindness and compassion’. Principles of person-centredness underpin these values at a policy and strategy level (Department of Health 2007; DHSSPS 2008). There is, however, evidence to suggest that whilst organisations might aspire to a standard of care that reflects these values, the standard of care in acute
hospitals often falls short (Goodrich & Cornwell 2008; NHS Confederation 2012). This emphasises the need to focus on attitudes, behaviours and relationships (Goodrich & Cornwell 2008, DHSSPS 2008), and reflects the importance of working in ways that promote a person-centred approach (McCance et al 2011).

Whilst the idea of person-centredness might be well understood at one level, the challenge is often delivering it in practice. We might think we are delivering care that looks like one thing, but in reality it is quite another. McCormack et al (2011) suggest that contextual factors such as organisational culture, the learning environment and the care environment itself, pose the greatest challenge to person-centredness and the development of cultures that can sustain person-centred care.

Furthermore, there is growing evidence to suggest that facilitation through emancipatory practice development programmes can develop person-centred cultures, but more importantly this approach moves away from one off change events to continuous reflection and development of critical relationships that can be sustained over time (McCormack 2008 et al). Emancipatory practice development is described as an approach to sustained and continuous quality improvement, where the focus is on learning and the creation of a practice climate where practitioners can implement care and work differently with the aim of promoting effective person-centred practice (Manley & McCormack 2004, Manley et al 2008). The programme reported in this paper describes the implementation and delivery of an emancipatory practice development intervention, which targeted a cohort of nursing teams working within acute care settings in one healthcare organisation in the UK.

**Aims of the Programme**

The overarching aim of the Programme was to enable nursing teams to explore the concept of person-centredness within their own clinical setting, in order to improve care delivery. At the end of programme it was anticipated that participants would be able to:

- demonstrate a greater knowledge and understanding of the principles of person-centredness?
- demonstrate an understanding of the emerging challenges to providing person-centred care?
- identify outcomes for staff and patients as a result of practice change?

The Person-centred Practice Framework developed by McCormack and McCance (2010)
provided the theoretical underpinning for the programme (refer to Figure 1). The programme was comprised of facilitated activities that focused on four themes:

Theme 1: Promoting an awareness and understanding of person-centredness
This theme focused on activities that promoted an increased understanding of person-centredness and awareness of the factors that enable or inhibit this way of working. The 40 programme participants attended a workshop and undertook a series of activities – introduction to the person-centred nursing framework, overview of programme, values clarification and reflective journaling.

Theme 2: Developing a shared vision
Underpinning a practice development approach is the identification of assumptions, values and beliefs. It is argued that by making assumptions conscious, explicit value and beliefs can be articulated (Manley 2000), which is crucial in shaping a vision for nursing practice. At workshop 2, the 40 participants developed a vision for the programme and then brought the knowledge and skills of this process back to the work place and completed a values clarification process with the teams they worked with, resulting in the development of a team shared-vision for person-centredness.

Theme 3: Determining the existing quality of the user experience
This theme focused on analysing existing information sources that provide evidence of quality of service delivery in each participating area. Data sources used included retrospective review of compliments and complaint, collection of patient stories (n=3) and involvement in observations of practice (n=3). Observations of practice involved observing in an area over a period of 30 minutes and feeding back observations to the staff involved (McCormack et al 2009). The purpose of this activity was to gain greater understanding of the environment and the working culture within their own team and how this impacts on the delivery of person-centred care. Patient stories involved interviews with patients to understand their experience of person-centred care and to capture what was important to them and what would improve their care experience (RCN 2007). Similarly, the purpose was to gain greater understanding of the experience of patients being cared for in their own area. Individuals from the participating sites undertook relevant training to ensure that these activities were conducted in an ethical and professional manner. The Person-centred Nursing Framework was used to analyse data generated from these activities as a means of identifying practice changes and developing action plans that formed the focus for theme 4.

Theme 4: Developing practice
Based on the outputs from Theme 3, the focus at this stage was on developing one aspect of practice, using small cycles of change that demonstrate improved outcomes for patients. A ‘culture analysis’ of each of the 10 participating sites was also undertaken to inform decisions around the selection of practice change activity. Each of the Practice Changes had a detailed action plan and was systematically evaluated from the perspective of the relevant stakeholders.

