Sjuksköterskans kärnkompetenser kapitel 4

Personcentrerad omvårdad

Original kapitel

PERSON-CENTRED NURSING

AUTHORS:

Professor Tanya McCance,

Professor of Nursing R&D, Institute of Nursing & Health Research

Ulster University

Email: tv.mccance@ulster.ac.uk

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 is considered the preferred approach in health and social care, as evidenced in policy and strategy development globally (World Health Organisation 2015, Department of Health 2016). 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. At that time, the review along with others by McCormack et al (2010a) and McCance et al (2011) highlighted the limitations of the research into person-

centredness: it mostly focused 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). The knowledge base underpinning person-centredness, continues to expand, with greater clarity on person-centredness as a concept relevant to international healthcare, and an increased understanding of the key components that need to be considered for effective implementation of person-centred practice (Health Foundation 2014, McCormack et al 2015, Dewing & McCormack 2016). This has led to the development of conceptual frameworks and models depicting the components of person-centredness (e.g. Rosvik et al 2011, Lynch et al 2018), which have significantly enhanced our understanding of how we can effectively operationalise person-centredness in practice. Additionally, there has been significant development of methodological approaches that can capture the complexities of person-centred nursing, alongside the development of tools to enable measurement (De Silva 2014, McCormack et al 2017).

The Concept of Person-centredness and Person-centred Nursing

Much of the early literature about person-centredness and person-centred practice emanated from 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). It is a concept that also has its origins within humanistic psychology (Rogers 1980; Heron 1992). The term ‘person-centredness’, however, is being used more freely within health and social care strategy, policy and practice but 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, person-centred nursing has similarly evolved.

The Person-centred Nursing Framework is recognised as a model for nursing and is described as a middle-range theory in that it has been derived from two abstract conceptual frameworks, comprises concepts that are relatively specific, and outlines relationships among the concepts (McCormack and McCance 2016).

The essence of nursing depicted within the person-centered nursing framework reflects the ideals of humanistic caring in which there is a moral component, and practice has at its basis a therapeutic intent, which is translated through relationships that are built on effective interpersonal processes. Therefore, person-centeredness in nursing practice requires the formation of therapeutic relationships among professionals, patients, and others significant to them in their lives and the building of these relationships are based on mutual trust, understanding, and sharing collective knowledge (McCormack, 2001; Dewing, 2004; Binnie & Titchen 1999). The definition used within the framework 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, 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 (McCormack & McCance 2017).

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.

