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*Understanding and achieving person-centred care in an acute medical ward setting.*

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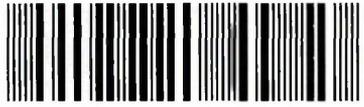
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# **Understanding and Achieving Person-Centred Care in an Acute Medical Ward Setting**

**Helen Ross**

**A doctoral project report submitted in partial fulfilment of the  
requirements of Sheffield Hallam University for the degree of  
Doctor of Professional Studies**

**September 2015**

**This doctoral project report is dedicated to the loving memory of my Mum and Dad, Joan and John Ross, who always taught me to follow my heart.**

**Thank you.**

**It is also dedicated to the memory of my beautiful old Labrador, Harry, who sat faithfully with me throughout the many months of writing this report.**

## Acknowledgements

This work would not have been possible without the consistent support of my supervisory team, Professor Angela Tod, Professor Amanda Clarke and latterly, Doctor Nicola Clibbens. Thank you for your unwavering belief in my ability to complete this research and for sharing your experience and expertise.

Throughout the research the enthusiasm and commitment of all the people taking part in the study has been amazing. This work is testimony to your motivation and compassion to provide the best care possible for the people in your care. Thank you for sharing your experiences with me and taking time to be part of this research. I couldn't have done it without you (literally).

I have also been supported both formally and informally by colleagues in the Local University and NHS Foundation Trust. On a day to day basis, I could not have completed this research without the faith my work friends have had in my abilities. Thanks are due specifically to Linda Jackson, Valerie Hales, Doctor Sam Debbage, Doctor Judy Redman and Doctor Peter Allmark, who at one time or another have all acted as a critical friend (and more) and given me the space and time to complete this work.

Finally, and by no means least, thank you to my wonderful family and friends who have travelled along with me through the ups and downs again, always having faith in what I was trying to achieve.

Thank you to Steve, Maria, Jack and Lyndon for being loving, patient and understanding.

To all my friends who have been there for me, thank you and now we can go out for lunch again!

*'But what's more important than valuing patients? Because you can do as many technical things and tick off as many boxes as possible but if people are unhappy and not cared for correctly as people. You know, we call them patients but they're people! If that isn't right then how could anything else be right?' (Kath - Nursing Lecturer).*

# Understanding and Achieving Person-Centred Care in an Acute Medical Ward Setting

## Abstract

Person-centred care is a concept often referred to in healthcare. However, it is unclear how it applies to everyday clinical practice. This qualitative study aimed to explore how the concept was understood and achieved in an acute medical ward setting in order to identify potential areas for development related to research, education and practice. The research design was influenced by an interpretive approach with the aim of accessing the meanings that participants assigned to the phenomenon of person-centred care and making this evident to others. A purposive sampling strategy identified 21 participants. These consisted of seven registered nurses, four student nurses, three healthcare support workers, three allied health professionals, two professional development co-ordinators and two nursing lecturers, who all took part in either individual or paired semi-structured interviews. Gathering data from this range of practitioners adds new perspectives to the body of knowledge on person-centred care.

Data were analysed using Framework Analysis, which resulted in a model of person-centred care being developed iteratively as a result of data analysis, *a priori* knowledge of the researcher and the findings of the literature review. The study findings emphasise that all elements of the model; organisational culture, the philosophy of the care environment, characteristics of relationships, personal qualities of staff and principles of person-centred care interlink with each other to indicate what needs to be in place for person-centred care to be achieved. The model also provides a possible structure to inform the planning of future development within education and practice.

The study outcomes identify potential areas for development within research, education and practice. These include, working towards a shared vision of person-centred care in the study setting by using work based activities in order to identify ongoing development needs; the testing and evaluation of the use of the model of person-centred care in practice and education and the investigation of the feasibility of conducting a health economic study to explore the cost-benefit of providing person-centred care in acute care settings.

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## **Chapter 1 - Introduction to the doctoral project report**

This introduction is designed first to give an introduction to the rationale for the study and, secondly, to enable the reader to gain an understanding of the Doctorate in Professional Studies (Health and Social Care) at Sheffield Hallam University (DProf).

### **Introduction to the study**

This doctoral project report presents the findings of a study which to explore how person-centred care was understood and achieved in an acute medical ward, primarily from the perspective of nurses and allied health professionals. Insights and examples of good practice were gathered from participants to explore and promote person-centred care in an acute medical ward in order to identify future requirements for education and practice.

During the first stage of the study the aim was to explore how person-centred care is understood and achieved on an acute medical ward from the nurses' perspective. The second stage of the study compared the nurses' perceptions to those of allied health professionals working in the same setting. The data were analysed using Framework Analysis (Ritchie and Spencer 1994), which led to the development of a model of person-centred care. The final stage of the study was to present the model to experienced nurses working in practice and professional development and higher education in order to combine their perception of the future education and practice development needs with those of the nurses and allied health professionals in the study.

The outcome of the study was to identify areas for development within research, education and practice with the aim of providing a more consistent approach to person-centred care. Whilst the focus of the study is person-centred care it must also be acknowledged how the doctoral process, personal beliefs and relationships within the study setting have had an impact upon the research process and interpretation of the findings. Therefore the next section of the introduction will set the research in context with the research training undertaken as part of the doctorate in professional studies.

### **The Doctorate in Professional Studies**

The DProf is delivered over a 4 year period with each doctoral student having up to a maximum of 7 years to fully complete their studies. The first year of the DProf is a taught programme containing two modules - 'Review of Learning and Professional Experience' and 'Research for the Working World'. The initial module is designed to encourage the student to critically reflect on their personal and professional experiences, and consider their readiness for studying at level 8. The second module builds on this by helping students develop an understanding of research approaches and processes which form the theoretical basis for the research activity to be undertaken as part of the programme. The module also seeks to prepare students for the reality of research in demanding and ever changing work environments. Each module is assessed by a 6,000 word assignment which requires critical analysis, underpinned by epistemological, ethical and philosophical discussions. The second year of the DProf focuses on project planning with the aim of supporting

students to develop, justify and submit an 8,000 word research proposal to the University Research Degree Sub Committee. Students must also deliver an oral presentation in support of their proposed research project. This is assessed by a rapporteur and feedback on the student's performance is taken into account when the Research Degree Sub Committee evaluates the suitability of the research proposal.

The project planning module also requires doctoral students to obtain approval from the appropriate ethics committees for the study to proceed. Upon successful completion of this module, the student moves into the research phase of the programme.

The final stage of the DProf has four components in its assessment:

1. Submission of a critically reflective account of the personal and professional learning during the whole doctoral programme (8,000 words).
2. The production of a publishable paper - see Appendix 1 (Ross, Tod and Clarke 2014).
3. The production of a doctoral project report of 50,000 words.
4. Successful defence of the study in an oral examination.

These assessments focus on the impact the work undertaken has had on practice innovation, and the actual or potential of the study outcomes to influence change in the researcher's area of practice (Sheffield Hallam University 2004).

## **What makes person-centred care important to me?**

Person-centred care is a concept often referred to in health care and may have different meanings to different people (Goodrich and Cornwell 2008, Goodrich 2009). This position is explained in more depth at the beginning of the literature review in Chapter 2.

In order to clarify my own views and thoughts about person-centred care, this section of the introduction provides the personal context which influenced the research study presented here. As a foundation for this study the following personal definition of person-centred care will be used: Person-centred care relates to appreciating each person as an individual with his or her own values and beliefs. It involves upholding productive relationships by working in a collaborative, respectful, open and encouraging manner in order to promote high quality care.

Person-centredness has been central to my professional practice as a nurse for the past 38 years and this principle remains fundamental to my current role as a lecturer in nursing. From a personal perspective; the role of the nurse in supporting people throughout their life span during health, illness and ultimately death is one of the most privileged positions to be in. The potential impact nurses (or other health care practitioners) can have on another human being's quality of life is often powerful and untold. I have been witness to this in both my professional role and from personal experience of being a patient, relative and friend of people receiving healthcare. In some cases the experiences have caused me to challenge my own thoughts about caring, compassion and human relationships in healthcare.

Having a strong sense of self has made me aware of the potential significance of personal identity and respect for personal values for other people. An awareness of the unique nature of the person emerged in 1982 when I was working as a staff nurse on a medical ward. I was caring for the headmaster of my secondary school and became embarrassed by the way I spoke to him. When explaining his proposed care I realised that I sounded condescending. This made me stop and think about the way I communicated with everyone else in my care; if it was unacceptable to speak to my headmaster in this way then it was unacceptable to speak to anyone in this manner. This has had a profound and positive effect upon my personal and professional approach to communication with others.

It must be acknowledged that my personal values have influenced my nursing practice and ultimately the approach taken in this research study. One could also argue that nurses' personal beliefs may be influenced by their experiences of caring for others. An example of this influence in my personal life is the act of preparing Advanced Directives in preparation for a situation where I may be unable to make my wishes known to those who may need to make decisions about my care. However, it is important to realise that everyone is different and to appreciate that not everyone will have the same motivation or the opportunity to prepare such directives. Such decisions in my personal life are inextricably linked to my experiences as a nurse and link closely to my beliefs about the value of person-centredness. The beliefs and values I hold about personal identity have to be recognised as a strong driving force for my eagerness to study person-centred care. This strength of feeling, together with the experiences within the DProf programme needs to be recognised as instrumental in directing the research study.

## **Impact of the Doctorate in Professional studies**

When I began my journey within the DProf I was encouraged to explore my past learning in depth. This was designed not only to develop critical thinking, but to acknowledge how past experiences had shaped personal and professional learning. Recalling early experiences of caring was challenging and sometimes emotionally upsetting. This raised questions for me about how caring, knowledge and skills are developed. Reflecting upon experiences of care contextualised my past learning and allowed me to consider how these experiences have influenced my persona and the aspirations I had for my doctoral study.

One of the most memorable sessions in the DProf programme centred on sharing a seminal moment that we perceived had shaped our personal and professional learning. My reflection was entitled 'Where is the person?' It recounted the experience of caring for a woman who had been admitted with advanced cancer. She did not want to be in hospital. As a nursing team we battled against all odds to get her back home to her remote farmhouse in order for her wish to die at home to be met (Appendix 2). This incident had an intense impact upon my way of being as a nurse and will always remind me of the centrality of the person in care. Although my research ideas were in their infancy when this session took place the feelings this activity provoked, continued to be a strong influence in determining the direction of my research.

## **Making the study a reality**

My interest in exploring person-centred care was stimulated further when, as the Link Lecturer in the study setting, I became involved in discussions with student nurses and registered nurses about the significance of rehabilitation nursing and, in particular, person-centred care. The discussions were initiated following a series of occasions when student nurses had questioned the value of having a long placement (between 8 and 10 weeks) on the stroke rehabilitation unit. The rationale for their questions seemed to centre upon them contrasting their experiences with those of other student nurses who were on placement in extremely acute care settings such as the Accident and Emergency department (A&E). During the informal conversations with student nurses various aspects of nursing care were discussed and, in particular, the learning opportunities available within the clinical placement related to person-centred care.

One memorable discussion with a ward sister focused upon the care of a man who had been admitted to the ward following a stroke and was resisting the help offered to him by the nurses. We considered whether understanding more about the man's life and interests might aid nurses (including student nurses) to care for him in a more beneficial manner. It was also questioned whether meeting his needs more effectively would in turn, have a positive impact on nurses' sense of fulfilment in their work and enhance their understanding of the value of person-centred care. These uncertainties about care delivery resonated with my experiences as a nurse and a nursing lecturer. Following the discussion I began reviewing some of the published literature in order to ascertain current perceptions in health care practice around person-centred care.

This helped establish the need for the proposed study and allowed me to return to the ward for more informed discussions with nurses in order to form the foundation for the research proposal.

When considering the possibility of the research study I spent time talking to nurses on the stroke rehabilitation unit, the ward sisters, specialist nurses, a nurse consultant, matron and the director of nursing for the medical unit about their feelings of undertaking the study to ensure the proposed study was also seen as being worthwhile from their perspective. This engagement was vital to affirm my role as a research collaborator who was genuinely interested in the subjective experiences of the nurses and allied health professionals working on the ward (Mearns and McLeod 1984). This approach was crucial to ensure the research developed as a collaborative study and the participants felt actively engaged in the research, as opposed to having research 'done' on them. The combination of personal experiences and discussions within the study setting indicated the need for a more in-depth review of the literature. This was designed to set the scene for the study and provide the theoretical context for the work.

In order to contextualise the findings presented here, it is important to recognise that the study occurred at a time of uncertainty for the ward team due to reconfiguration of services. Despite these difficulties, the participants continued to be motivated to share their thoughts and feelings within the study. This emphasises their commitment to the provision of person-centred care.

The unpredictable nature of healthcare has to be recognised when conducting research in the working world. It is likely that participants have competing demands, requiring the researcher to be flexible and work in an supportive manner within the ever changing climate of healthcare practice.

**Please note the following points:**

1. Throughout the doctoral project report the person in receipt of care is referred to as a patient. On first reading, this may appear to contradict the term person-centred care, as it may be seen as objectifying the person. The rationale for using the term 'patient' is that the participants used the term patient and it continues to be the term used to denote a person who is in hospital, particularly in acute care settings.
2. For the purpose of this study the term 'nurses' included registered nurses, student nurses and unqualified health care support workers.

## **Chapter 2 - The Literature review**

### **Introduction**

The aim of this chapter is to present the process and findings from a review of the literature. The literature review includes literature which provides insight into the underpinning theories related to the development of the concept of person-centred care. It also includes national policy and guidelines as well as primary research studies on person-centred care and related concepts in order to provide context and background to the study (Grant and Booth 2009). The review outlines a historical perspective within the literature and considers the ongoing development of person-centred care with specific emphasis on healthcare and nursing. It is worth noting that there is a wide range of literature available that refers to certain aspects of care for example; spirituality or interpersonal skills, which will have an impact upon person-centred care. However for the purpose of this literature review the search was focused on literature which is explicitly about person-centred care and/or practice.

The literature review objectives were to:

- Review and report the background and development of person-centred care in healthcare and nursing.
- Critically review the quality of primary research on the topic of the research report.
- Identify emerging themes from the primary research reviewed.
- Use the findings of the review to inform the present study.

## **Searching the literature**

In order to prepare for the review several databases were accessed:

Cumulative Index for Nursing and Allied Health Professionals (CINAHL Plus with full Text), MEDLINE, Psych Info and PubMed Central (search strategy and matrix are shown in Appendix 16).

The initial literature review was conducted in the early stages of the research study. Therefore, for completeness literature published after February 2012 is presented as part of the Discussion Chapter (Chapter 5) in order to ensure the study findings remain contemporaneous. All databases were searched using the search terms person-centred (to include patient-centred) covering the time period January 2000 – February 2012. In CINAHL Plus and MEDLINE this identified 651 papers. A further search was performed combining the search terms person-centred (to include American spelling and patient-centred) and care, this identified 542 papers. By adding in the term hospital this reduced the number to 47. A separate search was performed using the terms person-centred and practice and this identified 198 papers. In total the papers reviewed in this initial stage were 245.

In addition, Pych Info identified 529 papers when using only the term person-centred (to include patient-centred). When 'in hospital' was added this reduced to 99 papers which were reviewed and a further 9 papers were added. Repeating this process in Pub Med Central added 11 papers to give a total now of 67 papers to review in-depth. Furthermore, incremental searching was used by following up the references from key papers.

It was decided to present the literature review chronologically, which comprised of initially reviewing seminal work to outline the core theoretical principles underpinning person-centred care. In addition to reviewing the core principles more contemporary papers were included, this covered literature which reported on research, education, clinical practice and health care quality and policy. This approach was designed to set the scene for the study and provide a context for the work, rather than to present a systematic review of the literature.

Following the search the papers were reviewed and a total 21 contemporary papers which reported on research, education, clinical practice and health care quality and policy were included in the final literature review. These were also supported by key theoretical texts and relevant policy and guidelines.

### **Defining person-centred care and related concepts in healthcare**

When considering the term person-centred care it is clear that several terms are used synonymously in healthcare literature and policies, these are explained briefly below in order to begin to understand some of the definitions:

- **Person-centred care or practice:** often used when describing the care of older people (often in residential care settings) and people with dementia. (Kitwood 1997, Ford and McCormack 2000, Nolan et al. 2002, 2004, Thompson 2004, McCormack and McCance 2010, Ruddick 2010).
- **Patient-centred care:** commonly used within hospital settings along with the term Individualised care (Pelzang 2010)
- **Person-centred planning:** this term was introduced in the Valuing People Strategy (Department of Health (DH) (England)

2001) for people with learning disabilities. This was designed to fit services around people rather than the other way around.

- **Person-centred support:** some service user groups use this term to describe personalisation, which is aimed at the service user having some choice and control over the assistance and/or equipment needed to go about their daily lives; such as having equal access to housing or transport (Office for Disability Issues, 2008).

Using interchangeable terms may lead to misunderstanding and a mismatch of expectations related to person-centred care between healthcare professionals and service users.

In order to enhance understanding of the term, The King's Fund Point of Care programme explored the wide range of terminology used to describe patient-centred care (Goodrich 2009). Data were collected using a combination of focus groups along with paired and single in-depth interviews. The sample consisted of 30 staff from a mix of professional groups. Participants were asked to define good care, most struggled with the concept and conclusions were drawn that good care was not an abstract concept – it was either an attitude or a narrative and not often discussed at work. The next phase of the study was to explore reactions to the following words or phrases written on prompt cards:

- Basic care
- Person-centred care
- Patient-centred care
- Personalised care
- Dignity and Respect
- Humanity
- Customer care

*'Without exception all the words and phrases on the prompt cards provoked either mixed or negative reactions'* (Goodrich 2009, page 16). Most participants felt some of these words were not easy to understand and they preferred words which were seen as more commonplace or "human". The words they suggested included respect, dignity, sensitive, friendly, comfort, smile, compassion and communication. One phrase that resonated positively with all participants was 'seeing the person in the patient' as participants could understand what that meant to all parties. The findings in this study suggest that the language of research and policy does not translate well into the everyday language used by healthcare professionals and support staff in hospitals. An important recommendation from this study was that the use of academic or technical language should be avoided, or where it is necessary the meaning should be clearly explained, in order to engage staff at all levels within healthcare (Goodrich 2009).

### **The core theoretical principles underpinning person-centred care**

As far back as the 1800s the role of the nurse was conveyed as being focused on the patient rather than the illness. Florence Nightingale noted that emotional wellbeing was as important as meeting the physical needs of the patient (Nightingale 1860 - unabridged republication, 1969). Almost one hundred years later, disciplines, such as psychotherapy regarded person-centred approaches as crucial to building therapeutic relationships with the client. Carl Rogers introduced the idea of being person-centred in the 1940s. For Rogers, client-centred therapy recognises that each person possesses qualities that he or she can draw strength from. This allows the individual to work through solutions to his or her problems, providing that they are facilitated to achieve this in a

positive environment. Facilitating client-centred therapy requires the therapist to enter into the client's world and relate to them on a personal level during therapy.

Being appreciated as a person in therapy is achieved by developing a professional relationship, built on respect, acceptance, genuineness and empathy (Rogers 1961). However some may see these elements of therapy as too simplistic, advocating that the interaction between the client and the professional should go further by promoting reciprocity. For example Martin Buber suggests there is an additional need for confirmation of the person not only from a professional stance, but on a personal level by relating to each other on an equal level as revealed in the dialogue between Martin Buber and Carl Rogers in 1957 (Anderson and Cissna 1997). Buber suggests that humans know they exist as persons only as one is known by the other. This perception is directly affected by authentic and positive relationships which go beyond respect and unconditional positive regard, by being transparent, with nothing hidden (Smith 1958). This challenged Roger's theory of client-centred therapy by stating that a relationship between a professional and client can never be truly reciprocal because of the very fact they are in a professional relationship where the balance of power remains unequal. Nonetheless, theories such as Rogers' client-centred therapy that originate from existential philosophy and psychology continue to influence current approaches to nursing and other caring professions. As a result of such philosophies there has been a gradual shift from a medical model of care, based on a scientific approach; to a more subjective view of care delivery placing value on the experiences and choices of

the person being cared for rather than those of the carer (Pelzang 2010, Ruddick 2010).

During the 1950s as the notion of client-centred care was being developed, it was also recognised that the relationships between nurse and patient should have a therapeutic effect and be built upon high quality interpersonal skills (Peplau 1952). Peplau developed the theory of interpersonal relations which provides a framework for understanding the patient experience in psychiatric nursing (Peplau 1997). She refers to the art and science of nursing and ascribes values such as compassion, concern and advocacy to the artistic component of nursing. Peplau developed the theory largely from the study of human interactions. She talks of the need for connectedness with the patient and their family. In common with Buber (Smith 1958) she recognises that *'people define other person's directly and unwittingly...'* (Peplau 1997, page 166). Therefore the manner in which the nurse behaves towards the patient will have a direct impact upon the self-worth of the patient. This reiterates the value of therapeutic relationships, which promote connectedness and, consequently, person-centred care. For Peplau, a key component of being person-centred is the switch in focus from the care giver to the person being cared for, however, by using the term patient some would argue the power still lies with the care giver (Slater 2006).

Humanistic approaches to care have also been championed by other nursing theorists; Jean Watson developed her theory of caring in the 1960s and defines the person as a 'being in the world'. The concept of 'being' encompasses mind, body, and spirit. Each element of the person is influenced by their self-concept.

Watson considers nurses must pay attention to each aspect of the person in order for meaningful care to take place. In addition she expresses the need for nurses to care about themselves as an antecedent to them being able to care effectively for others (Watson 1985). Watson's theory has three elements: the carative factors, the transpersonal caring relationship and the caring occasion/moment.

Watson uses the term 'carative' to describe the humanistic aspect of nursing as opposed to the curative stance taken in medicine. She describes a transpersonal caring relationship as being a mutually beneficial relationship which promotes respect and dignity. Watson describes the caring occasion or moment as being where the cared for and the care giver (nurse) come together to share the experience. Therefore the caring occasion or moment becomes 'transpersonal' when *'it conveys a concern for the inner life world and subjective meaning of another...'* (Watson 2008, page 79). Once more the concepts of reciprocity and authenticity are perceived as essential to the caring relationship. The caring moment links back to the work of Rogers when he refers to *'the effective moment'* in a therapeutic relationship (Anderson and Cissna 1997, page 29). This occurs through an open and honest approach to care, including a shift from task orientated work to truly seeing the person; rather than nurses possessing a purely functional view of care needs.

Watson refers back to Florence Nightingale's concept that the environment has a direct impact upon the patient's wellbeing (Watson 1999). Here the concept of environment goes beyond the physical and includes human elements, such as attitudes, relationships and recognition of humanity (Watson 2010). All of these

concepts have an impact upon the way nurses view and respond to the needs of the person in their care.

The work of Kitwood (1997) was also significant in raising awareness about the impact of person-centred care approaches. He was one of the first authors to describe personhood in relation to dementia care and defines it as:

*'...a standing or status that is bestowed upon one human being by others, in the context of relationship and social being. It implies recognition, respect and trust.'*

(Kitwood 1997, page 8)

He goes on to ask questions about who is viewed as a person and what that means in terms of the way a person is treated by others. Kitwood's (1997) work provides a theoretical underpinning for dementia care and his legacy remains evident by continuing to influence current dementia care (Brooker 2007, Edvardsson et al. 2008, Kirkley et al. 2011). He places an emphasis on how maximising wellbeing in the person living with dementia can have a positive impact on their care. Maintaining individual uniqueness is central to this belief and requires carers to look at the whole of the person's life not just the dementia to achieve this.

Kitwood (1997) also explored the care culture and how this may have an effect upon the care delivered. He applies the term Malignant Social Psychology (MSP), which has its roots in the way society perceive people who have dementia. MSP is presented as episodes within care that undermine personhood, whereby people are: ignored, intimidated, infantilised, disempowered, overpowered or objectified, although it is emphasised that this is rarely done with malevolence (Kitwood 1997). The culture of the care

environment will influence these malignant elements of care (Kitwood 1997). He concludes that short training sessions can often sensitise staff in formal care settings to the presence of MSP. However the most persistent and difficult behaviour to modify is 'talking about a person in their presence', which is a form of ignoring the person. This has also been recognised in more recent studies of dementia care (Adams and Gardiner 2007). These observations are also relevant to research in acute care settings, as shown in the next section of the review.

### **Using measurements of patient satisfaction to identify the quality of person-centred care**

Since 2002 it has been the responsibility of the Care Quality Commission (CQC) to monitor staff and patient satisfaction surveys in the UK (Coulter, Fitzpatrick and Cornwell 2009). Prior to the CQC taking on this role, individual organisations had conducted patient satisfaction surveys to gauge the quality of care. One such survey investigated patient dissatisfaction and, as a result of the responses, the author formed the concept of 'personal identity threat' (Coyle 1999). This concept was used as a basis for further research, designed to explore the concept in more depth by investigating the frequency and distribution of inpatient experiences of 'personal identity threat' (Coyle and Williams 2001). The research used a cross-sectional survey design. The findings revealed that when patients felt that their personal identity was undermined, as it made them feel dehumanised, objectified, stereotyped, devalued or disempowered. There were differences in responses between men and women, with women being more critical of the care they received. There was a suggestion that this was because women had a higher expectation of

care delivery since they were often informal carers. There were also positive responses about doctors and nurses, who were generally perceived by the respondents as being approachable.

A questionnaire was distributed to two hundred and twenty five patients upon their discharge from three general wards in a hospital in Scotland. Ninety seven patients responded (43%); leaving 57% non-responders. Coyle and Williams (2001) attempt to dispel concerns about the effect the low response rate may have had on their findings by referring to previous large scale surveys (Lasek et al. 1997), which claimed non-respondents had little impact upon their study findings. Nevertheless the possible reasons for not responding to the survey need to be considered when reporting findings of research studies. For example these patients may have chosen not to respond because they were unsure of the repercussions of their answers, should they be re-admitted to the hospital ward. The questionnaire used a five point Likert scale to ask about positive and negative representations of personal identity. Using a Likert scale generates non-parametric data which has no exact measurement between the points on the scale (LaMarca 2011). Therefore the rich interpretation and meaning cannot be drawn from the responses. Given the focus of the study was on people's experiences of a specific phenomenon, more meaningful outcomes could have been gained from the study if it had included qualitative methods to explore the reasons for the responses. Nonetheless the findings suggest improvements need to be considered in the following areas:

- Involvement in care
- Information giving
- Staff sensitivity to the impact of illness and treatment on patient's life
- Approachability & availability of staff

The concerns about approachability and availability of staff originated from patients not wanting to disturb nurses who looked busy. Possible solutions gained from previous research are referred to in the recommendations; for example a suggestion that when nurses spend five minutes with patients at the bedside (to discuss care), it has a positive impact upon patient satisfaction (Dingman et al. 1999).

Although the concept of spending short bedside checks was presented during the 1990's, it links readily with the more recent initiative of intentional rounding. This structured way of carrying out and recording regular checks on individual patients is advocated by the King's Fund Point of Care programme to ensure patients' essential care needs are met (Fitzsimons, Bartley and Cornwell 2011). In addition to being linked with reducing harm to patients, such as pressure ulcers and falls, there are reports that this type of regular interaction between nurses and patients can reduce anxiety and improve the care experience for patients and staff (Meade, Bursell and Ketelson 2006). Some within the nursing profession may raise objections to intentional rounding, seeing it as a tool which reduces nurse-patient interaction to a task orientated, tick box approach (Hunt 2012). However it is expected that the skilled nurse will recognise the need for using intentional rounding as an adjunct to competent and compassionate person-centred care (Fitzsimons, Bartley and Cornwell 2011).

## **Strengthening the body of work on person-centredness**

How a patient is treated as a person is vital to their perception of the quality of their care experience. This connection has been recognised by many working in healthcare, nevertheless until the last decade there were few empirical studies which explored the impact of person-centred care on care quality and outcomes. In order to address this shortfall, McCormack and colleagues have conducted a series of rigorous research and practice development studies since the early 2000s. As a foundation for this now substantial and growing body of work, McCormack (2001a) explored the meaning of autonomy for older people in a hospital setting. The research was directed by a hermeneutic philosophical approach. Hermeneutics is recognised as a way of interpreting and interacting with qualitative data in order to gain an understanding of the world from the participant's view and to examine underlying (or unspoken) narratives. (Wiklund, Lindholm and Lindstrom. 2002).

Initially, McCormack (2001a) used conversational analysis to analyse the data generated from 14 case studies of nurse-patient interactions. The study highlighted that the way professionals communicate and interact with the person, their family and carers has an effect upon their ability to remain autonomous in decision making. The findings relate to issues of power, control, access to information and professional authority. Some of the conversations analysed indicated that the nurses or other professional had a predetermined agenda, thereby holding power and control over the outcome of the conversations, particularly related to decision making. The impact of conversations were not viewed in isolation; other aspects of care were also identified as negatively affecting autonomy, such as the organisation of care,

fixed care routines together with the prevention of reasonable risk taking (McCormack 2001b).

The findings from McCormack's (2001a) study were used to develop a conceptual framework to overcome the theory-practice gap and promote a person-centred approach to nursing practice, when caring for older people (McCormack 2003). Central to the framework is the concept of '*authenticity*', where decisions are based upon the personal beliefs and values of the person receiving care; as opposed to the dominance of traditional ways of working. Developing '*authentic consciousness*' as described by McCormack builds upon the earlier work of Rogers (1961) and Watson (1985) by recognising the importance of the nurse connecting with the person's way of '*being in the world*'. Respect for people is essential to the concept and is described as '*mutual respect*' and '*sympathetic benevolence*'. Other crucial elements include listening to the person and entering their world in a genuine manner. This involves respecting an individual's rights, using the perspective of the person and creating a positive social environment, which is seen as promoting wellbeing for all. One of the key messages from this work is that person-centredness goes beyond individualised care. It requires the carer to display such characteristics as compassion, concern and respect for the person. This awareness promotes partnership working based on a '*negotiated relationship*' with the older person which is seen as paramount to facilitating person-centred practice.

The outcome of the study was not only to develop the framework as a theory, but to consider how this can then be realised in everyday practice. The paper presents 29 principles for action with the aim of nurses being able to utilise

these to challenge and guide their approach to care (McCormack 2003). The use of research findings to influence practice is a productive outcome and encourages nurses to use evidence to support the delivery of person-centred care. However nurses may be deterred from using ideas within the paper initially, as the language used such as '*authentic consciousness*' requires the reader to interpret the terms and relate them to their practice setting. The use of unfamiliar terms in the literature can initially form a barrier for nurses in practice, as they may perceive that to gain an understanding of the theoretical concepts is too time consuming in their already busy work schedules.

Between 2000 and 2006 several concepts developed simultaneously based on the findings of qualitative research studies related to person-centred care, relationship centred care and caring in nursing practice. One of these studies, conducted by McCance (2003) was aimed at developing a conceptual framework for caring in practice. The framework is based on the findings of a qualitative research study which explored the patients' experience of caring provided by qualified nurses during an inpatient stay in an acute hospital. Interviews were conducted with 24 patients following their discharge home.

McCance used an interpretive hermeneutic approach, incorporating a narrative method of data analysis. This was based on Denzin's (1989) definition of narrative which, although specific criteria is not given in McCance (2003) is described in previous work as an account (story) that is relevant to the '*narrator*' and '*audience*' (McCance, McKenna and Boore 2001). Donabedian's (1980) structure, process and outcome approach is used as a basis for presenting the framework, which relates closely to the measurement of care quality. The

framework identifies the importance of organisational support for person-centred care alongside the nurse's interpersonal skills in developing trusting relationships with the patient in order to provide for the physical and psychological needs of the patient McCance (2003). These findings link with the work of McCormack (2001a, 2001b, 2003) and draw comparisons between Watson's carative factors (Watson 1985) and the 'five Cs' of compassion, competence, confidence, commitment and conscience defined by Roach (1984).

McCance's (2003) study reveals a potential relationship between the structure and processes of caring with the outcomes of care. The outcomes include patient satisfaction, wellbeing and a positive impact upon the care environment. Although this study was conducted in a different manner to Coyle and Williams (2001), it is worth noting that McCance (2003) also identified the perception that nurses were very busy, therefore the patients did not want to disturb them. Within both studies this appeared to have a direct and negative impact upon the provision of person-centred care. The findings suggest this relates to a combination of organisational factors such as the shortage of nurses and inadequate skill mix. In addition personal qualities, such as the nurses' attitudes and level of commitment contributed to the outcomes of care. In conclusion to the study McCance (2003) recognises the need to test the usefulness of the conceptual framework for caring in practice.

McCabe (2004) also identified similar concerns to McCance (2003) when exploring nurse-patient communication. The aim of McCabe's study was to generate a valid and reliable interpretation of the participant's lived experience

(McCabe 2004). Unstructured interviews were conducted with a purposive sample of eight patients in a general teaching hospital. Data analysis was described as being a reflective process involving description & interpretation of themes and sub themes.

Four main themes were identified: lack of communication, attending, empathy & friendly nurses. The findings suggest that nurses communicate well when using a personal approach; which patients found reassuring. Some patients saw nurses as 'too busy', whilst others felt assumptions were made about their concerns and needs. Many patients felt communication was more task centred when nurses were busy (seen as out of the nurses' control), but felt unable to 'bother' them. Two patients thought nurses were subservient to managers or doctors, which led to them being more task orientated. However some particular nurses always found time to talk with patients for a few minutes even when they were really busy. Communicating with patients on a personal level did not appear to relate to the level experience or seniority of the nurses; in fact McCabe suggested student nurses were able to do this more readily than the registered nurses as they did not have competing demands or were not fully socialised into being task orientated.

Being genuine was seen by patients as extremely important and was displayed both verbally and nonverbally by the nurses. Empathy was also seen as being vital in adding *'the human touch'* to the care the patients received. This was perceived as making the difference between helpful relationships being formed or not. In connection with the findings from Coyle and Williams (2001) the point was made that the interaction between the nurse and patient did not necessarily

need to be lengthy, but the nurse's attitude and congruent body language was very important to patients. Despite patients' criticisms of the nurses all participants commented on how friendly and happy the nurses were generally. The use of humour was seen as important and made the patients feel more able to approach the nurses. A variety of factors were seen to have an impact upon nurse-patient communication; in common with other studies, the organisational culture was seen as vital in supporting nurses to become more person-centred.

McCabe's (2004) research was guided by hermeneutic phenomenology, where ideally the researcher should work through the emerging themes with the participants; thus achieving credibility of the findings (Van der Zalm and Bergum 2000). There is no evidence of this in the paper reviewed. However McCabe (2004) explains that she included one full transcript along with a 'thick' description of the themes in the final report in an attempt to improve the integrity of the study. Working through the themes with the patients may not have been feasible if patients had been discharged following the interviews. These practical problems represent the reality of research in clinical practice. Despite these limitations and the small sample size, the research indicates the need for further patient focused studies to identify the type of interpersonal skills and organisational support that would enhance person-centred care.

In 2004, in order to expand the body of evidence further McCormack conducted an overview of the literature on person-centredness in gerontological nursing (McCormack 2004). Initially he went back to examine the meaning of the word person. After exploring much philosophical writing, he referred to Kitwood's

(1997) definition of person-centredness (as shown on page 18), which in turn was based on the concepts developed by Rogers (1961) and Buber (Smith 1958). The idea of 'being' is developed further by McCormack in this review, forming a foundation for person-centredness:

- Being in Relation - relationships with others
- Being in a social world - respecting the person's narrative
- Being in place - context / culture of care environment
- Being with self - respect for values of person and significant others

Considering these four concepts individually and their interplay with each other can bring together the specific needs of the person with the overall plan of care. Within these concepts, central themes of: knowing the person, centrality of values, biography, relationships, seeing beyond immediate needs and the need for authenticity were identified (McCormack 2004). Models of care can only guide practice and everyday care requires motivation from all parties to provide person-centred care. One way McCormack (2004) suggests we work towards this is to acquire an understanding of the person's values and try to work with these in a beneficial manner within everyday practice. In conclusion the review states that there was a lack of '*...robust studies in gerontological nursing articulating the benefits (or otherwise) of person centred nursing from individual (patient and nurse) and organizational perspectives.*' (McCormack 2004, p36).

By acknowledging the relationship element of person-centred care there are natural links with relationship-centred care (Nolan et al. 2004). Nolan describes person-centred care as a 'watchword' for the quality of care. This connection to

quality has also been acknowledged in more recent studies (Innes, Macpherson and McCabe 2006, RCN 2009, Lehuluante, Nilsson and Edvardsson 2012). Once again the principles of person-centred care for people living with dementia, (Kitwood and Bredin 1992, Kitwood 1997) were used as a basis for understanding the concept. Nolan et al. (2004) also refer to the work of Packer (2000) who questions whether person-centred care can ever be achieved in reality or whether it is a concept zealously pursued by some within healthcare. She suggests that person-centred care only exists in the language of care and not in actual care delivery. This mismatch between what professional carers say and do continues to be a concern (Adams and Gardiner 2007).

Nolan et al. (2004) suggest that person-centred practice is inadequate in itself, instead there needs to be a vision of the person in relation to a network of social relationships. Whilst accepting there needs to be respect for personhood, Nolan et al. (2004) advocate a wider view of the need for relationships than they perceive McCormack (2001a, 2001b, 2003) represented. However on examining McCormack and colleague's ongoing work it becomes clear that the term 'person-centred' relates to all persons in the relationship, not solely the person in receipt of care (McCormack and McCance 2006, McCance et al. 2009, McCormack and McCance 2010; McCormack, Dewing and McCance 2011).

Nolan et al. (2004) describe the importance of relationships between nurses, patients, family and other professionals. Hence Nolan refers back to his original work (Nolan 1997) which helped develop The Senses Framework in long term care settings. The underlying belief of this framework is that all parties involved

in caring for older people should experience relationships which promote 'six senses': a 'sense' of security, belonging, continuity, purpose, achievement, and significance (Nolan et al. 2004). When these are all present it is anticipated that the care environment will be conducive to providing relationships which are satisfying for all involved.

The Senses Framework had previously been tested within an acute hospital setting for older people; by means of interactive focus groups and workshops with multidisciplinary practitioners, unqualified (paid) carers, family carers and older people (Davies et al. 1999). The realisation of the framework relies upon relationships being formed and maintained with the older person and their family. Since the foundation of the Senses Framework, critics question the clarity of how this happens in practice and, in particular, with people who have dementia; when forming relationships may be more challenging (Adams and Gardiner 2007).

Accepting this limitation the framework is seen as very relevant to the care of older people and for the carers themselves. A significant proposition from this body of work is that in order to provide an environment where the framework would be successful there would need to be inspirational leadership and a change in working culture in some institutional and community settings.

## **Uniting research, theory and practice**

The context of person-centredness was set in the early 2000s by researchers such as McCormack (2003), McCance (2003) and Nolan et al. (2004), however there remained a disconnection between the outcomes of research (such as conceptual frameworks) and the practice of person-centredness (McCormack 2003). The translation of the terms and concepts used in conceptual frameworks into practice may present a challenge to some nurses; for example facilitating an enabling relationship may be seen to relate to advanced nursing skills. Therefore it is unclear how the novice nurse acquires these complex skills (Dewing 2004). One potential solution offered by Dewing is the use of critical companionship, whereby an experienced practitioner works alongside a novice practitioner (Titchen 2000). However doubts have been expressed about the probability of this happening in everyday practice due to the need of understanding both the practice specialism and the application of the conceptual framework (Dewing 2004). This concern arises partly because the facilitation of the critical companionship framework requires high level professional craft (practice) knowledge within a team (Titchen 2000). The workload pressures on staff within current healthcare environments may also lessen the likelihood of success. In many ways this form of coaching is how nurses learn in practice. However it is likely to be informal and therefore using a more structured method such as Titchen's (2000) framework might ensure a more consistent approach to practice education. Working in such structured way requires a long-term commitment from the organisation to practice development in order to support person-centredness. This requires sustained investment in partnership working within practice settings to foster trusting and

ongoing relationships between researchers and practitioners (McCormack, Dewing and McCance 2011).