The core components of the above programme were focused mainly on activities within teams from the participating areas, however, some interventions within the programme involved patients or their families and may also have impacted on other members of the multidisciplinary team working in these areas i.e. observations of practice and patient stories.

**Programme Management**
The programme was implemented over a period of 18 months. Programme management structures comprised of a high level Steering Group comprising of internal and external stakeholders and an Implementation Team comprising of Ward Managers, Nursing Development Leaders and Service Managers from each of the participating sites. Service user’s involvement was obtained through involvement in programme activities e.g. patient stories and observations of practice.

**Programme Evaluation**
The programme was evaluated using an insider/outsider model, whereby, the programme facilitators were internal to the organisation and they worked with two university-based academics who acted as evaluators alongside the facilitators.

Evaluation of the Person-centred Care Programme aimed to address several related research questions, which are presented below.

How does a facilitated programme focusing on exploring the concept of person-centredness:

- impact on nurses and midwives understanding of person-centredness in practice?
- increase nurses and midwives understanding of the emerging challenges to providing person-centred care?
- impact on outcomes for staff and patients as a result of practice change?

**Methodology**
The methodology used was programme evaluation using multi-methods in order to assess the effectiveness of the components within the programme, identify contextual issues that impact on programme delivery and its implementation, and identify outcomes and practice changes as a result of the programme. Polit and Beck (2004) identify evaluation research using a range of qualitative data collection methods as an appropriate approach in the evaluation of a complex intervention, such as the programme described in this chapter.

Setting and participating sites
The organisation in which the Person-centred Care Programme was delivered employs approximately 20,000 staff, of which almost 6,800 are nurses and midwives. The organisation provides services for 340,000 people in the city and regional services for the whole population. Ten nursing teams were recruited from across the organisation and selected using clearly defined criteria as outlined in Table 1.

Table 1: Inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Target sample</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
</table>
| Teams         | ➔ Previous practice development involvement or programme activity which focused on developing practice  
                 ➔ Agreement of ward manager/team leader to participate  
                 ➔ Evidence of service support from Associate Director of Nursing and Senior Manager  
                 ➔ Access to an Nursing Development Lead (a facilitative support post) linked to the selected area, who has experience of using a practice development approach | Currently involved in other service/ developing practice initiatives  
                 Areas where there are significant performance issues |
| Nursing Development Leads (NDLs) | ➔ Responsibility for supporting the area  
                 ➔ Knowledge and skills required to facilitate a developing practice activity or have access to appropriate support to undertake facilitation of the site | Currently involved in other significant service/ developing practice initiatives |

The ward manager, plus two other programme participants, were invited to be part of the programme, with each team accompanied by a Nursing Development Lead (NDL) attached to their area whose role is to support the ward manager/team leader. These individuals attended the formal programme events, and were expected to lead all aspects of the programme back in the workplace. The teams selected to participate in the programme spanned a range of clinical specialities and were geographically located across four different hospital sites within the organisation.

Table 2: Participating sites

| Participating Acute Hospital sites |
Data collection methods
Multi methods were used to establish the impact of the programme, which are summarised below.

- Process evaluation was collated throughout each phase of the work and was drawn from fourth generation evaluation (Guba & Lincoln 1989), which involves the repeated use of claims (favourable assertions about the topic) concerns (unfavourable assertions about the topic) and issues (questions that reflect what any reasonable person might ask about the topic). This was undertaken globally at Project Team meetings, but data were also collated for the individual participating sites.

- Reflective accounts provided by programme participants undertaken at the beginning of the programme and following completion of the themed activities. A simple reflective tool was used drawing from the work of Johns (1993)

- Qualitative interviews using focus groups with programme participants and facilitators. The format for the focus groups comprised key questions relating to the programme objectives.

- Patient stories from service users cared for in each of the participating site.