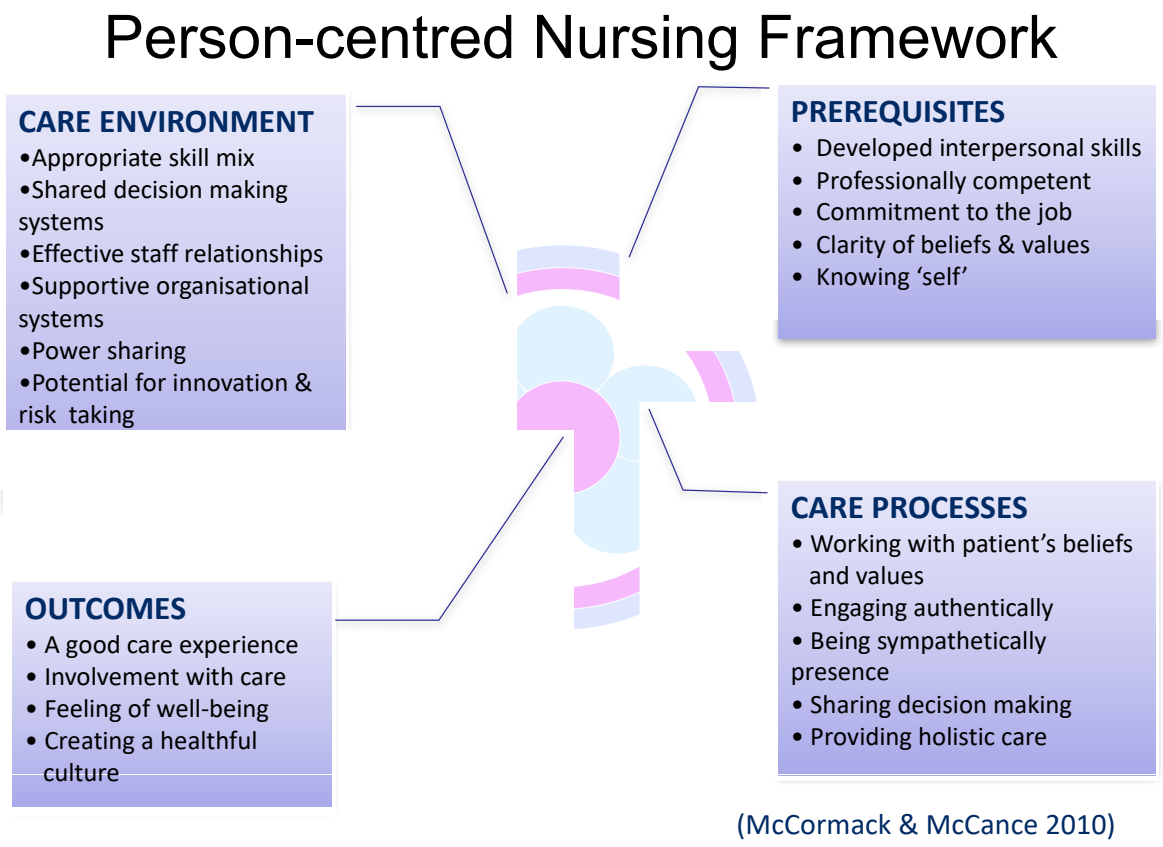

Figure 1: The Person-centred Nursing Framework

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 acknowledging 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; potential for innovation and risk taking and the physical environment. 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. Finally, the *physical environment* recognises the impact of our physical surroundings on person-centred practice. These characteristics of the care environment are consistent with the conceptual development of the concept of context (Kitson et al 2008). 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; engaging authentically; being sympathetically presence; sharing decision making; and providing holistic care. 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 are important forms a foundation for decision making that adopts a 'negotiated' approach between practitioner and patient" (p35). Being sympathetically presence highlights an engagement that recognises the uniqueness and value of the individual and reflects the quality of the nurse-patient relationship. Finally, providing holistic care focuses on treatment and care that pays attention to the whole person through the integration of physiological, psychological, sociocultural, developmental and spiritual dimensions of persons.

Outcomes are the results expected from effective person-centred nursing and include: a good care experience; involvement in care; feeling of well-being; and creating a healthful culture. A good care experience reflects the evaluation a patient, or indeed a nurse, places on their care episode. 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). A healthful culture is described as one in which decision-making is shared, staff relationships are collaborative, leadership is transformational, innovative practices are supported and is the ultimate outcome for teams working to develop a workplace that is person-centered.

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.

A Case Study of the Development of Person-centred Nursing

"It's a nice place, a nice place to be": **the story of a practice development programme to further develop person-centred cultures in palliative and end-of-life care**

The case study reproduced here is based on a more detailed publication reporting the processes and outcomes of a transformational practice development/research project that was first published in The *International Practice Development Journal:*

McCormack, B., Dickson, C., Smith, T., Ford, H., Ludwig, S., Moyes, R., Lee, L., Adam, E., Paton, T., Lydon, B and Spiller, J. (2018) 'It's a nice place, a nice place to be'. The story of a practice development programme to further develop person-centred cultures in palliative and end-of-life care, *International Practice Development Journal,* Volume 8, Issue 1, Volume 8, Issue 1, Article 2 https://doi.org/10.19043/ipdj81.002

CONTEXT

Current evidence suggests person-centred ways of working are crucial in palliative and end of life care (Yalden et al. 2013; McMillan Cancer Support 2015). Respecting persons' needs and wishes, shared decision-making, family involvement and sensitive communication are highlighted in the literature (Leadership Alliance for the Caring for People at the End of Life 2014; van der Eerdener et al. (2014). van der Eerdener et al. (2014) reported a qualitative study exploring the experiences of patients' and their carers' experiences of person-centred end of life care in five European countries. Participants reported feeling valued as a person- rather than being an illness, discussing prognosis and treatment openly and honestly, and

the formation of trusting, personal relationships as key considerations. 'Being there' and information sharing between professionals that reduced the need for repetition of their story were also identified as hallmarks of person-centred care.

Marie Curie Care UK (MCC) has an overall strategic direction of the development of person-centred palliative and end of life care, reflecting this evidence. It also reflects the 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015– 2020' (National Palliative and End of Life Care Partnership 2015). Embedded within Marie-Curie's strategy and 5-year plan are their espoused values,

'Always compassionate, making things happen, leading in our field and *people at our heart'.*

The People Strategy (Marie Curie 2015) highlights the need for recruiting and retaining an appropriate skilled and diverse workforce who feel confident and capable to deliver care and experience well-being whilst embracing change and keeping quality improvement central. However, McCormack et al. (2017) posit person-centredness will only happen where there are cultures in place that will enable staff to experience person-centredness for themselves. The Marie Curie organisation therefore decided to use The Marie Curie Edinburgh Hospice (thenceforth referred to as 'The Hospice') as a case study for developing and modelling a person-centred culture, as a means of exploring how the processes could be transferred across the organisation and identifying outcomes that could be used to demonstrate effective workplace cultures in action.

The programme built on the learning from previous projects that have focused on the development of person-centred services (Boomer and McCormack 2010; McCance et al. 2013; McCormack et al. 2015) and aimed to further develop the processes used and

outcomes achieved. Experience and evidence from practice and research has shown that person-centred care is more likely to be implemented where there is a culture that integrates person centred thinking into everyday work (Yalden 2013). This is particularly important for new or developing organisations. Task orientated ways of working and hierarchical ways of thinking can easily become the norm in organisations that do not make explicit their commitment to a more person-centred approach. According to Manley et al (2011) workplace cultures are those that impact at the point of care delivery. They suggest effective workplace cultures reflect the characteristics of a person-centred culture.

Emancipatory and transformational practice development are identified as methodologies for bringing about culture change that are consistent with the values underpinning person-centredness (McCormack and McCance 2010). The aim of transformational practice development is to increase effectiveness in person-centred practice through enabling healthcare teams to transform the culture and context of practice and in this case, to transform the experiences of care by staff and service users/families (McCormack & Titchen 2007; Titchen & McCormack 2008; Titchen et al 2011). Transformational practice development focuses on creating the conditions for all persons to flourish, as a process (ways of working) and as an outcome (the person's experience). This is achieved through a series of phases aimed at helping all staff become empowered to act, utilising staff knowledge and expertise to identify the need to change, encouraging reflection on and in practice and supporting staff to challenge themselves and each other and take ownership for addressing barriers. However, operationalising this methodology is not without its challenges (McCormack et al 2013) and experience from previous similar programmes has shown that success is achieved by including all grades of staff in the practice development programme (Boomer and McCormack 2010; Manley et al. 2011; McCance et al. 2013; Yalden 2013; McCormack et al. 2015) and that there is a direct link between the participation of leaders in the programme and outcomes achieved (McCormack et al 2009; Mekki et al 2017).