One example of such collaborative work came from a study which initiated a practice development programme where the researchers worked alongside older people, their family and carers on a Transitional Care Unit in the NHS in order to explore the use of biographies to encourage person-centred care (Clarke, Hanson and Ross 2003). The study explored the experiences and views of older people, their family and practitioners of using a biographical approach, which provided opportunities for the older people, if they so desired to talk about their life experiences. Carers who worked in a local nursing home who were already using a biographical approach to care assisted the research team to prepare for the study. This involved taking part in informal training sessions with the research team and the nurses caring for older people in a hospital setting. Working together allowed nurses who were interested in using a biographical approach to share ideas and experiences with the researchers, carers from the nursing home and each other. This also gave an opportunity to have discussions about the potential advantages and disadvantages for all parties.

Once the life stories (which were unique for each person and may have included written recollections, or written pieces from family members and photographs) were compiled, older people and their families were asked how they felt about sharing their life stories and whether they felt it had any impact upon their care. The findings endorse other studies by concluding that understanding individuals within healthcare has great value; to the person being

cared for and their family and can encourage practitioners to see the person rather than just seeing another patient. The use of life stories also has the potential of promoting reciprocity as healthcare practitioners tend to develop closer relationships with individuals and their families making their work more enjoyable and rewarding, which is likely to improve the quality of person-centred care (Clarke, Hanson and Ross 2003, Nolan et al. 2006, McKeown et al. 2010).

One of the strengths of this work is the involvement of both registered nurses and support workers, since this reflects the reality of care giving. During the study the practicalities of registered nurses being fully engaged with the project became a problem due to workload pressures. Therefore the research became more focused on the role of the support workers; this challenge has been reported in other studies (Thompson 2004). The difficulties experienced in the study could indicate there may be problems integrating and sustaining a biographical approach in everyday practice. One of the main challenges for healthcare professionals is using the time they have with the patient effectively to develop therapeutic relationships, which recognise and respect what is unique to that person (Webster 2004). Within more acute care settings in-depth life stories may not be feasible; however, listening to a person's story can be valuable at any point in a person's life. Although time is often in short supply, there is value in nurses getting to know something about the patient to allow them to personalise their care. It is only possible for this to happen if healthcare staff choose to make the effort and will not happen by chance (Dewing and Pritchard 2000). Ultimately, person-centred care requires a team approach and a philosophy of care that underpins this at every level of the organisation (Webster 2004).

In order to recognise the changing health care needs of older people in acute care settings Peek et. al (2007) developed The Older Person Acute Care Model (OPAC) in Australia. Implementing the model was inspired and informed by the emerging research on person-centred care from the United Kingdom (Nolan et al. 2002, Clarke, Hanson and Ross 2003, McCormack 2003). The older person is at the centre of the OPAC model, keeping in mind the complex nature of care required by the person as they age and the need for a multidisciplinary team approach. The basis of the model is the belief that older people make a valuable contribution to society. They are recognised as a unique individual and their rights to choice, involvement in care decisions within a therapeutic relationship are seen as key to the implementation of the OPAC model.

Peek et. al (2007) piloted the use of the model in one combined medical and surgical ward to determine effective ways of engaging staff in implementing the model and managing the change process. The initiative was given support from the head of nursing within the organisation to emphasise the importance of the project. Nursing staff were supported by the appointment of the first clinical nurse specialist in the acute care of older people, their role being to model and lead best practice in this field. In turn they were supported by a clinical nurse consultant who provided support and acted as a critical companion. Introducing the model to nursing staff and generating interest and engagement were crucial in the early stages. This involved gaining the views of staff about what they valued in relation to their work on flip chart paper left in place for a week on the staff notice board to encourage discussion.

Respect for each other and for their patients was shown as a significant factor, along with care concerns such as pain management and care of the dying. There was also an expressed need for team building amongst staff. This process led to nurses approaching the clinical nurse specialist to form several small groups interested in developing the quality of care on the ward and, as a result, there were several proposals to improve palliative care including pain and symptom management from a multidisciplinary team approach. Being person-centred requires competence as well as compassion in care, therefore addressing the nurses' concerns about the quality of palliative care was a significant first step in realising high quality person-centred care. This small scale practice development project uses an evidence based model to explore ways of improving the care of older people in a person-centred manner. It also adds to the international body of work, which once again highlights the need for shared values and commitment within the organisation in order to support and sustain person-centred care.

The link between workplace culture, leadership and person-centred practice is a recurring theme within the literature (Watson 1985, Kitwood 1997, Davies et al. 1999, McCance, McKenna and Boore 2001, McCormack 2001, 2003, McCance 2003, Nolan et al. 2004, McCormack et al. 2009). In developing a framework for person-centred nursing McCormack and McCance (2006, 2010) accentuate not only the relationships with the person and their family but the need for seeing the broader context of person-centred practice. This includes considering issues of professional power, locus of control, authenticity, the care environment, appropriate skill mix, effective staff relationships and the importance of shared values within the team (McCormack and McCance 2006, 2010). These

elements present a complex picture of practice, which requires careful thought regarding how they act and react with each other in a care setting.

Some have criticised the Person-Centred Nursing Framework (McCormack and McCance 2006, 2010) for being too abstract as it combines two conceptual frameworks: First, the concept of caring (McCance 2003) and secondly the concept of person-centred practice (McCormack 2003a). Each concept is perceived as difficult to define individually therefore to combine the two may be regarded by critics as unrealistic (Watson 2009, Edvardsson 2010). However the underlying principles of each framework are focused upon improving the quality of person-centred care by the use of research, education and practice development.

Despite these criticisms, the Person-Centred Nursing Framework is being used as a basis for continued practice development in order to augment the impact of research into the reality of care (McCormack et al. 2009, Gribben and McCance cited in McCormack and McCance 2010, McCormack 2011, McCormack Dewing and McCance 2011). By using a structured approach to practice development there is a hope that insensitive care will be minimised and person-centred practice will become embedded in every aspect of care from the language used in everyday care through to fostering organisational cultures which hold person-centredness at the centre of their work (McCormack 2011). Moving practice forward is challenging in current healthcare environments; however, education and practice development must be continued to facilitate positive change. Reflections on past experience of mistreatment have previously been used to advocate high quality person-centred care (McCormack and McCance 2010, page 10), yet it is still evident that in some cases care

remains inadequate; for example the abuse of residents at Winterbourne View (DH 2012a). Such experiences reinforce the need for a structured and committed approach to education and practice development.

### **The continuing link between person-centred care and care quality**

As referred to earlier in the literature review patients have stated in patient satisfaction surveys and research studies that it is important to them to have their healthcare needs considered in a holistic manner (Robert et al. 2011, Picker Institute Europe 2012). By way of response to these findings, guidelines have been published which reflect patients' wishes and guide nurse education and practice (Nursing and Midwifery Council (NMC) 2007, 2010, The Royal College of Nursing (RCN) 2009, National Institute for Health and Clinical Excellence (NICE) 2012).

The accounts of patient experiences of healthcare are now being considered as equally important to the measurement of efficiency and outcomes of care, thus providing a more rounded view of quality (Lewis et al. 2010, Commissioning for Quality and Innovation (CQUIN) 2010). The findings of exploratory studies are being acted upon in conjunction with results of patient satisfaction surveys (Robert et al. 2011). Patient Reported Experience Measures as well as Patient Reported Outcome Measures are being examined, therefore linking closely to the recommendations of NICE (2012). As a result of using these combined perspectives of quality measurement, a 'friends and family' question has been introduced to assess the quality of service provision.

The question is posed as: 'How likely are you to recommend our ward/department to friends and family if they needed similar care or treatment?'

The remainder of the questions which explore the patient experience cover the following characteristics of care:

- Compassion, empathy and responsiveness to needs, values and expressed preferences
- Co-ordination & integration of care
- Information, communication and education
- Physical comfort
- Emotional support, relieving fear and anxiety
- Involvement of family and friends

(Robert et al. 2011, p27)

Such innovations indicate there are increasing efforts across the healthcare system to avoid a 'mismatch' between performance measurements and what matters most to patients (Robert et al. 2011, NICE 2012, NHS Institute for Innovation and Improvement 2012). Policy drivers naturally have an impact upon organisational direction. However, placing emphasis on one question such as; the family and friends question may not be enough to determine the depth of somebody's experience of healthcare (Graham 2013). It is vital that person-centred care is not only determined by policies, but retains the focus of care on the person being cared for rather than purely paying lip service to the notion of person-centred care in order to meet government led targets.

## Person-centredness in differing care settings

Although the present study is based in an acute medical ward it is useful to consider how the concept of person-centred care is understood in other care fields, in order to consider the similarities and differences in relation to the present study.

With the aim of understanding person-centredness in the practice of mental health care Ruddick (2010) begins by referring to the '*symbiotic relationship that spirituality has with person-centred care*'. Based on his experience in mental health care, he proposes that spirituality is often overlooked, or alternatively, if spirituality is spoken about by the client, it is often seen as a symptom of their illness.

In connection with the provision of spiritual care and in common with other fields of nursing, the espoused qualities associated with providing person-centred care such as acceptance and empathic understanding are not always evident in the care setting (Ruddick 2010). This often relates to barriers to person-centred care being formed, potentially caused by staff labelling the client (by diagnosis). This may cause the nurse to treat the person differently or contribute to discrimination. Therefore Ruddick asserts that being person-centred requires nurses to reflect upon their own beliefs and values and act in accordance to support person-centred care. This places an emphasis on the need for nurses to possess emotional intelligence, thereby enabling recognition of their own emotion and those of others in order to care compassionately for others (Goleman 2006). Emotional intelligence is thought to link closely to the personal

attributes of the nurse, but can also be enhanced by personal and practice development.

In a very different setting, Wheeler and Oyeboode (2010) gathered opinions and perspectives from carers in nine nursing homes specialising in dementia care (36 staff). The aim was to explore the elements of communication from staff to staff, staff to resident and staff to family (Wheeler and Oyeboode 2010). Findings show that high quality care is based on positive interactions where carers see beyond the dementia by really seeing the person. When this happens, staff also report feeling more satisfied within their job. However, maintaining person-centred interactions is a challenge as the physical demands of the job often lead to a task focused approach. Having acknowledged this there is some recognition that delivering everyday care provides an opportunity for person-centred interactions (Wheeler and Oyeboode 2010).

Understanding the person's social history can help carers better understand the resident and their behaviours. Care homes that adopt a person-centred approach to care are more likely to try harder to involve the resident in care decisions, support, appreciate and empower staff, residents and family. High quality care is facilitated by all staff meeting regularly, having shared goals where everyone's contribution is valued. This enables each staff member to draw strength from the team and leads to higher levels of job satisfaction. (Wheeler and Oyeboode 2010).

Kirkley et al. (2011) explored person-centred care in a respite care home for people with dementia, with the aim of developing tools for evaluating its

application in practice. Five key themes were identified: understanding of person-centred care, attitude to service development, service priorities, valuing staff and a solution focused approach. Consistent with other studies, organisational culture is reported to have an impact on how valued the carers feel, influencing attitudes throughout the whole establishment. An enabling management style is perceived as enhancing the approach to care and encourages the sharing of good practice through group discussions. This, in turn, fosters a solution focused attitude, allowing for experimentation with new ideas. Within such a supportive culture, unsuccessful outcomes are viewed as a learning opportunity rather than a failure.

Kirkley et al's (2011) study also indicates organisational barriers to person-centred care such as bureaucracy and the concern that being person-centred may involve an increased risk to the resident. The outcome of such concerns may mean carers are less likely to allow flexibility in order to meet individual care needs for fear of repercussions. The researchers show recognition of the 'public voice' versus the 'private voice' in the responses of the individuals being interviewed. This may be experienced when interviewing participants in qualitative research, as some participants may respond as they perceive the interviewer expects them to. It is a worthwhile concept for all researchers to consider when reflecting upon similar qualitative data. The findings highlight the need to investigate the cultural values present in the care home in order to look beyond the claim of staff being too busy (short staffed) or poorly resourced to provide person-centred care (Kirkley et al. 2011).

This limited view of study findings in mental health care and dementia care homes show resonance with the findings of the previous studies within this review by identifying facilitative factors such as the need for an organisational philosophy of person-centred care, the value of relationships, seeing the person rather than the diagnosis and maintaining person-centred interactions. The findings also suggest the need for further research to explore the barriers and facilitators of person-centred care.

### **Barriers to person-centred care**

Within the literature review, many of the studies have highlighted what facilitates person-centred care; however, Innes, Macpherson and McCabe (2006) specifically explored the role of frontline workers within community care services (older people, disabled people & people from ethnic minorities) to establish the barriers to and opportunities for the delivery of person-centred support / care. Discussion groups were held with frontline workers (mainly unqualified, paid workers) and service users. The findings highlight that the term person-centred care is mostly used in the literature in relation to the care of older people and people who have dementia. Service users value the personal qualities of their carers such as patience, compassion and empathy. The relationships built between the service users and frontline workers are seen as essential to the experience of high quality person-centred care.

Barriers are related to a conflict between the bureaucratic management systems, which focus on budgets and commissioning and the concerns care givers have about individual care needs. These findings resonate with the findings of West, Barron and Reeves.(2005) where nurses in acute hospitals

reported feeling unable to meet a number of patient needs, this included (amongst others) emotional needs, information giving and effective discharge planning. There was recognition that in part, this was related to lack of time; however, there was also concern about not being able to control the care environment to meet the personal needs of patients and family for privacy and dignity. Both studies identify a desire from the nurses and frontline carers for further training related to social skills, interpersonal relationships and developing communication skills. The aspects of concern identified by the nurses in the study relate closely to findings from patient satisfaction surveys (Picker Institute 2005) where one in five patients felt that they were not involved at all in decisions about their care and treatment while in hospital.

One of the common barriers to person-centred care referred to in the literature is the translation of theory into practice (McCarthy 2006). McCarthy's study involved participant observation, examination of nursing records and semi-structured interviews with six registered nurses who were preceptors (mentors) to student nurses in an acute surgical environment in an Irish hospital. Several in-depth theoretical propositions related to the practice and teaching of person-centred care were used to analyse the data generated. These were derived from the literature and used to explore and explain themes emerging from the triangulated data (see page 632 of McCarthy 2006).

Two main themes were identified from McCarthy's data:

- Translating person-centred care into personal practice.
- Translating personal interpretations of person-centred care into student teaching.

Registered nurses were confident when using their practical skills, but did not have a clear understanding of person-centred care. They appeared to be anxious about a lack of theoretical knowledge related to person-centred care, so felt unable to support teaching and learning of this concept when guiding students in clinical practice. They also had a limited appreciation of classroom learning and were unconvinced about its relevance to practice. Care delivery reflected the medical model of nursing and focused on teaching students facts or listing important things to remember.

The registered nurses were caught between the demands of the service, the profession and of being person-centred. This led to fragmentation of care and subsequently, students' needs were often neglected due to the pressure of work. Despite this, registered nurses could identify aspects of nursing which could be improved upon, such as spending more time with patients and students and valuing them as people. This small scale study in a surgical setting may be limited in its application on a wider scale; however, the study makes several recommendations related to practice education and research, which again link to previous studies; the need for an organisational philosophy which supports person-centred care and accommodates the need for preceptors (mentors) to work effectively with student nurses. In order to facilitate productive student support McCarthy also suggests further education to enhance the knowledge and skills of the preceptors. In addition, she advocates further research to explore the preceptor (mentor), student and patient perspectives of person-centred care in order to facilitate a clearer understanding of its meaning in the reality of everyday practice.

## **Conclusions drawn from the literature**

It is clear from the literature review that person-centred care is a concept that remains difficult to define as it has different meanings depending on the context of care and the subjective interpretation of individuals. There appears to be a long history of person-centred care in nursing, even if it is not explicitly named as such and it has strong roots in the care of older people, people who have dementia and people who have a learning disability. It is significant to note that, in the past, these are populations where care has been criticised for not seeing the person. The unique nature of each person lies at the heart of person-centred care and actively listening to a person's story if they want to tell it, is important to understand their needs. Characteristics such as compassion, empathy, genuineness, and respect facilitate person-centred care and are valued by people. Such characteristics are likely to lead to high quality personal interactions, which are appreciated more than the length of the interaction.

Strong, trusting relationships and partnerships are vital at all levels for successful person-centred care, meaning it cannot happen in isolation as it relates to the possession of shared goals and a philosophy of care which sees person-centred care as a priority. Where staff are encouraged to share ideas and leadership is empowering, person-centredness is likely to flourish. Several studies have shown a link between care that is perceived as high quality and person-centred care.

## **Relevance of the literature to the study**

Much of the previous research focuses on the care of specific client groups or care settings, particularly more long-term care environments. Understanding more about person-centred care from the perspectives of registered nurses, support workers, student nurses and allied health professionals working together in an acute medical ward setting will allow comparisons to be drawn to previous research. This will enhance understanding of the concept in more acute care teams and environments. Using their perspective alongside those of experienced nurse educators will also help to develop a more detailed understanding of the future development needs for education and practice.

## **Chapter 3 Research Methodology and Methods**

### **Introduction**

This chapter presents an overview of the underpinning methodology and methods for the study. The first section discusses the research design, including the philosophical foundations of the study and methodology. The second gives an explanation of the research methods; this includes a description of the study setting, sample and recruitment of participants. This is followed by a summary of data collection and data analysis techniques. Finally ethical considerations are discussed. The chapter concludes with reflection upon the research process.

### **Research aims and questions**

The aims of the study:

- To describe what facilitates person-centred care from the perspective of nurses working in an acute hospital medical ward.
- To identify areas for development within education and practice that have the potential to enhance person-centred care in an acute medical ward setting.

To achieve this, the following research questions were addressed:

- What do nurses understand by the term person-centred care?
- How is the facilitation of person-centred care described by nurses in the study setting?

- How do the views of the nurses concerning the facilitation of person-centred care correspond with the views of other healthcare professionals in the study setting?
- What areas for development within research, education and practice can be identified from the data that have the potential to enhance person-centred care in a medical ward setting?

The study was conducted in three stages; stage one explored person-centred care from the viewpoint of registered nurses, support workers and student nurses. Stage two involved interviewing allied health professionals, who were working with the nurses in the study setting when the research took place. The aim was to explore their perspective of person-centred care and compare this with the data gathered in stage one. Stage three explored the implications for education and practice from the perspectives of nurse educators in view of the findings of stages one and two.

The study was a qualitative exploratory study designed to examine the phenomenon of person-centred care. Exploratory research is used in order to investigate and develop explanations of social phenomena, which in this study was person-centred care. Exploratory research is used when little is known about the topic under investigation (Lincoln and Guba 1985). In the case of person-centred care, although there is a shared understanding of the phenomenon of person-centred care in the literature, much of the previous research has been focused on established care teams working in specialist fields, such as the care of older people or the care of people living with

dementia. The research aims were addressed at an exploratory level in order to provide a unique perspective on person-centred care, specifically in an acute hospital medical ward environment. The findings of this study provide further understanding about the phenomenon of person-centred care from a range of practitioners who worked together in the study setting. This provides an opportunity to consider person centred care in a new context in light of what is already known about person-centred care, thus extending the body of knowledge. Further insights are explored by including the perceptions of student nurses about person-centred care during their clinical placement; an aspect which has not received attention in previous studies. Including student nurses' perspectives enables expansion of the existing body of knowledge about how nurses learn to be person centred.

The third stage of data collection explored the implications for education and practice from the perspectives of nurse educators in view of the findings of stages one and two. This unique contribution provided direction on which aspects of education and clinical practice are worthy of further development and study (Hart 2003).

## **The philosophical foundations of the study**

The aim of the study was to understand person-centred care by accessing the meanings that participants in the study setting assigned to the phenomenon (Denzin and Lincoln 2000). Therefore an interpretive approach was viewed as appropriate, as there was an assumption that the phenomenon of person-centred care would be interpreted by the participants in the context of their social world.

In order for there to be consistency between the philosophical foundations of the study and the research design, there needs to be some understanding of the ontological and epistemological foundations of the study (Snape and Spencer 2003). Ontology is concerned with what there is to know about the world and how this exists (Crotty 1998). It is related to the assumptions concerning what constitutes social reality and the values concealed within those assumptions. It is important to consider the ontological stance of the researcher so it can be assessed whether the methodology used was suitable to uncover the social reality of the participants within the study. For example, questions such as how does person-centred care exist in the study setting, what does it look like, what is it made up of and how do these elements interact with each other were considered (Koshy, Koshy and Waterman 2011).

The personal views that influenced the methodology of this study relate to the philosophy of Critical Realism. Within the philosophy there is a fundamental belief that physical, biological and social reality can only be understood by considering the context in which the phenomenon is evident. It is advocated, that natural and social reality needs to be viewed in three layers; the Real, the

Actual and the Empirical (Morton 2006). The Real element includes the structures that have generated the actual events, the Actual element relates to an actual event which is generated by specific structures or mechanisms. Lastly, the Empirical element includes observable experiences (Morton 2006).

Critical Realism identifies with the belief that there is a reality, which is independent of human knowledge and is a product of individual interpretation of any given phenomenon. From a critical realist perspective, the application of this to the present study is explained by the following principles:

- 'An external reality exists independent of our beliefs and understanding'
- 'Reality is only knowable through the human mind and socially constructed meanings'

(Snape and Spencer 2003 p16)

Inherent within these principles is the theory that "all beliefs are socially produced" (Bhaskar 1998 p.57). Therefore, although the reality of person-centred care exists in everyday practice to varying degrees in the study setting, it does not mean this reality is easily accessible to the researcher. In order to learn more about the practice of person-centred care an exploratory qualitative research approach was required with the aim of interpreting the social world of the participants in the research setting and making this evident to others (Snape and Spencer 2003). The social world of the participants working together in the study setting involved complex interactions, which were influenced by many unobservable aspects, such as organisational culture (Sayer 2000). Therefore, although interpreting participant's responses may give some confidence in the existence of the phenomenon, the findings will form a limited view of person-

centred care and may not account for the underlying causal systems within the study setting (Collier 1994).

Before commencing the research three assumptions were made on behalf of the researcher; firstly that there is a shared social reality within the world of nursing, secondly that nurses are inherently compassionate and thirdly, nurses strive to be person-centred in their care delivery. However the context of the study setting had an impact on how transferrable the findings from this study are to care delivery in other settings. Transferability refers to the extent the research findings can be judged as applicable to another setting, population or context (Denzin and Lincoln 2000, Lewis and Ritchie 2003). It is likely that although the findings may be context specific, there will be some elements in common with other research studies and settings. These assumptions had a major influence when choosing the topic of study, interacting with the participants and interpreting the research data (Crotty 1998).

Epistemology refers to the '*ways of knowing and learning about the social world*' (Snape and Spencer 2003 page 13). It provides a philosophical basis for deciding what kind of knowledge is possible and how we can ensure it is sufficient and authentic enough to show the meaning of the research to others from the perspective of the participants. This qualitative exploratory study sits within the interpretive dimension of social science, whereby the researcher and the social world have an impact upon each other. Early views of Interpretivism were developed by Max Weber (1864 – 1920) with the notion of understanding a phenomenon in context rather than explaining it purely by focusing on cause and effect as seen in natural sciences (Holloway and Wheeler 1996).

As acknowledged earlier in this chapter, in order for the social reality of the participants to be visible (to some degree) to others, their perspectives need to be interpreted by the researcher. Studying the social world of others requires an appreciative understanding of their standpoint (Hammersley 2013). Therefore, it was essential to work with sensitivity in the study setting as I did not want the participants to think that I was being critical of their care. This was achieved by working with empathy when conducting interviews in order to promote trust and respect (Streubert Speziale and Carpenter 2007). It was particularly important to develop a shared understanding of the participants' beliefs, attitudes and practices to allow interpretation of the phenomenon of person-centred care in the context of acute hospital ward. Stories told in an appreciative atmosphere have the potential to enhance relationships and increase understanding of the participants' beliefs, attitudes and resulting practices.

Listening to the stories told required more than just attention to the words spoken, there was a need to attend to the relationship between what was said, how it was said and possibly what was not said. It was also essential to engage with the meaning portrayed by each research participant in order to reduce ambiguity during data analysis. Being supportive throughout the research process also influenced the building of new relationships, whilst strengthening the existing relationships. This had the potential of reducing any perceived imbalance of power (Bright, Cooperrider and Galloway 2006).

In harmony with the underpinning philosophies of Interpretivism and Critical Realism; if the participants felt confident that I could be trusted to remain appreciative, it was more likely to create the opportunity for stories to be told,

which may not normally be heard. This was an important tenet for person-centredness and the intended outcomes of the study. Bearing this in mind, it is important to recognise that the researcher cannot be neutral or objective because of the inherent relationship between the research phenomenon and the participants. However the researcher can be transparent about the assumptions that underpin the study and how this has had an effect upon the research process.

One way of demonstrating transparency within qualitative research is by the researcher being self-aware. This can be made evident by the use of reflexivity; a concept used to explore the relationship between the researcher, the study setting and participants (Etherington 2004). In this study it was important to reflect upon situations which may have influenced data collection; for example uncovering how a participant may be expected to act or respond in an interview (see excerpt from research diary in Appendix 5). My dual position of being the university link lecturer and researcher will undoubtedly have had some affect upon the data collected. Being reflexive enables the researcher to be honest and acknowledge the potential impact upon the study and, in turn, allows the reader to understand this. It is also important to recognise that the construction of meaning within qualitative research is not only influenced by personal approaches but is affected by other outside influences on the participants, researcher and setting, for example: social, political, cultural, environmental, economic factors and this should be reflected in the discussion of the findings (Denzin and Lincoln 2000).

In addition to being a reflexive researcher it was important that the research approach valued not only the researcher's beliefs, but those of the participants in order to develop trusting and respectful relationships (McCormack 2003). Hence the methods had to convey an open, honest and non-threatening approach (Etherington 2004). It was crucial that if the study was exploring person-centred care, the whole approach within the research study should embody a person-centred philosophy. Therefore it was crucial that as the researcher I conveyed genuineness and empathy within all interactions, to ensure the participants felt their subjective experience was being understood and valued within the context of their work.

In conclusion it is clear that the philosophical foundations of the study and resulting methodology of the researcher have an impact upon the whole research process and outcomes. Working in an appreciative manner within the study reflected not only the underlying principles of Interpretivism, but those of person-centredness, thus providing a holistic connection between the philosophical framework and methods (Lewis 2003).

## **Methodology**

Understanding the philosophical position of the researcher is essential in order to demonstrate the relationship of this to the research design. However it should not be seen in isolation as the practicalities of the research also need to be considered; for example asking the question - what research approach would best fit with the purpose of the research (Snape and Spencer 2003).

In order to consider the above relationship it is useful to understand the early development of the study, which was initiated following discussions between myself in the role of link lecturer from the local university and nurses who worked in the study setting. This initial dialogue became the focus of further conversations, when registered nurses expressed an interest in being involved in exploring person-centred care further and subsequently, looking at how this could develop nursing practice on the ward. From a personal perspective I also had an interest in exploring how understanding more about the phenomenon of person-centred care could be used to enhance pre and post-registration nurse education.

### **Limitations of using a qualitative exploratory study approach**

Qualitative research is concerned with discovering the meaning, attributes and characteristics of a phenomenon and how people make sense of their world (Leininger 1985). This exploratory study by its very nature presents a limited view of person-centred care as it was looking at the phenomenon specifically from the perspectives of the people who took part in the study, which is an accepted outcome of an interpretive research approach (Hammersley 2013).

In order to examine how the findings may be meaningful to other world views the discussion chapter will offer explanations and identify the relevance of the findings of the present study to the world of healthcare. Interpreting the data in a transparent and trustworthy manner will also increase the credibility of the findings, particularly if this enables others who have experience of, or are familiar with the phenomenon of person-centred care to identify with the exploratory findings (Sandelowski 1986). As acknowledged earlier, personal and epistemological reflexivity throughout the research process can enhance the trustworthiness in qualitative research. Personal reflexivity relates to the influence of one's own values, experiences, beliefs and social identity on the research process. Epistemological reflexivity requires reflection upon the assumptions made (about the world, including the world of nursing and about knowledge) that have been made during the research study as highlighted within the philosophical foundations of the study (Carolan 2003).

Of particular relevance to the present study was the need to consider the impact of my two roles as a university link lecturer and researcher. I was aware that the roles could be seen as conflicting and adversely influencing the power relationships within the study. For example, there may have been concerns about the true anonymity of participants if they spoke about something which may affect the student experience on the ward. Therefore this could have discouraged some participants from responding openly in the interviews. Power sharing in qualitative interviews may be presented when reporting findings as equal; however, most commonly the interviewer controls the interview by holding the interview guide and initiating the questions (Brinkman and Kvale 2005). Therefore the perceived roles of the interviewer and interviewee will

have some influence upon the course and outcome of the interview. Although there was an interview guide, it was there essentially to support the interview process and ensure that the discussions in the interview remained pertinent to the research aims, rather than be used as a rigid set of questions.

Alternatively, it could be asserted that the existing relationships built in my everyday role as the university link lecturer had a positive and encouraging influence on the study. By being part of the social world of the setting, it was likely that the participants within stages one and two of the study already trusted me to work in an appreciative and mutually beneficial manner (Fontana and Frey 2000). Fostering this level of trust offered the unique opportunity to gain in-depth insights into the reality of person-centred care as it was perceived by the participants. One could argue that this level of trust and therefore in-depth appreciation may not have been achieved had the research been conducted by a stranger. Despite this perspective, the participants' perceptions of their relationships with me will have had some unidentified effect upon their behaviour and the conversations within the interviews. Nevertheless, acknowledging this and having an awareness of the potential power imbalances will have helped to reduce the influence it had on data collection and analysis.

### **Research Design**

The study utilised individual and paired interviews. The resulting data were subjected to Framework Analysis (Ritchie and Spencer 1994). The study was conducted between 2010 and 2014 and involved three stages with the principal data collection and analysis taking place in stage one. The data collection for

stage three was ongoing up to September 2013. The stages of the study are shown in Table 1.

**Table 1: Stages of the Research Study**

Stage of the study	Participants	Purpose	Data collection	Data analysis
Stage 1	Registered Nurses n=7 Student Nurses n=4 Support Workers n=3	Explore perceptions of person-centred care	Semi-structured interviews & follow-up interviews or discussions	Framework Analysis (FA)
Stage 2	Physiotherapist n=1 Physiotherapy Assistant n=1	Explore perceptions of person-centred care & compare to Stage 1 findings	Paired semi-structured interview	FA & comparison to Stage 1 findings
	Occupational Therapist n=1		Semi-structured interview	
Stage 3	Professional Development Co-ordinators n=2 Nursing Lecturers n=2	Feedback upon thematic framework exploration of relevance to education & practice	Paired Semi-structured interviews	FA & thematic framework used to analyse and explore data for new themes and implications for education & practice
Final process of analysis in Stage 3	Analysis and Synthesis of stages 1-3 of the study in order to develop and refine the components of the Model of Person-Centred Care			

### **The study setting**

The study was conducted in a large NHS teaching hospital in the north of England. When the study began in 2010 the ward specialised in stroke rehabilitation; however, shortly after data collection began, the Medical Directorate underwent a major re-configuration of stroke services. This meant that the ward changed speciality to become an acute medical ward, specialising in respiratory medicine. A decision was made between me, the supervisory team and the ward sisters to continue with the research study on the original ward. The rationale for this was that the majority of permanent staff had chosen to stay on the ward, they had already agreed to the study and had an expectation it would proceed. In addition, student nurses would continue to

undertake clinical placements on the ward and I would remain as the link lecturer. It therefore remained pertinent to explore person-centred care in this acute care environment. It was useful too, to examine the interview data for different perspectives of care as the speciality changed from stroke rehabilitation to acute respiratory medicine.

The ward has twenty eight beds divided into four single sex bays with six patients in each bay and four single rooms. When it was a stroke rehabilitation ward, patients were transferred from the acute stroke wards or general medical wards once they were medically stable. This would involve an assessment being made of the rehabilitation needs of each patient before they were transferred to the ward. As a stroke rehabilitation ward it was common for a person to be an inpatient for several weeks, and occasionally, this extended into months. As an acute medical ward, the patients are admitted from the accident and emergency department, the emergency admission units and through domiciliary medical referrals. Some patients stay for brief periods of a few days, whereas others may stay for weeks. Many patients have long term respiratory conditions and have frequent readmissions for acute exacerbation of a chronic illness.

### **Gaining access to the study setting**

In the early stages of the research, I spent a lot of time visiting the ward and discussing the possibilities of conducting a study exploring person-centred care, initially with the two ward sisters and later with the matron and director of nursing. An informal summary of the research proposal was sent to the matron and director of nursing by email. The nurse managers gave permission for the

study to continue. Permission was also gained from the medical director and the finance director.

During these early stages of the study, I also met with two clinical nurse specialists and the nurse consultant in order to keep them informed about the proposal and gather feedback from them about the design of the study. At this time, the nurse consultant met monthly with a carers support group (for relatives and carers of people who had suffered from a stroke). I attended one of their meetings on 18<sup>th</sup> August 2010 and presented my ideas to them. We discussed the purpose of the study and it was suggested by the carers, that more specific questions were included about the involvement of relatives in the decisions and delivery of care. The carers were also concerned about the nutritional aspects of care; in particular, about the offering of choice and support for eating and drinking. This meeting occurred at a time when there had been concerns raised in the media about patients leaving hospital malnourished, therefore this aspect of care might have been uppermost in their minds (Bowcott 2010, Age UK 2010). These consultations were very helpful in determining the direction of the study and, as a result, the interview guide was adjusted to reflect the carers' requests.

## **Ethical considerations**

Prior to explaining the recruitment of participants to the study, this section of the chapter reflects upon ethical processes in general, and, as applied within this study. Ethical standards are designed to protect the participants of any research study and involve four key principles, all of which are equally important and were given careful consideration within this study (Beauchamp and Childress 2001):

- Respect for autonomy
- Beneficence
- Non-maleficence
- Justice

### ***Respect for autonomy***

The participants were given an explanation of the study using a combination of verbal and written information to enable them to understand the purpose of the study and therefore decide if they wished to take part in the study (Appendix 7). They were invited to contact me, my research supervisor or an independent person from the NHS Trust Research Governance Department if they had any queries about the study. Part of respecting autonomy involved making sure the participants did not feel pressured to take part in the study, as they may have felt there was an expectation to respond to my requests for volunteers. Consent was sought from each participant after they had a chance to read the information sheet and ask any further questions before taking part in the study. The consent form made it clear that they were free to withdraw from the study at any time without having to give a reason (Appendix 8).

How interview data is used and interpreted can become an ethical problem during a research study as the direction of an interview cannot be predicted. The stories constructed within an interview may be different to the stories at another point in time. This could mean participants may say something they regret afterwards. Consent must be sought within any research study but when consent is given before an interview this may be less informed than asking for consent afterwards (Clarke 2006). Participants may have changed their mind after the interview, particularly if they had expressed a view that they were unhappy to share with others, in retrospect. As a way of checking the participants were happy to continue with the original consent I returned their interview transcript to them following the interview. The aim of this was to be sure they were happy with what had been recorded within the interview and it also made sure that if anything was unclear it could be clarified (Clarke 2006).

### ***Beneficence and Non- maleficence***

The possible benefits and disadvantages of taking part in the study were outlined in the project information sheet. Issues of confidentiality and privacy were also explained in detail to the participants before taking part. This may have been a worry to some participants as the number of participants in the study was small and it may have been easy for others to work out who had said certain things in their interview even though the names of people taking part were not used. There was also the concern of individuals being identified in future publications. Participants were assured that personal details would be removed, pseudonyms used and they would not be identified in any published work.

Within the study there was the potential that participants may have spoken about distressing topics therefore I needed to decide how far to probe if a participant became upset. In reality this did not occur, but I still had to prepare for this. This would have involved considering the relevance the story had in ethical terms to the purpose of the enquiry. Even if continuing the interview was legitimate, a degree of professional judgement would have been used to decide whether to continue or stop the interview. This potential dilemma required me to be a skilled communicator and listener, taking account of the unsaid as well as the said within the research interviews. I also had to be aware that I may not have had the skill to deal with the situation and may have needed to refer to other professionals for support; such as a counsellor.

It was also crucial to ask the question: what would I do if a participant described care that was unsafe or neglectful in the interviews. It was agreed within the ethical framework for the study that if such an incident had occurred then it would have been necessary to make the research participant aware of my responsibilities under the Nursing and Midwifery Council (NMC) code (NMC 2015). I am bound by the NMC code as a UK nurse registrant and any such concerns would have been raised with the senior ward sister as appropriate. This point was discussed and agreed with the senior ward sister during the preparatory phase of the study. There was a high possibility that participants self censored sensitive information within the interviews, as there were no instances of concern during the period of data collection.

## ***Justice***

Research participants may be seen as being in a weak position within the research process therefore being vulnerable to manipulation (Crookes and Davies 1998). The relationships built within the interviews had to be approached with care. It was crucial that I had an awareness of the potential for harm as well as catharsis within the research interviews (Seibold 2000). Interaction between the researcher and participant along with a willingness by the researcher to invest something of themselves in the relationship is vital within qualitative research (Oakley 1981; Reinharz 1992). This usually results in a reciprocal relationship within the interview, but one may argue that once the interview is concluded then the researcher holds the data and therefore has the power to make decisions about how the data is used and interpreted. My professional role (other than that of a researcher) could have been perceived as being more influential than the role of the participants (particularly by the student nurses). It was therefore important for me to be aware of any perceived inequality in the relationships and to act in a manner likely to reduce the impact of this within the study.

## **Ethical processes within the study**

The study received NHS and University Research Ethics Committee (REC) and NHS Research Governance approval. REC approval was from the South Yorkshire committee. A risk assessment was also performed to ensure potential problems and solutions were considered prior to the study commencing (see Appendix 3 for all of the above approvals).

### **Storage of data generated from the study**

Manual data was stored in a locked filing cabinet in a locked office. Electronic data was stored on a password protected computer. All personal details were restricted to the researcher. All data were obtained and stored in line with the Data Protection Act (UK Government 1998) and followed the National Health Service Confidentiality Code of Practice (NHS 2003) to ensure that personal information was protected at all times. The sponsor and supervisory team also checked that these policies and procedures were followed closely. As the chief investigator, I am the only person to have access to this data now the study has ended. This data consists of personal details which will be stored for a maximum of 6- 12 months after the study has finished and research data which will be stored for a maximum of 5 years after the study has finished.

### **The study sample**

The study sample consisted of nurses working on the ward (the term nurse in this study refers to registered nurses, healthcare support workers and student nurses), staff from allied health professions and experienced nurses working in professional development and higher education (Appendix 6 shows the characteristics of the research participants). Purposive sampling was used to identify potential participants in order to explore the perceptions of key people who have access to important sources of knowledge arising from a specific experience (Morse and Field 1996; Holloway and Wheeler 1996). The sample were able to explore the concept of person-centred care, as they were individuals who held pertinent nursing / healthcare knowledge and were involved in clinical practice or healthcare education (Holloway and Wheeler 1996).

### ***The study was conducted in three stages***

**Stage one** of the study was the larger component of the study. It involved the use of semi-structured interviews and follow-up interviews or discussions with seven registered nurses, three healthcare support workers and four student nurses working on the ward. The student nurses were on clinical placement on the ward as part of their pre-registration nursing programme managed by the local university. The placements typically lasted between 8 – 10 weeks, everyone else held a permanent post. The aim of the interviews was to explore nurses' understanding of the term person-centred care, seek their views on what facilitates this in practice and their perceived education and development needs for themselves and other healthcare staff (some participants chose to have an individual interview, where others were interviewed in pairs).

**Stage two** of the study involved the use of semi-structured interviews with allied health professionals; a physiotherapist, a physiotherapy assistant and an occupational therapist working on the ward. The aim of the interviews was to explore the similarities and differences between their responses and those of the nurses.