Data analysis
A creative hermeneutic approach was used, drawing on the work of Boomer & McCormack (2010). This approach to data analysis reflects Gadamer’s (1993) philosophical perspective on hermeneutics, and the use of the arts to support new ways of working and learning (Simons and McCormack 2007). Boomer & McCormack (2010) describe this approach as “the hermeneutic analysis of multiple data sets in groups that brings together hermeneutics, staged facilitation and creativity” (p.368). The focus is on bringing understanding to the nature of the social world from the subjective interpretation of the individual and the more general underlying abstracted meanings. The stages involved in using a creative
hermeneutic analysis as described by Boomer & McCormack (2010) were used to analyse the evaluation data from this programme and were as follows:

1) Clarifying and coding of available data
2) Individual reading of the data and formation of general impressions, observations, thoughts and feelings
3) Creating an image of impressions (intuitive grasp) of the data (the image should capture the essences of the data).
4) Telling of the story from the creative work in pairs (each person tells the story of their creative work identifying the meanings of the images produced and the second person writes the story verbatim).
5) Theming using the creative image and the story (written) as the centre piece and other notes made at step 1
6) Discussing the individual themes within small groups who (as a whole) devise shared themes
7) Matching raw data to categories from step 5.
8) If more than one small group, presenting categories to each other and discussing and agreeing a final set of categories across all small groups.

Within the programme evaluation the hermeneutic creative analysis was conducted by the Implementation Team and facilitated by the external evaluators. The data analysis process following completion of the hermeneutic analysis involved a review of the analysed data and discussion and further refinement by the Project Team. This led to a clear set of identified themes and subthemes, which were then tested with the programme participants and then finalised.

Ethical considerations
This study was subject to governance approval in the health care organisation and was also submitted to the local Research Ethics Committee. The main ethical considerations related to: ensuring informed consent; ensuring anonymity and confidentiality, where possible; ensuring participants experienced no distress or harm as a result of taking part in the study; and having mechanisms in place to deal with unforeseen issues that may arise in practice during the conduct of the research. The Project Team secured all relevant approvals before commencement.

Presentation of Results

15
The main findings highlighted that the practice development programme enabled staff to engage with the principles of person-centredness through working differently, building relationships and trying to maintain momentum and energy to move forward. This in turn impacted on how participants were able to live out person-centred care within their own practice through embracing person-centred values and being confident and competent. The impact of the programme, however, was mediated by conflicting priorities that included a sense of feeling pressurised, limited staffing and resources, and the challenges of an evolving context.

**Enabling engagement**

Engagement with the person-centred care programme, at a conceptual level and at an operational level, was key in both a personal and team journey towards a better understanding of person-centredness in practice. At the outset there was recognition from participants that engaging staff in the programme would be challenging, but there was also an enthusiasm at an early stage that the essence of person-centred care was at the heart of nursing.

"Why I was excited by the project was that in the midst of all we are having to deal with, this is giving credence and recognition to the core principles of why I became a nurse...” (Focus Group 1)

Utilising a practice development approach that was grounded in the principles of collaboration, inclusion and participation (McCormack et al 2006) promoted positive ways of working. In addition, the facilitation approach of the programme and the support structures and processes put in place were drawn from the practice development evidence base to enable participants to fully engage with the programme. Whilst there were two lead facilitators delivering the programme, each participating site had a nursing development lead who facilitated delivery of the programme in the practice setting.

Establishing and sustaining this local facilitation presented a range of difficulties. The knowledge and skills of facilitators were variable and range from those with little experience of facilitation within a practice development context, to those who had significant insight into emancipatory practice development. However, access by the participating areas to support within the programme was important as the facilitators were central to facilitate engagement with their own teams. Furthermore, there was recognition by the site facilitators of the importance of facilitation as a way of working, however, there was also acknowledgement of
the need to further develop knowledge and skills in relation to facilitation expertise that were less technical in nature.

Participating in the wide range of tools, methods and approaches within the programme, including clarifying values and beliefs, creating a shared vision, observing practice, obtaining feedback for service users through the use of patient stories, and engaging in critical reflection made the programme real for participants. In particular, participating with activities such as ‘Observations of practice’ was very positively received and were viewed as instrumental in helping bring the programme to the ward staff. Similarly, insights gleaned from collecting and reading patient stories were very powerful and increased and kept staff engaged in the critical dialogue.