PROGRAMME AIM AND OBJECTIVES

To implement a programme of practice development to further the development of a culture of person-centred practice in the MCC Edinburgh Hospice.

OBJECTIVES

1. Enable participants/key facilitators and managers to recognise the attributes of person-centred cultures in hospice care.
2. Facilitate learning and development about transformational practice development to support person-centred practice in the hospice setting.
3. Promote quality of care and wellbeing for all persons in the care facility.
4. Develop skilled facilitators who will champion and lead a person-centred approach to practice ensuring sustainability of the practice development programme in the organization.
5. Utilise a participant generated data-set to inform the development and outcomes of person-centred practice.

METHODOLOGY

The programme was theoretically informed by McCormack and McCance's theories of person-centredness (2010, 2017), with a focus on continuously developing person-centred cultures as places that embrace meaningful engagement with people as colleagues and as patients/families. To operationalise this theoretical perspective, the methodology of Transformational Practice Development was employed. This approach to practice development focuses on developing cultures that enable all persons to flourish. This is achieved through critical and creative engagement in facilitated learning. The focus of the learning is the individual practitioner's/individual teams' work. Through creative and critical

reflective activities, learners are enabled to bring about change in themselves and the cultures and contexts in which they practice. The learning is set within a strategic context to ensure it is embedded in organisational cultures. The methodology of transformational practice development was operationalised through active learning (Dewing 2010). This is a form of action orientated learning concerned with work and work practices whereby the style of learning and consequent activities is underpinned by principles of active engagement in observation of care and practice by self and others, critical reflection with self, critical dialogue with others and doing or action with others in the workplace. Participants are guided to increase the range of active learning methods they use in their day to day work, who in turn learn to use active learning methods in their workplaces with team colleagues.

The Setting

The Edinburgh Hospice is one of nine Marie Curie hospices across the UK. All the services offered by the hospice work together to meet the palliative care needs of people with progressive, life-limiting illness. The aim of the service is to provide specialist, evidence-based palliative care that enhances quality of life for people affected by cancer and other illnesses. The hospice inpatient unit employs more than a hundred staff to provide care and support for up to 20 adults over the age of 16. In addition, day and community services are provided. A team of trained volunteer staff also support the hospice in various activities such as working on the reception, offering drinks and snacks, and gardening.

The Participants

The programme commenced with a group of 13 people from mixed disciplines (the core group). The group consisted of, the Hospice Manager, Practice Development Facilitator, two Lead Nurses, one Charge Nurse, one Clinical Nurse Specialist, two Registered Nurses, two

Health Care Assistants, one Secretary, one Physiotherapist and one Medical Consultant. The group membership changed over time for a variety of reasons including sick leave, retirement and leaving the organisation.

Programme Structure

The programme was structured over 12 months and centred around 10 'programme days' of learning and development. Each of these programme days incorporated 3 hours of facilitated active learning with the core group on the identified themes. Whilst the programme appears linear in design, each session incorporated elements of previous learning and responded to the learning and development needs of the participants. The focus of each programme day and the activities engaged in were informed by the work of Dewing, McCormack and Titchen (2014).

Evaluation

The processes and outcomes were evaluated within a collaborative framework drawing upon reflective dialogue data between lead facilitators and programme participants, individual interviews with key stakeholders and observations of practice using the Workplace-culture Critical Analysis Tool (WCCAT) (McCormack et al 2009). Data gathered using these multiple methods were analysed to identify changes in the practice culture at the beginning of the programme, as a means of providing a starting point for comparing the findings of ongoing evaluations. All data were mapped onto a matrix we developed derived from The Person-centred Practice Framework (McCormack & McCance 2017), so that two matrixes were used to compare the data at the 'starting point' and periodically as the programme progressed. A timeline of changes was created to help the participants plot the journey over time and what had been achieved. At the end of the program, the participants engaged in a

collaborative reflective workshop where they identified outcomes of the culture transformation, identifying how this reflected their shared vision and their shared understanding of the reasons for this transformation. A framework of 'human flourishing was used to shape this reflective workshop.

Ethical Approval

Ethical approval to conduct the study was secured from QMU Ethics Committee and the Marie Curie Research Group.

FINDINGS – UNFOLDING A STORY OF FLOURISHING

Human flourishing occurs when we bound and frame naturally co-existing energies, when we embrace the known and yet to be known, when we embody contrasts and when we achieve stillness and harmony. When we flourish we give and receive loving kindness.

(McCormack & Titchen, 2014)

The term 'human flourishing' can be traced back to Aristotle who suggested that *'human flourishing occurs when a person is concurrently doing what he [sic] ought to do and doing what he wants to do'.* Aristotle's moral perspective of human flourishing is at the heart of what it means to be a healthcare practitioner, with a moral requirement to do and want to do the right thing for others. McCormack and Titchen (2014) argue that to achieve this outcome requires an understanding of what is required of us as practitioners (the evidence that informs our practice) whilst at the same time being able to want to do what is the right thing and to enjoy doing it. McCormack and Titchen built on this Aristotlean position and through a process of critical creative inquiry, identified 8 conditions for persons to flourish:

1. Bounding and Framing
2. Co-existence
3. Embracing the known and yet to be known
4. Being still
5. Living with conflicting energies
6. Embodying contrasts
7. Harmony
8. Loving kindness

We use these eight conditions for human flourishing to re-present the processes and outcomes arising from the transformational practice development programme.