**Stage three** of the study included member checking with study participants who had already been interviewed in stages 1 and 2. This process aimed to validate the findings and gauge whether the model of person-centred care made sense. Further consultations with experienced healthcare staff (Appendix 17) and semi-structured interviews with two professional development co-ordinators and two nursing lecturers enabled exploration of the practical application of the recommendations for education and practice. The final process within stage

three involved the synthesis of all stages of the study in order to develop and refine the model of person-centred care.

## **Recruitment to the study**

### ***Recruitment in stage one of the study***

Initial interest in taking part in the study was invited from the eighteen qualified nurses and fourteen health care support workers who worked permanently on the ward. In addition to this there were up to four student nurses accessing the ward as a clinical placement at any one time and information about the study was also available to them.

The Ward Sisters gave verbal information about the study to potential participants and expressions of interest were also sought by the use of posters. Contact details were also given to allow the potential participants to make contact freely without feeling obliged to take part in the study. Once ethical approvals had been granted, potential participants were given participant information sheet (Appendix 7) and asked when it would be convenient to meet with them to discuss the study. They were given at least 24 hours to consider whether they wanted to take part in the study. When a potential participant decided to take part a mutually convenient time and place was arranged for the interview to take place. On arrival for the interview, checks were made to ensure the participant was happy to continue and the consent process was explained. Two copies of the consent form were signed, one kept by the participant and one kept for the research records (Appendix 8).

### ***Recruitment in stage two of the study***

After data collection and analysis in stage one of the study were complete, recruitment for stage two began. This involved participants from stage one explaining about the study to the physiotherapy and occupational therapy team on the ward. Once contact had been initiated the recruitment process mirrored the steps in stage one of the study.

### ***Recruitment in stage three of the study***

Recruitment for stage three was different as it involved a combination of informal (Appendix 17) and formal data collection.

1. Discussion with registered nurses and support workers who were already part of the study took place informally whilst working on the ward. Checks were made to ensure that the participants were happy to continue with the study and ongoing verbal consent was sought and given.
2. An informal meeting with a service development worker for community mental health was set up via a colleague who felt there would be some congruence between this research study and service development taking place in community mental health within the region. The meeting was used to support data analysis and check the clarity of the emerging thematic framework with someone who was unconnected to the study, but who had insight into person-centred care.
3. An informal consultation with the research interest group in the NHS Trust where the research study took place involved requesting an invitation to the quarterly meeting for the purpose of sharing the interim findings of the study and gaining feedback on the clarity of data analysis.

Each member of the group gave verbal agreement to taking part in the consultation at the meeting and notes were taken by the group secretary.

4. The professional development co-ordinators and nursing lecturers were recruited to the study following a meeting where the ongoing study was being discussed and expressions of interest were sought following the meeting. They volunteered to take part after verbal information about the study had been given to potential participants. Their interviews were designed to examine the findings in relation to identifying future developments for education and practice.

## **Data Collection and Analysis**

### **Data collection in stage one of the study**

Semi-structured face-to-face interviews formed the basis of data collection. The rationale for using face to face interviews was to enable in-depth insight and understanding of the participant's experiences. The data generated from interviews is viewed as being co-constructed, in research terms as it is created as a result of dialogue between the interviewer and interviewee (Brinkman and Kvale 2005). From a critical realist perspective it was important to recognise the value of collaboration and reciprocity within data collection to gain a sense of the reality of person-centred care from the participants' viewpoint (Edwards and Holland 2013). Therefore it was crucial to foster productive communication within the research processes, which would enable the researcher and participants to come to a new understanding of the phenomenon of person-centred care as it exists in the study setting (Snape and Spencer 2003). This was facilitated by creating an atmosphere of openness and appreciation, which conveyed my genuine interest in their responses, stories of

care and, outcomes of the research (Arthur and Nazroo 2003, Etherington 2005). Demonstrating a willingness to share personal experiences and answer questions in a non-hierarchical manner also helped to put participants at ease in order to encourage a more in-depth exploration of the research questions (Oakley 1981).

### **Developing the interview guide**

The interview guide was developed following the literature review and was revised as a result of further reading, suggestions from the supervisory team and concerns raised by the carers group. Using an interview guide could be seen as inhibiting an open conversational style of interview (Fontana and Frey 2000). However as previously highlighted, it was used as a framework of questions to ensure that the interview met the aims of the study rather than being a rigid agenda. This meant that as participants introduced new ideas these could be responded to within the context of the interview conversation, thereby maintaining an appreciative and reciprocal approach within the study. As a result new questions were added to the interview guide where pertinent, thus developing the interviews in a collaborative manner (Appendix 9).

Where possible, the interviews took place away from the ward environment, with the aim of enabling the participants felt more relaxed and avoid unnecessary interruptions. Having choice about the location offered the participant some choice and control thereby allowing them to take part in the interview on their terms. The interviews were digitally recorded and transcribed in full. Although demographic information was collected, all identifying details were removed from the transcripts.

Conversations often took place around the interview. The value of these conversations needs to be acknowledged in the study. The conversations which took place before and after the interviews were not recorded or transcribed, but formed part of the field notes and reflective journal. These were used to support the primary data collection and allow comparisons to be made during data analysis. All elements of data collection were available to be shared with participants and supervisors in order to check for relevance and understanding of the data. This is an essential element if research is presented as being collaborative in nature.

Taking part in the interviews involved a time commitment from the participants and it was recognised that this may have been difficult for busy staff. The time commitment was approximately 30 - 40 min for the initial interview and 15 min for the follow up interview or discussion. It was important that any times agreed were adhered to in order to reduce the burden or stress longer periods may have caused. A small hand held digital recorder was used for recording the entire interview. The room used to interview nurses was off the ward, but connected to the ward so there was an awareness of everyday noises. This included noise from patient call bells, talking and, on one day, a faulty fire alarm, which was very distracting. The reality of the clinical environment is imperfect when gathering data; however, it is recognised that these are challenges that the researcher needs to circumnavigate when conducting research in the working world.

## **Conducting the interviews in stage one of the study**

Active listening was vital during the interviews to allow me to realise when a topic needed further investigation (Legard, Keegan and Ward 2003). It was also important that the participants felt confident that their privacy was guaranteed and all contributions to the study were valued. Being able to discuss their understanding of person-centred care and give examples from their work may have had benefits for the nurses. Listening to the participants in an appreciative manner may also have allowed the participants to recognise existing strengths within the team and look at their care delivery in a new light (Bright, Cooperrider and Galloway 2006). All data needed to be included as it would have been easy to take account of in-depth material from the more confident participants, missing the significance of contributions from less confident or less articulate participants (Arthur and Nazroo 2003).

The original intention in stage one of the study was to conduct follow-up interviews with each participant in order to discuss their perception of potential education and practice needs within the team based upon the emerging themes from their interview responses. This was not possible due to the workload demands of the nurses. Following a review of the data collection methods, it was decided that follow-up data could be obtained using a mixture of interviews, informal discussions (recorded as written notes) or written feedback from participants and attached to their interview transcript (Appendix 10). Each participant was given a summary of their interview. The aim of this was to enable them to check that it was an accurate representation of their interview and clarify any points that were unclear. This also gave the participants the opportunity to censor any material they felt apprehensive about sharing with others.

### **Data collection in stage two of the study**

Stages two and three were designed to challenge and expand upon the data in stage one, therefore the sample sizes were smaller. In stage two, the aim was to gauge how the views of the nurses concerning the facilitation of person-centred care corresponded with the views of other healthcare professionals in the study setting. The interviews were arranged to take place in the therapist's office which was just off the main ward. The interview guide was adapted and questions added to reflect their roles (Appendix 9). The first interview was a paired interview with a physiotherapist and physiotherapy assistant. It was helpful having the two perspectives emerging together in the interview. This helped my understanding of their complementary roles in the ward team. The second interview took place with an occupational therapist who also worked closely with the nursing and physiotherapy teams.

### **Data collection in stage three of the study**

Stage three of the study was designed to explore the emerging findings and gain feedback about the utility of the model of person-centred care, which was generated from the analysis of stages one and two of the study. It also provided an opportunity to examine the findings in relation to identifying future developments for education and practice. This stage began by conducting informal discussions with two registered nurses and two support workers who were participants in stage one of the study.

Member validation is a recognised method of increasing the credibility of qualitative research findings. The prime aim was to present the model to the participants, in order to assess how far my interpretations of the data

corresponded with the social world of the participants (Lincoln and Guba 1985). Although this is an accepted approach in qualitative research, there are limitations. It is important that the researcher is clear about what the participants are validating. For the purpose of the present study the purpose was to gain feedback from the participants about the usefulness of the findings when applied to the reality of care delivery. This approach fits with the more recent term; member reflection, which looks at whether the research is meaningful to the participants and they can understand the research process and outcomes (Tracy 2010). Member reflection goes beyond the premise of ensuring the participants' views are represented accurately in the findings, or that the researcher has interpreted their views correctly. It offers the opportunity for participants to offer their perspective upon the findings, which may not necessarily mean they agree with everything presented (Tracy 2010).

This process of enhancing the credibility of the findings of the present study also included using the interim research findings as a foundation for three interactive workshops about person-centred care. The joint facilitation of these with the three ward sisters and a practice development facilitator, took place after the first stage of data collection was completed. The workshops took place during 'time out' days for all levels of permanent nurses in response to the change in speciality of the ward and the consequent changes in team dynamics. Although member reflection was not the sole purpose of the days, the days did provide an additional opportunity to disseminate and reflect upon the study findings. The activities within the workshops generated an opportunity for the nursing team to have dynamic and frank discussions about the emerging findings and existing nursing practice by reflecting upon the facilitation of person-centred care in everyday care on the ward (Appendix 14).

Another opportunity to reflect upon the findings occurred during an informal consultation with a research interest group that is active in promoting the application of research into practice in the host NHS Trust. The group members are experienced health care professionals and experienced nurse researchers. The aim of this activity was to further examine the emerging model of person-centred care and consider if it was relevant to inform education and practice. As a result of the consultation and further reflection on behalf of the researcher, the three main elements of the model remained. There were minor changes to the terms used; as experienced nurse researchers felt that the term 'professional' should not be used when referring to the participants as some were not registered professionals, therefore the term was changed to 'carer' to reflect this concern. The consultations supported the development of the model and also began the process of dissemination of the emerging findings (Appendix 17).

Following the informal consultations further purposive sampling was used in order to explore the perceptions of experienced nurses employed within professional and practice development and higher education. A paired interview took place with two professional development co-ordinators who worked in the Learning and Development Department at the NHS Trust where the study took place. This led to the final part of data collection in the study which comprised a paired interview with two nursing lecturers from the local university who taught on the undergraduate nursing programmes. Both interviews were conducted in pairs due to the pressure of workload on behalf of the participants. However, sharing ideas and holding a three-way discussion within the interviews was beneficial in meeting the aim of the stage three of the study.

The aim of the semi-structured paired interviews was to examine whether the model of person-centred care made sense to these participants and to explore implications of the findings for education and practice. The participants had no direct connection with the ward, but all were experienced nurses who had insight into nurse education and practice. It was important that they had not been involved in the earlier stages of data collection in order to gauge how meaningful the findings were to education and practice. The interviews conducted in stage three also created an opportunity for the social world of the participants in stages one and two of the study to become evident to others and look for connections with the perspectives and practice of others outside of the study setting (Dadds 2008, Tracy 2010). For these reasons, rather than having a specific interview guide notes were made prior to the interviews as an informal guide (Appendix 11). The notes were designed to act as a prompt rather than be prescriptive, as the model of person-centred care formed the main focus for guiding the interviews.

### **Data Analysis**

The data were analysed using Framework Analysis, which was originally developed to be used in applied qualitative social research. This differs from the traditional view of research undertaken to generate pure theory, in that the outcomes of the research are expected to be acted upon in practice. This research approach offers insight and explanation of social behaviour, which is grounded in the experiences of those affected by the issue being explored (Ritchie, Spencer and O'Connor 2003). Four categories of research questions are recognised in Framework Analysis: contextual, diagnostic, strategic and evaluative. The categories of the research question used in the present study are explained in Table 2.

**Table 2: Categories of Research Questions Within the Study**

<b>Category</b>	<b>Stage of the study</b>	<b>Research Questions</b>
<b>Contextual</b>	Stage one (Doctoral)	What do nurses understand by the term person-centred care?
<b>Diagnostic</b>	Stage one (Doctoral)	How is the facilitation of person-centred care described by nurses in the study setting?
<b>Contextual and Diagnostic</b>	Stage two (Doctoral)	How do the views of the nurses concerning the facilitation of person-centred care correspond with views of other healthcare professionals in the study setting?
<b>Diagnostic and Strategic</b>	Stage three (Doctoral)	What areas for development can be identified from the data for research, education and practice that have the potential to enhance person-centred care in a medical ward setting?

<b>Category</b>	<b>Stage of the study</b>	<b>Research Questions</b>
<b>Strategic</b>	Stage four  (Post-doctoral - using the findings from stages one to three to formulate a needs analysis)	What type of education or practice activities would have the potential to enhance person-centred care in a medical setting
<b>Evaluative</b>	Stage five (Post-doctoral)	What return on investment is evident following education or practice activities

Adapted from Chapter 9 'Qualitative data analysis for applied policy research' by Ritchie and Spencer in Bryman and Burgess (1994, page 177).

Framework Analysis provided a structured and in-depth approach to data analysis. Seeing the discrete but interrelated stages used in Framework Analysis (familiarisation; identifying a thematic framework; indexing; charting and mapping and interpretation) enables the reader to know how the findings have been determined. Applying systematic analysis to the data was a challenge as the content of the interviews was complex and lengthy. The aim was to maintain the authentic meaning of the original data, whilst being able to show a structured approach to analysis and a clear relationship between the data and the interpretation of the findings.

## **Application of Framework Analysis within the study**

Data analysis was continuous and iterative throughout the study. It involved analysing data across stages, participants and themes. This included questioning the meanings attributed to the data, going backwards and forwards to re-assess the interpretations and connections made within the different stages of the study (Ritchie and Spencer 1994). The largest proportion of data were generated during stage one of the study; however, stages two and three added further depth. The same methods of analysis were used across all stages of the study. The responses of participants, and a priori knowledge built from nursing experience and reading the literature informed the revision of analysis.

Prior to formal transcription, each interview was summarised in order to provide a quick return of the interview content to the participant following their interview. This was done to allow the participant to see what they had said in the interview and change anything they felt was misrepresented or expand on points they felt were unclear (Clarke 2006, Tetley, Grant and Davies 2009). Taking this action was necessary to ensure that the interpretation of the interview remained authentic. Preparing the summaries was also a good way of revisiting the interview and clarifying points discussed within the interview. It offered the opportunity to check understanding of the interview content and add to field notes. To begin the process of data analysis the interviews were transcribed and checked for accuracy before being entered onto NVivo for coding of the data. Due to time constraints, the support of a transcriber was used. This was vital for the progress of the study. On receipt the transcriptions were checked against the recording for accuracy. Despite not completing the transcripts

personally, knowledge of the data emerged as the transcriptions and recordings were re-examined numerous times during data analysis, particularly in the familiarisation stage of using Framework Analysis.

### **Familiarisation**

Immersion in the data took place by reading and listening to the transcripts and interviews. By June 2012 recurring themes had been identified from examining the data in stage one of the study (Appendix 12, page 2). At this point it was crucial to ensure the data were not being made to fit pre-conceived themes or influenced by a pre-formed framework of findings from the research literature. It must be acknowledged, however, that subconsciously it is likely the theme titles have been influenced by reading, personal beliefs and personal and professional experiences and education. Therefore it was important at this stage to keep returning to the raw data in order to confirm the existence of a topics and themes in the interview transcripts.

This initial period of data analysis was designed to allow the data to 'speak for itself' (Ritchie, Spencer and O'Connor 2003). During this stage the data management software (NVivo 9.0) was used to organise the data. This enabled the transcripts to be stored and managed in order to start the process of sorting, coding and listing (see Appendix 12, page 3 for example of coding the data). Only when this step had been completed (by reviewing the data repeatedly) could the next phase of constructing a draft thematic framework and manageable index begin.

During these early periods of data analysis, it was important to pause and check that the framework and index construction was a true representation of the data. I worked with support of my supervisors to ensure the data was examined closely in order to be confident that there was consistency in the indexing. Each supervisor and I analysed three transcripts to verify coding; one from each of the participant groups (in stage one of the study) in order to compare and contrast individual researcher perceptions of the data. This process was designed to enhance the rigour of data analysis and assist in the next phase of developing the thematic framework.

### **Identifying a thematic framework**

After the initial coding, the first thematic framework was refined following further in-depth analysis of data and themes (Appendix 12, page 7). An assertion was developed from the data that each element in the three themes (characteristics of relationships, personal qualities of staff and respecting the principles of person-centred care) act together to shape the philosophy of care on the medical ward. The organisational culture and philosophy of the care environment influences how the participants perceive and facilitate person-centred care.

### **Indexing**

Although NVivo software was used to manage the data and code the transcripts the next phase of verifying the analysis and thematic framework was done by hand. This involved making a note of every instance in every transcript when the codes shown in the matrix were evident. The activity could have been achieved by using the software package, but it felt more effective to visualise

the data on paper. Having paper copies to work from provided the opportunity to flip back and forth between the pages and between transcripts to ensure an accurate and thorough analysis. This stage allowed reanalysis of the data including critical challenge of the matrix and checking its correlation to the original transcripts to aid accurate interpretation of the findings.

Once this had been completed and the indexed matrix had been refined further it was shared with four of the original participants from stage one of the study to gain feedback on its congruence with their interpretation of the interview themes. One participant said that they could clearly see where the themes had come from and they could almost recognise their own responses in the thematic framework (to become what is now described as the model of person-centred care). The other three participants agreed that the model was easy to follow and showed a direct relationship to aspects of person-centred care discussed during their own interviews.

### **Charting**

The fourth phase of Framework Analysis involved arranging the data previously indexed into charts of the themes, using a matrix approach (Ritchie, Spencer and O'Connor 2003). The activity was testing as it was vital to ensure that any data taken from the transcripts were easily identified again. Judgements during this period of data analysis were based on searching for similarities and differences between the initial themes and subthemes in the matrix. This was difficult as in some instances data could have fitted into more than one theme or subtheme. Spending time examining the data further resulted in final adjustments to the model of person-centred care (Appendix 12, page 10).

Charting involved the reduction of the raw data into brief summaries (Appendix 13), whilst maintaining the understanding of the original interview/conversation (Ritchie, Spencer and O'Connor 2003, Ward et al. 2013). Retaining the context and manner in which the key points were portrayed in the study was important. When checking the summaries for relevance the content could be easily monitored in NVivo by using the index shown in the full text transcript of each interview. Summarising the relevant sections of the transcripts was a challenge; it is difficult to know how much detail to include or remove. The key seemed to be to make sure that the summarised material made sense to someone without prior knowledge of the original transcript and reading the summary for the first time. In this case the supervisory team were able to assist as they had only seen three transcripts in full. The final model of person-centred care, which was developed iteratively from the process of framework analysis, is shown at the beginning of Chapter 4 (page 91).

## **Mapping and interpretation of the meaning of the data**

During this phase, cross-case analysis was carried out to explore who was saying what within the sample. This process indicated how themes represented the contributions of the different participants and staff groups within the study. It was also important to identify when a subtheme did not appear in a transcript. This allowed identification of certain concepts, where they were more noticeable or experienced differently in one group of staff than in another. This is often carried out informally in qualitative research analysis; however, using a structured matrix helps the reader decide how claims have been reached by providing an audit trail, particularly if the findings of research are being used to develop theory (Bradley, Curry and Devers 2007).

This phase of Framework Analysis also ensured that the model of person-centred care was a true representation of the data and not something that had emerged from my own perspective of the subject of person-centred care. An example of this is where the sub-theme 'responsive, culturally sensitive assessment, planning and delivery of care based on individual need' positioned in the main theme; 'Respecting the principles of person-centred care' required some further analysis. When the data was re-examined, the responsive nature of the assessment, planning and delivery of care appeared explicitly in the text, whereas being culturally sensitive appeared to be implicit in the data. Following this process of analysis 'being culturally sensitive' was removed from the model of person-centred care, in order to ensure the model remained true to the data.

### **Framework Analysis in stage two of the study**

Stage two of the study involved the use of semi-structured interviews with a physiotherapist, physiotherapy assistant and an occupational therapist working on the ward. The aim of the interviews was to explore the similarities and differences between their responses and those of the nurses. This meant that the use of Framework Analysis was different at this stage as the model of person-centred care had been developed using the data from stage one of the study. The transcripts were entered into the same database (NVivo 9.0) and the same methods were used to cross reference within the themes. However during this phase of data analysis the aim was to look for similarities and differences between the data generated from stage one and stage two. Data analysis was not a linear process, but involved revisiting the themes and looking for new themes emerging from the data in stage two. This involved considering how different participants within the different stages of the study described person-centred care and their experiences of delivering such care. This phase allowed investigation of the impact of professional roles and looked at how person-centred care was seen from other professionals' perspectives within the multidisciplinary team.

### **Framework Analysis in stage three of the study**

Again, analysis in stage three was by necessity different as the aim was to explore the clarity of the model of person-centred care developed after analysing the data gathered during stage one and two of the study and examine its relevance to education and practice.

The informal discussions referred to in the data collection section of this chapter were used to examine the clarity of the model of person-centred care and consider any changes that would make it more relevant to inform education and practice. For this reason they were not formally analysed, however they were used to support the data analysis and lead into the final, more formal data collection in the form of paired interviews of stage three.

The interview transcripts from stage three of the study were entered into the database (NVivo 9.0) and coded to the themes shown in the model of person-centred care. Following this, new codes (specifically related to stage three of the study) were generated. The purpose of the stage three interviews was not only to examine whether the model of person-centred care made sense to these participants, but also to explore their perspective about the implications of the findings in stage one and two for education and practice. As with stages one and two of the study, data analysis involved indexing, charting, mapping and interpretation of the meaning of the data. As the sample sizes were smaller this was less onerous in terms of the numbers of transcripts involved, however it was equally challenging since it was important to ensure cross case analysis, a clear audit trail of the analysis and, ultimately, an accurate interpretation of the data in order to aid in the synthesis of the whole study findings.

### **Limitations of Framework Analysis**

As with all qualitative data analysis methods there were limitations to using Framework Analysis. It was a lengthy process and it had to be undertaken using the systematic steps described by Ritchie and Spencer (1994). The most

important aspect of using Framework Analysis was to remain thorough in its application and not lose sight of the need for rigour in every aspect of the research process, thus providing transparency and an audit trail in order for the findings of the study to be seen as trustworthy (Lewis and Ritchie 2003). Successfully using Framework Analysis requires critical reflexivity, which can be enhanced by sharing with others involved in the study (Gale et al. 2013). Research supervision provided the ideal forum for critical discussion and reflection to take place. This presented further questions and challenges, which enabled more in-depth engagement with the process of analysis. Chapter four will draw on the data analysis by presenting the findings of the study using summaries and case studies to illustrate the themes and subthemes shown in the model of person-centred care.

### **Reflections upon the methodology**

On reaching the conclusion of the study it is important to reflect upon the effectiveness of the methodology. The study took a convoluted route partly due to changes in the study setting. However the collaborative nature of the study remained constant throughout. For example the initial ideas for the study were generated together with nurses working on the ward. As a result of early discussions with experienced nurses and the carers group, the interview guide was altered. In addition, any new ideas suggested by the participants during the study were incorporated into the study in a timely manner. As the original impetus for the study came from nurses in practice, a collaborative and explorative approach was congruent with the ongoing nature of my relationship with the study setting.

Taking part in the interactive workshops on the 'time out' days was successful in maintaining engagement and momentum in the study. In addition, focusing on the strengths and values of those working in the study setting in my everyday work (as their university link lecturer) helped maintain positive and productive relationships. This reflects the original intention and philosophy of the research approach, which was to explore the phenomenon of person-centred care in an appreciative manner in order to stimulate reflection and discussion about team development that has the potential to enhance person-centred care in an acute medical ward setting.

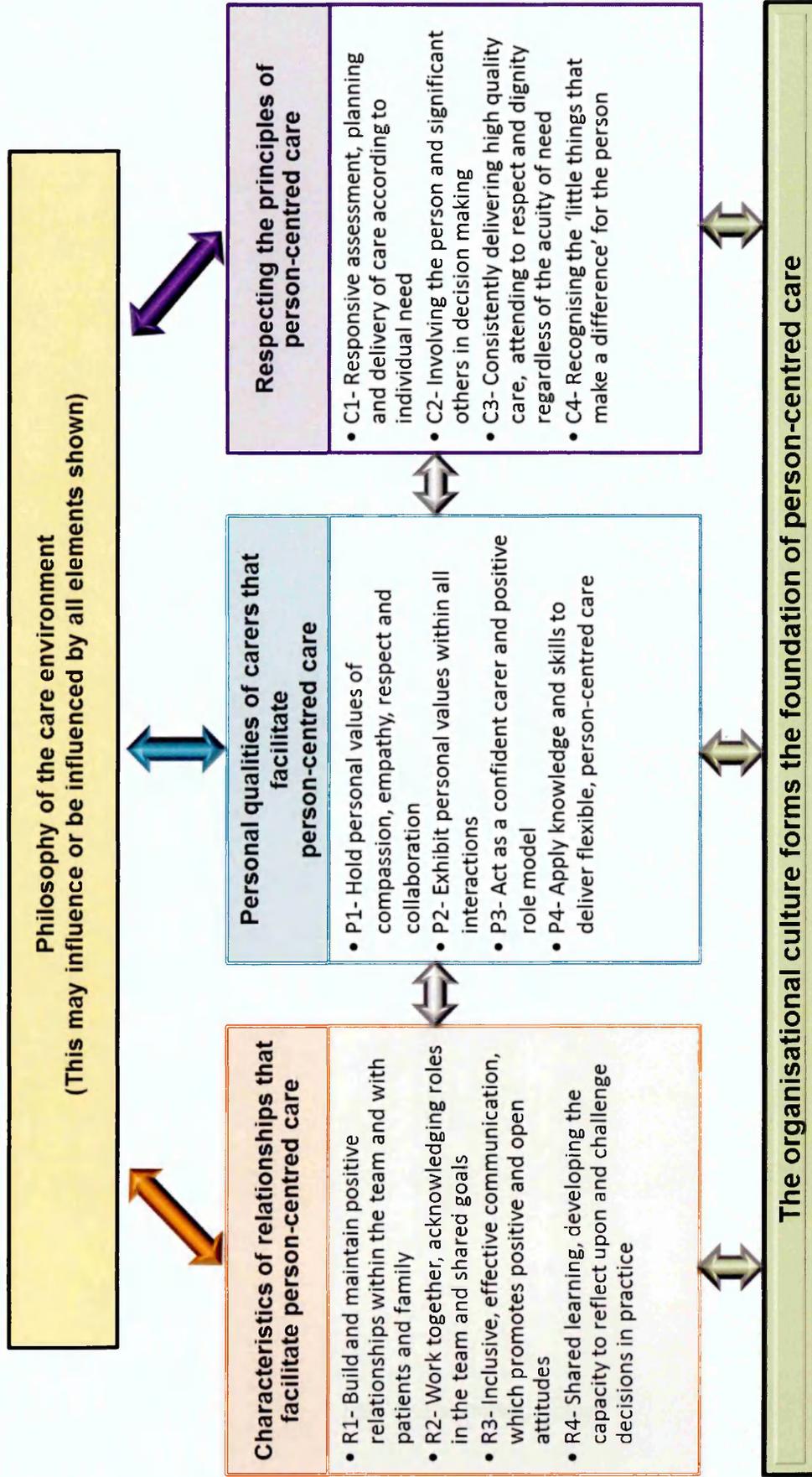
## Chapter 4 – The study findings

### Introduction

The purpose of this chapter is to describe the research findings from all three stages of the study. By integrating all stages of the study, the findings will describe how person-centred care is understood and achieved on an acute medical ward from the nurses' perspective; compare the nurses' perceptions to those of allied health professionals working in the same setting and consider the implications for education and development as identified by nurses, allied health professionals, professional development co-ordinators and nurse lecturers who took part in the study.

To provide a logical structure for the chapter, the research findings are presented using the themes and subthemes generated from the data analysis, which form the model of person-centred care (Figure 1). The model was developed iteratively from the *a priori* knowledge of the researcher, the literature review and data analysis from the present study. First, it indicates what needs to be in place for person-centred care to be achieved in an acute medical ward setting. Secondly, it creates a possible structure for future education and development concerning person-centred care.

**Figure 1: The Model of Person-Centred Care**



Quotes from participant interviews are used to explain the different elements shown in the model of person-centred care (Figure 1) and individual case studies are used to provide a more in-depth understanding of the findings. Each participant has been given a pseudonym within the findings chapter to protect their identity, but also to present the findings in a manner which indicates the individuality of the people who volunteered to take part in the study.

**Pseudonyms used:**

Registered Nurse 1 - Susan	Support Worker 1 - Geoffrey
Registered Nurse 2 - Dorothy	Support Worker 2 - Ivy
Registered Nurse 3 - Kamaria	Support Worker 3 - Gillian
Registered Nurse 4 - Denise	Student Nurse 1 - Petrina
Registered Nurse 5 - Joan	Student Nurse 2 - Michelle
Registered Nurse 6 - Jane	Student Nurse 3 - Alex
Registered Nurse 7 - Rameela	Student Nurse 4 - Carol
Allied Health Professional 1 - Eve	
Allied Health Professional 2 - John	
Allied Health Professional 3 - Sarah	
Professional Development Coordinator 1 - Elizabeth	
Professional Development Coordinator 2 - Mary	
Nurse Lecturer 1 - Beverley	
Nurse Lecturer 2 – Kath	

**Abbreviations used in the findings chapter**

RN – Registered Nurse	SW – Support Worker
StN – Student Nurse	AHP – Allied Health Professional
MDT - Multi-Disciplinary Team	Physio – Physiotherapist
OT – Occupational Therapist	NL – Nurse Lecturer
PDC – Professional Development Coordinator	

## Characteristics of relationships (R)

### **R1 - Build and maintain positive relationships within the team and with patients and family**

When considering the understanding participants had in all stages of the study about the term 'person-centred care', getting to know and understand the person featured strongly in participants' responses. It therefore became apparent that the characteristics of the relationships with the person and their family were crucial in providing the foundation for person-centred care. Relationships within the care team were also seen by the participants as fundamental in supporting a person-centred approach to care.

As a foundation for building trusting relationships, participants acknowledged the need for staff to be welcoming to the patient and their family as described by Rameela, a registered nurse: *'Building that relationship is about being friendly and approachable; a smile goes a long way...'* (Rameela - RN7).

Rameela saw this as a simple and effective way of helping the patient and their family feel welcome in the initial stages of a hospital admission. Other participants also stressed the importance of maintaining the relationships throughout the person's time as an inpatient.

Strategies to help build and maintain relationships were described during the interviews. These included making the most of the time spent with the patient and having ongoing contact with the patient and their family in order to get to know about personal care needs as described here by Gillian, one of the support workers:

*'...99% of the time I am usually in the same bay with the same patients, which is better for patients because they know you then by your first name. If you've looked after them for a few days you get to know their little ways and then they do tell you things that are worrying them.'*  
(Gillian - SW3).

The people interviewed during the study valued opportunities for care givers, patients and their family to get to know one another:

*'...when you create that bond I think you tend to look at them more as a whole rather than just as a medical patient or just a patient that you look after when you come to work.'* (Petrina - StN1).

Forming *'that bond'* was also described by others as helping the patients' needs to be identified more readily. Here, Denise, a registered nurse indicates the influence of developing relationships upon the delivery of person-centred care:

*'It's about trusting relationships... definitely and respecting the person, they are not just a patient, they are a person... Involving the family is a massive part of person-centred care, because their family know everything about them, they just know them inside out.'* (Denise - RN4).

Sarah, an occupational therapist was similar in prioritising, "getting to know" the person and their individual needs as early as possible. Initiating relationships often involved chatting to the patients and checking that the plan of care was consistent with their wishes:

*'I always check... "This is the plan for what we'd like to do, is that okay with you?"...'* (Sarah - AHP3).

Establishing and maintaining relationships in an informal, yet professional manner was also recognised by Carol, a student nurse participant as influential in supporting person-centred. This is illustrated in Case Study 1.

### **Case Study 1 – Carol**

R1 - Build and maintain positive relationships within the team and with patients and family

#### **Background**

Carol was a third year student nurse at the beginning of the final year of her pre-registration programme. Here she refers to her experiences from a previous placement on a specialised rehabilitation ward where patients were often in hospital for months at a time.

#### **Experience**

Carol described the atmosphere on the ward as less stressful than other wards she had worked on, as nurses and patients interacted with each other in a social manner, rather than just on a clinical level. This had a relaxing effect upon everyone. Each patient had something personal to them by their bed, such as a stereo. She thought this made their bed space feel special to them; as opposed to feeling impersonal or bare, which can happen in clinical environments.

This meant the ward did not have the traditional atmosphere of a hospital ward which may be perceived by some patients as being inflexible and medically orientated. Here Carol explains why she thought a more relaxed atmosphere worked so well on the rehabilitation ward, when thinking about forming relationships which foster person-centred care:

*'All the staff were encouraging and very positive to keep the patients positive and motivated. The patients even had their own little stereos. They all decided what kind of music they wanted on in the day and just little personal things, all the time. At every single stage it was always personal, every bit of care.'*

She goes on to explain her perception of the impact of this approach on the patient and their families:

*'Oh it had a really positive [impact on the person's recovery] because they didn't feel like they were in hospital it was a less stressful situation and they felt almost privileged to have that kind of care because they knew that was the best care that they could have. When their relatives came in we worked with them and the patients together as you would a student nurse, to look after their relative, but in every way it was really relaxed and informal and they were all treated with dignity and respect. It was a really good experience.'*

#### **Impact upon person-centred care**

The case study illustrates how constructive relationships with the patient, their family and MDT members have a positive impact upon person-centred care. During the discussion Carol compared this experience to previous experiences of working on other wards. Here she expresses the view that achieving person-centred care was not directly related to the amount of time available for care delivery, but was associated with forming positive relationships, which correlated directly to the approach to care within the team:

*'It was a really good experience... and the patients still had as many needs as any other kind of ward. Still as heavy and still as demanding as anywhere else but the attitude that staff had made a massive difference to the patients and the other staff.'*

(Carol - StN4)

Carol's account and those of others who took part in the study demonstrate how building and maintaining positive relationships is crucial in providing an

environment which is welcoming and inclusive. This experience had a positive effect upon the feeling of wellbeing for all, thus encouraging a collaborative approach to care.

## **R2 – Work together, acknowledging roles in the team and shared goals**

Working in a collaborative manner required the whole team to form positive relationships and work towards the same goals; this was facilitated by good communication between the team members, the patient and their family. Petrina, a second year student nurse recognised the need for a team approach to care: *'It [person-centred care] requires a lot more input from everybody to give individualised care.'* (Petrina - StN1). Sarah, the occupational therapist on the ward agreed with this view, in particular the need for clear communication between the wider team:

*'... if you keep up good communication in the MDT it does seem to help the care of the patient generally...'* (Sarah - AHP3).

Working together also required family involvement; for example a relative coming to the ward to help care for the patient. Here Geoffrey explains how this worked on the ward:

*'...sometimes they can help with the physiotherapy and care in the morning with an OT or with us.'* (Geoffrey - SW1).

Kamaria, a registered nurse agreed with Geoffrey by explaining her commitment to working with the patient's family: *'I think to get the family to help*

*provide care while they're supported in hospital is a big thing.'* (Kamaria - RN3). Family involvement was particularly important when preparing for the reality of providing care after discharge or to aid recovery in hospital. Being flexible in care delivery encouraged family participation in care, which had a positive impact upon patient recovery, either in the short term or when considering long term care needs.

Cohesive working was felt to have a positive impact on the whole atmosphere on the ward. For person-centred care to flourish, participants described specific conditions that needed to be in place. An example of this is articulated by a Rameela, a registered nurse who recognised that being person-centred had to be a philosophy throughout the organisation:

*'You see it's not just about one nurse doing it; it's got to be the whole organisation that's doing it.'* (Rameela - RN7).

The organisational commitment was directly related to providing appropriate resources, such as adequate staffing levels and having the correct balance of nursing skills available in the team. One of the ward sisters, Jane describes the importance of getting the skill mix right when planning off duty to optimise the level of person-centred care given: *'we look at what skills we've got as nurses as to what the patients are requiring.'* (Jane - RN6). This links directly to participants understanding each other's role in order to facilitate constructive team work.

Working to each other's strengths was a recurring subject of conversation in the interviews:

*'I think if you've got a good team and you know what each person is capable of you can get the job done correctly...you do a good job because you do it as a team.'* (Ivy - SW2).

Working effectively together was also influenced by the ward sisters having an open leadership style. This encouraged team members to support to each other when working to meet the personal needs of individual patients:

*'It [person-centred care] is a lot to do with leadership...'* (Denise - RN4).

*'...our ward sister and ward manager lead from front really and they will muck in and give personal care... they do ask your opinion about things and they're quite prepared to help you.'* (Gillian - SW3).

Being directly involved with care delivery meant that the ward sisters were an active part of the team, thereby influencing person-centred care on a daily basis: *'...they don't sit in the office with the door locked and they are part of team.'* (Gillian - SW3). Having a dynamic approach to managing the ward was perceived as motivating. It inspired team members to trust each other's judgements about care and offer support to each other when working to meet the personal needs of individual patients. Working towards a common goal allowed team members, including students to feel more supported when being person-centred; as explained by Carol, one of the student nurses:

*'...if all the staff are happy and the staff aren't judging the fact that it's taking a longer time to do something, for example it might not take you 10 minutes, it might take you an hour do something properly.'*

(Carol - StN4).

Eve, a physiotherapist also spoke about the benefit of having an understanding of each other's roles and learning from each other in order to enhance person-centred care:

*'...we work closely as a team... We can learn from others, good and bad ways of doing things.'* (Eve - AHP1).

In comparison, Sarah, who was an occupational therapist, felt concerned that some MDT members did not truly understand each other's roles and she sensed this could impact negatively upon person-centred care: *'I don't know how much, such as the doctors, know how much input each profession has...'* (Sarah - AHP3). Since therapists needed to work together with other professions to provide optimum care, it was articulated as crucial to have a common understanding of how the care provided by each team member interlinked in order to provide person-centred care. Not all participants felt that there was a lack of understanding about roles within the team. For example Susan, a registered nurse described having a strong MDT, which portrayed a clear understanding about differing roles:

*'The consultants are quite down to earth and approachable and the physios and the OTs work closely with the nurses. Everybody sort of*

*intermingles really well and I think that it shows when families know the names of each individual therapist, I think that's really good for the patient to know, a face and a name and somebody that they see on a regular basis.'* (Susan - RN1).

Having an understanding of each other's roles was identified by participants as promoting strong relationships in the team. Working together in a supportive manner also contributed positively, not only to the level of person-centred care on the ward, but the perceived wellbeing of staff members. This is illustrated in by the reflections of Gillian in Case Study 2.

### **Case Study 2 Gillian**

R2 - Work together, acknowledging roles in the team and shared goals

#### **Background**

Gillian was a support worker who had worked on the ward for four years. She had been closely involved with caring for a woman at the end of life and reflects on the experience.