As previously mentioned, the practice development approach which emphasised collaboration and inclusion as a way of working, was also evident in the practice changes undertaken within some of the participating sites. For example, one participating site emphasised the benefits of working collaboratively and inclusively in bringing about a practice change which had a focus on nurse-facilitated discharge. This change was not only dependent on engagement of the nursing team, but also engagement of other professional staff, including the established senior medical staff working in this area. The approach and resultant outcomes achieved by this team are summarised in Figure 4. Engagement obtained through this process subsequently impacted on relationships formed within and across the team and resulted in the achievement of a range of organisational objectives, and also promoted a way of working that enabled sustained critical dialogue.

Through evaluation of the programme the importance of building relationships between different stakeholder groups in promoting effective person-centred care, was highlighted. The impact of the programme on developing person-centred relationships was articulated by participants and reflected a different way of working with team members and colleagues that was about valuing self and others.

“The programme is about developing respect and good relationships between everyone to try and improve patient outcomes “(Focus Group, Round 1)
Challenging and influencing the established ways of working that contribute to team culture and developing relationships, beyond traditional boundaries, was also highlighted within the evaluation data, and is again a characteristic of a practice development approach.

“Another challenge for participants was dealing with what some perceived to be “some of the old guard from the medical side of things who are still clinging onto some of the old power struggle, and I think some of this does pose a challenge for nursing, but interestingly some of the newer staff and newer medics...there is a change to the culture, a change to the environment...I think it would lend itself much more to some of the things around being more person centred”. (Focus Group, Round 1)

**Figure 2: Example - Working with a multiprofessional team to change practice**

This practice setting was a 23 bedded cardiology interventional ward. Patients were admitted to this ward for a variety of procedures such as coronary angiogram, percutaneous coronary intervention (PCI), implantation of pace makers and specialist cardiac devices. From the data collected during theme 3 the team decided to focus on improving processes to enable more effective nurse facilitated discharge (NFD). Whilst this was a Trust objective, there was also changing patterns in service provision to enable same day discharge as opposed to overnight stay in hospital.

The ward staff began by completing a baseline audit to determine what was current practice and shown that both practice and related documentation was not standardised nor consistent. Due to the increased throughput of patients for interventional procedures nursing staff were concerned that the care being delivered would become very task focussed and lose the essence of person centeredness. The nursing team began to develop policies and protocols to support NFD but soon realised that to do this would have significant impact on the wider multidisciplinary team. At this stage the ward sister began to engage the seniors medical consultants and other members of the team in the practice change through staff meetings and dialogue with key consultants. Once the policies and protocols where agreed and in place, alongside a competency framework and development programme, a pilot phase was commenced for a 4 week period.

Significant outcomes where achieved through this practice change as evidenced through the evaluation, which comprised audit and staff and patient feedback:

- there was an increase from zero recorded NFD on the patient classification system to 100% of patients admitted for Coronary Angiogram and Percutaneous Coronary Intervention (PCI) having a NFD.
- the flow of patients was significantly improved, with patients discharged either 4 or 6 hours post procedure, thus reducing hospital length of stay
- effective discharge planning led to a more positive experience for patients
- nursing staff felt more competent and confident to make appropriate decisions and to engage in NFD
- this approach supported staff within the multidisciplinary team to be more open to challenge.

Furthermore, the challenges in communicating within the practice setting and across the organisation were recognised and participants reflected the need for effective communication between the programme leads and the participating sites, between the site facilitators and their teams, and between the multidisciplinary team and service users. The positive aspects of communication particularly around receiving positive feedback were emphasised, but in contrast the challenges of fragmented communication were also
identified. The mechanisms for communicating were also a constant source of contention within the data.

“Disseminating information about person-centred care in the ward was considered to be more difficult, because ward meetings were rare. When meetings did occur, these are described as one-way communication from the ward manager to disseminate what staff perceived as copious amounts of information about projects and targets all of seemingly equal priority to the Trust...” (Focus group, round 1)

In response to this challenge emerging from the data, one site considered how they could enable engagement through more effectiveness team meetings and focused on this as their practice change. Interestingly, this development also led to engagement with medical staff and a refocusing on general ward communication to ensure continuity of care for patients.