1. Bounding and framing

McCormack and Titchen (2014) suggest developing a 'frame' of reference for both how we see the landscape (the culture) of the setting and the direction of travel we need to adopt to enable the subtleties of the landscape to be observed, engaged with and lived. A developed understanding of the need to pay attention to the existing culture of practice to enable person-centred services to evolve was required. Thus, the journey began by the group getting to know each other, not by their job role, but as people. This is fundamental to person-centred practices and is a way of encouraging people to authentically engage with each other and to achieve connectivity which Gaffney (2011) suggests is vital to human flourishing. Establishing a safe environment for open and personal sharing is critical to this activity as persons will only share what they feel safe to share in a supported environment, and without this safety they will not flourish. Each member of the group was invited to create their own self-portrait, using creative materials. This proved to be enlightening and fun. Whilst at the time, the group felt too much time had been devoted to this activity, they came

to know this was part of establishing the path on which they would journey and they often referred to elements of ‘knowing’ each other they had developed through this activity. The portraits exercise also enabled the basis of a discussion about shared values to be developed.

Person-centred cultures are rooted in explicit values which are reflected in a shared vision. This vision would become the evaluative statement, central to the work of the programme. Individuals in the group were encouraged to undertake a values clarification exercise (Warfield and Manley 1990). The dialogue that followed this activity enabled the group to establish ways of working together in a person-centred manner. They also developed three different vision statements in small groups that reflected their espoused values. The group recognised they would have to find ways of engaging with all stakeholders, including patients, carers, volunteers and staff to ensure everyone's voice was heard and for the values to be truly shared. They were encouraged to repeat the process within their own areas of practice using creative methods as they saw fit. The group used graffiti boards, existing formal meetings, conversation and imagery and the same written values clarification exercise. The data collected were analysed using critical creative hermeneutic analysis by the group members and the facilitators. Key values were extracted and compared to the initial vision statements. The group then worked together to develop a shared vision statement that would serve as the anchor of the programme:

'Our vision for a person-centred culture is one that enables individuality, promotes autonomy and encourages aspirations in a secure and supportive environment'.

2. Co-existence

The core group used the vision statement as a marker of the existing culture. Data were collected and analysed to understand what needed to be done to realise the vision. Being attuned to the connections that exist in the care setting enabled the group to recognise when disconnections were happening and to rise to the challenges associated with such disconnections. Through dialogue, the data collection and analysis methods described earlier were agreed upon. Through a process of critical creative hermeneutic analysis, the core group identified five overarching themes:

a) ***Knowing the person***: The theme of 'knowing the person' reflected the extent to which staff in the hospice made efforts to know patients and families.

b) ***Promoting individuality***: Enabling patients to express their individuality was generally a positive aspect of services at the hospice. Overall, the staff at MCC attempted to promote autonomy and individuality with patients, whenever it was safe and feasible to do so.

c) ***Balancing routines with informed choice***: One key message that came from the feedback was that the staff took steps to enable them to spend more time with the patients and ensured that the patients' dignity was preserved.

d) ***Team effectiveness***: most members of staff made positive comments about working at MCC. However, some staff members were leaving the hospice, which was attributed to problems with team effectiveness. Staff commented on the 'emotional labour' of the job and the need for greater staff support.

e) ***The physical environment***: Many people commented on the visual aesthetics of the wards. Such aesthetics included the size of the rooms, the patients' views of the gardens, the balcony and the bright colours that coat the rooms' walls. But there were some comments about how to improve the overall visual impact of the hospice, the need to reduce noise (especially at night) and the management of different odours throughout the hospice.

The different data collected largely demonstrated a positive experience for patients and families. The intent to provide individualised and person-centred care was obvious in the data and the efforts that staff went to in doing so, recognised by patients, families and co-workers. However, the theme of 'team effectiveness' revealed issues pertaining to team working, communication and consistency of approach, as well as some issues concerning the general hospice environment. This suggests a focus on person-centred care without paying attention to the need for a person-centred culture. Each of these issues became developmental themes for the core group to work on, in collaboration with other members of the hospice team.

3. Embracing the known and yet to be known

The team were invited to engage with the data to raise consciousness of person-centred practices within the hospice. Interacting with the data was an important part of the process as, to flourish, they needed to understand elements of their own personhood. McCormack and Titchen (2014) suggest, through a meaningful engagement with 'other' the hidden gems of our personhood can be revealed and made known to us. Following data collection and analysis of the initial data, the group felt they needed to pay attention to ongoing engagement of patients, staff and volunteers. They raised the issue of not knowing, what Gaffney (2014) refers to as valued competencies, i.e. they did not know about each other's talents. They used the forthcoming summer fete to find out about each other, their strengths and willingness to contribute. The group recognised that it is these hidden aspects of persons that need to be surfaced to create a culture that enables all persons to flourish. This event was also used as an opportunity to model person-centredness by enabling all persons associated with the hospice to express those aspects of 'self' that shaped them as persons – their beliefs, values, needs, wants, desires, hopes and dreams. These were reflected in the

consideration of the areas for development and how the different talents of staff could be maximised and used as assets to the ongoing development of the person-centred culture of the hospice. 'Mini-projects' were then established, each led by a member of the core group and working in collaboration with members of staff from across the hospice services. Some examples of these are found in Table 2.