#### **Experience**

Gillian was on night duty caring for Molly who was dying from cancer. Molly's husband had been present all night and care delivery was intensive and demanding for all. Achieving high quality person-centred care for Molly and her husband required nurses to recognise when their colleagues needed support. Gillian explains her experience:

*'Obviously it was quite upsetting, but it was very satisfying towards the end of Molly's life. Her husband wanted us to be with him all the time, I think he was quite scared about what was going to happen... he had certain ways that he wanted us to do things. He had a certain nightie he wanted Molly to wear and he had certain underwear he wanted her to wear and she had to have her hair done a certain way...*

*it was all because her children were coming in to see her. It was very sad really and he wanted his own music playing in the room for Molly. It was a very peaceful ending for her.*

*It was very draining physically and mentally as well, it was hard for me and another support worker who I was working with. The staff nurse who was on that night came and said "Gillian, can I just borrow you for a few minutes?" She didn't actually need me to do anything, but it was just to give me a bit of a breather because she knew I'd been swamped down...'*

### **Impact upon person-centred care**

In this case study, person-centred care was enhanced when individuals in the team understood one another's role; this enabled them to work more effectively to deliver exemplary care. They were able to build trust and work intuitively together to support each other and the family:

*'If you work in a good team like that you kind of know how you all work. So I came out and had a breather and then went back, but I think if you're working alright together you know [each other's needs]. If you know your staff nurse and your team that you're working with, you know what role you play.'*

The case study also demonstrates the close relationships formed between the nurses, Molly and her family. This involved working together as a team in ways that corresponded to the needs of Molly and her family to ensure their experience of care was the best it could be.

Chatting with Molly, her husband and family; trying to provide normality in the midst of end of life care was essential. Such occasions made a valuable difference to the quality of person-centred care received:

*'... Molly's husband would just shout and say "Any chance of a cuppa?" and we'd make one for him and we'd have a laugh and a joke with him.'*

This everyday banter was important to Molly and her husband, easing the strain of the situation. Gillian concluded by saying she felt satisfied that as a team they had helped

Molly and her family during one of the most difficult times of life:

*'... there were certain things she wanted doing; and that's what we did, the best we could.'*

Reflecting on this experience encouraged Gillian to think about her educational needs; she explains what she thinks would help her deliver more effective care:

*'I'd like to know a bit more about end of life care, because there are a lot of problems we come across... sometimes you don't understand and you need a bit more education.'* (Gillian - SW3).

Having a high level of support and cooperation within the team was conveyed as being facilitated by good communication between team members. This was enhanced when team members felt confident in their approach to care and able to contribute constructively to team discussions and decisions about care.

### **R3 – Inclusive, effective communication, which promotes positive and open attitudes**

An inter-relationship between teamwork and positive communication emerged from the participants' accounts. Both elements were perceived by staff as providing a work environment which was motivating to work in. This had a direct impact on the ability of the team to support a more person-centred approach to care. Effective communication was described as being crucial in helping the whole team understand the patients' perspective:

*'I think it all boils down to communication between all of us really about what patients need and what they express... they tell a few people different things and then you have to gather it all together.'*

(Gillian - SW3).

Listening to everyone in the team helped participants feel that their opinions were taken seriously and encouraged everyone to be involved in the discussions and decisions about care: *'I think the views and the opinions of the junior staff are important...'* (Rameela - RN7). Recognising the need to support junior staff and value their input in order to assist the team in providing person-centred care encouraged Alex, a second year student nurse to share relevant information with others in the team:

*'I think communicating with other members of staff is a big issue, especially in handover. You just put a few words in about the person [individual needs] and it can help a lot in their care during the rest of their stay.'* (Alex - StN3).

Feeling confident in their role (and acceptance) in the team was essential for student nurses to contribute to handover in a manner that they perceived would enhance person-centred care. For example another student nurse, Petrina described how she wanted to fit in with the team whilst on placement:

*'... you feel like you want to fit in and if you don't think the same way [as the others in the team] that you're not penalised.'* (Petrina - StN1).

In accordance with the nurses, Eve, John and Sarah, the allied health professionals who worked on the ward also identified the link between good communication in the team and high quality person-centred care, as shown by Eve and John in Case Study 3.

### **Case Study 3 - Eve and John**

R3 - Inclusive, effective communication, which promotes positive and open attitudes

#### **Background**

Eve was a qualified physiotherapist who had worked in the NHS for 11 years and John was a physiotherapy assistant who had worked in the role for three years. They discussed the benefits of working in an open and positive manner as a team in order to enhance person-centred care.

#### **Experience**

Initially, John had worked on critical care and was looking after a woman called Edith there. As he changed roles he also looked after Edith as she transferred from critical care to the medical ward. He saw her health improve through teamwork in both care environments.

John was impressed by the amount of support provided for Edith from the MDT and the support given to different members of staff within the MDT. A central element of Edith's care was the need to build her confidence. This required excellent communication within the team. John explains his perspective of the experience:

*'Communication between staff was great...we had to build Edith's confidence. We had to start her back from scratch really. She had no confidence, she had nothing really and we just kept it going, kept increasing her confidence, kept getting her up and doing a little bit. She'd have a back step, I think she ended up with norovirus and that knocked her back and then we kept going, kept going, kept her confidence up and then she got discharged.*

*I'd seen Edith from when she came into critical care, but it was nice to see her progress and all the teamwork that everybody put into Edith to actually get her to standing point. It just looked so far away for her to say "I can't get up, I'm so weak, I feel ill" and now "Look, I'm standing with a frame, I'm walking, I feel like I'm getting*

*a little bit of strength back" ... from talking to discharge. I thought that was really good from all sides, nursing, physio and doctors.'* (John - AHP2)

Eve agreed with John by explaining how she saw the role of effective and inclusive communication as crucial in supporting person-centred care in the MDT:

*'It's good communication between nurses and physios and everybody really. 'Communication, is the most important thing as John said, the big thing is just handing over, making sure everybody's singing from the same hymn sheet and it's also about respect [in the team], which I suppose helps with the communication.'*  
(Eve - AHP1).

Having respect for each other's roles and having positive attitudes towards each other was a vital element of maintaining effective communication within the team.

This involved making the best use of the range of skills within the team in order to improve person-centred care:

*'... they're [the nurses] aware of your role and they help you by sharing information and that helps to build a better working environment I think, and the better a working environment; the more geared towards the patient's wishes it is.'*

(Eve - AHP1).

### **Impact upon person-centred care**

This Case Study demonstrates how positive and open attitudes within the MDT assist effective communication and teamwork. All of these elements enabled the needs of the patient to be met in a more person-centred way. This was facilitated by team members supporting their colleagues in their respective roles, sharing care responsibilities and decision making in a productive manner.

Eve and John focused upon how constructive team relationships, effective communication and shared learning support person-centred care. However not everyone may have the skills or feel confident about communicating in the

MDT; hence Sarah recognised that it was worth investing in the development and maintenance of good communication skills with team members:

*'Some [team members] are really good at it and some aren't used to communicating with people. They've gone through school, university then wherever... Sometimes it helps sitting them down, getting them to be reflective...'* (Sarah - AHP1)

Similarly, student nurse Michelle appreciated the value of reviewing specific experiences of care as a team in order to help identify the learning opportunities present in everyday practice:

*'...maybe it would be worth just getting staff to think about the bigger picture, always discussing with the rest of the team and looking at the care holistically I suppose, rather than just treating the illness.'*

(Michelle - StN2).

Having the shared opportunity to reflect upon care allowed all team members to recognise good practice and the potential shortfalls in achieving a person-centred approach to care.

#### **R4 - Shared learning, developing the capacity to reflect upon and challenge decisions in practice**

Experiencing a shared approach to practice learning was more likely to occur when team members were open about discussing care and were prepared to share their knowledge and understanding with others to offer insight into how care decisions were made. Feeling confident to challenge the norm was seen by participants as essential to ensure the patient's individual needs were met. Developing clinical confidence appeared to depend on the relationships within the team and the level of support expected (and received) from the more senior staff. An open style of leadership as previously acknowledged facilitated an atmosphere where all levels of staff felt secure to reconsider care decisions in order to ensure care was more person-centred.

Working in an environment which encourages team members to use their initiative in order to personalise care, requires high levels of trust between everyone in the team. The nurses realised that providing safe person-centred care depended upon them working together to reflect upon an individual care situation, but most importantly recognising when to seek guidance from more senior team members if they were unsure about a care decision:

*'They [the ward sisters] support you; you can speak to them if you're not happy with things and so you know you've got support. They allow you to do your job as well, but I think they know who does their job well, so they just trust you to do it.'* (Ivy - SW2).

Developing trust within the team was an important component for shared learning, thus encouraging staff to be open to suggestions about more person-centred approaches to care. In order to ensure the team were working

effectively with the patient and family to provide person-centred care the nurses' role often involved explaining treatment choices after the doctor had been to visit the patient on the ward as described here by Denise:

*'It is only when the doctors walk away that we as nurses say 'Are you alright with everything you have been told, do you want to ask any questions?' then they sometimes say they don't understand what has been said.'* (Denise - RN4).

Making sure patients understood and were happy with the proposed plan of care was recognised as being a major component of supporting person-centred care. This also involved questioning care decisions on behalf of the patient when their best interests were not perceived as being represented. One example of this is given by Rameela, an experienced registered nurse, as she describes an occasion when a doctor wanted to discharge a patient, without having a full understanding of his circumstances:

*'It's like this morning when the doctor said "I want to discharge George" and we said "No, he can't cope at home, he needs homecare. He's 91 and he can't go home. George's wife has dementia, he's having chemotherapy." The doctor really wanted to send him home...'*

(Rameela - RN7).

With the support of the ward sister, Rameela managed to defer the discharge to allow further assessments to take place whilst George was still in hospital. Rameela saw George more holistically as she had cared for him over a longer

period of time. By explaining the complexities of his personal circumstances she was able to help the doctor see the person. This suggests that nurses have a pivotal role when making care decisions as they often have a greater understanding of the needs of the patient and other family members.

Prioritising care based on individual need rather than care being influenced by the perceptions of others in the team was also articulated well by student nurses in the study. Petrina discussed the following situation in relation to a registered nurse on a previous placement displaying discriminatory views about a patient during handover:

*'It's hard as a student nurse to try and speak up and say that's wrong or "you shouldn't be doing it like that, you should be doing it like this" because you do kind of get pressured into how you should act and you daren't speak up... it's going to affect your learning, they're [registered nurses / mentors] not going to want to get you involved in things and it's just not nice to be penalised for just speaking up for something that might be wrong or right.'* (Petrina - StN1).

This perception portrayed by Petrina suggests that student nurses frequently didn't challenge care decisions outright for fear of repercussion (i.e. the reliance on the registered nurse to assess them). Petrina felt that one way around this was for student nurses to role model caring for patients in a person-centred manner in the hope that others would follow their example:

*'... I just went and helped him with whatever he needed, but I don't think I would have the confidence to say: "Excuse me, that's not right". I think I'd rather just go ahead and do it myself rather than go and tell that person [another nurse]... I believe it [my practice] should have an impact on people and they should think just because she [the other nurse] thinks that doesn't mean I have to think that and I can go and do what I want, I've got my own mind. Hopefully other nurses and support workers will think for themselves; not just go on what other people have told them.*

(Petrina - StN1).

In an environment where student nurses felt able to speak out without fear of being '*penalised.*' (Petrina - StN1), student nurses felt more able to challenge perceptions of care needs and even share knowledge they had gained from their studies with others in the care team. Sharing their learning was an opportunity for students to demonstrate knowledge and understanding about nursing and feel accepted as part of the team. This was especially important to the student nurses when it enabled them to contribute to discussions about care:

*'Students obviously don't know more than the registered nurses... I've just done an assignment on dignity and privacy, so sometimes we can bring little bits of things onto the ward: Just reminding some staff and other students as well.'* (Alex - StN3).

Recognising the value of the contributions of all team members had a positive impact upon the working environment and was a factor in facilitating shared learning within the team.

Kath, a nursing lecturer also reflected upon the importance of positive and open attitudes within the team to aid learning and in turn influence person-centred care:

*'...there are some areas where students are supported more than others, and those are the areas where other staff are supported, it's that learning culture... taking it from an opposite point of view we want all nurses going out of the university to have and foster a positive culture of care. So I think we need to embed these [concepts] in university learning so students are able to work towards that, because some of the students will be the team leader (and some of them quite quickly); the team leaders that can influence care on those units or work in teams.'*

*(Kath - NL2).*

Beverley and Kath, the nursing lecturers also recognised that person-centred care was about a coordinated approach to care, encouraging all team members to work in a person-centred manner through developing relationships: *'...everybody on that ward is personally accountable for person centred care and promoting that culture.'* (Beverley - NL1). They also looked at what the framework meant for them as educators and indicated that as a whole they saw the model of person-centred care as a basis for learning:

*'I'd see it [model of person-centred care] more as a learning tool, because a lot of these things I'd expect people to be doing anyway, so I would think of it as something to use with somebody that's perhaps quite inexperienced or if there were issues with a member of staff...'*

*(Kath - NL2).*

*'What I was tempted to do was look at what it [the framework] means to me... to use it as a teaching tool... I mean the first concept of the forming of relationships, is not necessarily only with the patient or client, but may well include the relationships between all those in the team.'*

(Beverley - NL1).

The elements of the model of person-centred care were perceived by the nursing lecturers as a set of minimum standards, having the potential to be used to guide practice education in order to achieve high quality care within the organisation.

Both Elizabeth and Mary, who were professional development coordinators (PDC) emphasised that from their perspective within the NHS Trust, person-centred care was about having a common philosophy. In order for this to occur, there needed to be importance placed upon the everyday aspects of relationships across the whole organisation. This approach needed to be encouraged and supported at all levels throughout the hospital:

*'...so it's every single member of the staff, from how they were treated in the car park, to how they've been greeted at the front door when they've come through to find their way to wherever it is... I've seen some porters do fantastic jobs, they're taking patients for tests and things and they're chatting to them and trying to take away those worries.'* (Mary - PDC2).

Using positive examples from everyday practice linked with the views of Sarah an occupational therapist interviewed in the study. She suggested one approach to help improve person-centred care would be to focus on a positive

care event as a whole team in order to analyse the experience, embrace the successful elements and apply the principles to future practice.

*'I think it probably would be good to dissect looking at how something worked to let everybody see what involvement each person [in the MDT] had to get that patient to that stage.'* (Sarah - AHP3).

Sarah's proposal to explore person-centred care inter-professionally connected closely to views expressed by Beverley and Kath, the nursing lecturers, who felt that education and development needed to be ongoing rather than a one off activity, such as a time out day:

*'... good examples would be more positive as a learning experience, but then with the opportunity to perhaps look at the things, what went wrong but also what's right. I think the Department of Health, when it's promoting something, tends to look at what's going right and give examples, so it would be sort of following that pattern... I wondered if something like an hour every week might be more beneficial [than a full day] where you had a team together, a team meeting, what's good this week, what isn't so good because then it's more immediate and it is linked into practice rather than going away.'* (Kath - NL2).

Kath's viewpoint correlated with the informal findings from the team time out days (Appendix 14); that education and development should be ongoing. Involving positive examples from practice, as advocated here by Beverley also corresponded with the team views as expressed in the time out days:

*'I always feel that we should lean towards the positives in order that people don't always think it's about examination of what we do wrong, because none of us are perfect... if we always do that then we often haven't got time to praise ourselves when we do things well, that we need to learn from.'* (Beverley - NL1).

Incorporating these actions within everyday practice was identified as the key to ongoing development in the team. This perspective links back to the relational aspects of supporting shared learning in order to achieve person-centred care. The next section of the findings will explore how the personal qualities of carers influence person-centred care delivery.

## **Personal qualities of carers (P)**

The findings in this section relate to the personal values and behaviours that are perceived by the participants as supporting person-centred care. Participants identified that the personal qualities of MDT members had an influence on positive relationships which encouraged a person-centred approach to care.

### **P1 - Hold personal values of compassion, empathy, respect and collaboration**

As a prerequisite for person-centred care, participants acknowledged the importance of team members possessing a set of values in order to deliver person-centred care effectively. These values included compassion, empathy, working in a respectful and collaborative manner with all involved in the care and having a personal interest in the patient and their story. Holding and exhibiting these values individually and collectively led to care being more person-centred.

For example, it was recognised by Geoffrey, a support worker that being admitted to hospital was often a stressful time for patients and their family. One way to help them feel more at ease was by listening and talking to them in order to create a more relaxed atmosphere:

*'... when you come in hospital you can be a bit afraid, you're not going to know what's going to happen and I think sometimes I can make patients laugh and that eases the fear of where they are...'* (Geoffrey - SW1).

Showing empathy with the patients and their family was reiterated by the John, the physiotherapy assistant as he acknowledged the benefit of chatting to patients to help them feel more relaxed during physiotherapy:

*'...like having a bit of banter with the patients... you usually get them to talk to you on their own level and then you become, not friends, but you can get on that personal level with them and you can work with that and it [the relationship] starts from there.'* (John - AHP2).

In some cases, however, adopting a more formal approach was more conducive to person-centred care, dependent upon the preferences and needs of the individual person in receipt of care. There was an emphasis on the need for healthcare staff to recognise that each member of staff, like the patients were individuals. This meant that not all team members felt comfortable working in an informal manner although this did not automatically mean that they were less person-centred in their care delivery as explained by Eve below:

*'...it's about the personality type of the person that's delivering it [care]... It's the freedom [of staff] to be themselves because everybody is different and people do approach their work very differently and as long as fundamentally the right work is getting done to the standard that you expect, how you go about doing it can vary.'* (Eve - AHP1).

This illustrates the need to gauge the appropriate level of formality within care relationships, since the informal approach to care may not be appreciated by all patients, their family members or the individuals delivering care.

In accord with other participants, student nurses also exhibited empathic care. Here Alex, a second year student nurse illustrated this by explaining how she made sure patients were not left in hospital gowns unnecessarily: *'I think that it is important to help them put on their own clothes.... to make it more personal.'* (Alex - StN3). Wearing hospital clothing was described as impersonal and undignified; therefore, when there was a choice of clothing, she felt strongly that the patient's dignity should be protected by this simple act. This appeared to be appreciated by the patient and their family:

*'... I made sure he had his pyjamas on and his wife came up to me and said "Oh thank you for that, he looks a lot better."'* (Alex - StN3).

Such examples of care were seen as vital to delivering high quality person-centred care, particularly if the patient was unable to act for themselves. This demonstrates how everyday interactions within the provision of care were recognised as meaningful for the patient and their family. Making every interaction count and using the time spent with patients effectively was emphasised by Carol, a third year student nurse, since spending long periods of time with the patient may be impractical in a busy care environment: *'When you have one to one time with a patient then spend that time one to one.'* (Carol - StN4). Denise, a registered nurse agreed that being person-centred should be integral within care. For her, it was intuitive, therefore part of her everyday practice:

*'...for me it's [person-centred care] my bread and butter, but I don't know if it's the same for everybody. It is kind of what I live by.'* (Denise - RN4).

Using the time spent caring for the patient to be truly focused on the patient rather than nurses talking only to each other or talking 'over' the patient was identified as one way to achieve this.

Nurses also realised that the manner in which they communicated with the patient made a big difference to person-centred care. Showing compassion and empathy within everyday interactions was essential. Picking up cues from the reactions of the patient whilst caring for them was also crucial in helping staff understand the patient:

*'...communication is very important...not talking to a person like a bull in a china shop, to go in gently...'* (Ivy - SW2).

Listening in a compassionate and empathic manner to what the patients and their family were saying either verbally or non-verbally enabled nurses to be more confident that the care delivered was meeting the patient's actual needs, rather than conjectured needs.

As described here by Gillian, exhibiting a personal interest in the patient, their family and friends was a prominent feature in the participant's accounts and linked closely to being able to provide more person-centred care, which in turn had a positive impact upon job satisfaction:

*'If I'm helping a patient I like to talk to them about their life because they're not just a person in a bed who's ill, they have got a life and a family...'* (Gillian - SW3).

Equally, Eve portrayed care based upon her personal values of compassion, empathy and working in a respectful manner. This encouraged the patient to take a key role when discussing and deciding about care priorities:

*'... [the patient] will say "No, I don't really want to progress onto a stick' or 'I'd do this"...' (Eve - AHP1).*

A three-way communication between the patient, John, the physiotherapy assistant and Eve, the registered physiotherapist was used in order to reach decisions about therapy and ongoing care needs. This emphasised the collaborative and respectful nature of their relationship.

Although participants demonstrated personal values which were congruent with person-centred care, the findings indicate that this was not the situation for every nurse working on the ward. This presented a dilemma for Jane, one of the ward sisters when she was considering how to ensure consistency in the quality of care delivered on the ward as shown in Case Study 4.

#### **Case Study 4 - Jane**

P1 - Hold personal values of compassion, empathy, respect and collaboration

##### **Background**

Jane, a ward sister who had been qualified for 30 years gave an account of a recent care experience that had a positive impact upon some nurses on the ward, but also highlighted some concerns she had about the delivery of person-centred care within the nursing team.

##### **Experience**

Jane described her recent experience of caring for Grace; an older woman at the end of her life. She was incontinent, confused and needed full assistance with all

care. Jane talked about her frustrations when some nurses didn't see the person they were caring for. She used a poem which is well known in nursing to illustrate what she meant<sup>1</sup>.

*'Some people will see this little old lady sat in this bed, she's incontinent, she needs feeding and things like that and they don't see the person and what she might have been and what she's done and it's exactly what that poem says.'*

Jane went on to explain there was one staff nurse who had been caring for Grace who had built up a relationship with Grace and her family. Following Grace's death her daughters made contact with the nurse:

*'...her daughters brought a card in for staff and for one nurse in particular to say thank you and they bought some photographs of when Grace was younger and she was so beautiful. It was Anna, one of the staff nurses they brought it in for.*

*Anna was touched, but she was really upset by it too, because she saw Grace as a person, as an individual but some staff didn't'. We felt the other staff should have shared in that as well because they don't always see patients as people do they?'*

(RN6).

Impact upon person-centred care

This case study emphasises the personal values of compassion and empathy portrayed by Jane and Anna when caring for Grace and her family. It illustrates the positive impact of caring for Grace in a person-centred manner for all involved.

However there was an underlying regret that not all nurses realised the potential positive impact on all involved, when care is perceived as compassionate and caring by the person and their family.

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<sup>1</sup> The poem 'Look Closer' was written by Phyllis McCormack and is shown in Appendix 16. This has also been used nationally to emphasise the value of person-centred care (Waring 2005).

In accordance with Jane, other participants acknowledged the value of seeing photographs to help carers connect more easily with the patient as a person. There was also a perception from Denise, that older people in particular enjoyed showing carers their photographs and talking about their life:

*'...they have been our age once and they are not just an old person laid in a bed who is not very well, they are a person and they have had a life themselves... a photograph has a positive impact as well because usually there is story behind a picture and you can make relationships that way.'* (Denise - RN4).

Sharing a photograph often prompted conversation about something more personal to the patient, for example hobbies and interests, instead of talking purely about medical matters with the nurses: *'... Yeah not just can you do me a sputum sample please (laughs).'* (Jane - RN6).

Attending to patient's stories and experiences was described by participants as another way of helping them gather some insight into the person in an informal manner. It was also more likely to promote person-centred care when personal values based on compassion and empathy were portrayed within the conversations.

## **P2 – Exhibit personal values within all interactions**

Developing trusting relationships beyond the initial contact with the patient and their family was often enhanced by participants developing mutuality with the people in their care. This was implicit in many of the interviews; for example here Geoffrey, a support worker shared his perception of the relationships he developed with patients and their family:

*'I think you get a lot of satisfaction, I'm not going to say you feel part of the family, but you feel closer to that person. As families get to know you they ring up and ask for you in person, just things like that.'*

(Geoffrey - SW1).

The interaction between the participants, the patient and their family often involved listening to people's stories and acknowledging the importance of the stories to the delivery of person-centred care: *'...listening to their stories helps you find out what is it that makes that person feel like they are "them"'*

(Dorothy - RN2).

The stories shared with the nurses and allied health professionals in an acute care environment were often told in context with the person's current care needs rather than an in-depth life story that would be more likely to be gathered in more long term care settings. Some stories shared with nurses were not purely about the patient's current situation, but offered a deeper understanding of the patient's personal needs as shown here by Rameela:

*'They bring something with them. They bring a little package with them, their identity, their sort of background, their experiences of life... they could be in hospital for one day or they could be in four weeks... and you become a part of their world if you know what I mean.'* (Rameela - RN7).

Nurses realised the value of taking time to listen to each person's story with empathy, often using the information to shape the patient's care. One way of

achieving this was to listen carefully to what was being said (or conveyed by their behaviour) and respond in a compassionate manner: *'To me it is important to be gentle and just caring.'* (Ivy - SW2). Ivy also claimed that when observing other carers she could tell if they were person-centred by the way they communicated with patients and their family. This was important in establishing patterns of care that would promote and maintain person-centred care.

Likewise the allied health professionals recognised that displaying empathy when interacting with patients helped them feel more at ease during their hospital stay. In a similar way to Gillian in Case Study 2 (page 101) John, the physiotherapy support worker talked about providing some normality within the provision of care to reduce the fear and anxiety some patients and family experience from being in hospital:

*'... you've got to bring some normality to their lives whilst they're in and I feel that having a friendly attitude helps; you've got to gain their trust. That works for me.'* (John - AHP2).

Communicating in an informal, yet respectful manner was articulated by a number of participants as helping team members to establish that patients were happy with their proposed plan of care, thereby maintaining a person-centred focus. This indicated that participants recognised that although someone was in hospital they were still able to make informed choices about the care they were willing to accept.

In contrast, there was a feeling portrayed by some participants that if staff thought that they knew what was best for a patient without genuinely listening to the patient's wishes, care was likely to be less person-centred:

*'People [MDT team] need to listen as well not just think you know what's best [for that person] because you don't. You should sometimes listen and watch to see what's going on and then take your lead from there.'*

(Ivy - SW2).

Making sure patient's personal preferences about care were understood, was perceived by some participants as being particularly important when caring for older people, as sometimes care needs could be based on assumptions related to their age or perceived ability, rather than listening to the patient and their families.

Sometimes patient's stories were more challenging to gather or understand, particularly if the patient had communication problems. In extraordinary or challenging circumstances, listening with empathy and compassion was just as important as in less challenging or everyday situations. Actively listening to the patient, taking cues from the unspoken as well as spoken communication emerged as essential to aid understanding of complex personal needs as shown by Susan in Case Study 5.

**Case Study 5** Susan

P2 - Exhibit personal values within all interactions

**Background**

Susan was a registered nurse who had been qualified for 5 years. Here she talks about how she and her colleagues built up a relationship with a woman called Barbara who had been admitted to the ward from a supported living home for people with learning disabilities.

## **Experience**

Trying to understand Barbara's perspective helped the team care for her more effectively by focusing on her individual needs. Listening with empathy and compassion was identified by Susan as aiding understanding of Barbara's complex personal needs:

*'... because she doesn't have a really good speech pattern we have had to get to know what each individual sound means and when she points to certain things, what does that mean?'*

Barbara had learning difficulties and was very reliant upon her normal daily routines to keep her calm:

*'We've had to get to know her routine, how she lived at home, how she was cared for... so that has been a growing experience for us as well. On top of that she's had to get used to us because she's used to a certain set of people coming in to see her each day and it's all new surroundings and people and faces and sounds so from her point of view it's been quite distressing and quite hard work, so we've sort of learnt together.'*

*Now, she's been with us a couple of weeks, she knows our faces and she also knows who she can wrap round her finger and who she can't. Again that is a relationship that's been built from scratch and now we know her and she knows most of us and we know how to care for her so that's a really good working relationship. Although it's quite stressful at times, it does work.'* (Susan - RN1).

By building an understanding and empathic relationship with Barbara the nurses ensured her care remained focused on her individual needs. The approach to her care recognised her uniqueness which had a positive impact upon the outcomes of care interactions.

## **Impact upon person-centred care**

This case study demonstrates how respecting regular routines and interacting with

patients with care and compassion was important to maintain person-centred care. This patient appreciated being cared for by only a few people, rather than seeing different nurses or therapists every day. Therefore arranging this was crucial to delivering care for Barbara based upon the values of empathy and compassion

Barbara expressed herself loudly and regularly, especially if she was unhappy. Consequently the nurses easily recognised her need for normality in her care routines. Respecting daily routines for other patients who may not display their feelings and frustrations as readily may be more challenging to achieve for staff working in a busy care environment. One way of increasing the probability of respecting patient's normal routines was for nurses to work regularly in the same team thereby allowing the nurses, patients and family to get to know each other more easily. By building relationships in this way, nurses formed a picture of the person and their needs. This meant it was more likely that they would use their knowledge and understanding of the person and their medical condition to adjust ward routines to meet the person's needs.

### **P3 – Act as confident carer and positive role model**

Whilst person-centred care was the focus of the study it became clear it was not only about the care of the patient. Person-centred care included caring about everyone involved in the care situation. For this to take place, it was crucial for the ward sisters to be aware of the need to treat people as individuals and to encourage others to do the same:

*'...when you get new staff then you should be encouraging them and setting a good example.'* (Kamaria - RN3).

In common with each other, the three ward sisters spoke about offering encouragement and support to inspire role modelling at all levels within the nursing team. The ward sisters believed this motivated the nurses to develop confidence to work flexibly in order to support person-centred care, thus becoming a role model to others. The ward sisters stated that from their perspective role modelling was not dependent on seniority, but happened within the team as a whole (see evidence from a student nurse on page 111). Jane, one of the ward sisters also described how a support worker on the ward acted as a role model for a younger support worker, thus promoting person-centred care:

*'...hopefully the things that Beth does for patients, Alice will see and pick these qualities up... it's not only having the experience; it's the maturity as well.'* (Jane - RN6).

Personal and professional maturity was perceived as being central to role modelling. One ward sister Dorothy, felt maturity was not only about age, but was more a natural way of being for an individual member of staff:

*'... I think it's maturity as well...often you get mature heads on young shoulders and there again it's not something that you could particularly teach people, they've either got that nouse or they haven't.'*

(Dorothy - RN2).

Acting as a role model required the nurse to be able to ascertain what elements of the organisational rules and routines could be safely flexed in order to meet person-centred needs. This often came with experience and confidence, whatever the role of the nurse:

*'... generally speaking, people are able to identify what's important, what rules you can bend and what you can't and it probably is down to experience.'* (Jane - RN6).

Although there were circumstances when junior nurses acted as role models, there was also an appreciation that in some cases more experienced nurses found it easier to enact, due to expectations related to their role; for example being a mentor. The reality of being a junior member of staff or a student nurse meant being a role model presented more of a challenge than the ward sisters realised.

Student nurses Alex and Carol, who were interviewed together, talked about their experiences generally (not just on this ward) and were hesitant about the outcome of attempting to be a role model, since they felt that more experienced staff might not listen to them or view their practice as exemplary. This was despite the previous example given by student nurse, Petrina of using role modelling when direct verbal challenges to care felt too difficult to attempt (page 111). Nevertheless, Alex and Carol acknowledged that as a student nurse it was possible, in some cases to lead by example and this could have a positive impact upon the approach to care practiced by other staff:

*'Yeah you could show somebody that you've managed to get a patient to eat a good amount of food and they see that and you could explain how you've been able to do that, so you're leading them [other nurses] to be able to do it themselves.'* (Carol - StN4).

However Alex, who was interviewed at the same time as Carol was not so confident that more experienced nurses would follow a student nurses' example: *'But they wouldn't follow a student nurse; I don't think though (laughs).'* (Alex - StN3). In spite of the student nurses' reservations about who could act as a role model, the concept of sharing knowledge and experience with others by being a positive role model was shown in the findings to link to the display of personal values of compassion and empathy of all staff involved in care delivery. In contrast, other participants' views were in accord with the ward sisters' views. For example Denise, a relatively junior registered nurse (qualified four years) conveyed her feelings about facilitating person-centred care and clearly recognised the impact of her own (and others) role modelling upon student learning:

*'I think as a student you do look a lot to your mentor and follow what they do. I remember a lot of things my mentors did, good and bad. Hopefully you just pick up good things and use the bad things as an example of what not to do.'* (Denise - RN4).

If student nurses observe their mentor caring for patients in a person-centred manner it was perceived by participants to have a constructive influence upon the quality of care received by the patient and their family.

Support workers also had a role in helping student nurses or inexperienced nurses and Geoffrey described how he would do this:

*'I'd start off by saying talk to the patient as a human being, not just as one person of 28, every person on this ward is different, talk to them as an individual.'* (Geoffrey - SW1).

Participants commonly explained how they would offer advice to a novice carer by asking them to think about their own expectation of care if a loved one was being cared for in similar circumstances to the patient. This was perceived by some participants as a bench mark for the provision of high quality person-centred care:

*'When you think about looking after a person, think to yourself if it was my mum I would like her to be dressed properly, I would like her to be comfortable... and everything is neat, her hair combed properly, her teeth brushed and just general appearance.'* (Ivy - SW2).

This technique was used by support workers and registered nurses when they were working alongside student nurses. For example if a student nurse seemed prepared to accept a patient's reluctance to get washed or have a shave without question, Joan, a registered nurse tried to help the student nurse understand the importance of personal hygiene for patient wellbeing:

*'... it's alright helping a patient get washed and dressed, but if you haven't cleaned their teeth or brushed their hair or you've not shaved them ... I say "... would you like to come and see your Dad looking like that?''* (Joan - RN5).

In order for student nurses to fully understand individual care needs, participants explained that it was essential to involve them in every stage of a

patient's care, including discussion about the rationale for care decisions. For instance, explaining how more experienced nurses would go back to the patient who appeared reluctant to wash and gently explain the benefits of getting washed or shaved and offer to help the patient.

As a result of reflecting on their experiences of working alongside student nurses, some registered nurse participants expressed worries about the current pre-registration education in comparison with their own education and training. One concern expressed was that in today's NHS, student nurses had little time to sit and talk to patients as they were too busy learning about all the documentation of care rather than care delivery. This meant they appeared to be lacking in *'hands on'* experience when they arrived on the ward: *'... some of them [student nurses] when they come to us they've not washed a patient at all...'* (Joan - RN5). This was echoed by other experienced nurses when they compared their *'apprentice style'* nurse training to current nurse education:

*'I was trained a long time ago [25years] and my training was hands on care. Today, newly qualified staff nurses are coming onto the ward, I don't want to be disrespectful to them, but they lack skills in hands on care... They don't have the opportunity to go and sit with the patient and talk to the patient.'* (Rameela - RN7).

This was frustrating for the registered nurses as they felt that this interfered with the overall ability of nurses to give the level of person-centred care they aspired to. One solution suggested by participants' was to afford student nurses more time to get to know their patients and get involved with personal care. Here, Ivy

agreed that some student nurses needed prompting to see the patient's personal needs. However she offered a cautionary note to others when comparing current nurse education to the past by recognising that student nurses benefit from positive criticism and encouragement during practice learning:

*'But you don't want to be over critical; you don't want them to think that you're picking on everything they do, because everyone's different so they're bound to do things slightly different from you and your way isn't always right and I suppose their way isn't always right. I don't know, there should be a medium somewhere but I don't know how to get to that.'* (Ivy - SW2). In addition to junior staff or student nurses working alongside experienced support workers and registered nurses, it was also identified as being important to supplement the experience with other methods of teaching and learning. For example having the opportunity to 'test out' differing approaches to care delivery under the supervision of a registered nurse or other qualified healthcare professional. Participants also realised the benefit of student nurses reflecting upon their practice experiences in discussion with more experienced nurses. This helped student nurses understand how professional judgements were used to aid care decisions and retain the emphasis on person-centred care.

Despite the criticisms of present day pre-registration nurse education there was no evidence to support the concerns in the student nurse interviews. Student nurse participants repeatedly demonstrated professional insight and awareness of person-centred care (See Case Study 1, page 95). Their explanations of care priorities corresponded closely with the feelings articulated by experienced nurses; that person-centred care was not only a way of determining high quality

patient care, but was an expression of the person-centred values held by the participants.

In the later stages of the study when considering the educational implications of the findings, the views of the nursing lecturers related closely with the findings from the student nurses. They acknowledged the importance of student nurses possessing qualities such as empathy and compassion when delivering care. Nursing lecturers reflected upon the importance of prospective student nurses holding personal qualities which were likely to promote person-centred care. Attracting the desired type of applicant to pre-registration nursing programmes, required a co-ordinated recruitment process. Therefore recruiting suitable candidates was not solely dependent on examining attitudes at the interview stage as explained here by Beverley and Kath:

*'...we do put a lot of time and effort into considering our recruitment, from how we advertise initially, how we market the programme, how we would shortlist from the applications and then how we would interview in order to attempt to ensure that the students that start on the programme actually come with some of the qualities that we would look for.'*

(Beverley - NL1).

*'Thinking about what's happening in healthcare at the minute... the section [in the model of person-centred care ] on personal qualities, how they interact with others showing insight, compassion and empathy is particularly pertinent... In my area when we're interviewing it is personal qualities that are increasingly more and more the issue and the values of those people that we assess at interview. So that's a very strong issue.'*

(Kath - NL2).

Beverley and Kath, the nursing lecturers had confidence that once the student nurse started on the programme, the education they received in and clinical practice built on the personal qualities demonstrated at entry level in order to develop competent and compassionate nurses:

*'...the skills and knowledge that students will require over their career lifetime will be transformed and altered... but unless they've got the right attitudes and personal qualities and those are the things that we want to be right from the beginning, those are actually the most difficult things to change. So I think it is so important for us to get that right, as students go out into placement.'* (Kath - NL2).

Another aspect of supporting the development of personal values congruent with person-centred care was the perceived influence the nursing lecturers had in the practice environment in their role as a university link lecturer:

*'I think we do have influence in practice because I work as a link lecturer and I also work as a lead link lecturer so I have an influence in another role related to the potential culture of the areas that are deemed to be suitable [for practice education] ... therefore we do have some influence I think as educational experts'* (Beverley - NL1).

The role of university link lecturer provides support for the learning environment in terms of preparing the placement for student learning and assessment. They also provide education and guidance for registered nurses who act as mentors to student nurses during clinical practice. Undertaking these activities

strengthens the link between the theory of nursing and practice learning, consequently strengthening the likelihood of student nurses being enabled to deliver competent and safe person-centred care.

#### **P4 – Apply knowledge and skills confidently to deliver flexible person-centred care**

Feeling able to organise flexible care delivery was described by participants as aiding person-centred care. Nonetheless, the nurses spoke about the need for some routine in care delivery in order to achieve the treatment outcomes for patients, particularly when the ward speciality was stroke rehabilitation. Similarly, when the speciality became acute respiratory care certain treatments; for example nebuliser therapy had to be administered by the clock and, inevitably, this had an impact upon how flexible care delivery could be for specific patients.

When care delivery was flexed around patient needs, the nurses felt confident their decisions would be upheld by the ward sisters. The ward sisters recognised that, despite advocating flexibility in care delivery, time pressures could interfere with person-centred care, but still encouraged nurses to be adaptable in their everyday approach to care delivery, as described here by Dorothy:

*'...as I said if you can justify why you think it's appropriate to bend the rules a bit then that's fine. I think we are driven by the need to get the job done, but sometimes it's not going to hurt if somebody doesn't get a wash at a certain time if that's what they want to do.'* (Dorothy - RN2).

This meant that the patient's hygiene needs were met at a time which suited the patient rather than being dictated by routine. Considering the normal routine of patients was likely to be more beneficial to wellbeing and recovery. For example, some patients responded better to care if they took their time to get up in the morning as explained by registered Kamaria:

*'I think if somebody doesn't particularly want to get up as soon as we put the lights on at 7.30am or eat at 8 o'clock then you can adjust your workload...'* (Kamaria - RN3).

There was also recognition from Alex and Carol, the student nurses, that making generalised decisions about the timing of activities such as getting out of bed or eating breakfast was not necessary to fulfil care needs and was not conducive to person-centred care:

*'When they put the big lights on at quarter past seven I'm thinking... "Just put the little lights on for a little bit" (laughs)... "Don't blind them first thing in morning!" Imagine if you couldn't sleep all night, then these massive lights come on at quarter past seven (laughs)'* (Alex - StN3).

*'I think sometimes people see it as it's their workload ... so I'm going to forget all about patients and individual needs and just think what tasks I've got to do. That's where I think it goes wrong sometimes.'*

(Carol - StN4).