A further theme of maintaining momentum throughout the programme was also highlighted. There were times when there was a high level of commitment and energy and this would have been reflected in the level of engagement across the participating sites. There was also a view that this was the right thing to do and a desire to promote person-centredness in everyday practice, which in itself helped to maintain momentum. In contrast however there were times, when maintaining momentum was a challenge due to the organisational context

“Difficult to keep momentum and energy going. It needs an awful lot of energy and this is often hard to find. Takes an enormous amount of time from working day. Sometimes this is difficult because it is so busy on the ward. The end product will be good but difficult to instigate” (Reflective account, workshop 3).

The leadership role within the ward was considered pivotal in engaging staff and maintaining momentum particularly in areas where there was a high staff turnover. There was, however, a more fundamental message that was about developing person-centred cultures and relates to the theme of living person-centred care in every day practice.

“But they can role model it and keep it going so that people can learn from it because staff change, especially the senior leaders..... and the Ward Managers that is a big part of their role but staff change, staff come and staff go so before you know it in 6-months time 6 people have gone from your ward and you sort of feel like you are starting all over again but if it’s continuous and built into everyday practice, and it’s part of the ethos of the ward, it should be built in. It becomes part of the culture” (Focus Group participant. Round 2).
Conflicting priorities

Feeling pressurised within the environment was a strong theme arising from the data. This was described in the context of multiple organisational priorities and the pressure to deliver within specific deadlines. This created a real sense of frustration for participants, where on the one hand they recognised and valued the importance of person-centred care, but on the other the reality in practice made this way of working unobtainable.

“Mixed feelings today. I know that the theory is an excellent one and that in a "utopian" world it would be perfect, but I feel bogged down with lots of other things at the moment, like high impact bundles. Frustrated at times as cannot achieve what I perceive I need to do due to time constraints, workload, and other perceived priorities”. (Reflective account, Workshop 3)

Feeling pressurised was further compounded by the continual challenge of adequate staffing and resources. This played out at every level in the programme from staff attendance at workshops and project team meetings, to the delivery of aspects of the programme in practice. Some areas managed this dynamic and continued to engage in the programme, while others struggled to keep the project moving forward.

“I know for us because of staff shortages....I know for a fact the staff haven’t got near the information files to read them because they just don’t have the time, it’s a way down the list and trying to put our action plan into place is really really difficult, we are wanting to move forward with it and we are wanting to get the morning sessions sorted out that we can talk to staff about this and bring them on board and get them, but we don’t have the

Participants were keen to stress significant workload pressures amidst a changing organisational context. The focus on strategic review of services, was leading to different models for care delivery and changing roles. All of this, they reported, led to increased demands and greater workload.

“Volume and conflict, each person’s project is expected to take priority, and if each of us had applied for a specialist post in whatever field, that would be our priority. But for the people who are delivering the care, it’s all funnelled down and we have to feed all these projects, as well as meet the patient’s needs. We agreed the principles ... However somebody ... has to recognise that it has become impossible to address each patient in a person-centred way”. (Focus group. Round 1)
This was an important dialogue that was recurring throughout the delivery of the programme. From the perspective of the facilitators there was evidence to suggest that they viewed the programme as a ‘project’ to be delivered, as opposed to ‘facilitation of a way of working’ that enabled development of person-centred practice as an ongoing activity.

“When participants are talking about person-centred processes, these are mainly conveyed as aspirations. They provide examples of care that exemplify distinct person-centred moments rather than person-centred care”

**Figure 3: Example - Applying a person-centred approach to organisational change**

This Operating Theatre Unit comprised of a suite of four operating theatres and one five bedded post-operative recovery unit caring for those from the opposing ends of the age spectrum and everyone in between. The core team of 38 staff had varying degrees of perioperative experience; some of whom had previous insight into the person centred concept and framework, having taken part in a pilot in 2002/2003.