Table 2: Mini Projects

- Celebrating the Vision Statement:
  - Wordle and display in hospice reception
- Administration team development:
  - 'Can do approach'
  - Improvement in atmosphere and welcome at reception
  - Making things possible – shared commitment to the culture of the hospice
  - Initiative
- Induction
  - Multi-disciplinary inductions implemented using PCC tools and approach
- Creating Spaces for Reflection
  - Schwarz Rounds
  - Communicative spaces for open dialogue
- People of Marie Curie
  - Personal portraits and photos of MC staff and volunteers
  - Post on Facebook and highlighted in hospice newsletter
- Hospice Presentations
  - 2-hour presentations x 6 annually for internal MC staff and volunteers and external visitors covering all MC services and activities
  - 'virtual' tour of the hospice
  - Ongoing updates
- Staff Support and Development
  - Person-centred workshops
  - Role clarifying workshops between RNs and HCAs
  - Regular team meetings
- Reviewing of Existing Data
  - Staff Retention
  - Inspection and regulation reports

4. Living with conflicting energies

The programme offered a unique opportunity for skilled facilitation of 'moments of crisis', described by Fay (1987) as pre-cursors for change in being and doing. Crises aren't major events in a person's life, but instead are 'jolts' that may alter a particular perspective or cause us to pause for reflection and reconsideration of the direction we are taking. From the start of the programme, the core group found it difficult to accept that taking time out of clinical practice to focus on self, then focus on culture change was a worthwhile use of their time. Despite the deepening commitment to the programme, during sessions, there continued to be different demands on participants' time and invariably, there were interruptions and different members were pulled back to the clinical area. Although there was enthusiasm to engage and participate in the programme and an acknowledgement that time was needed to build robust relationships, they found it challenging to grasp the importance of learning different ways of being to ensure sustainability. Instead the group wanted a graphic representation of the programme, with a clear plan that could be followed.

As the programme drew on principles of transformational practice development, rather than a narrow focus of quality improvement or change management, it was important to spend time ensuring collaborative, inclusive and participative ways of engaging and making time for learning in and on the process. Working together creatively enabled the core group to come to understand the efficiency of creative ways of working and that they could use similar methods to engage patients, families, other staff and volunteers. By doing this from the beginning the programme became a collective endeavour with all stakeholders and a platform for shared decision-making. By module 3, members of the group reported feeling *'things were beginning to happen' a* person-centred learning environment was emerging and, rather than waiting for concrete plans, they had begun examining their practice and seeking local solutions.

Participating in an assessment of the workplace culture and context (Manley et al 2011), there was recognition of using the shared vision as an evaluative statement that they could work together to find out what the existing culture and context of care was like and take ownership of developing person-centred practice. The group also recognised by analysing the data themselves, themes relating to person-centred care emerged, but team relations were less visible. The facilitators helped the group to consider how they would collect further data by modelling person-centred practice and a holistic style of facilitation (Rycroft-Malone et al 2016).

Conflicting energies emerged in a perceived dissonance with the organisational values and some worry about the inaccessibility of the language around person-centredness. Rather than seeking to explain, the facilitators opened dialogue where group members were encouraged to voice their concern and try, through dialogue to question their thinking. They decided that it was important not to lose any of the voices that had contributed to the shared vision, otherwise this would impact on shared ownership. They also decided to update other stakeholders by identifying how their contributions were visible in the early work.

5. Being still

Making dedicated time for the programme was challenging because of the busy environment in the hospice. Despite commitment of the team, attendance at the core group sessions was variable. Throughout the programme, the group met at additional times to take the work forward. Creating spaces for quiet reflection and stillness is a real challenge in busy healthcare environments. Creating spaces for quiet reflection, critical engagement and meaningful connection with others are essential elements of an environment that enables all persons to flourish. One example of this is the work the team did to develop Schwarz Rounds.

Schwartz Rounds were introduced to the hospice almost in parallel with the person-centred cultures programme, and the programme provided an effective platform for integrating the Schwartz rounds with the rest of the person-centred developments that were happening.

The aim, as advocated by the Foundation (https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/) was to provide a structured forum where all staff, clinical and non-clinical, came together regularly to discuss the emotional and social aspects of working in healthcare. Rounds were generally well attended by staff from clinical and non-clinical areas (20-30 people usually, although 90 when person-centredness was the topic). Feedback was sought from practitioners:

'Thought provoking' *'Touching, relevant, poignant'* *'Thoroughly enjoyed taking part'*

'Fab discussion – lots to take away and think about' *'Good to share and learn together'*

'Very good, made you stop and think about things, which I think is useful during a busy day'

'Really gave insight in to the value of the team' *'Nice to hear the human side of people'*

'Good to hear different perspectives' *' Helps me better understand my work environment'*

'Inspiring and bonding' *' I think we are getting better at sharing our thoughts and our fears'*

'Very much enjoyed the stories from staff working in different areas / departments of the hospice. Gave a most enjoyable and welcome insight into their roles and the impact this has on people's lives, working in our unique setting of the hospice. Sharing is supportive and very worthwhile. Look forward to the next Schwartz round.'

An example of how learning became a facilitated activity in The Hospice, demonstrates a shift towards a person-centred culture - introducing moments of stillness for Healthcare Assistants (HCAs) to reflect. The aim being to uncover patterns of practice, both positive, person-centred, as well as ritualistic, task-focussed practices. During the workshops, the HCAs were also encouraged to think about their core values and agree new ways of working, together and in the wider team. Critical questions that arose from the sessions were captured for broader dissemination with the team and formed the basis of action plans.