Inherent within the nurses' urge to complete all the tasks was the concern that if the nurse didn't achieve their set workload within an expected timeframe they would be labelled as lazy.

As described on page 110 there was an underlying concern that generally, student nurses felt that they had to conform to the expectations of the registered nurses to fit in to the existing way of working on placement in order to pass the placement. It was unclear whether this was solely the student nurses' perception or whether there was a real possibility that they might not pass their placement if they challenged the status quo.<sup>2</sup> Having this worry is likely to impede student nurses in developing the clinical knowledge, skills and confidence necessary to provide flexible person-centred care.

The student nurses' concerns of the time pressures interfering with the ability to be person-centred were similar to those of registered nurse participants. For example here Denise, a registered nurse participant lamented for the time she had to spend with patients when she was a student nurse:

*'you see things a lot differently when you are a student nurse, as you have so much more time as a student to sit with a patient and get to know them. Whereas when you are qualified you don't have time to make those relationships, it's really sad, but you can only do so much in a day.'* (Denise - RN4).

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<sup>2</sup> Student nurses were discussing their experiences from a variety of clinical environments, therefore their accounts may not have related specifically to the study setting.

Other registered nurse participants offered solutions to free up valuable time to be spent with the patient. One example given by Susan, was delegating work to others, working as a team and finding more flexible, less time consuming ways of working in order to free up time for person-centred care:

*'Everybody [in the team] is individual anyway, but I find that if you have a good relationship with your support workers you can just ask and things get done... as long as they know that you're willing to do the same sorts of things and it's not that you're not wanting to do it...'* (Susan - RN1).

Working more flexibly together to meet individual care needs was also spoken about by the allied health professionals; one way to achieve this was by having a daily meeting within the MDT. Sarah, the occupational therapist describes a new approach to managing care called the 'board round'. She believed this helped use the time available for person-centred care more effectively. It involved the MDT meeting every morning to discuss each patient and check their overall progress:

*'The consultants and doctors come as well as physios, OTs, nurses and we'll all input into the discussions. It's just a quick 15 minute discussion... We feed back where we're at with the social and discharge planning and obviously if the patient's not been well or if anything's changed that's brought up as well.'* (Sarah - AHP3).

The daily 'board round' was originally designed to improve communication between the MDT members and speed up discharge planning with the aim of increasing patient flow through the ward. Moving away from long MDT meetings (which could take up to two hours), was recognised by participants as a way of freeing up time for nurses and allied health professionals alike to work more flexibly and deliver care based on individual patient need rather than being bound by routines and lengthy meetings. However, it is worth noting that the 'board round' takes place away from the bedside and therefore only involves healthcare professionals, rather than including the patient in the discussions.

For flexible person-centre care to work effectively there was a suggestion that the organisation needed to recognise the benefits of supporting care teams to work together more consistently, as referred to here by Elizabeth, a professional development co-ordinator:

*'I also think there's a need for somebody to pull all of that information together about the team itself, so that it's [person-centred care] multidisciplinary, across all the team. For example domestics, do we have areas whereby that domestic is regularly the domestic for that area so they've got ownership of what's going on, in that "it's my kitchen, it's my ward, it's my bay" sort of concept. Or are these people who any day of the week could be anywhere because the task that they're doing is the task that they're doing...'* (Elizabeth - PDC1).

The views of the professional development co-ordinators correlate with those of the nurses by acknowledging the contribution of an organisational ethos of person-centred care within every role in the Trust.

The following section of the findings explores how the characteristics of relationships and the personal values and beliefs of the participants link together in order to respect the principles of person-centred care.

## **Respecting the principles of person-centred care (C)**

This final section of the findings considers the principles of person-centred care. It also examines how all previous elements of the model of person-centred care interlink in order to enable the principles of person-centred care to be respected.

### **C1 – Responsive assessment, planning and delivery of care according to individual need**

As acknowledged in the first section of the findings building and maintaining positive relationships was situated at the heart of assessment and responsive care delivery (see section R1). Effective person-centred care related directly to the MDT trying to understand what was important to the patient and their family. One way of facilitating this was by taking time to make sure patients had an individual assessment rather than making assumptions about care needs. Dorothy emphasised this by saying:

*'Sometimes we don't ask, we just assume, just make a judgement and I think it's something that you've always got to just step back and think about... you really have got to take the time to assess people and their needs... which we don't always do.'* (Dorothy - RN2).

Other nurse participants were clear that their role was to ensure care delivery reflected the patient's needs as described by Rameela below:

*'It's all about the patient, it's not about when I want, what I want and how I want, it's what the patient wants...'* (Rameela - RN7).

As nurses cared for patients over a period of time they were often the people who assembled a comprehensive portrait of them, which helped the team to develop a more in-depth understanding of the person. In Case Study 6 Denise illustrates how seeing the person in the context of their whole life rather than simply a patient in hospital enhances responsive care delivery.

### **Case Study 6 - Denise**

C1 - Responsive assessment, planning and delivery of care according to individual need

#### **Background**

Denise is a registered nurse who had been qualified nurse for 4 years when she was interviewed. She reflected on an experience which happened shortly after she had started working on the ward as a newly qualified nurse.

#### **Experience**

Denise cared for Mrs Bratley an older woman who had developed communication problems following a stroke. She highlights the importance of looking at the patient as a whole in order meet their care needs and describes the risk of nurses having a superficial view of the patient, particularly when they first meet a patient:

*'At first when you see a patient they just look elderly, she just looked the same as any other patient, just elderly, everybody kind of looks the same and they are not individualised they are just seen as an old lady in a bed.'*

Following the initial meeting Denise got to know Mrs Bratley's family and they told her what she was like before she came into hospital and brought in a photograph, taken the week before she had the stroke. This helped Denise build a picture of Mrs Bratley, enabling her to talk to her more easily:

*'I just couldn't believe how different and younger she looked. It made me think*

*about my own family, I thought "that could happen to my Nan tomorrow" and that's how she looked now.'*

One striking image was how Mrs Bratley now had her hair combed to one side, which was nothing like the hairstyle she had just the week before. As a result Denise paid extra attention to caring for Mrs Bratley's hair:

'I always tried to make sure that I 'buffed' her hair up a bit and made a special effort to do her hair.'

Denise realised that often nurses see patients as being elderly, rather than taking time to see them as an individual person and think what they were like before they came into hospital. (RN4)

#### **Impact upon person-centred care**

Seeing the photograph and listening to family's stories had a profound effect upon the way Denise saw Mrs Bratley and her approach to the care she gave. Denise saw the potential of using photographs to encourage person-centred assessment, planning and delivery of care. She acknowledged that there is usually a story behind every picture and talking about what was happening when the photograph was taken could be used to break the ice and build relationships with the patient and their family. This case study illustrates the importance of seeing the person being cared for when assessing, planning and delivering care in order to support person-centred care.

Like Denise in the case study, Carol, one of the student nurses also talked about the value of using photographs, based on her experience of this in long term care. However, despite the positive impact described by Jane in Case Study 4, Carol had reservations about using photographs in the open ward where they might be seen by everybody, as she felt that some patients might not want their photographs in full view of everyone or not want other patients to

ask them about the photograph. Accepting this limitation, Carol still thought it was useful for nurses to see a photograph:

*'... because it would prompt you to have that conversation and say "Who's that in that picture?"...'* (Carol - StN4).

Getting to know the person and their family featured repeatedly in the findings. Several strategies designed to support responsive, individualised care have been identified in previous sections of this chapter (for example R1 and P1). The findings also illustrate that once the patient and their family feel confident that the people caring for them have their best interests at heart, assessment of need and care delivery is likely to become more collaborative as highlighted in the next section of the findings.

## **C2 - Involving the person and significant others in decision making**

This section describes how participants promoted person-centred care by collaborating with the patient and their family when making care decisions. As previously emphasised, listening to the patient and their family was central to all interactions. This strengthened person-centred care, not only in everyday care, but when making complex care decisions. For example, when planning for ongoing care needs if the patient was unable to return to their home. This naturally made decision making more difficult.

There was an appreciation of the need for sensitivity in these instances and participants were clear that the patient's wishes were listened to when the patient had mental capacity:

*'I think on this ward they are really good, they really try to meet people's needs and taking into account their beliefs; what they want.'*

(Denise - RN4).

Geoffrey, one of the support workers views were in accord, as he recognised the need for the full engagement of the MDT:

*'It's [the patient's wishes] discussed with nurses and doctors, it's just through discussions. Nurses, doctors, physiotherapists, occupational therapists, social workers; the whole team...'* (Geoffrey - SW1).

During the earlier stages of the study when the ward specialised in stroke rehabilitation, participants described how complex care decisions were managed. Similarly, such decisions have relevance to the care of people with long-term respiratory conditions, who were often cared for on the acute medical ward. Although participants generally commended the involvement of the patient and their family in care decisions; not all participants were convinced that the MDT team listened enough to the patient. Sometimes this occurred if the discharge arrangements desired by the patient conflicted with what the MDT felt would be safe or manageable. Here Kamaria reflects on the discharge of a young man following a stroke. His discharge home failed and she believed this had occurred because the MDT did not truly listen to his needs:

*'Perhaps because we think we know best. I don't know. I think sometimes it is very difficult weighing one thing up against the other isn't it?'* (Kamaria - RN3).

Identifying when decisions about care didn't work out positively for patients allowed participants to reflect upon patients' level of involvement when ongoing care plans were being made and therefore consider how this experience may be enhanced for patients in the future. It was common for a family member to be involved in discussions about ongoing care needs. Occasionally, conflicting views occurred between the family and the patient. In these cases, a meeting was called to discuss everyone's perspective. Eve, the physiotherapist describes who would be involved in the meetings and her perception of the amount of control the patient has on the outcome:

*'...there would be the doctor that's looking after the patient, the nurse looking after the patient, possibly the discharge liaison nurse, the therapists, the patient and a family member or friend or somebody like that with the patient...If the patient has mental capacity then, from the meetings I've been to, it's 100% their decision, which isn't always what the MDT would believe to be the safest but we try and support as best we can their decisions and make them a safe discharge back home.'*  
(Eve - AHP1).

The occupational therapist, Sarah was interviewed separately, nevertheless her views corresponded with Eve; that the MDT endeavoured to work effectively

together with the patient and family to identify care solutions that will meet the expressed needs of the patient: *'...predominantly it is up to the patient...'* (Sarah - AHP3). Generally, participants conveyed their commitment to support patients in their decisions even when it differed from their perspective. They identified that patient and family involvement in care decisions was more effective when their role in decision making was respected by all healthcare professionals. Promoting collaborative decision making in order to facilitate person-centred care was also emphasised as a central feature of nurse education by the nursing lecturers:

*'...if we're going to talk about care being patient centred [in university], then it's got to revolve around the patient and their wishes rather than the professional wishes, which sometimes are very different.'*

(Beverley - NL1).

From an educational perspective, both nursing lecturers highlighted establishing partnerships with the patient and their family as a principle for high quality care. Within university, student nurses were also encouraged to consider how they might support patients and their family if their decisions conflicted with the professionals' perspective. Kath felt that the beliefs and attitudes of the carers formed the foundation for person-centred care:

*'... It [person-centred care] is a mind-set... it's a way of looking at things which encompasses all this [the elements of the model of person-centred care], but it is that approach; culture, it's the way of doing things...'*

(Kath - NL2).

Although negotiated care was promoted within the present curriculum, both nursing lecturers felt it was a topic that would benefit from further emphasis within the theory and practice of pre-registration and post-registration nurse education, as explained here by Beverley:

*'I did particularly like that one [involvement in decision making] and if anything I'd want to strengthen that a bit.'* (Beverley - NL1).

Both Beverley and Kath were convinced involving the person and significant others in decision making did not stand alone, but required all the features shown in the model of person-centred care to be in place to ensure success:

*'...therefore the culture of that area needs to support that [involvement in decision making]... Part of it is making sure there's time to build a relationship with the patient in order for them [the patient] to have the complete knowledge to be able to participate in decisions about their care.'* (Beverley - NL1).

The nursing lecturers' interpretation of the pre-requisites for person-centred care favoured an open and encouraging approach within the MDT in order to promote a care environment where patients and family feel comfortable to question and discuss care options: *'...everybody [in the team] is personally accountable for producing person centred care and promoting that culture.'* (Kath - NL2).

The opinions expressed by Beverley and Kath, the nursing lecturers connected with the findings from the nurses and allied health professionals; by recognising the importance of following the patient's wishes as far as practical:

*'... obviously there's lots of different individual needs to take into account, depending on whether the patient is confused or whether they've got capacity and whether they're involved in that meeting or whether it's done as a best interest type meeting.'* (Sarah - AHP3).

Overall, little was said explicitly about how care decisions would be facilitated if a patient did lack mental capacity. Where reference was made to it, participants indicated that the best interests of the patient would be represented as closely to their perceived needs as possible:

*'If they don't have the capacity, (it depends on where it lacks), if it's memory or safety or things; it often comes down to safety then we'll take the viewpoint of the patient and the support network that they have at home to make that decision.'* (Eve - AHP1).

An increased understanding of dementia care was an area of practice that allied health participants identified they would benefit from:

*'I really do like the idea [of further training]. I think that rather than seeing the dementia side of the person you're seeing the life. You're seeing a little bit of them before.'* (John - AHP2).

The need for further education to support person-centred care was also illustrated when Michelle and Petrina, two of the student nurses expressed concerns about how patients with cognitive problems such as dementia were regarded in acute care environments. This was based upon their experience of several care environments (not specifically in the study setting), where they felt people with dementia were treated differently. Both student nurses perceived that care was focused on the dementia rather than looking beyond the condition to consider the patient more holistically:

*'... sometimes they get overlooked if they've got dementia or if they're a little bit confused, there's sometimes barriers between not just nurses but also doctors, support workers.'* (Michelle - StN2).

*'What do you think those barriers might be?'* (Interviewer)

*'Maybe just knowledge about it [dementia] or even not having a great deal of confidence to tackle it, but not in a way where I've ever seen anybody harm anybody or neglect anybody, just a little bit unsure.'*  
(Michelle - StN2).

This view was upheld by Petrina, who was interviewed separately:

*'I feel like sometimes... nurses say "Oh they're confused, they don't know what they're on about." They [the nurses] look at the dementia rather than looking at other medical issues or social issues.'*

(Petrina - StN1).

The unease expressed in the interviews is worth noting, since there are an increasing number of people with cognitive impairments, such as dementia being admitted to acute medical wards.

How patients' preferences of care are represented when they lack mental capacity is of great concern when aiming for high quality person-centred care. This relates directly to the next section of the findings which looks at how the quality of care can be maintained regardless of the acuity of need.

### **C3 - Consistently delivering good quality care, paying attention to dignity and respect regardless of the acuity of need**

Independently, during the interviews participants drew comparisons between the experiences encountered in extremely acute environments such as A&E or Medical Admissions Units (MAU) and care environments that were perceived by participants as requiring less urgent care (such as the study setting). Recognising immediate medical needs was crucial to safe care, however seeing the person as an individual and thinking about their needs beyond their medical condition remained central in helping nursing staff care for the patient more effectively.

Once the patients' medical condition was stable it was perceived that care became more person-centred. Some participants however, believed that the principles of person-centred care could be applied in any care setting. It was often simple actions that conveyed compassion and respect for the patient and their family. For example if clothes had been torn during an emergency procedure it was essential to think about whether the patient or family wanted the clothes rather than throwing them away, assuming they had no value, as explained here by Carol:

*'Sometimes when patient's clothes have been ripped or damaged in A&E nurses have thrown them away... It might be something that's got some significance, even though we might think it's not worth saving.'*

(Carol - StN4).

There was acceptance that such acts were not as vital as saving the patient's life, but still had the potential to make the difference between good care and excellent person-centred care. In some cases, the challenge of providing person-centred care in emergency care environments was overwhelming. Here Susan conveys her perception that care which was focused purely on the medical needs of the patient, in some cases did not match the nurse's expectations of providing holistic care:

*'I went into nursing thinking I was going to be caring for the individual person... When I worked on MAU you had to put all that behind you and it's just basically a medical condition. It's not a patient and it's not a person, it's just this [condition] that needs attention and needs treatment... I found it incredibly difficult....'* (Susan - RN1).

Working in MAU was described by Susan as like working on a conveyer belt: *'They're a patient, you deal with them and then you move onto the next one.'* (Susan - RN1). All participants acknowledged that the priority in A&E and MAU was to stabilise the patient by giving medical care, but there were often additional time pressures in these environments which were perceived as interfering with the level of person-centred care:

*'From my experience in A&E, they don't really have time to look at that whole person there, it seems to be; treat the medical issue there. They forget about everything else and then that seems to get picked up later when they're doing assessments on the other ward [the patient is transferred to], they tend to get looked at more wholly there than in A&E for example.'* (Petrina - StN1).

Susan related back to her earlier statement of working in MAU feeling like working on a conveyer belt, when she expressed concerns that working in emergency care environments for prolonged periods may adversely affect the way nurses deliver care; implying that care delivery may be perceived by the patient and their family as efficient yet dehumanised:

*'At first I found it [working in MAU] really difficult and then it just becomes the norm, which is quite sad. You just don't get to know anybody. I think that's the side of nursing that you see on the TV and the news. That's the high adrenalin side of nursing, but it's not a very personal place at all, it's very black and white.'* (Susan - RN1).

These experiences appear to contradict the feelings of students portrayed at the beginning of the study; when they wanted to experience more acute care setting rather than have a placement on the stroke rehabilitation unit. In connection with these perceptions, Mary, one of the professional development coordinators who had previously worked in A&E as a senior nurse explains her perspective of this phenomenon:

*'Students feel short changed because their friends are dealing with all the buzz of A&E, that's a short lived placement, their career is going to be focused around giving what I think are essential cares and that support is important. The glory, the buzz, is short lived... this framework, is the essence of nursing, it's not what they show you on television and I think you could build on each one of these three elements in the framework throughout pre-registration nursing, just building on it each year.'* (Mary - PDC2).

Having experience in A&E provided insight into care delivery in emergency settings led Mary to express the belief that person-centred care can occur in any situation, which differed from the feelings portrayed by other participants. She describes how the application of 'person-centred moments' (McCormack and McCance 2010) in A&E can affect the person being cared for and, at the same time, be used to support practice learning:

*'... that moment is a reaction, because you see that that patient needs something there and then, and you do it and that's the moment and it's gone, but the impact that that moment can have can be profound... I think it really works, I mean it's not just patients is it, those moments could be with relatives, just that moment of breaking some bad news and the way it's done with a new member of staff.'* (Mary - PDC2).

Demonstrating respect and compassion within everyday interactions can undoubtedly enhance person-centred care and help others learn how emergency care can be implemented more sensitively.

Using professional judgement to weigh up the best approach to care at any given time was a skill that nurses developed with experience. This allowed nurses to provide safe and effective care in a sensitive and empathic manner regardless of the acuity of need, consequently protecting the patient's personal needs at a potentially distressing time:

*'Because they're quite acutely unwell... I think we've got to learn to decide what's best for that patient at that time.'* (Dorothy - RN2).

As acknowledged previously in the findings, caring for patients using a more holistic approach was depicted as having a positive impact upon the person being cared for and the person delivering their care (see section P1 and P2). This could often be achieved by paying attention to aspects of care that at first may seem minor; however, as can be seen in the next section of the findings, these seemingly small things can make the difference between good care and excellent person-centred care.

#### **C4 - Recognising the 'little things that make a difference' for the person**

The views of the nurses and allied health professionals' were comparable in identifying that often the characteristics of care described as *'little things'* made a big difference to the patient and their family. These related to many different things, for example: making a cup of tea in the night, chatting to patients about everyday issues, helping patients to socialise with each other, assisting with food and drink.

Once again, the student nurses showed insight into their role in supporting person-centred care by identifying various aspects of care that would make a difference for the patient: *'Even cutlery can be a big issue, like seeing*

*somebody with a big spoon when they've got a very small mouth (Carol - StN4).*

Individualised assessment helped student nurses realise how helping patients feel more comfortable could aid their recovery by picking up on cues from the patient.

Here, Alex demonstrates this understanding when she realised that a man in her care would eat his lunch if he had a drink of lemonade:

*'So I gave him that lemonade and sat with him and encouraged him to eat his Sunday dinner and he ate it all.'* (Alex - StN3).

This seemingly simple act of helping the man drink the lemonade brought in by his daughter helped the man, but also gave assurance to his daughter when she visited about the quality of care her father was receiving.

Susan also recognised that on most shifts a small amount of time can be dedicated to the *'little things'* that patients' find important:

*'Taking them for a little walk round the ward and having a chat with other patients, little things like that, otherwise they're just sat on their own in the chair with their own company. I wouldn't like to be sat on my own.'*

(Susan - RN1).

John, the physiotherapy assistant also recognised the value of social interaction for the patient's recovery and discussed how chatting to the patient about their hobbies could help with their therapy:

*'... just talking with them really, about things that they actually enjoy doing, like golf.'* (John - AHP2).

Although these aspects of care were labelled as *'little things'* from the participants' perspective, some of the care described appeared to be fundamental to high quality care; for example eating, drinking and social interaction with others.

Susan, a registered nurse, was concerned that the impact of the *'little things'* might not always be realised in the midst of a busy ward environment. She illustrates this by reflecting upon the care of a woman who was unable to communicate her personal needs:

*'...we were tidying up her locker and we found a bag of make-up and we thought 'we've never seen her in make-up'... She obviously does wear make-up because she'd brought it with her. We asked her about it and her eyes brightened up and we were able to make her face up and from that date it was like a different person emerged.'* (Susan - RN1).

The discovery of the makeup happened by coincidence in the midst of the busy ward routine; yet, the nurses quickly recognised the significance of applying make-up for the woman. The positive psychological effect it had on her was extraordinary and illustrated Susan's understanding of the potential advantages of person-centred care. Such examples of everyday care have the potential to make a big difference to the quality of person-centred care.

Within Case study 7 Dorothy reflects upon how assumptions based upon age, previous care delivery or the impact of a medical condition can have a negative effect upon person-centred care.

### **Case Study 7 - Dorothy**

C4 - Recognising the 'little things that make a difference' for the person.

#### **Background**

The ward manager Dorothy is a registered nurse who has been qualified for over 35 years. Here she reflects upon her mum's recent experience of hospital care.

#### **Experience**

Dorothy's mum was in hospital following a mild stroke, and she describes her concerns about basing care on assumptions:

*'I think we all still have to learn to see people as individuals. I've had experience with both my parents being in hospital recently... I went to visit my mum and she'd got a beaker with a lid on and she's quite able to drink from a cup. I said "What have you got that for?" and she said, "They just gave it to me", so I said "Well tell them you don't want it".*

*But then I thought... do we do that? We obviously do that; we just say, "oh it's a little old lady, she's better with a lid on."...'*

Dorothy was keen to emphasise that care should be based on the patients' needs, not what suits the nurses. It may be perceived by the nurses as easier to take control or do something out of convenience due to a seeming lack of time to assess the true needs of the patient: *'We do something because it's easier, it's automatic...'* Dorothy was upset that it had been assumed her mum needed a beaker with a lid:

*'My mum isn't an invalid, she doesn't need to have a lid on, but then somebody else might have thought "She's 85 and she's had a stroke, she'd better have a lid*

on.”...’

Patients may feel unable to challenge the nurse as they may not want to cause a fuss. Dorothy recognised that sometimes she and other nurses do make assumptions about patients, which may compromise person-centred care. This made her question current practice on the ward:

*‘I did actually see a gentleman on this ward last week with a lid on his cup and I said “Do you want a lid on that cup?” and he said “No, not really” and I took it away.’*

Once something happens, once or twice it can become an established pattern; therefore nurses are likely to perpetuate it without realising that the action may be against the patient’s wishes:

*‘...I think the little things make the most difference, because it’s about a person’s dignity. I think eating, going to the toilet; just everyday personal things make more impact to the person’s stay in hospital than the medical care.’ (RN2)*

#### **Impact upon person-centred care**

Using her mum’s experience helped Dorothy reconsider the care that patients receive on her own ward. Although, generally nurses have the best intentions of caring for patients in a person-centred manner, making assumptions about a patient’s capability may detract from meeting their needs. Therefore a thorough individualised, ongoing assessment is required to avoid this.

In common with Dorothy, other participants found it helpful to imagine how a family member (or they themselves) may want to be treated in order to promote person-centred care. Nonetheless it is essential for nurses to remember that while their parent may appreciate care being delivered in a particular way, another person may find the approach wholly inappropriate to meet their needs. The *‘little things’* were also recognised as crucial when considering the educational needs within the study. For example one professional development

co-ordinator expressed clearly that every action, however small, is meaningful for the patient and their family:

*'Within the Trust nothing is menial, everything we do has a purpose and a point to it... and we don't know what that patient is going to remember, what's going to strike them as a fundamental aspect of their care delivery...'* (Elizabeth - PDC1).

The significance of *'little things'* was restated by one of the nursing lecturers, Beverley, when she reflected upon the potential use of the model of person-centred care in practice and education across healthcare as a whole, not exclusively in nursing:

*'When I first read it [the model of person-centred care], that caught my eye, yes I think the little things, are hugely beneficial and taking it from the context of healthcare, if you looked at front of house and hotel management and ensure that the little things that make a difference would be key in training people.'* (Beverley - NL2).

## Summary of the findings

In the participants' accounts it was evident that person-centred care had to be considered at every stage of care delivery, starting with assessment of need being from the patients' perspective rather than the professionals' perspective. Building a picture of the patient was portrayed as helpful in respecting person-centred care. Within the different themes, participants related person-centred care more readily to physical care needs rather than explicitly referring to psychosocial needs. Nevertheless, there was evidence that participants used professional judgement to work in the best interests of the patient.

There was a common feeling from participants that person-centred care needed to be supported from an organisational perspective. This linked closely to having a ward manager and other senior nurses who encouraged a positive team approach. In the participants' accounts of practice, successful person-centred care was associated with positive team relationships, shared values and support for each other; for example, feeling able to *'bounce ideas off each other'* (Michelle - StN2).

Good communication between the MDT members helped facilitate an atmosphere where patients, family and staff all felt valued and able to discuss or challenge care needs openly. The understanding of each other's roles and positive team attitudes facilitated collaborative working, clinical confidence and supported practice learning. There was a perception that working in a positive learning environment had a direct and constructive impact upon the quality of person-centred care. As a result, care was often adapted to individual needs, rather than staff feeling bound by routine or inappropriate care decisions.

Participants described the positive impact of high levels of support within the team, particularly in complex care situations. Where care was described as being less person-centred, it was evident that the elements referred to above were lacking. Recounting experiences of care that participants perceived as negative appeared uncomfortable for them, as they gave the impression in their interviews of feeling disappointed in the level of care that had been given. This linked with their personal beliefs in relation to the delivery of high quality person-centred care.

In addition to person-centred care being related to team values, it was portrayed by participants as being strongly associated with the personal qualities of the healthcare staff providing care. Nurses, allied health professionals and educational staff alike recognised the value of having a respectful, compassionate and empathic approach within everyday interactions at all levels. It was clear from the explanations given by participants that some of these skills were inherent within the person giving care. Yet, participants felt some skills could be taught by a combination of theory and practice learning; including role modelling. There was some uncertainty about who could act as a role model and how tacit knowledge could be passed on to less experienced staff, student nurses or student allied health professionals. Clinical confidence helped with role modelling and enabled the team to be more flexible in care routines, which reduced the likelihood of task orientated work.

Having a relaxed atmosphere with flexibility was only part of the process and would, in isolation not necessarily mean that care was person-centred. Identifying the potential barriers to person-centred care allowed participants to

apply their knowledge and skills to a care situation which enabled them to reflect upon practice and consider alternative solutions. There was a tension in some acute care environments between being person-centred (which may be perceived by others as more time consuming) and getting the job done. One solution to this was to ensure that the time spent with the patient and family was meaningful, making sure all interactions were person focused. Some participants identified the use of photographs as a way of helping them connect with the person and encourage reciprocity within the care relationship. Sharing a photograph often prompted personal conversations in addition to clinical discussions, which in turn gave further insight into individual needs.

Concerns were raised by some registered nurses and support workers about the ability of student nurses and newly qualified nurses to provide 'hands on' care in a person-centred manner. These concerns were not upheld when analysing the data from the student nurses, recently registered nurses or nursing lecturers. There was, however, a common notion that related positive personal attitudes to high quality person-centred care, commencing with the recruitment of potential student nurses, through to participants that had qualified over 30 years ago.

Nurses, allied professionals and educationalists alike identified the importance of actually listening to the patient, family and each other. This overarching finding was perceived as vital to enable everyone to work effectively towards realistic, safe person-centred care. Participants were clear that patients were fully involved in care decisions if they had the mental capacity to make

decisions. Although reference was made to working in their best interests when a patient lacked mental capacity, it was unclear how participants facilitated this.

The educational needs of the team were conveyed throughout the findings and relate to elements of care that the whole MDT would see relevance in. For example: more information about end of life care. This is a topic relevant to all healthcare practice; however, since the ward speciality changed to acute respiratory care the significance was more obvious. There were suggestions from participants (including student nurses) about using examples from practice in order to celebrate success, reflect upon areas for development and strengthen learning within the team.

## **Conclusion**

Participants discussed their perceptions of what facilitates person-centred care, which are summarised in the model of person-centred care. They have identified strategies for improving care; some of which relate to clinical practice, whilst others relate to specific actions within education and practice that have the potential to enhance person-centred care in the study setting. These findings will form the basis of discussion within the next chapter.

## **Chapter 5 - Discussion**

### **Introduction**

The purpose of this chapter is to discuss the contribution of the study findings in relation to what is already known about person-centred care and thus illuminate the unique contribution of the study to this body of knowledge. The model of person-centred care, developed from the study findings, is used to structure the discussion. Following this, reflections on the methodology are presented. The chapter concludes by discussing the potential areas for development within the fields of research, education and practice.

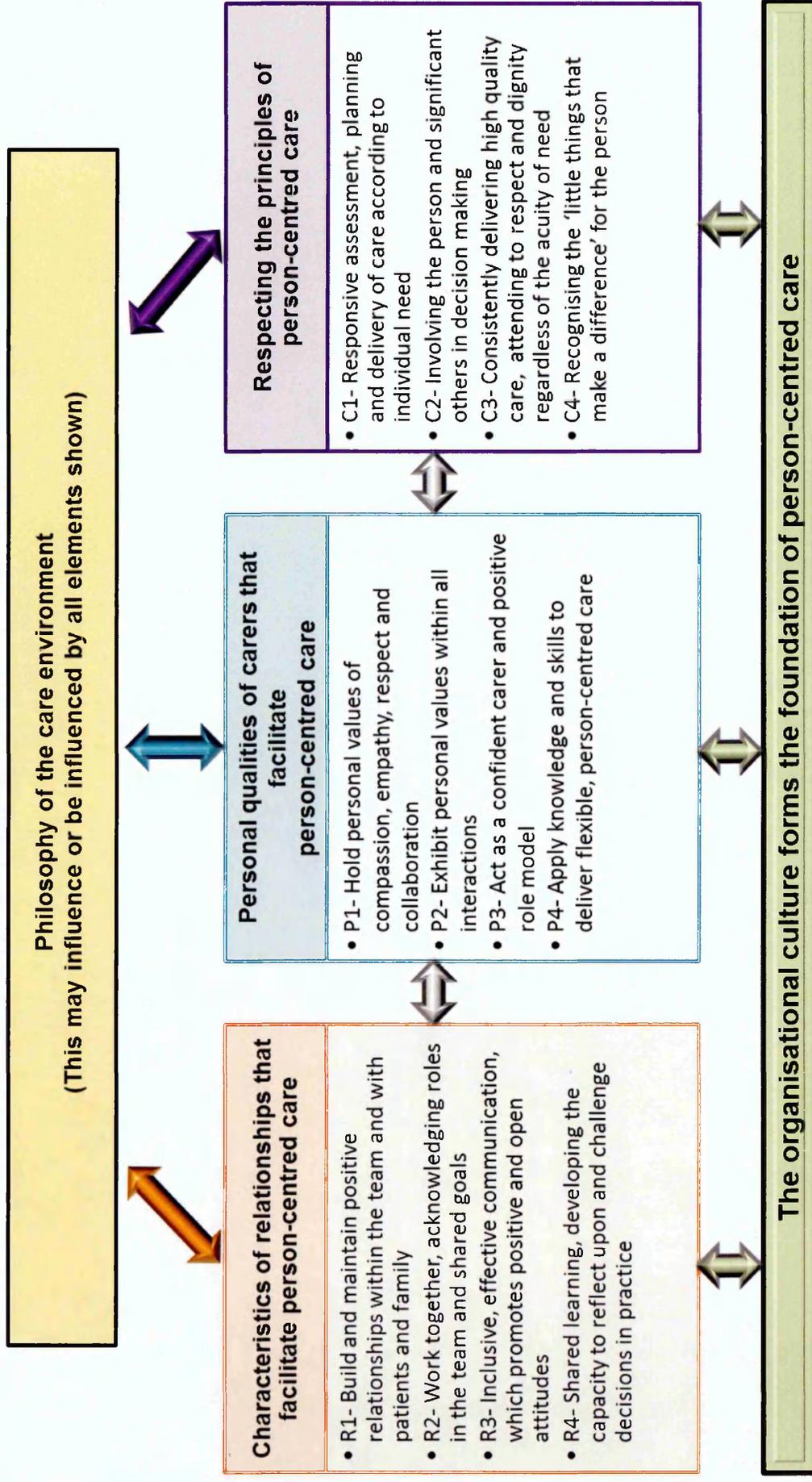
To recap, the aims of the study were: firstly, to describe what facilitates person-centred care from the perspective of nurses working in an acute hospital medical ward; secondly, to compare the nurses' perspective with the views of other healthcare professionals in the study setting; and, finally, to identify areas for development within research, education and practice that have the potential to enhance person-centred care.

Listening to the participants' perspectives on the reality of person-centred care was instrumental in developing an understanding of the concept as it existed in this study setting. The participants used their own everyday experiences from practice to articulate what the term person-centred care meant to them. One of the fundamental findings of the present study was that all participants recognised the presence of person-centred care, to some degree in their everyday practice. In addition participants acknowledged that valuing people as

individuals including their views about their own care needs is central to the success of person-centred care.

The proposed model of person-centred care (Figure 1) forms a visual representation of the findings, thus allowing the key elements of person-centred care, as perceived by the participants to become evident to others. The proposed model indicates what the findings of this study suggest needs to be in place for person-centred care to be achieved. It also creates a suggested structure for future development in education and practice, thus promoting a more consistent approach to person-centred care. At this stage the value of the model of person-centred care is hypothetical. Therefore, its relevance to enhancing person-centred care will require testing in education and practice, which would enable further refinement of the individual elements of the model. On viewing the proposed model, it is important to recognise that the individual elements shown do not stand alone, but need to interlink in order to nurture high quality person-centred care.

**Figure 1. The Model of Person-Centred Care**



***Build and maintain positive relationships within the team and with patients and family***

The importance of building and maintaining reciprocal relationships within the team and with patients and their families was one of the principal findings of the study. One key message was that for participants, person-centred care holds the premise that everyone matters. In order to foster meaningful relationships with patients and their families, all team members need to feel supported individually and as a team. This requires each team member to feel valued as a person, along with the recognition of their unique and complimentary roles within the team.

Getting to know the patient and '*forming a bond*', was described in the present study as being '*a massive part of person-centred care*'. The participants recognised the positive influence of having an open and inclusive team approach in building and maintaining relationships. Previous research findings have also shown that building meaningful relationships with everyone involved in care is crucial to achieving person-centred care (McCormack and McCance 2010, McCance et al. 2013). Seeing the person, rather than seeing them as just another patient has been identified as central in building therapeutic relationships (Clarke et al. 2003, McCormack 2003). Feeling part of a meaningful relationship has also been recognised as beneficial in building or

restoring self-esteem and personal wellbeing (Nolan et al. 2004, McCormack and McCance 2010).

The participants in the present study described relationships which were built upon reciprocity, understanding and an ability to share something of each other. These findings show resonance with ongoing work in Scotland, where there is a educational programme aimed at improving healthcare services by focusing more on people, their families and carers (Healthcare Improvement Scotland 2014). One example is the perspective of person-centred care provided by Tommy Whitelaw; Tommy has been working as a campaigner with the aim of improving person-centred care. He uses personal experience of being an informal carer for his mum to inspire care staff to be understanding and compassionate in their caring roles. He stresses that every interaction is crucial and that if each care worker showed kindness, understanding and a genuine desire to help it would give the persons involved hope and strength.

He also urges that relationships should be honest, involve human touch and that care workers show a genuine interest in finding out about the person in the context of their whole life, not just about the medical condition or diagnosis. Within his story, Tommy emphasises the sad fact that '*nobody ever asked about Joan*'; his mother's life, in all the years she received care. The focus, for his mother, remained solely upon the medical condition (Healthcare Improvement Scotland 2014)<sup>3</sup>. Despite the present study being focused on person-centred

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<sup>3</sup> Tommy's story can be accessed via: <https://www.youtube.com/watch?v=c6sm4jOxeQs>

care from the standpoint of nurses and allied health professionals, it is reassuring to note that the perspectives presented by Tommy emphasises the same caring concepts as described by the study participants.

Viewing person-centred care from differing perspectives helps to confirm the findings of the present study that emphasise the value of building personal connections within care relationships. The association between Tommy Whitelaw's campaign and the study findings underlines the need for people to feel like they matter to others. This fundamental human need has been recognised formally as an approach when caring for people living with dementia (Sheard 2013). The concept of Mattering was originally developed from social psychology and relates directly to the earlier notion of client-centred therapy. It is described as a therapeutic approach to counselling and places the person at the centre of the relationship. Mattering has strong links to Kitwood's earlier work in dementia care, where he suggests an association between a person's '*standing or status*' and their relationship with others (Kitwood 1997, page 8); or the extent to which they 'matter'. Mattering focuses on the external validation of an individual by others on an interpersonal and societal level (Rosenberg 1985). It centres on the person's feelings; for example feeling important, attached, missed, interesting, depended upon (Sheard 2013). These feelings relate closely to the underlying principles of person-centred care and the findings of the present study.

***Working together, acknowledging roles in the team and shared goals / shared learning and developing the capacity to reflect upon and challenge decisions in practice***

This section will combine two elements of the model together as the team interaction within the study relates to working towards shared goals and developing shared learning in order to positively influence person-centred care. Several examples of the influence of shared goals and cohesive teamwork are given in the findings. For example Carol, a student nurse described the positive impact of the social interaction between the staff and with people and their families, receiving care on a specialised rehabilitation unit (Case Study 1, page 95). Carol's story illustrates how vital it is to work within a unified team, which promotes a sense of belonging, thus encouraging a more person-centred approach. This has been acknowledged in the literature as being more likely to promote staff wellbeing, which links directly to the ability to provide compassionate, person-centred care (Dewar et. al 2013). In accordance with the work of Dewar et. al (2013), Eve and John the physiotherapist and physiotherapy assistant in Case Study 3, (page 105), recognised the value of working in a team who have a shared vision and open lines of communication. They believed that investing time within the team to encourage personal growth built a more productive care environment.

The use of critical reflection within the MDT was recommended by Eve and John as one way of strengthening team attributes, which they felt could have a positive effect upon the team's ability to be more focused upon the personal needs of the patients in their care. Eve recognised that it was worth investing in

the development and maintenance of good communication skills with team members and in her role as physiotherapist encouraged others to discuss aspects of care openly. Promoting an open, non-threatening atmosphere also led participants to build the confidence to challenge care decisions in an environment where they would feel supported rather than criticised. Hence it was important for the team to develop trusting relationships with each other and feel supported by senior team members.