The unit decided to consider person-centeredness from a staff perspective as there was a significant challenge from a high level of vacancy control required as part of efficiency savings. Staff were required to undertake inter and intra site perioperative work across 3 acute hospital sites, which was generating anxiety and dissatisfaction within the Team. Therefore, the team decided to focus on facilitating cross site movement of staff in a person centred way. It was essential that staff movement contributed to safe and effective patient care, but also that staff felt that movement was fair and equitable and, where possible, tailored to suit their own personal and professional development needs.

The practice change focused on the collaborative development of a protocol, which reflected the Trust policy on staff movement. Staff were encouraged to share their personal thoughts regarding this relatively new requirement to move outside their immediate clinical area and how this could be a more positive experience for all those involved. This contributed to the development of a protocol, which all staff signed up to. Following implementation of the protocol, staff were encouraged to provide feedback on their experience using a structured questionnaire to determine to what degree the protocol had been successful.

This approach to changing practice achieved a number of significant outcomes, which included:

- staff engagement in changing practice, resulting in willingness and acceptance to move inter/intra site
- a significantly enhanced experience for staff who moved inter/intra site
- evidence that staff were more receptive to change
- increased understanding of the principles of person-centredness and the Person-centred Nursing Framework within the Team
- transferability of the learning to other organisational changes i.e. the successful transfer and merger of two independent teams into one using the person centred principles
- opportunities to share learning and celebrate success e.g. the team was successful winners of a ‘Team of the Year’ National Award for the person-centred work.

This organisation was undergoing significant organisational change, which resulted in a context that was constantly changing and evolving. All the participating sites were experiencing the impact of this and similarly as commented above some areas continued to
be able to function in this context and engage in the programme, while others struggled to keep the project moving forward. One participating site, however, embraced the person-centred care approach of the programme to manage the potentially negative impact from the changing context within their service that was requiring staff to work in quite different ways. The approach and resultant outcomes achieved by this team are summarised in Figure 5. This level of engagement subsequently, has an impact on how relationships are formed within and across teams.

Living Person-centred care
Whilst the values that underpin person-centred care were not new to participants, the significance was in how they embraced person-centred values in practice, even in the challenging context described above. The acknowledgement by participants of the difficulty in always recognising how person-centred values are reflected in practice, both in support of best practice but also in recognising aspect of practice that needed to change.

"It’s about getting back to recognise that those very important things ...... it doesn’t always have to be hi-tech, it’s just sometimes the most simplest things can matter an awful lot to a patient lying on a bed. So to me that's what I feel about it”

Figure 6 presents a patient story and is only one example of how participants where challenged to think about how they embraced the values of person-centredness in everyday practice. The strength of this type of feedback began to raise a level of consciousness for participants in relation to how person-centredness was demonstrated in practice, and reinforced the idea of espoused values (what we talk about) and how these values are reflected in our behaviour.

At the start of the programme, the participants articulated their concerns that this was just another project. However, over time, there was a fundamental shift in recognising the ‘person’ in person-centred care, a central tenet of this way of working.

....being person centred with each other, your colleagues, your peers, multidisciplinary team.....that is something that the staff didn’t necessarily understand and its only because they did the values clarification....to be honest with you ...they wouldn’t have had doctors down, speech therapists, it just would have been patients and relatives. (Facilitator account, Round three)
**Figure 4: A Patient Story**

I feel they do put the patient first which I think is a great comfort personally and you always do feel that you are the centre. I know there are maybe 20 people on this ward but you are made to feel that you are the centre of the attention of the people bringing it to you while they are with you and indeed if you need to ... staff are very caring people and do genuinely make an effort at all times to help as much as they possibly can ... There are one or two things that I must say to you, just made one or two small notes there are some nursing staff who don’t knock the door before they come in. My attitude is in a sense this has become my house. This is my house, I wouldn’t dream of in my job opening a door and going without knocking the door and waiting to be called in. Some nurses come in while I have visitors and they would say I have just come in to get .... and I have had to say look I will deal with that issue later on. For example I did tend to feel myself slightly on tender hooks because I use a catheter, nobody but nobody except my immediate family that’s my wife and my children know that I do that. Very frequently I would have my sisters in and I am sitting reading and somebody would turn round and say but the way how much did you get out of your catheter last night, when you find that people are coming in and saying I just want to take a note of whatever it may be I don’t know your output or how much water have you taken, it appears to be that they need to write stuff down supersedes really what I would feel, look I can get you that later on there is no problem with that at all and I am just a little bit wary when visitors come in and perhaps they give information that I don’t want other people to know.