6. Embodying contrasts

For persons to flourish, feeling respected and showing resect are key ingredients. Being respected as a person enables growth whilst simultaneously creating the conditions for the demonstration of respect for others. As well as identifying changes to practice and team-working, members of the core group identified specific learning arising from the programme of work. A template with key questions was distributed to all group members for them to complete. Key learning from staff mainly focused on recognising that person-centredness is not just person-centred care but is a way of being when engaging with all others. Following the programme one person identified:

> *I understood better what person centredness within the staff looked like and what it should feel like.*

Another reflected:

> *I have learned how important it is to step out of the comfort zone in a focussed way to really see what we are doing and how it might be different. I have also learned how important it is to use relevant examples to demonstrate how PCC has embedded in our hospice rather than trying to explain what it is!*

Participating in the programme also led to the use of more person-centred language:

> *I use the words 'person centred' a lot more now! It has made me think more about other people's roles and how what I do impacts on them, and how their role impacts on my role.*

Others identified that they were surprised how much the focus was on the team and that that is where the biggest changes seemed to have been made:

> *I don't think it has changed my practice, but I have seen very positive changes in a number of clinical and non-clinical colleagues in terms of engagement with, and feeling more part of, the hospice team*

7. Harmony

There is no beginning and no end to flourishing (McCormack and Titchen 2014). Acknowledging this brings dynamism to practice that responds to the context and the persons who shape that context. It creates a dance between the specifics of practice and the vision for transformation. It is also reflected in indicators of success collected from multiple sources. In this programme, we used routine collected data to demonstrate outcomes arising from the practice development work undertaken.

In May 2017, there was an unannounced inspection report published by the Health Regulator - Health Improvement Scotland (HIS). The 2016 report made 9 recommendations particularly around staff well-being and patient and family involvement in care planning. In the 2017 report, having invited comments from patients and families, HIS scored the hospice as excellent in four of the five categories, the fifth scored 'very good'. This improvement in scores commended the hospice on a positive environment, noting culture, and effective team-working where staff felt valued and respected. They reported evidence of a culture where feedback is sought and valued.
(http://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/independent_healthcare/hospices/marie_curie_hospice_edinburgh.aspx)

The transformation of the culture was also revealed in a review of complaints. There was a drop in the number of complaints from 30 in 2016 to 18 in 2017. What was remarkable in the 2017 review was a renewed approach to handling complaints which paid attention to reflecting and learning on the process of complaints, as well as responding to individual feedback. There was a sense of openness to change. Some examples included improvements to hospice procedures, environmental changes addressing safety issues and improved pathways of communication with patients and staff in community teams.

In response to high staff turnover and some instability in the hospice inpatient unit, (IPU) during 2015 and early 2016, a 6-month pilot was implemented, creating two supernumerary PDRN (Practice Development & Research Nurse) posts. The aim of these roles was to improve retention rates and staff well-being though mentorship and support, particularly for newer and less experienced nurses. Retention rates were scrutinized during and following the PDRN pilot. Numbers of RNs leaving the Hospice decreased by 40%. This followed a period of stability within the IPU.

Towards the end of the programme In July 2017, all staff were invited to complete a short survey about the workplace culture of the hospice. 24% of staff (N=28) responded which may reflect levels of enthusiasm for the work. 60% responded that they felt the culture had

become more person-centred, although their focus appeared to be on ‘patient-centred’ caring. There were however reports of person-centred cultures in responses:

'there is an increased willingness to discuss and give feedback in an open and honest environment without fear of being judged or ignored.

A new member of the team reported,

From my time of working here, I can see the person centre culture being at the forefront of MC. One example is when we helped organise [a celebration] for a patient’s relatives’ birthday a... The family were very appreciative and [now have] fond memories of the hospice.

Harmony is reflected in the embeddedness of the person-centred culture. The core group have ongoing plans to continue to develop practice. Mini projects are ongoing and becoming part of everyday practices. There is commitment to sustaining ways of working and ongoing development of the core group to include more members across the hospice. When asked what they would like to see happen next, 2 participants responded:

I’d like to see more things being done to bring staff together (if they want to obviously!) and more staff taking a lead in this, not just the same people. I’d like to see development of respect, recognition and understanding of roles, especially towards non-clinical staff. (Brigid)

and

I would like to see a specific piece of work with the HCAs that involves all of them. I would like the group to have a clear idea by December of how we maintain the momentum and how we establish the benefit for patient and families. (Juliet)

Celebrating success is occurring in several ways including sharing with other hospices and community services in Marie Curie, as well as presenting to the Executive Team and stencilling the shared vision in the reception area.

8. **Loving Kindness**

The person-centred development at The Marie Curie Hospice Edinburgh illustrates how a systematic, collaborative and inclusive approach to culture change can have wide-ranging effects on the lived experience. Using human flourishing as a framework helped us to get 'inside and underneath' the processes and outcomes and demonstrate a holistic approach to the development of person-centred cultures that keeps the person at the centre whilst dealing with improving areas of engagement and quality. This is consistent with the methodology of transformational practice development (McCormack & Titchen 2014). In this methodology, the purpose is to transform cultures towards those that are places where all persons' flourish. Transformational practice development is person-centred in its philosophy and uses methods that respect the diverse nature of persons, their ways of being and processes of engagement. It is not a linear process, but instead aims to 'be with' participants in ways that respect each unique learning journey. Transformation is sustained through active learning.