Their idea is reminiscent of the concept of group clinical supervision, which has been recognised as having the potential to transform (inter-professional) practice and encourage shared learning (Clouder and Sellars 2004). Although the merits of clinical supervision have been noted over several years, there remains ongoing debate about the facilitation and uptake of this approach in order to support and develop clinical practice, particularly in acute adult care settings (Dilworth et. al 2013). Recently the debate has been rekindled following specific investigations into care quality, such as the abuse of vulnerable residents of Winterbourne View (Care Quality Commission 2013). In such cases clinical supervision may be viewed by staff as being more about control and managing poor performance rather than as a means of supporting transformational practice. This may also be the position in acute adult nursing (Clouder and Sellars 2004); therefore it is important for the term 'supervision' to be better understood. Cross, Moore and Ockerby (2010) explored the clinical supervision of general nurses in a busy acute hospital ward and found the language of clinical supervision was a major barrier. The nurses in their study suggested using the term 'clinical support' rather than clinical supervision as they felt using the term 'supervision' implied they were being watched over. This

raises questions about the culture of general nursing, if nurses feel they are more likely to be criticised rather than supported. Clinical supervision has been more readily accepted in mental health nursing and counselling as a tool for enhancing professional practice and patient care, however in recent years an increased workload in mental health nursing has reduced the regularity and evidence of long term impact of clinical supervision on practice (Buus et.al 2010). In view of the complex nature of concept of clinical supervision it is worth exploring further, when considering the potential areas of development emerging from the present study.

***Inclusive, effective communication which promotes positive and open attitudes***

The study findings indicated the importance of working with a candid and positive style of leadership, in order to encourage the team to work constructively together with open and inclusive communication. This was exemplified by nurses and allied health professionals describing the ward sisters in the study setting as collaborative and supportive, encouraging open communication within the team. In order to ensure the maintenance of core nursing (care) values, the participants in the present study recognised the essential role the ward sisters had in inspiring the team to become and remain more person-centred. Gillian, a support worker explained how the ward sisters worked closely with the team, thereby influencing person-centred care on a daily basis: '*...they don't sit in the office with the door locked, they are part of team.*' (Gillian - SW3).

Having a proactive approach to managing the ward was perceived as motivating. The openness of the senior nurses inspired other team members to trust each other's judgements about care and offer support to each other when working flexibly to focus specifically on the person in their care, rather than being influenced purely by the person's medical condition or task orientated care. This finding reflects the importance of the ward sister working in a supervisory role in order to ensure safe and effective person-centred care (Royal College of Nursing 2011). Clark (2008) also highlights the influential role nurse leaders have upon team values and successful teamwork. This encouraging leadership style can also positively influence the philosophy of the care environment by empowering staff to make small changes in order to enhance person-centred care (Masterson et.al 2014). Such inspirational leadership has been recognised as vital in reinforcing the 'six Cs' of care: compassion, competence communication, courage and commitment stressed by the Chief Nursing Officer for England (DH and NHS Commissioning Board 2012).

As the present study occurred at a time of uncertainty for the ward team due to the reconfiguration of services, there was the potential of conflicting priorities in the care environment causing a disparity between the aspiration to be person-centred and the reality of everyday practice. The nurses described situations when it was a challenge to maintain high quality person-centred care due to workload demands and the change in speciality for the ward. Conflicting priorities within care environments have also been noted in the literature as negatively affecting person-centred care (Christie et.al 2012). During such times of disruption for the team it is important for the senior nurses to remain

supportive of flexible care in order to sustain person-centred care and avoid nursing care being influenced by routines or a mechanistic approach to care. The competing demands experienced in the NHS today can easily divert the attention of senior nurses away from the core values of nursing (Masterson et al. 2014).

The interplay between the philosophy of the care environment, the individual people working in the care environment and organisational priorities was also recognised in the present study and is represented in the model of person-centred care: *'... you see it's not just about one nurse doing it; it's got to be the whole organisation that's doing it'* (Rameela – RN7). Rameela's response resonates with the realisation in recent years that although the term person-centred care is still used in healthcare, what is actually needed is to create person-centred cultures, where all individuals feel they belong and are encouraged to thrive (Foundation of Nursing Studies 2013, McCormack, Manley and Titchen 2013, McCormack 2014).

Much of the previous work exploring the implementation of person-centred or relationship-centred care has also identified the connection between inspirational leadership, practice development, a change in care culture and effective person-centred care (Nolan et al. 2004, Kirkley et al. 2011, McCormack et al. 2011). These studies, in common with the present study findings recognise that in order to transform the care culture there needs to be an organisational commitment to learning in practice. However, recently the need for cultural change in care settings has been stated more explicitly in the

literature and healthcare policy as a consequence of investigations and reports into concerns about care (Parliamentary and Health Service Ombudsman 2011, DH 2012a, Francis 2013). The philosophy of the care environment also has a direct impact upon the level of staff engagement, the building of therapeutic relationships and patient and staff wellbeing (Green and Robichaux 2009, Maben et. al 2012, Dixon-Woods et.al 2013). It is therefore important to explore how the personal values and behaviour of the carers in the study setting influence the philosophy of the care environment.

## The personal qualities of carers that facilitate person-centred care.

### ***Hold and exhibit personal values of compassion, empathy respect and collaboration within all interactions***

By seeing person-centred care as their '*bread and butter*' the personal values of the nurses and allied health professionals in the present study reflect the findings in the literature, which recognise person-centredness as a life philosophy (Brewster and Ramcharan 2005). It is about being human, looking beyond labels or impairments and involves listening, observing and learning in an emotionally intelligent manner to begin to understand '*... what is it that makes that person feel like they are "them"*' (Dorothy – RN2). These personal qualities, such as having the personal motivation to listen, learn and focus on what is important for the person in receipt of care are instrumental in building a positive culture of care by fostering therapeutic relationships (McCormack and McCance 2010).

The significance of carers working with emotional intelligence to provide person-centred care was a compelling finding in the present study. Several examples of emotionally intelligent care within the team are evident in the case studies, which have been used in the findings chapter to illustrate differing aspects of therapeutic relationships. One example, in Case Study 2 (page 101) tells the story of Gillian, a support worker who was caring for Molly at the end of her life. Gillian's care of Molly indicates how the success of being person-centred and building therapeutic relationships, like the concept of Mattering, relies heavily on

the emotional intelligence of the people involved in delivering care (McQueen 2004, McCormack and McCance 2010, Adams and Sheard 2013). It is acknowledged that part of being emotionally intelligent requires the development of self-awareness in order to acquire an understanding of how personal values and beliefs can affect personal performance and interactions with other people (Goleman 2006). Similarly, self-awareness is seen as a pre-requisite skill for the success of person-centred care, which enables the recognition of ones' own emotional needs and those of others. It also involves gaining an understanding of how best to respond and communicate with another person in any given situation (McCormack and McCance 2010, Adams and Sheard 2013).

It became clear during data analysis that emotionally intelligent practice was evident in the participants' experiences. This indicated that the personal insight, empathy and compassion displayed by the participants within their everyday practice were central to the delivery of high quality person-centred care. Aadland (2010) believes personal values are socially constructed and based on individual beliefs and attitudes and they become evident either consciously or subconsciously in language and actions. Therefore being person-centred requires nurses to reflect upon their own beliefs and values to understand how their everyday practice resonates with the intention of being person-centred (Ruddick 2010). Taking part in the interviews may have given some of the participants the opportunity to pause and reflect upon their everyday practice by discussing their feelings about their involvement in care delivery, which may not have been readily available within the busy care environment of an acute medical ward. This may have been a step towards enabling participants to

understand how their own values and beliefs may impact upon care delivery, both individually and as part of the MDT (Sanders, Odell and Webster 2013).

Although there were examples of participants' practise corresponding to their personal values and beliefs in the present study, there were also other stories where participants felt dissatisfied with the level of person-centred care they gave, particularly in very acute environments. Susan, a registered nurse referred to how she felt about care delivery in the medical admissions unit: *'They're a patient, you deal with them and then you move onto the next one.'* (Susan - RN1). This corresponds with other work which has identified that it can sometimes be difficult to identify how espoused values and beliefs of person-centred care relate to the reality of everyday practice (Christie et. al 2012, Foundation of Nursing Studies 2013, McCormack 2014).

The disparity between the aspiration and reality of person-centred care found in the present study is a phenomenon which has also been acknowledged in other research studies of nursing practice and practice development (McCormack and McCance 2010, McCance et al. 2013). In medicine Ekman et al. (2011) found that the doctors in their study aspired to be person-centred in their practice and thought this would be naturally evident in the way they interacted with patients. However, when they were observed by the researchers; their approach to care remained disease focused. In common with nursing, reasons for this were attributed to the cultural expectations of the team and time pressures that they experienced in everyday practice. This suggests that, in addition to considering the personal attributes which enable person-centred care, it is worth exploring the influence of the philosophy of the care environment on facilitating emotional intelligence within the team.

When considering the interplay between the personal qualities of the carers and the other elements of the model of person-centred care developed from the study findings, questions are raised about the pre-requisites needed to be able to deliver person-centred care as identified in the work of McCormack and McCance (2006, 2010). They propose that the attributes of the nurse, which include; professional competence, interpersonal skills, commitment to the job, ability to clarify personal beliefs and values and self-knowledge form the foundation for person-centred care. The findings from the present study, when participants were reflecting on wider care experiences suggest that although McCormack and McCance (2006, 2010) identify self-knowledge as one of the personal attributes necessary it may not always be allowed to develop, if the care environment is very restrictive or hierarchical. Therefore, self-knowledge needs to be facilitated within a care environment which is not restrictive and hierarchical.

This was illustrated by Carol in Case Study 1 (page 95), when she compared the level of person-centred care in acute care environments with the care she had experienced in a specialised rehabilitation ward. She explained how everyone in the MDT (in the rehabilitation ward) shared something of themselves and worked in a relaxed, sociable manner. She also recognised this as a way of 'being' for that team and perceived their self-awareness and self-knowledge as instrumental in the success of person-centred care. One possible way to enhance self-awareness and self-knowledge for nurses in the present study setting would be to encourage team building activities as a foundation for strengthening person-centred care. Nevertheless, one off 'time out' days may not be the most effective way of facilitating this (McCormack, Dewing and

McCance 2011). As suggested by Kath, one of the nursing lecturers, *ongoing* team activities are more likely to be beneficial in supporting person-centred care than one off events. She suggested maybe an hour a week as a team looking at *'...what's good this week, what isn't so good, because then it's more immediate and it is linked into practice...'* Her perspective links back to the earlier suggestion from Eve and John of setting a programme of short MDT seminars to analyse real life case studies in recognition of the need to strengthen practice learning and supplement role modelling. This finding reinforces the notion that facilitated reflection or clinical supervision within the team has the potential to reinforce shared values and clarify their meaning in everyday practice and have an ongoing and positive effect upon person-centred care (Beckett et al. 2013, McCance et al. 2013, Patton, Higgs and Smith 2013).

Dewing (2010) advocates using an active approach to learning in the workplace and questions whether healthcare organisations genuinely invest in 'holistic' learning opportunities or are more likely to focus on learning which takes place away from the workplace. Active learning involves working with real problems and solutions in everyday practice. Supporting this requires skilled facilitation and a genuine commitment from the organisation. Dewing (2010) goes on to give examples of appropriate methods, such as problem based learning, action learning and supervision. One example she uses comes from the work on critical companionship, which is based upon an experienced practitioner helping someone with less experience to understand the nature of their practice knowledge (Titchen 2000). Titchen's seminal work enables the reader to understand the complexities of facilitating personal and practice development. However, her original work involved a close one to one relationship between

two people who were expert practitioners. Whilst there is much to be learned from her work; in order to facilitate day to day practice there is a need to consider how this relates to less experienced practitioners (Sanders, Odell and Webster 2013, Hardiman and Dewing 2014). It requires the facilitator to firstly understand themselves in order to develop meaningful relationships with others with the aim of facilitating active and sustained learning in themselves and others (Garbett and McCormack 2002). This perspective links with the next element of the findings, which relate to the need for experienced practitioners (or carers) to be confident in providing flexible person-centred care in a manner that supports knowledge translation.

***Act as a confident carer and positive role model / Apply knowledge and skills to deliver flexible, person-centred care***

A significant strength of the present study was the unique opportunity it gave to explore the concept of person-centred care from the perspective of student nurses. This enabled a comparison of their views to those of other nurses and allied health professionals and raised questions about knowledge transfer and the capacity of role modelling to facilitate this in clinical practice. Within the present study there was evidence of the impact of positive role modelling and conversely, how participants' used the experience of negative role modelling to strengthen their resolve to remain true to their personal and professional ideals of person-centred care. Denise, a registered nurse talked about her experience of being a student nurse, four years previous to the study: *'I remember a lot of things my mentors did, good and bad. Hopefully you just pick up good things and use the bad things as an example of what not to do.'* (Denise - RN4). Here,

Denise was using her past experiences in nursing to enable her to identify good practice and reject poor practice, thereby using it to reinforce her own beliefs about the value of person-centred care. In addition to role modelling, other participants in the present study talked about the team promoting openness thus, fostering a feeling of inclusion and encouragement, rather than experiencing resistant attitudes from colleagues as described by Stacey et.al (2011). Denise's experience illustrated the value of positive role modelling to facilitate practice learning, which has also been recognised in the literature (Baillie et.al 2015). However, it would be naive to believe that her experiences reflect those of every nurse. It is therefore essential to consider how the positive impact of role modelling can be strengthened in order to enhance the learners' understanding of the concept of person-centred care.

Exposure to poor role models can lead nurses to adopt bad habits in order to 'fit in' with the culture rather than risk increasing their stress levels when their personal values are constantly being challenged (Stacey et al. 2011, Felstead 2013). The data from the student nurses' interviews in the present study suggest that they had developed the ability to appreciate the unique nature of each person they cared for. This appeared more evident in student nurses' discussions about care than in some of the registered nurses' discussions. For instance, when Alex and Carol were interviewed together, they talked about their experiences across a number of different clinical environments where inflexible care regimes interfered with person-centred care. One illustration given, related to generalised decisions being made about activities such as getting everyone out of bed, eating or dressing at the same time. Providing choices about seemingly small aspects of care may appear insignificant when a

person is acutely ill. However the student nurses recognised that this may be the only opportunity a person has to exercise any control over their current situation, thereby maintaining some level of dignity.

Student nurses are taught to abide by ethical principles, work within the code of conduct and practise with respect for the people in their care during formal education and socialisation into nursing (International Council of Nurses 2012, NMC 2015). However, when they work in clinical practice these professional ideals can sometimes be challenged by the behaviour of other healthcare staff, including nurses. In such situations there is a risk that, rather than standing by their professional ideals of caring for people based on individual need and without discrimination, the student nurses become desensitised to poor practice. Mackintosh (2006) explored the impact of the process of socialisation on pre-registration student nurses' views about care and their ability to cope with becoming a nurse. Semi-structured interviews were undertaken with 16 student nurses in the first and third year of the programme. Mackintosh (2006) claims that the effects of socialisation and internalisation of the occupational norms are largely negative in relation to the role of the nurse as a carer. As a result of her findings, Mackintosh proposed that some student nurses are socialised in to caring less as they progress in their preparation toward the role of registered nurse, in order to help them cope more effectively with workload challenges. These findings raise questions for nurses and nurse educators in terms of the need for high quality role models and the effective mentoring of student nurses (Duffy 2015). However, as the study used a convenience sample of 16 student nurses who were based in one cohort, the study would

replicating to assess how applicable the findings were to student nurses in different cohorts and settings.

The findings from the student nurses in the present study challenge the findings in the Mackintosh study (2006). Rather than adopting bad habits, Petrina, one of the student nurses talked about how she cared for people in a non-judgemental, person-centred manner, despite the attitude of others. *'... I just went and helped him with whatever he needed... Hopefully other nurses and support workers will think for themselves; not just go on what other people have told them.* (Petrina – StN1). Petrina's perspective supports the view of Kath, a nursing lecturer who recognised that some clinical placements will provide a positive learning environment, whereas others may challenge the student nurses' ideals. Despite this understanding, she had an expectation that student nurses would uphold person-centred ideals *'...and foster a positive culture of care'*. (Kath – NL2). Nevertheless, relying on the individual student nurse being resilient and able to stand up for their values without formal support is inadequate. There needs to be a structured and sustained approach to mentoring student nurses, thus supporting excellence in care (Francis 2013, Traynor 2014, Willis 2015). Therefore, this must be considered when addressing the areas for development arising from the present study.

Clinical practice is unpredictable and complex; this makes facilitating learning more demanding than the planned learning experiences that students are exposed to in a university setting. Therefore it is important to consider ways to understand how [nursing] knowledge is formed, confirmed, utilised and

evaluated in order to enhance and make evident the practice learning available within everyday practice (Titchen and McGinley 2003, McCarthy 2006, Greggans and Conlon 2009, Patton, Higgs and Smith 2013). Within the present study Joan, a registered nurse explained what she would say to a student nurse if they had not fully recognised their patient's hygiene needs: '*I say "... would you like to come and see your Dad looking like that?"*.' Although this may be perceived as a positive step towards encouraging empathy and person-centred care, it may not be enough to help the student nurse appreciate the need for individual assessment and respect for the personal preferences of the person they are caring for. However, it does illustrate to the student the need to care about the person as well as caring for them, which is crucial in achieving person-centred care (Wild 2012, Rolfe 2014).

Eskilsson et.al (2014) suggested that the problem of knowledge transfer may be linked to learning and caring being seen as separate, whereas in practice both should be seen as interconnected. They maintain that caring can become just imitating the behaviour of the role model rather than creating an environment where reflective practice is the norm and there is a synergy between caring and learning within every interaction (Eskilsson et.al 2014). Schwind et. al (2014) express concern that nursing knowledge is invisible or taken for granted, therefore methods of unlocking this knowledge need to be considered. One approach may be the use of probing questions within everyday practice to help the student understand the nuances of care (Bott, Mohide and Lawler 2011, Price 2013). This requires investment in developing the facilitation skills of the people who would be seen as role models in practice. Understanding the practice knowledge and skills required for the success of person-centred care

can be complex and often difficult to describe, as these are personal and closely related to a specific situation and context (Polanyi 1958, 1967). In some instances the experienced practitioner may struggle to recognise the tacit knowledge they utilise in everyday practice, therefore this presents a challenge to the translation of this knowledge within the role modelling relationship. It also necessitates the student nurse feeling confident that their responses will be not be ridiculed, but that they feel supported and encouraged by the role model in an open and inclusive culture.

For role modelling and reflection to be effective it is crucial that both are seen as a natural way of working, rather than being contrived (Felstead 2013). This was illustrated in the present study when Ivy, an experienced support worker realised how she could identify genuine person-centred care just by observing the behaviour others. For example, in the way someone spoke to a patient and their family. Such authenticity is necessary to enable students or less experienced carers to appreciate the value of therapeutic relationships and by doing so respect the principles of person-centred care (McCormack 2003, McCormack and McCance 2006, 2010).

## Respecting the principles of person-centred care

For all of the elements of the model of person-centred care to be evident in everyday care, there is a requirement for individuals to practise with emotional intelligence and humanity within a culture of care and compassion. The philosophy of the individual care environment and the wider organisational culture underpins everything that happens within that organisation. Acknowledging the influence exerted by organisational culture indicates that it must form the foundation for successful implementation of person-centred care, which will impact on everyone working in the organisation and those who use the service (Foundation of Nursing Studies 2013, McCormack, Manley and Titchen 2013, NHS Partners Network, NHS Confederation 2013). This was illustrated throughout the findings of the present study, for example, when Elizabeth and Mary, professional development coordinators highlighted the importance of having a common philosophy, which encouraged people to work with humanity at all levels in the organisation. The care culture also has a direct effect upon student learning, as articulated in the present study by the Kath, one of the nursing lecturers as she talked about the benefits for practice education of working in '*a learning culture*', where there was an open and encouraging atmosphere, which helped student nurses feel supported. It has been recognised that positive learning environments are likely to create a positive approach to care (McCormack, Dewing and McCance 2011)

***Responsive assessment, planning and delivery of care according to individual need***

A notable finding of the present study was the emphasis participants placed upon the importance of getting to know the patient as a person. This was identified as central to avoiding the negative impact of assumptions, thus was perceived as a major influence on the provision of high quality, collaborative person-centred care. The findings of the present study presented a consistent picture of how knowing more personal aspects about the patient and their family made the difference between good care and excellent care. For example, Denise, in Case Study 6 (page 143), illustrated the value of seeing beyond the patient and seeing the person, through listening to stories, looking at photographs and having a genuine interest in getting to know the person in the context of their ongoing life.

The risk of making assumptions about care needs is more likely in the bustling environment of an acute medical ward if nurses don't make the effort to get to know more about the patient (Schwind et. al 2014). Assumptions in the present study were often based upon the appearance of the patient. For example the act of nurses giving a patient a beaker with a lid to drink because they were seen as 'elderly'. Participants felt this assumption was likely to be perpetuated by others without question because of the busy nature of the care environment. Examples of how seemingly small actions can either disable or enhance the sense of personal identity have been shown in other studies, particularly when exploring the care of people with dementia in acute care settings (Clissett et al. 2013, Clarke et al. 2011, Clarke and Gibbs 2013). However this could occur for

any person as Dorothy highlighted the fact that '*...sometimes we don't ask, we just assume...*'

In comparison, finding out more about the person has the potential to reduce the likelihood of making assumptions about care needs, thereby encouraging more responsive care (Schwind et. al 2014). This requires the carer to find out more about the person in their care in order to care for them more effectively as a person. In nursing it is recognised that knowing what matters to the person by building therapeutic, reciprocal relationship is crucial to high quality care person-centred care (Clarke, Hanson and Ross 2003, McCormack 2003..and others to be added.) Participants in the present study also described experiencing higher levels of job satisfaction when they made connections with the person and realised the positive outcomes of this in supporting more responsive person-centred care. Here Geoffrey, one of the support workers explains his perspective of the significance of getting to know the patient and their family. '*I think you get a lot of satisfaction, I'm not going to say you feel part of the family, but you feel closer to that person.*'

### ***Involving the person and significant others in decision making***

The participants talked about the significance of shared decision making, maintaining respect and dignity at all times and seeing the person rather than being directed by procedural requirements. For example, Eve talked of how the person's decisions would be fully supported by the MDT, provided it did not present a significant danger to that person. However, the reality of busy practice in an acute ward setting sometimes challenged the ideals held by the

participants (Wheeler and Oyeboade 2010, McCance et al. 2013). In the present study Kamaria, a ward sister recognised how conflicting priorities in the team could sometimes interfere with the MDT listening to the person's individual needs '*Perhaps because we think we know best...*' This perspective resonates with findings from a study which explored the issues that older people thought should be addressed when developing nursing curricula (Clissett, McGarry and Cook 2008). The older people in their study explained how a paternalistic approach to care or making assumptions about their needs interfered with their sense of dignity and independence, as opposed to working in partnership with healthcare staff (Clissett, McGarry and Cook 2008, National Voices, The National Council for Palliative Care 2015). Recently patients and healthcare staff have moved from partnership working to shared care whereby patients and their family work with healthcare professionals to enable them to take a more active and self-caring role in haemodialysis (The Health Foundation 2014). This development has been evaluated by patients as empowering, as they take more control of their care and regain their dignity and independence with the help of experienced practitioners (Barnes, Hancock and Dainton 2013). If this approach can be successful in renal care, which has traditionally been seen as medically orientated it has the potential to be developed for people who have long-term respiratory conditions such as seen in the study setting.

The nursing lecturers in the present study recognised the need for collaborative care and emphasised the centrality of working in partnership with patients and their family within healthcare education, thereby encouraging shared decision making. Beverley explained, that in order for this to happen the MDT team have to make sure there is time to build relationships with the patient '*...in order for*

*them [the patient] to have the complete knowledge to be able to participate in decisions about their care.'* (Beverley - NL1). Kath also talked about how students learned about managing conflicting viewpoints within inter-professional learning in order to respect person-centred decision making. The need for inter-professional learning has been widely acknowledged as a way of breaking down professional barriers and improving healthcare practice (Gordon 2006, Barr and Norrie 2010, Barwell, Arnold and Berry 2013).

There was evidence in the present study of the positive impact of inter-professional working, shared decision making and collaborative care. For example, Eve and John (physiotherapy) talked of how they would ensure any decisions took account of the wishes of the patient and family. The study did not explore explicitly whether the participants' perceptions were evident in practice. However, some of the traits required as a foundation for shared decision making were evident; attributes which form the foundation of a shift in power relationships such as, cohesive teamwork, facilitative leadership, open communication, motivated and engaged staff (The Health Foundation 2012).

Within the present study shared decision making was seen as an ideal to work towards, but participants felt full participation in decision making was not suitable for all, due to the mental capacity of the patient to participate. However, even when decision making may be compromised by lack of mental capacity, personal preferences can still be taken into account by the MDT (Wills 2010). Eve, the physiotherapist recognised that ensuring this happens can sometimes present a challenge in acute healthcare settings. She was however, confident

that if the patient had mental capacity to make decisions then their wishes would be respected. *'If the patient has mental capacity then, from the meetings I've been to, it's 100% their decision, which isn't always what the MDT would believe to be the safest...'* In cases where mental capacity was lacking she spoke about working in the patient's best interests with the family and MDT. Previous work has identified that special attention needs to be given to get to know the person with dementia. For example, for carers to understand how best to balance decision making with risk management. The overall aim of this approach would be to ensure that decisions made about care enable physical, psychological and emotional wellbeing for the person with dementia (Clarke et.al 2011). These perspectives of supporting decision making for people with dementia pose a challenge to care delivery in a busy acute environment, such as found in the present study. This is not only in terms of the time available for carers to develop an understanding of individual needs, but in terms of carers having the depth of specialist knowledge and confidence to support such balance in the decision making process and provide advocacy for the patient living with dementia and their family.

***Consistently delivering high quality care attending to respect and dignity regardless of the acuity of need***

The workload demands of working in an acute medical ward caused a tension between the nurses' intention to practice in a person-centred manner and competing workload demands (as shown in the previous section). As a result, in this study, nurses felt that the opportunities to build reciprocal relationships were often compromised. This presented a conflict between nurses' aspiration

to 'be there' for patients and the recourse to task orientated care in busy acute environments. The student nurses in the study noticed this tension and as a result emphasised the significance of making the limited time spent with the patient more meaningful, particularly when the ward was very busy. *'When you have one to one time with a patient then spend that time one to one'*.

This finding supports previous findings from a study which explored nurses' communication with older people at the end of life (Clarke and Ross 2006). They noted that nurses working in an acute care setting felt less supported to provide person-centred care in comparison to nurses who worked in a palliative care unit. Whilst the study was not specifically exploring person-centred care; the findings link directly to the differences in workplace culture between the two care environments. For example, there was team affirmation of person-centred care in the palliative care setting, as opposed to the tendency to be task orientated in the acute environment in order to get the job done. This again relates back to the need for the care environment to work towards becoming more person-centred by considering how to facilitate a team approach to care. For example, a team which doesn't frown upon the fact that care takes a bit longer to achieve as described by Carol *'...if all the staff are happy and the staff aren't judging the fact that it's taking a longer time to do something, for example it might not take you 10 minutes, it might take you an hour do something properly.'*

The findings of the present study highlights how being task orientated potentially has a negative impact upon the personal satisfaction of carers. However even when working within such time constraints, the registered nurses

referred to ways in which they gave attention to the brief relationships they experienced with patients in acute episodes of care. This may be interpreted in terms that McCormack and McCance (2010) would describe as 'person-centred moments'. Mary, one of the professional development co-ordinators in the present study contemplated the dichotomy between the ideals and reality of person-centred care in extremely acute care environments, she explained her feeling that even when time was at a premium, the connections made in a caring moment often had a profound and lasting effect on everyone present. She referred to the power of the moment, not only in terms of the person being cared for, but the positive impact it can have on the practitioner and practice learning. Endeavouring to make all interactions person-centred, the 'person-centred moments' become more consistent. This is more evident in everyday practice where the healthcare team share humanistic values such as mutual respect for individuals and their rights (McCormack and Dewing and McCance 2011).

### ***Recognising the 'little things that make a difference' for the person***

Paying attention to the '*little things*' was a recurrent and significant theme in the study findings, which was evident in all participant groups. Several participants explained how paying attention to '*little things*' can make a big difference for the person being cared for. For example, listening to people's stories and acknowledging the significance of their stories was essential in helping participants to relate with the patient and their family on a personal level and understand '*what makes that person feel like they are "them"*' (Dorothy). Nurses in particular seemed to relate paying attention to the '*little things*' as a way of

compensating for the lack of consistency in being able to meet professional and personal ideals of person-centred care in everyday practice. The power of the *'little things'* has been recognised in the literature in similar terms to those experienced in the present study (Carr, Hicks-Moore and Montgomery 2011). This involved actions such as; taking time to walk with a patient or helping them socialise with other people in the ward. Such actions relate to the compassionate nature of caring and may be *'more noticeable by their absence'* (Dewar 2013, page 49). The recognition of the value of these outwardly simple acts is the key to providing insight into how carers can relate in a more meaningful and humanistic way to those people in their care. Overlooking these seemingly *'little things'* has the potential to have a negative impact upon the wellbeing of the person being cared for (Malhotra 2014). When reflecting upon his mother's care in hospital, Dr Assim Malhotra suggests that depersonalised medical care makes patients sicker. In support of his perspective he quotes Krumholz (2013) who proposes that the stress of being in hospital has a detrimental effect upon the physiological systems and therefore increases the risk of further illness and re-hospitalisation. These findings are supported by other reports that state that the outwardly unimportant aspects of care make the difference between good care and excellent care (Carr, Hicks-Moore and Montgomery 2011, NHS Partners Network, NHS Confederation 2013).

Studies exploring the care of people with dementia in acute care settings have also identified that seemingly small actions can either disable or enhance the sense of personal identity (Clarke et al. 2011, Clarke and Gibbs 2013, Clissett et al. 2013). It is possible that because of the pressures in acute wards the interactions between carers and people who have dementia, for example are

unintentionally disabling, dismissive, patronising or impersonal. There is no doubt in some instances it is challenging to provide person-centred care in a busy care environment. It is all too easy for any patient, particularly someone who is quiet, withdrawn or has a cognitive deficit to be overlooked, not involved in decisions and disabled by nurses 'doing for' the patient, rather than facilitating more independent care (Clarke and Gibbs 2013, Nilsson, Rasmussen, and Edvardsson 2013). Apart from having a negative impact upon the person's psychological wellbeing there is also the risk of physiological needs remaining unmet, thereby increasing the likelihood of deterioration in their physical condition. Viewed collectively these findings suggest there is still a lack of knowledge in relation to the application of person-centred practice to acute care in general a hospital setting (DH 2012b, Alzheimer's Society and RCN 2013, CQC 2014). However, it also raises questions about the way acute services are commissioned and resourced. For example in his speech in July 2015 the Health Secretary, Jeremy Hunt stated that healthcare needs to be more human-centred (DH 2015). The failings in healthcare have been attributed in some part to the bureaucratic culture of the healthcare system (Care Quality Commission 2013, Francis 2013). However if services are poorly resourced the default position is to deliver care in a task orientated manner. This argument goes back to the earlier questions raised by Krumholz (2013) and Malhotra (2014): Are we making patients sicker by not paying attention to their personal needs and what impact is this having on the economics of healthcare?

## **Potential areas for development**

This qualitative exploratory study has provided an understanding of the phenomenon of person-centred care from the perspectives of nurses, allied health professionals and experienced nurse educators. Their explanations have provided insight into their experiences and desire to practice in more person-centred ways within their everyday practice. When examining the findings of the study there is much to celebrate in terms of the motivation of the participants to deliver person-centred care. However it is also evident that it can be a challenge to achieve consistently in a busy acute ward. This is compounded by the disruption to care teams caused by the recurring changes experienced in healthcare settings.

The discussion chapter has identified several potential areas for development, which relate to areas of research, education, healthcare commissioning and practice presented below:

1. It would be useful to test and evaluate the value of the model of person-centred care developed from the study findings. This could be achieved by using it as a basis for identifying inter-professional education and development needs in relation to being more person-centred in practice (from a pre and post-registration perspective). The design of the study would need to incorporate the views of healthcare professionals in practice and education along with service users and carers. The findings from such a study could be used to refine the elements of this model of person-centred care and identify its potential use in practice and education.

2. As a foundation for preparing for developments in practice it would be useful for teams to explore their personal and team values. This will require experienced facilitation and differing developmental approaches, pertinent to the individual teams. The 'Practice Development Workbook for Nursing, Health and Social Care Teams', holds a wealth of suggestions and resources designed to support person-centred practice (Dewing, McCormack and Titchen 2014). One example of a method to support facilitated activities is the use of EVOKE Cards (Stokes 2009, <http://www.evokecards.com>). These are pocket sized, cards with visual images and words that have been used in practice development to 'evoke' emotions and stimulate exploration of personal values and beliefs. This initial step would help the team members understand themselves and each other in order to support the development of shared goals, encouraging an inclusive learning environment and active learning.
3. As part of a continued approach to practice development; undertake a comparison between the ideal (or espoused) perspective on person-centred care, organisationally and locally within teams to the reality in the study setting in order to identify ongoing development needs. Research methods such as observation in clinical practice could uncover everyday indications of person-centred care in practice. Undertaking such a comparison will also enable a more comprehensive perspective on team philosophy and enhance understanding of the strengths and potential education and development needs for:
  - a. Individuals
  - b. Teams
  - c. Facilitators / Mentors / Preceptors / Clinical Supervisors

- d. Leaders within the team (not just senior staff)
  - e. Dementia care education in pre-registration and post-registration education and practice
4. With the support of experienced educators / practice development facilitators work collaboratively to identify the appropriate development of post-registration practice education and pre-registration education. Examples of activities may include:
- a. Explore the concept and impact of emotional intelligence on clinical practice. This would involve considering appropriate team activities which may facilitate and enhance self-awareness / self-knowledge.
  - b. Raise awareness of the impact of role modelling, particularly in relation to the role of the mentor and knowledge translation (including language and team approach). In view of the findings this would be particularly beneficial for supporting student learning in clinical practice. Nevertheless gaining a deeper understanding of how best to facilitate practice learning will be relevant to all within an active learning environment.
  - c. Use of the ordinary as opposed to only extraordinary incidents in practice for facilitated reflection / supervision within the MDT as suggested by McCormack, Manley and Titchen (2013) and Bott, Mohide and Lawler (2011). This will encourage the team to recognise 'person-centred moments' (McCormack and McCance 2010), to challenge assumptions and to develop an awareness of the impact of the *'little things'* for the person receiving care in order to enable a more consistent approach to person-centred care. Additionally, the Nursing and Midwifery Council will expect nurses to document reflection of a professional development

discussion with another NMC registrant as part of revalidation (NMC 2015). Taking part in group reflection or supervision may provide a platform for this and help nurses clarify how their personal and professional values contribute to high quality person-centred care.

5. The findings suggest that people working in healthcare do want to practice in person-centred ways and have a genuine human interest in the people they care for. However, the competing demands prevent this being the norm in everyday practice. In view of this perceived disparity it would be useful to explore the impact of person-centred care from a cost-benefit perspective. Some studies have developed measurements of care and the care environment (Edvardsson, Sandman and Rasmussen 2008, McCance, Slater and McCormack 2009). An evaluative study such as this would be difficult to design and outcomes may be challenging to measure due to the complex nature of the healthcare in the acute medical ward setting. However it has been stated that care providers in the NHS need to become more transparent in order to see how their organisation is performing compared to their peers (DH 2015). A health economic study could provide some of this transparency and add a valuable contribution to our understanding of the cost-benefit of delivering person centred care. This could in turn provide greater clarity for commissioners of health care and ultimately enable the reality of delivering person-centred care in practice to be properly considered as a fundamental part of a commissioned service.

## **Reflection on the methodology and methods**

This section of the chapter aims to reflect upon the suitability of the research methodology in achieving the aims of the study. The ontological basis of the study was informed by critical realism. Epistemologically, the study featured an interpretive approach due to the nature of the existing relationships between the study setting, participants and the researcher. It is therefore important to be transparent when considering the impact that this may have had on the research process and, ultimately, on the study outcomes. It is acknowledged that my previous relationships and experiences had an influence upon the analysis and interpretation within the study. In order to verify the analysis and interpretation, some participants and the supervisory team were involved in reviewing my interpretations of the data at several stages during the study, as described in Chapter 3. This was essential to ensure that my interpretations were seen as valid by the participants, and the supervisory team. Although it was my intention to work in an appreciative manner within the study, it was important to ensure holding this viewpoint did not interfere with the data analysis and interpretations of the findings.

The study was based within one team on an acute hospital medical ward, which was appropriate given the study's methods and methodology. The findings do resonate with the existing body of knowledge in this field and have also made a significant addition to our understanding from the perspective of acute medical wards and the experiences of student nurses as they learn. In order to advance this, further studies perhaps with samples drawn from more than one acute hospital, would produce more trustworthy and transferable data. The purposive sampling technique used in the study was designed to give a balanced and

unprejudiced representation of the differing roles within nursing in an acute medical ward setting. In terms of the allied health professional participants, the numbers recruited were representative of the number of physiotherapists and occupational therapists allocated to the ward. On reflection, it would have been useful to include other professional groups who form part of the MDT such as the medical staff in order to gain additional perspectives on the facilitation of person-centred care in a busy acute environment.

The inclusion of the experienced nurse educators gave insight into the congruence and possible use of the model of person-centred care to development and learning, both in clinical practice and higher education. In order to further develop an understanding of the process of learning, it would have been useful to return to these participants in order to utilise their knowledge and skills in more specifically outlining the next steps within research, education and practice.

When considering the suitability of the methodology, the research approach could have been even more collaborative in terms of participation in the design and implementation stages. The original ideas for the research came directly from the study setting and the research design was planned in conjunction with the supervisory team. In future it would be beneficial to involve practitioners from the inception of future qualitative research to enhance partnership working throughout the research process. Accepting this as a limitation, the study participants remained actively engaged and supportive of the research aims throughout the study. This was highlighted by the eagerness of participants to track the progress of the research, both individually and collectively; for

example when the interim findings were utilised within the team 'time out' days, which took place in January 2012.

One could argue that not including the rich data emergent the 'time out' days was a missed opportunity as the team were receptive to exploring the concept of person-centred care within their practice at this point in the study. Reflection upon the three interactive workshops with the nurses from the study setting raised questions about whether nurses working in clinical practice are encouraged to appreciate their own and each other's individuality. This reflection occurred following an activity within the workshops, which invited each nurse to share something unique about themselves with one of their work colleagues as a foundation for discussing the concept of person-centred care in everyday practice. It was noted with interest that they knew little about each other as people. This applied, as one would expect, to the newer members of the team but also to those who had worked together for several years. The lack of engagement with their own uniqueness and that of their colleagues may have an impact upon the nurses' ability to connect with the individual characteristics of the people within their care, therefore affecting their ability to be person-centred in their practice, a potential problem also noted by McCormack and McCance (2010).

At the end of stage one of the study, a more flexible approach within the research process would have enabled a more collaborative approach with the team. This may have deepened the study's exploration of this phenomenon of person-centred care for the individuals and the team as a whole. On reflection, there is value in working in a more reflexive manner within qualitative research rather than being rigid about the original research proposal. The level of trust

and commitment shown by the study site team offered the opportunity to enrich the research process and possibly enhance person-centred care at a time when they were ready to move forward together.

The formal and informal consultations with the Service User Development Worker and the Research Interest Group, which took place in the later stages of the study offered the chance to gain further insight into person-centred care from differing perspectives, thereby triangulating the data. Such conversations and discussions could be better utilised if they were recognised formally as data. This would have given the opportunity to incorporate ideas from outside of the study setting in order to consider the relevance to team development and person-centred care. For example, this could have involved using some of the experiences from the Service User Development Worker or the Research Interest Group perspective to challenge the status quo in the study setting.