The significance of this is not always clearly understood, but as emphasised by McCance et al (2011) an understanding of person-centredness as being applicable to all those involved in a caring interaction, reflects the potential impact of staff relationships and team effectiveness on creating a therapeutic environment.

The Person-centred Nursing Framework which underpinned the programme was seen as an enabler for staff to engage with person-centredness in practice. The Framework was introduced as a tool for participants to use in ways that would enable staff in engage in critical dialogue about person-centred care and to increase understanding of how these values are operationalised in practice. As the programme progressed there was evidence to suggest that it became easier for participants to use the framework and to relate it to their practice. Furthermore, the experience of participants would suggest that they used the framework as a 'heuristic', that is, as a focus for problem-solving, learning and discovery through their own experiences.

**Being confident and competent** was also key to this way of working. Many participants described their experience of the programme as a personal journey characterised by the
development of knowledge and skills, or indeed an increasing awareness of personal limitations or barriers to working differently. This emphasised the importance of participants learning to identify their own needs and being able to ask for support.

Engagement with staff is very rewarding, not only for me but also for them. Sharing the journey and supporting staff to develop new skills i.e. facilitation I strive to role model PCC. Recognise I don’t always get it right. Importance of reflection.. I have learnt what kind of learner I am and it has refocused my attention to what nursing is and should be (Reflective account Workshop 1)

Each of the ten sites outlined their own individual journey. The area specific developments in practice, which were identified as part of theme 4 within the programme, were a powerful motivating factor for most sites, and at one level did make some staff feel empowered, and to move towards a model that could support continuous and sustained improvement activity as part of everyday practice. However, there were other areas, which were at an earlier stage in their journey, but were growing in confidence and competence. There were a small number who appeared to find engaging in the programme too challenging. This highlighted the importance for staff to have a level of practice development competence to enable engagement in the programme.

Making Person-centred Nursing Real

In this chapter we have presented an overview of the theory and practice of person-centred nursing. The case study shows how a person-centred nursing theoretical framework was used to guide the development of person-centred nursing in practice. The activities used within the programme reflect a participatory approach to developing person-centredness – something that we would argue is of critical importance in helping nurses and other healthcare workers to experience complex theoretical concepts (such as person-centredness) in practice.

The processes used, and the findings from this programme evaluation confirm the impact of such participatory and collaborative processes in enabling engagement. The focus on building relationships and maintaining momentum as part of enabling continued engagement are similarly reflected in the evaluation of other practice development programmes. For example Boomer and McCormack (2010) showed how improved team working through participation, the development of trusting relationships, and the shift from a culture of passivity to one of being proactive all contributed to changing the culture of practice.
We know that one of the biggest challenges to working in a person-centred way that nurses face is that of managing conflicting priorities. Again, the case study highlights these conflicts happening in everyday practice. This conflict is a reality in contemporary nursing and healthcare environments and reflects the context in which care is usually delivered. The healthcare context is always evolving and changing and most healthcare practitioners are familiar with regular organisational reform. McCormack et al (2004) define context as “the setting or environment where people receive health care services”, and identify three key elements which form a context that ensures people are more likely to receive evidence-informed and person-centred care: culture, leadership and evaluation. The constantly conflicting priorities within an evolving context experienced by participants in the case study described here, raises crucial issues in relation to the culture of the organisation and the leadership at managerial and ward level. It highlights the need for clarity about leadership commitment, management responsibility and organisational clarity regarding the purpose and contribution of such a programme, in advance of the work commencing. Ensuring engagement in the programme from the outset, re-emphasises the impact of contextual factors, which according to McCormack et al (2011) “pose the greatest challenge to person-centredness and the developments of cultures that can sustain person-centred care” (p.1).