The relationship between person-centred care and person-centred cultures was particularly interesting in this programme. At the time when this work commenced, the results of a national patient survey by Marie Curie Care suggested high levels of patient-satisfaction with care provided in the Edinburgh Hospice. This was in part reinforced by the patient story data in this programme. More significantly however, our data revealed the lack of person-centredness experienced/felt by staff in the hospice and related services. The existence of person-centred care in the absence of a person-centred culture is an interesting conundrum! Buetow (2016) has argued that this raises moral questions that organisations need to

address, i.e. can staff be sacrificed for the outcome of person-centred care? This is a question that the hospice leadership and management team were not comfortable with in their service, i.e. the continuous loss of staff from the organisation while patients and families remain satisfied with their care. This dilemma in organisations however is not always addressed explicitly in the way that this team chose to, resulting in organisations either espousing a person-centred philosophy, whilst in realty focusing on patient-centredness (Buetow 2016). It was a revelation to most of the participants in this programme that person-centredness was about more than patients and that they had a right to consider these values for themselves. The results of this programme demonstrate an equalising of perspectives and respect for the personhood of all persons engaging with the service, irrespective of role and creating a person-centred culture that can be sustained over time. McCormack and Titchen (2014) suggest that this kind of culture represents the eight condition for human flourishing – loving kindness:

"*Loving kindness lies at the heart of flourishing; loving kindness towards oneself and others in the contexts and situations we find ourselves in our work. Speaking loving kindness is like feeling breeze on our faces, hearing the rustle and brushing of grasses and leaves as the wind gusts and lulls. It is something that is sensed more than actually spoken although it can be heard in the tone of voice, in the softness of the eyes and in compassionate acts. Loving kindness warms our hearts as the sun warms the earth and all living things ...".*

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

Binnie, A., & Titchen, A. (1999). *Freedom to practise: The development of patient-centred nursing.* Oxford, UK: Elsevier.

Boomer C and McCormack B (2010) Creating the conditions for growth: a collaborative practice development programme for clinical nurse leaders, *Journal of Nursing Management,* 18 (6): 633-644

Buetow S (2016) *Person-centred Health Care: Balancing the Welfare of Clinicians and Patients*. Routledge, Oxon.

Department of Health (2016) Health and Well-being 2026 – Delivering Together. DoH, Belfast.

DeSilva D. (2014) *Helping Measure Person-centred Care: A Review of Evidence about Commonly Used Approaches and Tools Used to Help Measure Person-centred* Care. London: The Health Foundation.

Dewing, J. (2004) Concerns relating to the application of frameworks to promote person-centredness in nursing with older people. *International Journal of Older People Nursing*. 13(3a): 39–44

Dewing J, (2010) Moments of movement: Active Learning and practice development, *Nurse education in Practice,* 10: 22–26

Dewing J & McCormack B (2016) Editorial: Tell me, how do you define person-centredness. *Journal of Clinical Nursing*, 26: 2509-2510.

Dewing J, McCormack B and Titchen A (2014) *Practice Development Workbook for Nursing, Health and Social Care Teams,* Wiley-Blackwell Publishing, Oxford.

Edvardsson D, Fetherstonhaugh D & Nay R (2010) Promoting a continuation of self and normality: person-centred care as described by people with dementia, their family members and aged care staff. *Journal of Clinical Nursing*, 19: 2611-2618.

Fay B, (1987) *Critical Social Science: Liberation and its Limits.* Cornell University Press, New York

Gaffney M, (2011) *Flourishing.* Dublin, Penguin.

Heron J. (1992) *Feeling and Personhood*. Sage Publications, London.

Kitson A, Rycroft-Malone J, Harvey G, McCormack B, Seers K & Titchen A (2008) Evaluating the successful implementation of evidence into practice using the PARIHS framework: theoretical and practical challenges *Implementation Science* 3:1 Doi:10.1186/1748-5908-3-1

Lynch BM, McCance T, McCormack B & Brown D (2018) The development of the Person-Centred Situational Leadership Framework: Revealing the being of person-centredness in nursing homes. *Journal of Clinical Nursing*, 27(1-2):427-440.

Leadership Alliance for the Caring for People at the End of Life (2014) One Chance to Get It Right: Improving peoples' experience of care in the last few days and hours of life. Retrieved from

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf (Last accessed on 1st October 2018)

Manley K, Sanders K, Cardiff S and Webster J. (2011) Effective workplace culture: the attributes, enabling factors and consequences of a new concept, *International Practice Development Journal,* Vol 1, Issue 2, Article 1 https://www.fons.org/library/journal/volume1-issue2/article1

Marie Curie (2015) *The Clinical Workforce Strategy, Learn and Develop Strategy and People Strategy.* London: Marie Curie Retrieved from https://www.mariecurie.org.uk/globalassets/media/documents/who-we-are/strategicplanbooklet2014-19_full.pdf (Last accessed on 1st October 2018)

McCance, T.V (2003) Caring in nursing practice: the development of a conceptual framework. *Research and Theory for Nursing Practice: An International Journa*l 17(2): 101-116.

McCance T, Gribben B, McCormack B and Laird EA (2013) Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme, *International Practice development Journal,* 3 (1) http://www.fons.org/library/journal/volume3-issue1/article2

McCance, T, McCormack, B & Dewing, J (2011) An exploration of person-centredness in practice. *Online Journal of Issues in Nursing*, 16(2): manuscript 1.

McCormack B (2001) *Negotiating Partnerships with Older People - A Person-Centred Approach.* Ashgate, Basingstoke

McCormack B (2003) A conceptual framework for person-centred practice with older people. *International Journal of Nursing Practice*; 9:202-209

McCormack, B. (2004). Person-centredness in gerontological nursing: an overview of the literature. *Journal of Clinical Nursing*, 13(3A), 31-38.