A significant aspect of the study design was the consultation with two groups of people who were either service users or carers. The first meeting took place as part of the preparation for the study and the second as part of the dissemination of the study findings. The latter group consisted of lay people who actively support the design, development and implementation of the current pre-registration nursing curriculum. During the dissemination meeting, the people in the group indicated that from their standpoint much of healthcare research and therefore research findings relate to the perspectives of professionals. They recognised the outcomes of such studies could be useful. They also felt it was unclear what the terms and findings of research (in general) mean to people in receipt of care; as the terms used in the research findings are usually defined by professionals, rather than service users or carers.

On viewing the model of person-centred care the people in the curriculum development group thought the attitude and personal values of the people delivering care are what matter the most to those receiving care. In addition, they gave a strong recommendation that service users and carers must be involved in the co-production of everything which impacts upon them. From their perspective, an example of this meant actively working as partners from the conception of an idea through to the implementation of research, education or care delivery.

Actively listening to the feelings of the people in the group strengthened my understanding of the nature of co-production as a researcher. This supports the proposition that any plans for future research must include user and carer perspectives throughout the process, rather than simply at the beginning and conclusion of the study. The intention of this study was to explore person-centred care from the perspectives of nurses and the MDT. However future research would benefit from widening participation and including the perspective of people who are users and carers.

Since the outset of the research study, much has been learned about the theory and practice of research. The data were gathered by using a combination of individual and paired semi-structured interviews. On reflection upon the facilitation of the research interviews it was apparent that my ability to encourage more in-depth discussions became more evident in the later interviews. Additionally, the data from the paired interviews appeared more in-depth than the individual interviews, due to the discursive nature of the interview. Paired interviews were also useful when comparing differing perspectives present within the data.

As a result of reflecting on the strengths and limitations of the study, in future it would be useful to consider a more flexible and collaborative approach within all stages of the research process. It is also possible that including other methods would strengthen the findings. For example, the use of observation in clinical practice as suggested in the potential areas for development. The use of differing techniques of data collection will require careful thought, preparation and confidence on behalf of the researcher (and possibly the research participants) in order to facilitate the collection of successful and meaningful data.

The opportunity to learn from the experience of conducting this research has been enormous. Throughout the study there have been positive relationships with the study participants. This has fostered a genuine interest in the progress of the study and reciprocal support between me and the participants within the various stages of the study. Sharing the insights and findings from the study with the participants as the study progressed, also enhanced the level of trust to work appreciatively with each other whilst recognising that some of the findings would challenge current practice. This approach links closely to my personal beliefs and the open relationships experienced in the study setting helped to build the confidence in the team to challenge the norm.

### **Dissemination**

It is important to ensure wider dissemination of the research findings in order to enable discussions with the participants, service users and carers and other healthcare professionals within research, education and practice. This will encourage consideration of the implications for future research, education and

practice. Dissemination has occurred at several points in the study and there are plans for future events as shown in Table 3.

**Table 3. Dissemination Plan**

<b>Event</b>	<b>Activity</b>	<b>Date planned or completed</b>
Team 'time out' days x 3 from Study Setting	Presentation of interim findings and interactive workshop with all registered nurses and support workers	16 <sup>th</sup> , 23 <sup>rd</sup> & 30 <sup>th</sup> January 2012
Sharing Good Practice Festival in host NHS Trust	Presentation and discussion of interim findings utilising Case Study 2 (Gillian page 101)	10 <sup>th</sup> July 2013
Paper published	Paper published in The Journal of Clinical Nursing (Ross, Tod and Clarke 2014)	22 <sup>nd</sup> July 2014
Service Users and Carers Group meeting	Short presentation of findings and model of person-centred care followed by discussion of implications for research education and practice.	14 <sup>th</sup> October 2014
Director of Nursing Away Day with Matrons, Senior Sisters & Charge Nurses	Presentation and discussion of the implication of findings across the Emergency Care Directorate	19 <sup>th</sup> November 2014
RCN Education Forum National Conference	Concurrent session presentation	10 <sup>th</sup> & 11 <sup>th</sup> March 2015
Nursing & Midwifery Department meeting in employing university	Presentation and discussion	To be arranged for Autumn 2015
Team education days within the study setting	To be planned with the Senior Sister and MDT	Scheduled January 2016

## Chapter 6 Conclusion

In conclusion to the doctoral project report, this chapter will summarise the key features of the research. The inspiration for the study began as a result of informal discussions with student nurses and registered nurses about person-centred care. The uncertainties this raised about care delivery resonated with my own experiences as a clinical nurse and as a nursing lecturer. My reflection on this shaped the research proposal. At the outset of the study, I articulated a personal definition of person-centred care; which related to appreciating each person as an individual with his or her own values and beliefs. My definition also included upholding productive relationships by working in a collaborative, respectful, open and encouraging manner in order to promote high quality care.

Having completed this study, I remain confident that this definition forms a solid foundation for being person-centred. Nevertheless, I have learned that being person-centred is essentially about being human and recognising that the concept of person-centredness will have different meanings for each person. Whilst it is important to hold personal values and beliefs conducive to person-centred care, the success of person-centred care in practice appears to rest with being able to develop *shared* values and beliefs in order to enable them to become a reality in everyday practice.

The study aimed to explore how the concept of person-centred care is understood and achieved in an acute medical ward primarily from the perspectives of nurses and allied health professionals working in the study setting, in order to identify future development within education and practice.

A review of the literature identified that much of the previous research focused on the care of specific client groups or specific care settings, particularly in long-term care environments. Few studies focused on understanding person-centred care from the perspectives of a range of practitioners who worked together in an acute care setting. There were few studies that drew comparisons between the different participant perspectives involving allied health professionals, student nurses and nurse educators. This informed the sampling approach to include seven registered nurses, four student nurses, three support workers, three allied health professionals, two professional development co-ordinators and two nursing lecturers.

This qualitative exploratory study took place in three stages and used an interpretive approach with the aim of making the social world of the participants evident to others. A purposive sampling strategy identified 21 participants, as shown above. Methods included:

**Stage one** used a combination of individual and paired semi-structured interviews and follow-up interviews focused on nursing roles. The interviews explored; their understanding of the term person-centred care, their views on what facilitates this in practice and; their perceived education and development needs.

**Stage two** used semi-structured interviews focused on allied health roles. These interviews also explored; their understanding of the term person-centred care, their views on what facilitates this in practice and; their perceived education and development needs. This was designed to provide a comparison to the perspectives presented by the nurses in stage one of the study.

**Stage three** used a combination of discussions, consultations and paired semi-structured interviews which focused on educationalists and professional development co-ordinators. The purpose of this stage was to gauge whether the model of person-centred care made sense and to explore the practical application of the findings. The final process within stage three involved the synthesis of all stages of the study in order to develop and refine the model of person-centred care.

The data were analysed using Framework Analysis, which resulted in the development of a model of person-centred care, which was developed iteratively from data analysis, *a priori* knowledge of the researcher and the findings of the literature review. All elements of the model; organisational culture, the philosophy of the care environment, characteristics of relationships, personal qualities of staff and principles of person-centred care interlink to indicate what needs to be in place for person-centred care to be achieved. Secondly, it creates a possible structure for future education and development concerning person-centred care.

The model of person-centred care was used as a structure to present the study findings. The findings show that nurses and allied health professionals are motivated to work together in a person-centred manner; however, this is often compromised in acute care settings due to a variety of conflicting priorities. There was also recognition that healthcare organisations need to support carers in delivering high quality person-centred care by encouraging an open and facilitative approach at all levels. This open and facilitative approach was characterised by good communication, positive team relationships, shared

values and support for each other. This subsequently fostered a respectful, compassionate and empathic approach within everyday interactions. It was clear from the explanations given by participants that some of these skills and values were inherent within the person giving care. Nevertheless participants felt some of the skills and values could be taught by a combination of theory and practice learning; including role modelling.

Nurses, allied health professionals and nurse educators identified the importance of actively listening to the patient, family and to each other in order for everyone to work effectively towards realistic, safe person-centred care. The participants shared examples of good practice, which have the potential to be used as a foundation for developing future education and practice.

Overall the study fulfilled the original aims and highlights the need for post-doctoral work to identify realistic priorities for research, education and practice. These priorities include; exploration of team values in order to work towards a shared vision of person-centred care in the team; comparison of personal and professional ideals with the reality of person-centred care in order to identify ongoing development needs; testing and evaluation of the use of the model of person-centred care in practice and education and the investigation of the feasibility of conducting a health economic study to explore the cost-benefit of providing person-centred care in acute care settings.

The outcomes of the study may also inform and strengthen the existing understanding and practice of person-centred care in the study setting. Applying the findings to theoretical and practice based modules within higher education

will promote a more consistent approach to practice learning and person-centred care in pre and post-registration healthcare curricula. Together these actions have the potential to support a more consistent approach to person-centred care in everyday practice, thereby increasing job satisfaction as portrayed here by one of the registered nurses who participated in the study:

*'...for me it's my bread and butter, it is kind of what I live by. When I come to work if I feel everybody is happy then I feel like I have done my job properly and if I don't feel they are happy, then it affects me when I am at home as well. It's about personal satisfaction in the care that you are giving.'* (RN4).

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ORIGINAL ARTICLE

### Understanding and achieving person-centred care: the nurse perspective

Helen Ross, Angela Mary Tod and Amanda Clarke

**Aims and objectives.** To present findings from the first stage of an exploratory study investigating nurses' understanding and facilitation of person-centred care within an acute medical ward.

**Background.** The term 'person-centred care' is used frequently in healthcare policy and practice. However, the ways in which the concept is translated into everyday nursing care continue to present a challenge. Person-centred care has been explored extensively within the care of older people, people with dementia and people with a learning disability. Little empirical research has been conducted in acute ward settings. This study starts to address that gap.

**Design.** The study used an action research approach.

**Methods.** Individual semi-structured interviews were conducted with a purposeful sample of 14 nurses. Framework analysis was used to analyse the data.

**Results.** Nurses had a clear understanding of person-centred care in the context of their work. They acknowledged the importance of relationships, personal qualities of staff and respecting the principles of person-centred care as they strived to provide safe, high-quality person-centred care.

**Conclusion.** The examples of care given by the nurses in this study resonate with the 'six Cs' emphasised by the Chief Nursing Officer for England in 2012, acknowledge the motivation of nurses to provide person-centred care and will contribute to the ongoing debate about nursing practice.

**Relevance to clinical practice.** In the light of recent criticisms of nursing and the implied erosion of public confidence in the provision of high-quality health care, it is important to recognise good practice and use the findings as a foundation for further and sustained development in providing person-centred care.

**Key words:** action research, acute care, education and practice development, nursing care, patient-centred care

Accepted for publication: 16 June 2014

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#### What does the study contribute to the wider global clinical community?

- Findings build on the existing knowledge of person-centred care.
- Principles are applicable to other clinical settings.
- Results are relevant to clinical practice and pre- and postregistration nurse education.

## Introduction

Over recent years, there has been a negative and critical focus on health care and nursing, particularly in the media (Cavendish 2011, Adams & Smith 2012, Patterson 2012). In some cases, this has been in response to specific investigations into care quality, such as the independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust (Francis 2010, 2013) and the abuse of residents of Winterbourne View [Department of Health (DH) 2012]. Such events concern both the public and health professionals and have stimulated an ongoing appraisal of health-care quality and caring roles (Abraham 2011, DH 2012, Cavendish 2013, Hemingway 2013, Lilley 2013).

As a result of these failings, the Chief Nursing Officer for England has called for a rediscovery of compassion in nursing (Department of Health & NHS Commissioning Board 2012) to provide high-quality care. When reflecting upon the concerns presented in media debates, it is easy to blame individuals, managers or government policies (Lilley 2012, 2013). However, it is also worth taking into account other aspects of the debate, such as the strength of evidence indicating nursing care quality has diminished and not committed to person-centred care (PCC). This study presents key findings of an ongoing research study conducted in a large teaching hospital in the UK. The study seeks to identify nurses' understanding of PCC and what factors facilitate such an approach to care within an acute medical ward.

## Literature and background

The term 'PCC' is used frequently in health care. However, its use and definition varies in different policy, guidance, research and in everyday practice (Goodrich & Cornwell 2008, Goodrich 2009). The ways in which the concept is translated into everyday nursing care continue to present a challenge (McCormack 2004, Price 2006, Edvardsson *et al.* 2008, Goodrich 2009, McCormack & McCance 2010, Nilsson *et al.* 2013).

Whilst much is written about PCC in general terms, there are few empirical studies that examine its use and impact on care quality and outcome in acute care. PCC has previously been explored in the literature, particularly with reference to the care of older people, people who have dementia and people who have a learning disability (Kitwood 1997, Ford & McCormack 2000, Nolan *et al.* 2002, 2004, Thompson 2004, Brooker 2007, Peck *et al.* 2007, Edvardsson *et al.* 2008, McKeown *et al.* 2010, Kirkley *et al.* 2011).

McCormack *et al.* have conducted a series of rigorous studies mostly based on the care of older people (McCormack 2003, McCormack & McCance 2006, McCance *et al.* 2008, McCormack *et al.* 2009, 2011). Their work emphasises the value of the nurse's relationships with the person and their family, but also the need for seeing broader influences on person-centred practice. They identify the importance of elements such as the dynamics of power and control, the effect of institutional discourse, authenticity, the care environment, appropriate skill mix, effective staff relationships and shared values within the team (McCormack & McCance 2006, 2010). These and other concepts drawn from this programme of work were used to develop a person-centred framework for nursing, using it as the basis for a series of practice development programmes (McCormack & McCance 2010).

Other researchers have developed instruments and indicators to measure factors that influence PCC from patients' and nurses' perspectives (McCance *et al.* 2008, Edvardsson *et al.* 2009, Slater *et al.* 2009). These factors include relationships in the care setting, involvement in decisions about care and the culture of the care environment. Whilst the focus of these studies is on the individual, many elements have congruence with the relationship-centred approach seen as essential to the 'Senses' framework by Nolan *et al.* (2004, 2006). The framework was developed specifically to address nursing practice and education in the care of older people. It emphasises the need for each person (patients, family and staff alike) to feel valued and recognised as a person through relationships which are satisfying to all. The need for skilled, knowledgeable and enthusiastic staff working in an open and encouraging environment where there is mutual respect and trust are also common features of person-centred frameworks (Kitwood 1997, Nolan *et al.* 2004, McCance *et al.* 2011). These factors identified in the literature show how multifaceted PCC is and how realising it in everyday nursing practice can be a challenge.

Some of the challenges to PCC that have been identified include conflict between bureaucratic management systems, which focuses on budgets and commissioning, and care givers' concerns about individual care needs (West *et al.* 2005, Innes *et al.* 2006, Kirkley *et al.* 2011, Nilsson *et al.* 2013). This mismatch between priorities of managers and of staff working at the grassroots can cause tension. Instead of creating a positive culture in the care environment, it can result in staff feeling less engaged with care needs (McCormack 2011).

Further research is recommended to facilitate a clearer understanding of the meaning and application of PCC in everyday practice (McCormack 2004, Nilsson *et al.*

2013). Whilst much of the previous research focuses on the care of older people, people with dementia and care home environments, a few publications explore the application of PCC in acute hospital settings (Peck *et al.* 2007, Gribben & McCance 2010 cited in McCormack & McCance 2010, NHS Education for Scotland 2012). However, there remains limited focus on the staff perspective of their educational needs in relation to PCC in acute hospital care. This study reports findings from the first stage of a larger study that aims to enhance understanding of PCC and identify recommendations for clinical practice, preregistration and postregistration healthcare education in higher education. The study focuses on the findings from the nursing component of the study.

### The study

The research presented here relates to the first stage of a larger qualitative exploratory study investigating nurses' understanding of PCC and the factors that facilitate such an approach to care within an acute medical ward. The study used an action research approach, informed by the values of appreciative inquiry (Cooperrider & Whitney 2005). Appreciative inquiry is a strength-based approach to organisational development. It works by looking at the collective strengths of the people working in an organisation with the intention of using this understanding to transform their way of working.

The larger study comprised three stages with stage one (presented here) being the biggest component. Stage one involved the use of semi-structured interviews and follow-up interviews or discussions with seven registered nurses, three healthcare support workers and four student nurses working on the ward.

Stages two and three of the larger study involved the use of semi-structured interviews and consultations with key informants, including allied health professionals (AHPs), nursing lecturers, clinical educators and other experienced nurses. These stages explored the similarities and differences between nurses and AHPs and started the process of developing educational responses.

### Aim

To identify the facilitators of PCC from the perspective of nurses (within this study, the term 'nurses' included registered nurses, support workers and student nurses) working in an acute hospital medical ward and the implications for education and to generate practical and applied outcomes

that would be useful in educational terms to help nurses understand what PCC is and consider how the principles can be applied in their own practice.

The following research questions were explored:

- What do nurses understand by the term PCC?
- How is PCC facilitated in the acute hospital medical ward?
- What are the implications for nurse education?

### Methods

Methods included individual and group interviews which were analysed using framework analysis (Ritchie & Spencer 1994). An action research approach was adopted. The study was initiated following discussions between nurses and the lead researcher (in the role as link lecturer from the local university) about the care of a man who had been admitted to the ward following a stroke and was resisting the help offered to him by the nurses. The discussions considered whether understanding more about the man's life and interests might aid nurses (including student nurses) to care for him in a more beneficial manner. It was also questioned whether meeting his needs more effectively would in turn have a positive impact on nurses' sense of fulfilment in their work and enhance their understanding of the value of PCC. This prompted the development of this research study exploring factors influencing PCC delivery.

Action research is seen as a way of encouraging practitioners to explore and take control of their own practice in the context of their working environment (McNiff 2002). It is approached in cycles and is emergent in nature. In the later cycles, the interpretations developed in the early cycles can be tested, challenged and refined. This study was the first cycle of an action research study and consisted of the following stages (Box 1):

Box 1. Stages of action research featured in the study

Stages of action research	Features of the study
Planning	Identifying the need for the study Reviewing the literature Developing the research proposal
Acting	Collecting and analysing the data (review of current practice)
Developing	Identification of the educational needs
Reviewing	Dissemination of findings Reflecting on the results Planning for the implementation of recommendations (second cycle)

The four principles of appreciative inquiry of being appreciative, applicable, provocative and collaborative were applied when framing the questions, analysing the data and making recommendations within the study to avoid critical connotations (Cooperrider & Whimsey 2005). Both action research and appreciative inquiry acknowledge the significance of individual values and their influence on human practices and recognise the worth of subjective knowledge as much as objective (Ritchie & Lewis 2003).

#### Ethical considerations

University and NHS ethics and governance approvals were obtained. The ward managers gave verbal information about the study to nurses on the ward, and written information sheets provided potential participants with more detail about the study. The lead researcher visited the ward regularly to answer any queries. Written consent was sought once potential participants had read the information sheet and had the opportunity to ask questions. The voluntary nature of participation was made clear, and it was emphasised that participants could withdraw from the study at any time.

#### Sample

A purposive sample of 14 participants (nurses) was recruited from an acute medical ward in a large teaching hospital in the UK for stage one of the study. Purposive sampling was used to select participants who had specific knowledge and experience of providing nursing care (Morse & Field 1996, Holloway & Wheeler 2010). See Table 1 for characteristics of the research participants for stage one of the study.

Table 1 Characteristics of the research participants

Stage of study	Role and identifier	Age band	Length of time in health care
Stage one (n = 14)	Staff nurse (RN1)	30–39	Five years
	Ward sister (RN2)	50–59	36 years
	Ward sister (RN3)	40–49	30 years
	Staff nurse (RN4)	20–29	Four years
	Ward sister (RN5)	50–59	30 years
	Staff nurse (RN6)	50–59	30 years
	Staff nurse (RN7)	40–49	25 years
	Support worker (SW1)	40–49	20 years
	Support worker (SW2)	40–49	25 years
	Support worker (SW3)	40–49	Four years
	Student nurse (StN1)	Under 20	1.5 years
	Student nurse (StN2)	20–29	Two years
	Student nurse (StN3)	Under 20	One year
	Student nurse (StN4)	20–29	2.5 years

#### Data collection

Semi-structured interviews were chosen to explore participants' understanding of the term PCC and to seek their views on the facilitators to this in practice. An interview schedule was used and adapted throughout the period of data collection as participants introduced new ideas for further investigation. Interviews were digitally recorded and transcribed. Although demographic information was collected, all identifying details were removed from the transcripts.

#### Data analysis

Data analysis was guided by the principles of framework analysis, especially useful when it is anticipated that research recommendations will influence practice (Ritchie & Spencer 1994). This uses a matrix to develop an analytical hierarchy, which ensures a systematic approach to data analysis. Framework analysis includes discrete but inter-related stages: familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation.

Framework analysis allows integration of *a priori* knowledge into the analysis alongside emerging codes obtained directly from the data. The *a priori* knowledge in this study related to the personal and professional knowledge of the researcher and existing literature. The interview transcripts were coded using a qualitative data management system (NVivo version 9, QSR international, Australia). The process began by reading the transcripts closely and coding them as topics emerged. At the familiarisation stage, the analysis generated broad themes. The themes were then explored in more depth to ensure they were generated directly from the data. This produced a more refined thematic framework (see themes in the Findings section). The thematic framework was used to reanalyse the data, challenge the framework and check its correlation with the original transcripts to aid accurate interpretation of the findings.

During data analysis, a sample of transcripts was checked by the supervisory team to substantiate the emerging themes. Then, the thematic framework was shared with five participants to gain feedback on its congruence with their interpretation of the interview themes. It was also shared with experienced healthcare professionals by consulting with an existing research interest group that is active in promoting the application of research into practice in the host NHS trust. This established the clarity of the framework and resulted in minor changes to the terms used; however, the three main themes remained as originally identified from the data.

## Findings

The findings are presented in two sections. The first section illustrates what the participants understood by the term PCC. The second section describes how the facilitation of PCC was perceived by the participants and is presented in three themes:

- Characteristics of relationships.
- Personal qualities of staff.
- Principles of PCC.

### Section 1 – Understanding of person-centred care

At the outset of data analysis, it was necessary to gain insight into the participants' understanding of the term 'PCC'. This enabled the analysis of how understanding of the term translated into everyday care delivery in the study setting. Participants demonstrated a good understanding of what the term PCC meant in the context of their work. They provided examples which showed understanding of PCC both when it worked well and sometimes when the challenges of everyday practice got in the way.

One registered nurse (RN) described the care of a woman who had a severe learning disability, which motivated the nursing team to become familiar with her routine. Participants recognised that the same effort should be made for someone who did not have such obvious needs. This attention to detail was seen by many participants as the key to PCC. Understanding more about the person and their personal identity was seen as vital in facilitating PCC; however, this was sometimes seen as happening in a haphazard way in the midst of busy ward routines:

'...We've had to get to know her routine, how she lived at home, how she was cared for... so that has been a growing experience for us... It is a relationship that's been built from scratch and now we know her and she knows most of us and we know how to deal with her so that's a really good working relationship. Although it's quite stressful at times, it does work.' (RN1)

The same nurse went on to explain about the care of another woman who had been on the ward following a stroke and had difficulty communicating her needs:

'I think one of the main things is to get to know your patients, see what they would find valuable...we were tidying up her locker and we found a bag of make-up and we thought 'we've never seen her in make-up'... She obviously does wear make-up because she'd brought it with her and we asked her about it and her eyes brightened up and we were able to make her face up and from that date it was like a different person emerged.' (RN1)

Some participants acknowledged that an acute care environment can lead to a problem-based approach to care, separating the person from their normal relationships and interactions:

I think we still, as nurses, see people as patients and not people. (RN2)

Participants described seeing their patients in bed with a 'set of problems' rather than seeing them as a person within a social network. Initially, this was often a necessity as patient safety was paramount, particularly when a patient had been admitted as an emergency:

'...you have got to make sure your patients are safe first and foremost and then build relationships after.' (RN4)

Support workers (SW) had similar feelings to registered nurses, recognising that it sometimes took extra effort to provide care that was person-centred in an acute setting. One way of enhancing PCC was to build relationships with the family:

'...you can always go that one step further for that person... you've got to listen to what the patient's telling you and sometimes you get to know the families as well and that gives you a good understanding... I think you get a lot of satisfaction, I'm not going to say you feel part of the family but you feel closer to that person, as families get to know you...' (SW1)

Participants said it was particularly important to get to know the family when the people themselves were unable to make their wishes known. This is illustrated below as another support worker told of the complex and compassionate care given to a woman at the end of her life:

'It was quite upsetting, but it was very satisfying towards the end of her life because he (her husband) wanted us to be with him all the time. I think he was quite scared about what was going to happen, apprehensive and he had particular ways that he wanted us to do things. He had a certain nightie he wanted her to wear and underwear she'd got to wear and she had to have her hair done a certain way... he wanted his own music playing. He'd got an iPod and he was playing his own music in the room for her and it was a very peaceful ending for her... when I went home I was upset but, I was satisfied that we'd done everything that he wanted and that she probably would have wanted. Yeah, it was good really.' (SW3)

The standard of care described above is exemplary; however, can the same be assumed of everyday nursing practice in an acute care environment?

## Section 2 – Presentation of the themes

### *Characteristics of relationships*

Participants highlighted the importance of relationships and communication with the person, their family and the care team to facilitate PCC and described some strategies for achieving this. Being friendly and approachable was seen as crucial by participants to the initial stages of building trusting relationships. This involved finding the time to listen and talk with the patients and their relatives to give information and help ease anxieties. Participants also identified that involving patients and relatives in care decisions and care delivery in a compassionate manner supported PCC. Empathy was referred to in many of the interviews, even if the exact term was not used:

'Involving the family is a massive part of person-centred care, as their family know everything about them; they just know them inside out. It's about building trusting relationships... definitely and respecting the person, they are not just a patient, they are a person.' (RN4)

'Some families come in and spend a day here learning how to care for their relative. I think to get the family in and help provide care while they're supported in hospital is a big thing.' (RN3)

The interview findings also indicated that the characteristics of the relationships within the care team were crucial in supporting PCC, for example acknowledging team contributions and working together towards shared goals. This was articulated well by the student nurses in the study:

'I think communicating with other members of staff is a big issue, especially in handover for example saying "oh he likes to eat his breakfast in bed first and then get up...he didn't want to wash before his breakfast," so it's about finding out their plan...'. (StN2)

'Students obviously don't know more than the (registered) nurses but sometimes they might have done assignments on different things. I've just done an assignment on dignity and privacy, so sometimes we can bring little bits of things (information) onto the ward...just reminding some staff and other students as well.' (StN3)

In summary, participants recognised the influence of constructive team relationships upon PCC and had insight into their role in supporting a positive care environment using their communication skills within the team to enhance care: student nurses (StN) noticed that constructive communication in the team and a relaxed, yet professional approach to care reduced stress levels for all involved and improved the experience of care for the patient and their family. These views were echoed by other participants.

### *Personal qualities of staff*

It was also acknowledged by participants that the personal qualities of nurses were equally important to relationships in encouraging a positive team approach to PCC. Personal values and beliefs that were congruent with PCC emerged as being vital if PCC was to be realised:

'I think it's staff attitude and understanding and time also has a lot to do with it... it is a lot to do with leadership, but I think it is also quite an individual thing... for me it (person-centred care) is my bread and butter, but I don't know if it's the same for everybody.' (RN4)

The nurses interviewed held similar beliefs regarding PCC being a fundamental requirement for providing high-quality care. These personal values were also discussed by the support workers in the study:

'I like to spend time, if I'm helping a patient, to talk to them about their life because they're not just a person in a bed who's ill, they have got a life and a family... because you've sat and had that time with them and you're a friendly face and they know they've already told their concerns to you so they will let you help them.' (SW3)

There was a clear recognition from participants that listening to and recognising the importance of people's stories were valuable in facilitating PCC. This was more likely to lead to flexible care delivery to meet the specific needs of the patient:

'It is important to empathise with their situation and to use a bit of judgement and discretion and maybe relax certain rules...Can't we do this because it'll mean so much more to that person?' (RN2)

Flexibility in ward routines was spoken about as a facilitator to PCC; however, for this to occur, the leadership style had to be congruent with PCC:

'If you've got a ward manager that is aware of people as individuals and encourages that, then you take your lead from them or your senior nurses...when you get new staff you should be encouraging them and setting a good example.' (RN3)

Role modelling was not seen as being solely the remit of the senior nurses. Student nurses and support workers also discussed how they could influence the way care was delivered. This was linked to personal confidence within the team and professional maturity, not necessarily to age or length of time in post.

### *Respecting the principles of person-centred care*

Participants recognised that providing PCC takes effort to ensure positive outcomes and needs not only a team

approach, but a philosophy of care which flows throughout the whole establishment. The principles of providing PCC involved recognising the importance of a person's wishes when considering care decisions. Even when the patient him/herself was unable to make the decision, the nurses and multidisciplinary team worked with families to consider what the best interests of the person would be. This often involved supporting the person or their family to ask questions when unsure about treatment or care decisions:

'Lots of the times we are advocates for them [patients]... when the doctor walks away we say "Are you alright with everything you have been told, do you want to ask any questions?" They sometimes say they don't understand what has been said... I think as long as the person has (mental) capacity, then I think it (their view) does get listened to. I think on this ward they are really good, they really try to meet people's needs and take into account their beliefs and what they want.' (RN4)

Responsive assessment of individual needs was also described by participants as an important aspect of PCC; this involved paying attention to all aspects of care that were important to the person:

'I think the little things make the most difference because it's a person's dignity. I think just everyday personal things make more impact to the person's stay in hospital than the medical care or whatever else. I think it does impact on somebody's recovery if they feel more comfortable... and if you can make it easier, from the beginning, I think it does make a difference to the person's stay and it probably makes a difference to how they recover.' (RN2)

'I'd say most shifts you can dedicate a small amount of time to little things that patients find important. Taking them for a little walk round the ward and having a chat with other patients, little things like that, otherwise they're just sat on their own in the chair with their own company. I wouldn't like to be sat on my own.' (RN1)

Job satisfaction was important to the participants; this often involved a personal connection being made with individual patients. 'Getting to know the person' featured strongly in the interviews and making time for the 'little things'. The little things (like making a cup of tea in the night when someone cannot sleep) often seemed to make a big difference to the person being cared for from the nurses' perspective.

## Discussion

Findings show that the participants recognise the value of delivering PCC and the positive impact this can have for all involved in the care situation. Their examples of care

delivery resonate with the 'six Cs' emphasised by the Chief Nursing Officer for England, Jane Cummings (DH & NHS Commissioning Board 2012): care, compassion, competence, communication, courage and commitment. The experiences of nurses in this study illustrate their understanding of the term PCC and the importance of high-quality safe practice in facilitating excellence in care. The insight presented by student nurses suggests that they also have an understanding of the nuances of care and the type of care environment that promotes person-centredness, despite literature that suggests that practice learning is lacking (Patterson 2012, Willis 2012).

McCormack and McCance (2010) believe that, in many care settings, rather than delivering PCC continually, nurses experience 'PCC moments'. These moments are apparent in this study showing their significance in everyday interactions in acute medical ward settings. 'Person-centred moments' become more evident and consistent where the healthcare team shares humanistic values such as mutual respect for individuals and their rights (McCance *et al.* 2011). The consistency of PCC is affected by the shared values across the whole organisation (Nolan *et al.* 2004, 2006, Webster 2004, Kirkley *et al.* 2011, McCormack *et al.* 2011, Nilsson *et al.* 2013). This facilitates a work (care) environment where staff feel valued, there is strong leadership, and management styles are perceived as enabling a more person-centred approach to care (Lynch *et al.* 2011, Francis 2013).

It is evident from the findings here that delivering PCC in a busy acute environment is a challenge. There is recognition of the competing demands in health care and some feelings of frustration when it is not possible to achieve the level of PCC that nurses would desire. Communication can become task-centred, rather than people-centred when nurses are busy (McCabe 2004, Francis 2013). Participants indicate that workload can be outside of the nurses' control and refer to the need for appropriate resources to be available to support PCC; this is reinforced by campaigns which support front-line staff (Scott 2013). However, there is an argument that the nursing profession needs to look beyond the claim of staff being too busy (short staffed) or poorly resourced to provide PCC (Kirkley *et al.* 2011, Hemingway 2013).

It is a financially challenging time in health care (O'Neill 2013); nevertheless, healthcare professionals need to ensure they are able to identify and uphold the characteristics of care that demonstrate a person-centred, holistic and collaborative approach to care [Nursing and Midwifery Council (NMC) and General Medical Council (GMC) 2012]. The

findings show that when care is focused on the person's unique needs, it has a positive effect upon the person receiving care, their family and the job satisfaction of nursing staff. The managers of health and social care need to consider the necessity to strive for high-quality PCC by developing an organisational culture where staff are encouraged and enabled to see the individual needs of the person in their care as paramount through the use of education and practice development (McCance *et al.* 2011, Francis 2013, Hemingway 2013).

#### Limitations to the study

The findings presented here relate to the first stage of an exploratory study investigating nurses' understanding of PCC and the factors that facilitate such an approach to care within an acute medical ward. The sample was small ( $n = 14$ ); however, this represented 50% of the staff on the ward and included registered nurses, support workers and student nurses. This gave a fair representation of the workforce involved in delivering nursing care on the ward and was sufficient to give relevant data about the approaches used on a single ward (Baker & Edwards 2012). However, the findings do need to be tested across a more diverse area in an acute care setting. Future studies would benefit from including patient and family perspectives to explore congruence between professional perspectives and those of people in receipt of care.

#### Conclusion

In conclusion, findings from the data indicate that characteristics of relationships, personal qualities of staff and respecting the principles of PCC act together to shape the philosophy of care on the medical ward. In turn, this philosophy influences how staff perceive and facilitate PCC. This affects the way they interact with each other, with the person being cared for and their family, which all impact on the level of person-centredness within that environment. There are some parallels from this study to the findings of other studies which explore PCC. Therefore, the findings of this study will strengthen the body of work which explores

the understanding and application of PCC, particularly in acute medical ward settings.

#### Relevance to clinical practice

The implications for practice arising from the first stage of this study relate to three key points. The first is that in the light of recent criticisms of nursing and the implied erosion of public confidence in the provision of high-quality care, it is important to recognise good practice and understand the motivations to achieve this. The second is a proposal that the study findings and thematic framework should be used in clinical practice and education. It can be used to promote the positive attributes of nursing and act as a building block for further and sustained education and development in providing PCC. Finally, the findings support the 'six Cs' emphasised by the Chief Nursing Officer for England in 2012 and will contribute to the ongoing debate and consultation about the Nursing and Midwifery Council Code (NMC 2013).

#### Acknowledgements

Judy Redman, PhD, MA, BA (Hons), Diploma in Adult Education (Nursing/Midwifery Professional Education), RN, who acted as a critical friend during preparation of the article.

#### Disclosure

The authors have confirmed that all authors meet the IC-MJE criteria for authorship credit ([www.icmje.org/ethical\\_1author.html](http://www.icmje.org/ethical_1author.html)), as follows: (1) substantial contributions to conception and design of, or acquisition of data or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content and (3) final approval of the version to be published.

#### Sources of support

No sources of support were used for this study.

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## Appendix 2 Helen's Seminal Moments (11-10-07)

### Where is the person?

Over the years of working as a nurse there have been occasions when the person seemed to be lost within the medical approach to their care.

### One example springs to mind:

A middle aged lady had come into the ward with advanced cancer of her right breast. Everyday a new lesion was breaking out on the surface of her breast and she had extensive, deep wounds which had very heavy exudate. This was her first contact with the healthcare system and she was very distressed at having to be in hospital away from her home and family. It was immediately apparent that she required palliative care. This involved pain control, wound care and attempting to meet her many psychological needs.

She lived in a remote farmhouse with no heating other than a coal fire, and no hot water. The house had animals, ducks and chickens running freely in and out of the house. She had two children, one daughter aged 18 and a son aged 20. Her husband was very aggressive when visiting and often arrived drunk to the ward.

Her priority was to go home as soon as possible but the consultant physician was having none of it saying it was ridiculous and she would be back within days. This caused great distress to the lady and she wanted to discharge herself. After much disagreement and lots of phone calls she did go home only for it to fail days later. The physician seemed pleased that his prediction had come true! However to go home remained her priority and we as nurses battled until we got everything that was needed. We worked closely with her family, particularly the daughter and made sure we gave everything that was necessary to enable this time to work more effectively. The district nurses were amazing and pulled out all the stops. The lady went home and died 4 days later in her own familiar surroundings.

### Despite all the rhetoric about holistic care there still appears to be little to show that this is actually occurring:

At present my neighbour is in hospital, following a fall at home 4 weeks ago. This was to explore the pain in his hip initially, but no injury was identified. Since going into hospital he has deteriorated, losing weight and not drinking adequately. He has developed a pressure ulcer and is verging on depression. He is sat out of bed almost continuously from 7am until 9pm with only the wall and the toilet door to look at. The layout of the ward means it is difficult to talk to anyone else if you are not mobile. His wife is anxious, not sleeping or eating very well and is unable to visit without assistance due to the distance from her home and her own physical difficulties.

He is as mobile as he was prior to admission but is now being delayed due to having a catheter in and awaiting hand rails to be fitted at home. He is desperate to return home and his wife is fearful that if he doesn't come home soon he will die in hospital.

### So what are the key issues?

Well the question for me is how can we as healthcare worker see the person behind the patient? (This is nearly the title of one of my joint publications). The more I think about our work as healthcare professions, the more I am convinced that this must be the key to providing the person-centred care that is so often advocated in the literature, but rarely evident in reality.

What is it that can enable that to happen in everyday care settings and how can this then go on to ensure care is provided in a timely and appropriate way for the person and their family rather than the routines of healthcare provision taking precedence?

Well I guess there are more questions than answers here but it has perhaps focused my thinking about the future direction of my research.

## Appendix 3 Ethical approvals

### Names of participating organisations removed

Faculty of Health and Wellbeing  
Faculty Research Ethics Committee  
Health and Social Care Division

Research Proposal Review Form

Review Summary

Name of researcher: Helen Ross

Project title: 'Person-centred care in a stroke rehabilitation unit: professional development needs of nurses

Name of supervisor: Angela Tod

Code for Decision: **Satisfactory Review Achieved**

Satisfactory Review with some advice

Unsatisfactory Review - needs amendments

[PLEASE SELECT ONE OF THESE THREE]

Signature of Reviewer: P Allmark/ A McDonnell

Date: 30/01/10

Feedback : PA: There are few concerns about the ethics of this project; those there are have been addressed. The science is satisfactory; the use of qualitative research with a framework of analysis is fine. The advisory team is well able to support the student in this.

AM: There should be more information on protection of privacy and ensuring confidentiality.

Site/Project files

An up-to-date project or site file must be maintained for the duration of the project and afterwards. The file might be inspected at any time.

Mental Capacity

Special procedures now apply to any research that involves adults without mental capacity to consent to that research. This applies both to the NHS and to Social Care Research. Please contact Peter Allmark to discuss if that applies to this study.