There is a need to assess the practice context in order to establish ‘context readiness’ (including the extent to which person-centred values and behaviours are present) as an important first step in undertaking development work of this nature (McCormack & McCance, 2010). Wilson et al (2005) present a similar argument highlighting the need to understand the culture of the individual workplace prior to implementing innovations or developments. McCormack & McCance (2010) offer a number of approaches and tools for evaluating practice context, for example the Context Assessment Index (McCormack et al 2009a) and the Workplace Culture Critical Analysis Tool (WCCAT) (McCormack et al 2009b). Nonetheless, a practice development approach encourages individuals and teams to explore their own context in a non-judgemental and transparent way and to be explicit with others about the stage they are at in terms of their journey towards person-centred practice. So whilst context readiness has been identified as particularly important, the use of a practice development approach can take account of this and support teams at whatever stage they are at.

The development of confidence and competence in translating person-centred values into practice is a key issue for nursing programmes. Undergraduate nursing programmes need to instil person-centred values in their programmes, but in addition there needs to be a focus
on helping future nurses to acquire the knowledge and skills necessary for enabling the continuous development of practice. Shaw et al (2008) describe the knowledge and skill set for practice development as that which includes: building person-centred relationships through one-to-one and group support; establishing vision and ownership; using the range of practice development methods and processes; working effectively in differing context and cultures; and accessing and using different types of evidence and resources.

Knowledge and skills that seem to be particularly difficult for nurses to develop expertise in and which are critical for being person-centred include facilitation skills and the ability to be truly critically reflective. This was also a finding discussed by Boomer & McCormack (2010) who identified competence and confidence in relation to becoming a facilitator and the importance of becoming reflexive articulating this as “heightened awareness, change, growth and development of self personally and professionally” (p.639). Consensus within the practice development literature would suggest that this is a significant challenge and there is a need to look at ways for practitioners to develop their ability to be reflexive. This also links to context readiness and where teams are at on their practice development journey.

Finally, reflecting on the themes from the case study evaluation data provides a good basis for anyone wanting to consider the development of person-centred nursing in their care setting. Each of the themes connects with each other and collectively they tell a story of the complexity of person-centred nursing and the need for a systematic approach to its development.

The themes highlight a number of important considerations:

1. There is a need for all team members to be engaged in the process of developing person-centred care and a team commitment to a project plan.
2. Clinical teams need to have a plan for the ongoing development of practice that embraces facilitation approaches and supported reflection on practice.
3. The inevitable contradictions and conflicts that happen in practice (as shown in the patient story in the case study) need to be discussed and understood as part of the challenge of working in organisations that are constantly evolving.
4. Team members need support and facilitation to help develop the confidence and competence to work differently and with clear principles that privilege participation and collaboration.
5. The care environment needs to be managed in a way that enables flexible approaches to practice and which does not enforce rigid ‘structures, processes and rules’ that work against person-centred values.
6. Developing an action plan that is based on an assessment of the practice context is an essential pre-cursor to commencing a person-centred practice development programme.

7. Undergraduate programmes need to integrate person-centred concepts and theories into the curriculum and engage in critically reflective dialogue with students about the opportunities and challenges associated with person-centred nursing.

**CONCLUSION**

In this chapter we have provided an overview of person-centredness and person-centred nursing. We have offered a framework for person-centred nursing and have illustrated the development of person-centred nursing in practice through a detailed overview of a practice development programme in one health and social care organisation. Developing person-centred nursing is not a simple task, nor indeed is it something that can be done in an ad-hoc way. Whilst many of the attributes of person-centredness require nurses to operationalise many of the caring and compassionate values that are at the core of nursing, critical to person-centred nursing is the context (care environment) in which nurses' practice. Whilst there is a professional expectation for nurses to exercise professional competence and to work to the highest possible standards (as stipulated by national regulatory organisations), it is imperative that health and social care organisations support the development of person-centred nursing through programmes of practice development, continuous quality improvement and life-long work-based learning. With such support systems in place, person-centredness for all can be made a reality!
REFERENCES


Edwards C, Staniszeweska S and Crichton N (2004) Investigation of the ways in which patients’ reports of their satisfaction with healthcare are constructed, Sociology of Health & Illness, 26(2): 159-183