McCormack B and McCance T (2017) *Person-centred Nursing and Health Care – Theory and Practice,* Wiley Publishing, Oxford

McCormack B & McCance T (2016) United Kingdom: The Person-centred Nursing Model. In Fitzpatrick JJ & Whall AL. *Conceptual Models of Nursing: Global Perspectives*, 5th Edition, p118-131.Boston, Pearson.

McCormack B and McCance T (2010) *Person-centred Nursing: Theory, models and methods.* Blackwell Publishing, Oxford.

McCormack, B., & McCance, T. V. (2006). The Person Centred Nursing Conceptual Framework. Journal of Clinical Nursing.

McCormack B, Borg M, Cardiff S, Dewing J, Jacobs, G Titchen A, van Lieshout F and Wilson V (2017) A Kaleidoscope of Hope: exploring experiences of hope among service users, families and practitioners in various health care contexts. *Holistic Nursing,* 35(3): 247-258

McCormack B, Borg M, Cardiff S, Dewing J, Jacobs G, Janes N, Karlsson B, McCance T, Mekki TE, Porock D, vanLieshout F and Wilson V (2015) Person-centredness – the 'state' of

the art, *International Practice Development Journal* http://www.fons.org/library/journal/volume5-person-centredness-suppl/article1

McCormack B and Titchen A (2014) No beginning, no end: an ecology of human flourishing, *International Practice Development Journal,* 4(2): paper 2 http://www.fons.org/library/journal/volume4-issue2/article2

McCormack B, Titchen A and Manley K (2013) The Contextual Web of Practice Development In B McCormack, K Manley and A Titchen (2013) *Practice Development in Nursing (Vol 2).* Wiley-Blackwell Publishing, Oxford. Pp: 275-295

McCormack B, Karlsson B , Dewing J & Lerdal A (2010a) Exploring person-centredness: a qualitative meta-synthesis of four studies. *Scandinavioan Journal of Caring Sciences*, 24: 620-634.

McCormack B, Dewing J, Breslin L, Tobin C, Manning M, Coyne-Nevin A, Kennedy K and Peelo-Kilroe L (2010b) *The Implementation of a Model of Person-Centred Practice in Older Person Settings*. Final Report, Office of the Nursing Services Director, Health Services Executive, Dublin, Ireland

McCormack B, Henderson E, Wilson V and Wright J (2009) The Workplace Culture Critical Analysis Tool, *Practice Development in Healthcare*, 8(1): 28-43

McCormack B and Titchen A (2007) Critical Creativity: Melding, Exploding, Blending, in, J Higgs, A Titchen, D Horsfall and H Armstrong (2007) *Being Critical and Creative in Qualitative Research,* Hampden Press, Sydney.

McCormack B, van Dulmen S, Eide H, Skovdahl K & Eide T (2017) *Person-centred Healthcare Research*. Wiley Blackwell, Oxford.

McMillan Cancer Support (2015) Achieving World Class Cancer Outcomes: A strategy for England – 2015-2020 Retrieved from: https://www.cancerresearchuk.org/sites/default/files/achieving_world-class_cancer_outcomes_-_a_strategy_for_england_2015-2020.pdf (Last accessed on 1st October 2018)

Merleau-Ponty, M. (1989) *Phenomenology of Perception* (translation by C. Smith with revisions by F. Williams and D. Gurriere). London, Routledge.

National Palliative and End of Life Care Partnership (2015) Ambitions for Palliative and End of Life Care: A national framework for local action 2015– 2020 Retrieved from: http://endoflifecareambitions.org.uk/wp-content/uploads/2015/09/Ambitions-for-Palliative-and-End-of-Life-Care.pdf (Last accessed on 1st October 2018)

Rogers C. (1980) *A Way of Being*. Houghton Mifflin, New York.

Røsvik J, Kirkevold M, Engedal K, Brooker D, Kirkevold Ø (2011) A model for using the VIPS framework for person-centred care for persons with dementia in nursing homes: a qualitative evaluative study. *International Journal of older People Nursing*, 6(3): 227-36.

Rycroft-Malone J; Burton C; Wilkinson J; Harvey G; McCormack B; Baker R; Dopson S; Graham I; Staniszewska S; Thompson C; Ariss S; Melville-Richards L and Williams L (2016) Collective action for implementation: a realist evaluation of organisational collaboration in healthcare, *Implementation Science* https://implementationscience.biomedcentral.com/articles/10.1186/s13012-016-0380-z

Slater, L. (2006) Person-centredness: A concept analysis. *Contemporary Nurse*, 23: 135-144.

Titchen A, McCormack B, Wilson V and Solman A (2011) Human Flourishing through body, creative imagination and reflection, *International Practice Development Journal* *http://www.fons.org/library/journal/volume1-issue1:* Article 1

van der Eerden M, Csikos A, Busa C, Hughes S, Radbruch L, Menten J, Hasselaar J, Groot M (2014) Experiences of patients, family and professional caregivers with Integrated Palliative Care in Europe: protocol for an international multicenter, prospective, mixed method study. BMC Palliat Care. 21;13(1):52. doi: 10.1186/1472-684X-13-52. eCollection 2014.

Warfield, C. and Manley,K. (1990) Developing a new philosophy in the NDU. *Nursing Standard,* 4(41): 27---30.

World Health Organisaiton (2015) *Global strategy on people-centred and integrated health services*. WHO, Geneva.

Yalden, J., McCormack, B., O'Connor, M. and Hardy, S. (2013) Transforming end of life care using practice development: an arts-informed approach in residential aged care, *International Journal of Practice Development,* 3 (2): 1-18 http://www.fons.org/library/journal.aspx