### Checklist for Independent Scientific Review

General	Yes	No	N/A
The aims of the project are clearly stated	✓		
The project is original in concept with evidence to support the project's originality in the literature review	✓		
The project is useful and relevant to clinical practice, policy making or workforce planning	✓		
The project is feasible in the time available	✓		
Service users have been involved in the development of the proposal where possible			✓
A completed project safety plan is included with the proposal	✓		
A completed registration form is included	✓		

Method / design / analysis	Yes	No	N/A
The design is appropriate for the identified aims	✓		
A clear rationale for the use of systematic literature review is included			✓
The review procedure chosen is appropriate			✓
The sampling strategy chosen is appropriate for the identified aims.	✓		
A power calculation has been undertaken if appropriate.			✓
Methods to be used to identify, approach and recruit participants have been included	✓		
Trustworthiness and rigour of data collection are considered	✓		
Measurement issues are addressed in relation to clinically appropriate measuring tools.			✓
The validity and reliability of the outcomes measures chosen have been considered (this included questionnaires to be used)			✓
An appropriate plan of analysis is included with reflection on the implications of the sample size.	✓		
The project attempts to look at individual data as well as aggregated data			✓
There is a logical and feasible research time plan with clearly delineated milestones.	✓		
Itemised costings are included			✓
Issues concerning racial and cultural diversity have been			

considered		✓	
Participant information and consent forms have been included	✓		

Have issues around controlling bias been considered			✓
Has a statistical opinion been included if appropriate			✓
Have indemnity issues been considered (FIN 12 included if appropriate.)	✓		
Have funding arrangements been made clear (ENT 1 enclosed if appropriate)			✓
Have methods for the dissemination of results been considered.	✓		
Have intellectual property arrangements been considered (if appropriate)			✓

### Checklist for Ethical Approval

SAFETY ISSUES - Refer to the project safety plan as well as the protocol.	Yes	No
Is there is any potential for physical or psychological harm or distress to research participants?		
If Yes: a) Are adequate mechanisms in place to minimise the risk and to tackle any harm or distress that occurs?	✓	
b) Is the potential risk of harm balanced by potential benefit to participants?	✓	
Is there is any potential for physical or psychological harm or distress to the researcher(s)?		
If Yes: a) Are adequate mechanisms in place to minimise the risk and to tackle any harm or distress that occurs?		✓
Are any of the participants likely to belong to a so-called vulnerable group, for example, children, people with mental health problems or with learning disability, people in a dependent relationship to the researcher(s)?*		✓
Is there a named Project Safety Supervisor?	✓	

\* See note on Mental Capacity on the front sheet.

RIGHTS ISSUES	Yes	No
Are issues of confidentiality, privacy and data protection adequately covered in relation to:		
a) The recruitment of participants?	✓	
b) The protection of the privacy of participants?	✓	
c) The protection and storage of confidential information generated by the study?	✓	
Will informed consent be obtained from the participants?	✓	
Is there a satisfactory:		
a) Participant information sheet?	✓	
b) Participant consent form? [Note: a consent form is not required for questionnaire studies.]	✓	
Does the research involve the removal of any human tissue from participants? Human tissue is, in effect, any sample taken from the human body apart from nails and hair.		✓
Does this proposal adequately address any issues of ethnic diversity or other diversity issues?		✓
Do you believe this proposal needs specialist ethics review?		✓

Funder: Unfunded

The Research Department has received the required documentation for the study as listed below:

- |   |  |
|---|--|
| <b>1. Sponsorship IMP studies (non-commercial)</b>        | N/A  |
| <b>Sponsorship responsibilities between institutions</b>  | N/A  |
| <b>Responsibilities of Investigators</b>                  | N/A  |
| <b>Monitoring Arrangements</b>                            | N/A  |
| <b>2. STH registration document: completed and signed</b> | NHS REC Form, V2.5:<br>H Ross, 29 Mar 10<br>D Patel, 26 Apr 10                         |
| <b>3. Evidence of favourable scientific review</b>        | Letter from Sheffield Hallam University:<br>Director of Studies,<br>unnamed, 09 Feb 10 |
| <b>4. Protocol – final version</b>                        | V1.0 dated<br>09 Apr 10  |
| <b>5. Participant Information sheet – final version</b>   |  |
| Nursing Staff   | V2.0 dated 10 Jun 10   |
| Multidisciplinary Staff                                   | V2.0 dated 10 Jun 10   |
| <b>6. Consent form – final version</b>                    | V1.0 dated 29 Mar 10   |

**Study Title:** Person-centred care in a stroke rehabilitation unit:  
professional development needs of nurses.  
**REC reference number:** 10/H1310/34

The Research Ethics Committee reviewed the above application at the meeting held on the 27 May 2010. Thank you for attending to discuss the study.

#### **Discussion**

It was observed that there was quite a lot of work involved for each cycle of the research and it was queried whether one year was a realistic timescale. You explained that this was not a traditional PhD. The qualification was for a doctorate in professional studies (health and social care). The researcher particularly wanted to focus on the earlier stages of the action research i.e. participation, data collection and analysis but she would only be making the recommendations. She would not be implementing the changes. The committee accepted this explanation.

It was observed that student nurses were to be included in the research and whilst it was accepted that both qualified and unqualified staff would probably feel quite comfortable in saying "no", it was felt the student nurses may feel coerced into taking part. You explained that you believed the inclusion of student nurses would be a very useful part of the study and added that the chief investigator was not directly involved in teaching any of the students working on the unit. In preference you believed it would be a valuable addition to have the students' perspective, but agreed you would be guided by the committee. You added that there would be no inducement involved and it would be stressed to participants that they were free to take part or not, as the case may be. The committee agreed that student nurses could be included in the study.

You were asked to clarify the recruitment procedure and explained that your impression was that the idea was to raise awareness of the study with the staff working in the unit and that would involve the use of posters and attendance at regular and appropriate meetings

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority  
The National Research Ethics Service (NRES) represents the NRES Directorate within  
the National Patient Safety Agency and Research Ethics Committees In England

taking part on the unit. Information about the study would be provided and people would be asked if they were interested in taking part in it. The purposive sampling would be applied to get a range of participants should the chief investigator be inundated with participants. The committee accepted this clarification.

It was observed that participants would have to spend quite a bit of time taking part in the study and it was queried whether that would be in their own time or work time, and if it was work time, whether that would be supported by management. You explained that the chief investigator had spoken to the ward manager and asked him for his support. She had also spoken to the matron and the director of nursing at Sheffield Teaching Hospitals NHS Foundation Trust who had all given their support to the study. The committee accepted this clarification.

There were some issues that needed addressing in the participant information sheet that are set out below.

#### **Ethical opinion**

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### **Ethical review of research sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### **Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

#### **Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.**

*For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>. Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.*

*Sponsors are not required to notify the Committee of approvals from host organisations.*

#### **Other conditions specified by the REC**

1. Submit amended Participant Information Sheet (with a new version number and date) for both nursing staff and multi-disciplinary staff as follows:
  - Include an additional heading i.e. "Who has reviewed this study" and under this heading indicate that the study has been reviewed and approved by South Yorkshire Research Ethics Committee.

The REC nominated the Co-ordinator [redacted] to be the point of contact should further clarification be sought by the applicant upon receipt of the decision letter.

It is responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers.

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering Letter		09 April 2010
REC application	1	09 April 2010
Protocol	1	09 April 2010
Investigator CV		
Participant Information Sheet: Nursing Staff	1	29 March 2010
Participant Consent Form	1	29 March 2010
Student CV - Mrs Helen Ross		29 March 2010
Referees or other scientific critique report		09 February 2010
Summary of Research Protocol	1	29 March 2010
Proposed Interview Guide	1	29 March 2010
Advertising Poster	1	29 March 2010
Participant Information Sheet: Multidisciplinary Staff	1	29 March 2010

#### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators

Dear Mrs Ross

Full title of study: Person-centred care in a stroke rehabilitation unit:  
professional development needs of nurses.  
REC reference number: 10/H1310/34  
Protocol number: 1

Thank you for your email of 10 June 2010. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 27 May 2010. Please note these documents are for information only and have not been reviewed by the committee.

**Documents received**

The documents received were as follows:

Document	Version	Date
Covering Email		10 June 2010
Participant Information Sheet: Nursing Staff	2	10 June 2010
Participant Information Sheet: Multidisciplinary Staff	2	10 June 2010

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

**10/H1310/34 Please quote this number on all correspondence**

Yours sincerely

- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

**10/H1310/34 Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dear Mrs Ross

Full title of study: Person-centred care in a stroke rehabilitation unit:  
professional development needs of nurses.  
REC reference number: 10/H1310/34  
Protocol number: 1

Thank you for your email of 10 June 2010. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 27 May 2010. Please note these documents are for information only and have not been reviewed by the committee.

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You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

10/H1310/34	Please quote this number on all correspondence
-------------	--

Yours sincerely

## Appendix 4 Risk Assessment Form

### Sheffield Hallam University PROJECT SAFETY PLAN: Risk Assessment Form

**1. Project Title** Person-centred care in a stroke rehabilitation unit: professional development needs of nurses.

**Location: Names of participating organisations removed**

**People affected:** Nurses and multidisciplinary team members

**Assessment carried out by:** Helen Ross

**Project safety officer:** Angela Tod

**Supervisor:** Angela Tod

**Signature of Supervisor**..... **Date**.....

ACTIVITY	HAZARD ASSOCIATED WITH THE ACTIVITY	HAZARD RATING (High, Medium or Low)	CONTROL MEASURES TO BE TAKEN
Interviews	Participants become upset when discussing their experiences of person-centred care.	Low	Explain that the interview can be stopped at anytime and that there will be support available from the researcher and the academic supervisor if needed.
	Environmental risks where the interviews will take place	Low	Interviews are likely to take place in quiet room near to clinical area to ensure privacy, may have unexpected interruption from clients. Will need to be aware of local policy for dealing with violence and aggression in case this arises from an unexpected encounter.
	Patient identity being disclosed	Low	Act in accordance with the NMC Code of Conduct
	Details of risks to patient are disclosed	Low	Act in accordance with the NMC Code of Conduct

Please keep this form in your Site File (Section 3 - Ethics) and update as appropriate

REC Ref: 10/H1310/34 Version 1 04/ 03/10

## **Appendix 5 Diary reflections**

My experience of conducting the semi-structured interviews changed over the time of the study. Initially I was focused on the prepared interview schedule. I felt anxious if the participant 'dried up' and I couldn't remember what else I should be asking. This interfered with the natural flow within the interview. I realised that if the participant was speaking freely then I relaxed and let them talk. However if a participant was hesitant I noticed that I was speaking too much. This was particularly obvious when the interview was seen as a written transcript. As time passed I learned to ask questions that allowed the participants to speak more freely. This led to shorter prompts or questions in order to clarify a point or encourage more detail about their perspective.

### **28<sup>th</sup> March 2011**

Active listening in this interview was more challenging than normal as the participant seemed uncomfortable when asked certain questions. For example when asked about leadership style:

**Me:** What do you think your ward manager or senior nurses could do to enable you to work more effectively, looking at the person rather than the patient?

**Participant:** Feedback from the work that you're carrying out... they've got to have a positive attitude haven't they, as ward managers.

**Me:** You take a lead from their approach to care or?

**Participant:** It depends because sometimes you get good managers `don't you and other times you've got bad managers. I've got no complaints.

### **Reflection**

Within this interview it appeared to me that the participant felt that she was going to be judged by me for saying something she perceived she should not.

This indicated that she did not have full trust in me and the confidentiality of the study. She was insightful, however overall the interview felt lacking in depth and flow.

I am unsure why this occurred. It could have been a mixture of my lack of skill in facilitating more in-depth responses, combined with her personality and a possible fear of saying something she perceived as being critical of the leadership style of the ward sisters.

This was the most awkward interview I have undertaken so far. However once the participant relaxed she revealed stories from her nursing practice from the 1970s that demonstrated a clear understanding of person-centred care and her desire to facilitate this in the care that she gave to patients more recently. On reflection this participant was quite reserved in her responses and this challenged me as an interviewer, which was useful allowing me consider how to conduct future interviews. This recognition was important, as it is easy to include more in-depth material from interviews that flow more readily or from participants that confirm my personal perspectives about person-centred care. This interview has made me reconsider my position as a researcher and realise that I need to build on my skills by being more attentive to the participants' responses. It will be useful to think about how I can explore the pertinent points raised in an interview without it feeling awkward for the participant.

## Appendix 6 Characteristics of research participants

### Characteristics of the research participants (N = 21)

Stage of Study	Role and Identifier	Age Band	Length of time in healthcare
<b>Stage one (N = 14)</b>	Staff Nurse (RN1)	30-39	5 years
	Ward Sister (RN2)	50-59	36 years
	Ward Sister (RN3)	40-49	30 years
	Staff Nurse (RN4)	20-29	4 years
	Ward Sister (RN5)	50-59	30 years
	Staff Nurse (RN6)	50-59	30 years
	Staff Nurse (RN7)	40-49	25 years
	Support Worker (SW1)	40-49	20 years
	Support Worker (SW2)	40-49	25 years
	Support Worker (SW3)	40-49	4 years
	Student Nurse (StN1)	Under 20	1.5 years
	Student Nurse (StN2)	20-29	2 years
	Student Nurse (StN3)	Under 20	1 year
	Student Nurse (StN4)	20-29	2.5 years
<b>Stage two (N = 3)</b>	Physiotherapist (AHP1)	30-39	11 years
	Physiotherapy Assistant (AHP2)	30-39	3 years
	Occupational Therapist (AHP3)	30-39	15 years
<b>Stage three (N = 4)</b>	Professional Development Co-ordinators (PDC 1&2)	PDC 1 = 50-59	41 years
		PDC 2 = 60	42 years
	Nursing Lecturers (NL 1&2)	NL 1 = 50-59	37 years
		NL 2 = 50-59	41 years

## Appendix 7 Project Information Sheet

### Names of participating organisations removed

**Title of Research Study:** Person-centred care in a stroke rehabilitation unit: professional development needs of nurses (and the multidisciplinary team)

You are being invited to be involved in a research study. Before you decide whether to take part it is important to understand why the research is being done and what it will involve. Please read the following information carefully and discuss it with friends and colleagues if you wish. Take time to decide whether or not you wish to take part. Do feel free to ask if there is anything that is not clear or if you would like more information. Contact details are at the end of this sheet

#### Why is the study being done?

Person-centred, holistic and collaborative approach to care is central to good quality care. Many health policies promote person-centred care. However the literature suggests the concept may not be fully understood in practice. None of the studies reviewed focused specifically on a stroke rehabilitation setting. This study aims to identify factors that facilitate (or hinder) person-centred care and the associated professional development needs for qualified and unqualified nurses and the multidisciplinary team, from the perspective of staff working in stroke rehabilitation.

#### Why have I been invited to take part?

You have been asked to participate because you are a member of the nursing team who has expressed an interest in exploring person-centred care and the associated professional development needs of staff.

**Action Research will be used in the study**, which is seen as an approach to research that encourages practitioners to explore and take control of their own practice in the context of their working environment. Action-research is increasingly being used within health programmes and has been recommended by the Department of Health as a valuable approach to research (DoH, 2001).

Action research is able to focus on the practicalities of clinical practice and aims to foster productive relationships between participants and researchers. The purpose is to produce practical knowledge which emerges from the experiences of the participants and this informs and facilitates change which is owned by the participants rather than imposed upon them.

#### Do I have to be involved in the project?

No – taking part is entirely voluntary. If you would prefer not to take part, you do not have to give any reason and no one will mind. If you choose to take part you can still leave the project at any time, and no one will mind. If you decide to join the project, you will be asked to read this information sheet and sign a consent form.

#### What will taking part involve?

If you volunteer to take part in this study you will be asked to take part in an individual interview with Helen Ross (the researcher) to explore your understanding, views and experiences of person-centred practice. This will take place in a quiet room near to the ward and will last approximately 30 minutes.

This will be followed up with one further interview to check the first interview content and explore the professional development needs arising from the conversations in the first interview.

**How will the data be recorded?**

The interview will be recorded using a digital voice recorder and this will then be saved on a password protected PC for use only by Helen Ross and the research supervision team.

**What are the possible disadvantages and risks of taking part?**

Taking part in the interviews involves a time commitment that may be difficult for people who are very busy (approximately 30 min for initial interview and 15 min for follow up interview).

For some people, thinking about experiences related to person-centred care may invoke feelings of concern about previous patient care. This may raise issues around personal and professional practice, which you feel you want to discuss in confidence. Part of our commitment to you would be to provide support and contact with professionals who can offer further support and advice should you need it.

**Are there benefits from taking part in the project?**

There is no direct benefit to participating in the study. However, some participants in this type of study enjoy reflecting on their practice.

**Will my taking part in this study be kept confidential?**

The recordings from the interviews will be entered into a password-protected computer for analysis. These will be destroyed once the transcripts of the recordings have been checked and the written transcripts will be stored in a locked place, with only the research team having access for data analysis. The names of all the people who have taken part will be changed, so individuals will not be recognised. The written transcripts will have all links to you removed at the end of the study and will then be kept for as long as they might be useful in future research.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder that is locked away securely. These documents will be destroyed three years after the end of the study.

It might be that in the interviews something of concern arises relating to patient care. If that happens, the researcher will consult with her supervisor to discuss what to do. She will act in accordance with her professional Code of Conduct.

**What will happen to the results of the research study?**

The findings will be disseminated in the following forums with the aim of supporting personal and professional development which will enhance person-centred care:

- ❖ A final report will be prepared for the sponsors and the healthcare staff from the research setting.
- ❖ Presentations and summary to the wider staff group of the NHS trust where the study will take place. The Learning and Development team will be invited, with a view to considering the next stage of the study i.e. the professional development needs of staff.
- ❖ Presentations and summary in the local universities with the aim of informing the pre and post-registration programmes for healthcare staff and particularly nurses.
- ❖ Professional journal publications
- ❖ Conferences presentations
- ❖ Service user groups (guidance to be taken from the advisory group)

The findings of the study will be used to consider the next stage of the work, which will be to develop and implement relevant education and development.

At the end of the project, you can ask for a summary report of the project. We will also invite you to local dissemination events where the findings will be presented.

**Who is organising the research?**

Helen Ross Senior Lecturer in Nursing is conducting the study in partial completion of a Doctorate in Professional Studies.

**Who has reviewed this study?**

The study has been reviewed and approved by South Yorkshire Research Ethics Committee

**What if I have further questions or concerns?**

If you have any queries or questions please contact:

Helen Ross Contact details supplied

**Alternatively,** you can contact my supervisor: Dr Angela Tod

Contact details supplied

If you would rather contact an independent person, you can contact Ramila Patel

Contact details supplied

**N.B. Information sheets were the same for all participants**

# Appendix 8 Participant Consent Form

## Names of participating organisations removed

Centre Number: xxxx

Participant Identification Number:

Study title:	Person-centred care in a hospital based medical ward: professional development needs of nurses (and the multidisciplinary team).
Chief investigator	Helen Ross
Telephone number	xxxx

**Please read the following statements and put your initials in the box to show that you have read and understood them and that you agree with them**

**Please initial box**

1. I confirm that I have read and understand the information sheet (dated ____ ) for the above study and have had the opportunity to ask questions.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time from the individual or group interview, without giving any reason. My legal rights will not be affected.	
3. I agree to the individual interview or group interview being digitally recorded and transferred to a secure computer for the purposes of the research. I understand that I may ask for the recording to be stopped at any time.	
4. I agree to the use of extracts from the individual interview or group interview being used in published reports and presentations resulting from the research. I understand that all personal details will be removed and I will not be identified in any published work.	
5. I understand that the data collected during the study may be looked at by responsible individuals from the Sponsor, the Research Ethics Committee and from the NHS Trust, where it is relevant to this research. I give permission for these individuals to have access to my data.	
6. I agree to take part in the above study.	

**To be filled in by the participant**

**Filing instructions**

1 copy to the participant 1 original in the Project or Site file

I agree to take part in the above study

Name of Participant	Date	Signature

**To be filled in by the person obtaining consent**

I confirm that I have explained the nature, purposes and possible effects of this research study to the person whose name is printed above.

Name of Investigator	Date	Signature

## Appendix 9 Interview guide

### Names of participating organisations removed

(Individual or paired interviews)

**Please note: the interview should be open and facilitative, some of the following may be asked to start the interview / conversation**

#### 1. Introduction

- Outline purpose of interview/discussion
- Ensure participant read information sheet
- Discuss confidentiality and digital audio recording (if used)
- Opportunity for questions
- Complete consent form and give copy to participant
  - Explain that the questions asked relate to exploring the concept of person-centred care.

#### 2. Person- centred care

- What does the term person-centred care mean to you?
- Could you talk about your experiences of providing person-centred care?
- What do you think are the main issues affecting person-centred care?
- What helps you to provide good person-centred care?
- What are the challenges to providing person-centred care?
- Have you any advice about providing good care person-centred care?
- During clinical practice you will have had experiences where person-centred care has been promoted. Can you give an example of this?
- Conversely, you will have had experiences where person-centred care has not been promoted. Can you give an example of this?
- If you were to work in a new environment, what would tell you whether or not person-centred care was at the heart of their philosophy of care?
- What approaches are you aware of which can promote person-centred care?
- How could you best be supported to provide good care person-centred care?
- Have you any advice about providing good care person-centred care?

### **3. Communicating about person-centred care**

- Can you describe any examples where you have talked/listened to people about their concerns regarding person-centred care?
- Can you describe any incidences where people expressed their concerns to you about care not being person-centred?
  - How did you react?
  - What did you do?
  - How was it followed-up?
- What do you think might help you to discuss these concerns with people?

### **4. Are staff trained to care for people with a person-centred approach?**

- Formal training
- Informal training?

### **5. Any other comments and general discussion**

#### ***Revised guide 10<sup>th</sup> Feb 2011 included new questions from further reading and interview experience***

- *How do patients become involved in decisions about their care?*
- *How much weight is given to the patient's view?*
- *How can you respect important routines for the patient?*
- *How do patients get to tell their story whilst they are in hospital?*

#### ***Revised guide for Stage 2 – Allied Health Professionals***

- What is your understanding of the term person-centred care in the context of your professional role?
- What are your (good / bad) experiences of providing person-centred care?
- What do you think are the main issues that facilitate person-centred care from a multidisciplinary perspective?
- What helps you (personally) to provide good person-centred care?
- Have there been times when you could see something that could have helped care be more person-centred but were not used, if so what were the circumstances?

## Appendix 10 Follow-up interview guide / questions asked

### Names of participating organisations removed

**Please note: the interview should be open and facilitative, some of the following may be asked to start the interview / conversation**

#### Introduction

- Outline purpose of follow-up interview/discussion / Ensure participant recalls reading information sheet and completing consent from initial interview
- Discuss confidentiality and digital audio recording (if used) / Opportunity for questions
- Explain that the questions which will be asked relate to exploring their initial interview summary about the concept of person-centred care.

**A) Thinking about your first interview overall, what are the main things that help facilitate Person-centred care?  
How can these be maximised?**

**B) What are the barriers to Person-centred care?  
How can these be overcome?**

**C) Again, thinking about the summary of your initial interview:**

**What do you think the educational needs are for the following groups in relation to facilitating person-centred care?**

- 1) Student Nurses
  - 2) Newly Qualified Nurses
  - 3) Existing staff
  - 4) Registered Nurses
  - 5) Support Workers
  - 6) Multidisciplinary Team, this may include:
    - a) Doctors
    - b) Physiotherapists
    - c) Occupational Therapists
    - d) Speech and Language Therapists
    - e) Any other groups
- D) If you were interviewed when the ward was a stroke rehabilitation unit, what do you think the differences are in your approach to person-centred care now the speciality is respiratory care?**
- E) What other points of interest related to Person-centred care would you like to discuss?**
- F) Is there anything else you feel should be considered within this study?**

**Questions asked if unable to arrange a follow-up interview**

**N.B.** the original set of questions had space for answers to be written

Dear

Ref

Thank you for allowing me to interview you earlier for the above study. I would be very grateful if you would now review the summary of your interview for the next stage of the research study and answer the following questions and then return this questionnaire to me in the pre-addressed envelope.

**Reading through your summary, please answer the following:**

Which things help you give person-centred care?

What are the barriers to giving person-centred care?

What education or training would help the following people understand and deliver care that is more person-centred?

Student Nurse

Support Workers

Registered Nurses

Therapists

Doctors

If you were interviewed about person-centred care when the ward was a stroke rehabilitation unit, what do you think the differences are in your approach to care, now the speciality of the ward is respiratory care?

Thank you for taking the time to do this review, I really appreciate this and hope your views will lead to recommendations for education and training to help staff deliver care in a more person-centred manner.

**Please return this questionnaire using the internal post (in the pre-addressed envelope) to:**

Helen Ross, Learning and Development Office, Address.....

## Appendix 11 Notes to guide interviews for stage three

### Names of participating organisations removed

**Please note: the interview should be open and facilitative, some of the following may be asked to start the interview / conversation**

- 1 Introduction
  - Outline purpose of interview/discussion
  - Ensure participant read information sheet
  - Discuss confidentiality and digital audio recording (if used)
  - Opportunity for questions
  - Complete consent form and give copy to participant
  - Explain that the questions asked relate to exploring the relevance and application of the model of person-centred care developed from data analysis
  
- 2 Looking at the model of person-centred care, what are your thoughts about the different elements of the framework?
  
- 3 How do you see the elements in the model of person-centred care leading to education and development for staff?
  
- 4 One of the ideas from staff is to use 'away days', which would include all staff (not just nurses) to raise the profile of Person-Centred Care (PCC) and to use good examples from practice to write scenarios that illustrate PCC.

What do you think to this idea?

#### **Other ideas have been:**

Role modelling for students / new staff

Team communication: using ward meetings

Using examples from Complaints to build on

Using examples from: End of life care, Managing care after death (relatives),  
Breaking Bad News

- 5 What do you think to these ideas?
  
- 6 What would you envisage the best use of the framework to be?

## **Appendix 12 Excerpts from Framework Analysis in the study**

### **Page 1**

The study was designed to explore person-centred care in a hospital based medical ward setting.

#### **The research aims:**

- To describe what facilitates person-centred care from the perspective of nursing staff working in an acute hospital medical ward.
- To identify the education and practice actions that have the potential to enhance person-centred care in an acute medical ward setting.

The study used individual and group interviews which were analysed using Framework Analysis. Regular meetings occurred with the research supervisory team to examine the progress of the study and in particular check the application of Framework Analysis to the data. This gave the opportunity for critical debate about the research process, but also the opportunity to discuss concerns about analysis thereby enhancing the rigour of data analysis. Example of the application of Framework analysis is shown below:

#### **Transcription**

Transcription in stage one of the study was undertaken by the same transcriber, which enabled a consistent approach to the formatting etc. Each transcript was checked against the recording for accuracy and the field notes added to as required.

Transcription in stage two and three of the study was undertaken by a different transcriber to stage one, but again checked as in stage one.

#### **Familiarisation with the interview data**

This involved reading the transcripts and listening to the data, this resulted in a crude list of emerging themes, shown below:

**List of themes emerging from the data**

<b>a priori issues (informed by the aims and introduced to the interview guide)</b>	
Understanding of Person- centred care (PCC)	Decision making
Routines	Choices
Length of stay	Nutrition
Education/ Training	Things affecting PCC
Good/ Bad experiences practice	Recognising PCC in
Family involvement	Student Nurses
<b>List of themes emerging from data</b>	
Personal care / Hygiene / Hair	Patient / Person
Choice / Control / Involvement	Food / Drink
Respect	Experience
Communication / Sharing Information	Life Skills
Relationships	Compassion
Involvement	Empathy
Flexible	Care
Safety	Little things (make the difference)
Rules	Part of your job
Relatives / Family	Feedback
Stories	Task Orientated
Listening	Paperwork
Time	Length of stay
Staffing Levels	Workload
Nurses	Beliefs / Religion
Advocacy	Dementia
Photographs	Elderly / Old Person
Staff Attitudes	Individual
Dignity	

## Coding the data

The data was initially coded by the researcher using NVivo 9.0. In some instances this was a sentence or a paragraph, notes were also made to relate back to later in the analysis. The supervisory team checked three transcripts from stage one of the study to make sure that there was consistency in the coding labels. Within NVivo there was the opportunity to see the number of instances a subject was spoken about within one transcript and across the sample. This allowed comparisons to be made between different participants, participant groups and across different stages of the study. See example below from the transcript of Registered Nurse 1 in stage one of the study:

Coding labels	Line	Transcript	Notes
Relationships	198	We have a <b>good, strong, multidisciplinary team</b> here because we do tend to have	Importance of team relationships
Roles in team	199	<b>a really stable base where everyone is well established</b> within the team so everybody	Trust built over time impact on communication
Teamwork	200	tends to know everybody else <b>so that communication is not such a trial</b> if you like.	
Communication	201	<b>The consultants are quite down to earth and approachable and the physios and the</b>	
Roles in team Working together towards shared goals	202	<b>OTs are very much in league with us,</b> they're not just another discipline that	Shared goals Involving others / relationships
	203	stand-off, they're very much nurse orientated. It works in a really good, strong way.	
Involving the person and significant others	204	<b>Everybody sort of intermingles really, really well</b> and I think that, it shows with the	Involvement of family and patient
	205	<b>families when they know the names of each individual therapist and I think that's</b>	
Relationships	206	<b>really good for the patient to know, a face and a name</b> and somebody they see on a	Knowing the person
	207	regular basis.	

<b>Name of node</b>	<b>Number of sources</b>	<b>Number of references</b>
Activities taking Nurse away from direct care	3	3
Care environment	8	11
Care management	7	14
Flexibility of care	11	20
Length of stay	7	9
Resources	3	3
Rules and Routines	6	12
Staffing levels	2	3
Stroke care Vs Resp care	5	7
Time	3	3
Workload	5	8

### Culture of care

<b>Name of node</b>	<b>Number of sources</b>	<b>Number of references</b>
Compassion	5	7
Concerns about care	10	15
Continuity of care	6	8
Culture of care	1	1
Dementia care	5	7
Dignity	9	13
First impressions of care	6	6
Holistic care	8	13
Indicators of good person-centred care	10	19
Indicators of poor person-centred care	3	4
Job Satisfaction	4	5
Little things make the difference	6	12
Recognising care needs	2	5
Understanding of person-centred care	13	16
What helps PCC	10	22

### Professional qualities

<b>Name of node</b>	<b>Number of sources</b>	<b>Number of references</b>
Advocacy	5	6
Approachable	4	7
Attitudes	6	13
Education and Training	9	14
Empathy	7	11
Experience and Professional Maturity	6	14
Experience of students	6	6
Leadership	10	15
Role Models	11	18

<b>Name of node</b>	<b>Number of sources</b>	<b>Number of references</b>
Choice	10	24
Decision making	6	8
Having a voice	2	3

#### Relationships

<b>Name of node</b>	<b>Number of sources</b>	<b>Number of references</b>
Communication	11	32
Family and Friends	12	29
Forming relationships	11	25
Knowing the person	11	28
Listening to the person	5	10
MDT Approach	9	13
Team work	6	11
What hinders PCC	12	27

Following the generation of broad themes the transcripts were re-examined to look for evidence of understanding of the term person-centred care and make detailed reference to this in the text. This was summarised by hand on flip chart paper in order to allow the whole of each participant group to be viewed alongside each other (Registered Nurses, Student Nurses and Support Workers). Themes were re-categorised by looking at the actual words used in the interviews and thinking about their meaning in relation to understanding person-centred care. At this stage it became apparent that some of the initial categories interlinked or overlapped so were renamed to reflect this, some were renamed as it became apparent their emphasis had not been reflected in the original broad themes.

For example Culture of Care as a theme was removed as on reflection when examining the data an assertion emerged that each element in the three themes (characteristics of relationships, personal qualities of staff and respecting the principles of person-centred care) act together to shape the philosophy of care on the medical ward. In turn this philosophy influences how the participants perceive and facilitate person-centred care, which affects the way participants interact with each other, with the person being

cared for and their family. All of these elements impact upon person-centred care at every level on the ward.

The thematic framework was constructed by using the words within the individual interview transcripts linking and categorising these with other related words or phrases to form an index for the framework. The main themes (Relationships, Personal Qualities and Principles of Person-Centred Care) and subthemes (index) developed within the thematic framework represent the characteristics of a positive culture of care. These values were identified by the participants as facilitating person-centred care. The subthemes represent the participant's understanding of the term person-centred care and application of this understanding to clinical practice in the study setting. This is considered in-depth in the presentation of findings within the thesis.

### **Explanation of terms used within the thematic framework**

In order to aid understanding of the thematic framework and its use in the data analysis the main themes are explained below; the concepts used to describe the subthemes at this stage were generated directly from the data, although the interpretation of these will at some level (even if subconsciously) have been influenced by a priori knowledge:

**Relationships** – denotes all types of relationships; either within the professional groups (nurse to nurse or inter-professional) or with patients and relatives.

**Personal Qualities** – individual characteristics of nurses (this includes, registered nurses, student nurses and healthcare support workers)

**Respecting the principles of person-centred care** – elements of care that indicate it is focused on the person. Once the framework was developed the themes and subthemes were applied to the raw data (interview transcripts) manually and in NVivo in order to challenge the concepts and ensure the data was being truly represented within the analysis and the findings remained grounded in the data; rather than representing only abstract concepts.

<b>Draft of Thematic Framework (with index)</b>	
<b>Relationships</b>	
R1	Building and maintaining relationships
R2	Collaboration
R3	Roles in Team
R4	Effective Communication
R5	Leadership
R6	Trust
R7	Support
R8	Learning together
R9	Positive Attitudes
R10	Team values
R11	Shared Decision making
R12	Confidence to Challenge
R13	Feedback

<b>Draft of Thematic Framework (with index)</b>	
<b>Personal qualities</b>	
P1	Professional Maturity
P2	Interpersonal skills
P3	Compassion and Empathy
P4	Role modelling
P5	Personal Values and Beliefs
P6	Advocacy
P7	Personal Motivation
P8	Organisational skills
P9	Application of Knowledge and Skills
P10	Insight
P11	Confidence

<b>Draft of Thematic Framework (with index)</b>	
<b>Respecting the principles of person-centred care</b>	
C1	Assessment / Planning
C2	Care based on individual need
C3	Consistency in standards of care
C4	Role of family
C5	Respect and Dignity
C6	Seeing the person
C7	Responsive / Flexible care
C8	Culturally sensitive care
C9	Choice
C10	Compassion and Empathy
C11	'Little things' that make a difference
C12	Control and Power
C13	Care setting

On further reflection it was clear that some themes overlapped and therefore the thematic framework was refined further, however for the purposes of audit and being able to check back to the data the original index as shown above was referred to ensure that the edited themes and indices did not miss anything from this original framework.

## The final thematic framework with references to the index

Thematic framework of person-centred care in an acute hospital medical ward setting (with reference to index)					
Characteristics of relationships that facilitate person-centred care (R)		Personal qualities of carers that facilitate person-centred care (P)		Respecting the principles of person-centred care (C)	
R1	Build and maintain positive relationships: <ul style="list-style-type: none"> <li>• Team</li> <li>• Patients</li> <li>• Family</li> </ul> <b>R1 R2 R6 R7</b>	P1	Hold personal values of: <ul style="list-style-type: none"> <li>• Compassion</li> <li>• Empathy</li> <li>• Respect</li> <li>• Collaboration</li> </ul> <b>P1 P2 P3 P10</b>	C1	Being responsive in care according to individual need: <ul style="list-style-type: none"> <li>• Assessment</li> <li>• Planning</li> <li>• Delivery of care</li> </ul> <b>C1 C2 C6 C7 C8</b>
R2	Working together: <ul style="list-style-type: none"> <li>• Shared goals</li> <li>• Acknowledging roles in the team</li> </ul> <b>R3 R5</b>	P2	Exhibit personal values within: <ul style="list-style-type: none"> <li>• Interactions</li> <li>• Care</li> </ul> <b>P1 P2 P3 P5 P6 P7 P10</b>	C2	Involving others in decisions: <ul style="list-style-type: none"> <li>• The person</li> <li>• Significant others</li> </ul> <b>C4 C9 C12</b>
R3	Effective communication: <ul style="list-style-type: none"> <li>• Promotes positive and open attitudes</li> <li>• Inclusive</li> </ul> <b>R4 R9 R10 R13</b>	P3	Positive role model exhibiting: <ul style="list-style-type: none"> <li>• Person-centred care</li> <li>• Confidence</li> </ul> <b>P4 P7 P11</b>	C3	Consistently delivering high quality person-centred care regardless of acuity of need <ul style="list-style-type: none"> <li>• Respect</li> <li>• Dignity</li> </ul> <b>C3 C5 C13</b>
R4	Shared learning: <ul style="list-style-type: none"> <li>• Reflect upon practice</li> <li>• Challenge decisions in practice</li> </ul> <b>R12 R8 R11 R12</b>	P4	Confident to be flexible when delivering care: <ul style="list-style-type: none"> <li>• Apply Knowledge and Skills</li> <li>• Person-centred care</li> </ul> <b>P8 P9</b>	C4	Recognising the 'little things that make a difference' for the person <b>C10 C11</b>

The final thematic framework was applied to each transcript using NVivo 9.0. This involved highlighting and selecting text in each transcript that related to the code (in the index) in the final thematic framework. When applying the framework there were times when several themes applied to the same paragraph. The example below shows how text was highlighted in relation to the theme **respecting the principles of person-centred care only**. The participant (Student Nurse 4) was discussing the importance of personal care:

379 I think you need to find out as well what makes that person an individual. What  
 380 is it that makes that person feel like they are 'them', like make-up sometimes, if  
 381 they haven't got something on their face they can feel completely and utterly  
 382 depressed and self-conscious. It's just that little tiny thing that they need just to  
 383 make them feel better, or like you say hair. If they look at themselves in the  
 384 mirror and they can see themselves then they can see a positive thing but if  
 385 they look in a mirror and they see something that they don't--. It's when patients  
 386 lose weight. I know from personal experience if I look ill I feel ill and I feel down  
 387 so if you can give the patient just something to make them feel like themselves.

**Respecting the principles of person-centred care** (denotes elements of care that focus on the person)

C1	Consistently delivering high quality person-centred care regardless of acuity of need C1 C2 C6 C7 C8
C2	Consistently delivering high quality person-centred care regardless of acuity of need C3 C5 C13
C3	Involving others in decisions: C4 C9 C12
C4	Seeing the 'little things that make a difference' for the person C10 C11

## Charting the data into the Framework

Once the data had been coded using the thematic framework it was then summarised in a matrix. NVivo was used to retrieve the data from each transcript relating to individual codes. The data was summarised using verbatim words from each transcript and notes were made about quotes that may be used to illustrate particular aspects of the findings. These actions helped to ensure that the claims made following data analysis clearly related back to specific points made by participants. Below is an example of some of the summaries from just one of the themes in the framework

Participant	P1 - Hold personal values of Compassion, Empathy, Respect & Collaboration	P2 - Exhibit personal values	P3 Positive role model.	P4 - Confident to be flexible when delivering care.
RN 2	See patients as people [p1,5],  Approachable staff [p5,125]	Think about person's needs not own  [p11, 273]. Avoid making assumptions [p11,274]	Personal / Professional Maturity  [p 4,95], Teach by	Fair approach to care / patient wellbeing [p6,151]  Judgement and discretion [p4,82], draw on own experiences [p11,265]
SW 2	Human interest, break ice, conversation [p11,261]  What if it was my family? [p5,104]	Listening to person[p7,162]  Support personal identity [p7,153]  Reduce fear [p12,276]	Two way communication [p4,89], Build confidence,  Teaching students [p10,233]	Choice and discussion about care [p7,151]
StN 3 & 4	How you interact (everyday talk) [p9,212]  Not just clinical care – taking time to listen [p10,232]	Look at individual, & working with family  [p1,09 & p2,38]	Lead by example [p6,130]	Dignity and Choice [p4,74]  Avoid routines for sake of staff [p6,147]

## Interpreting the data

The original research aims were reviewed at this point in data analysis and the concepts generated from the data were examined across the data set at all stages in the study to consider how the thematic framework had been influenced inductively from the data. The thematic framework was used to investigate the relationship between what the registered nurses, support workers and student nurses were saying about person-centred care in stage one of the study. It was also important to identify when a subtheme was not spoken about. This meant going beyond description of the data from individual transcripts by looking for potential explanations regarding the content of the data. Ideas were proposed, explored and expanded upon by the use of research notes / diary (example shown in Appendix 5) followed by discussion with the supervisory team.

Following completion of Framework Analysis a model of person-centred care was developed, which represents the elements which need to be present for person-centred care to be successfully achieved in everyday care. These elements were developed as a direct result of data analysis and were used within the thesis to structure the presentation of the findings and the discussion chapter.

The model is shown on page 91.

## **Appendix 13 Interview summary**

### **Example - RN 1 interview**

#### **What do you understand by the term person-centred care (PCC)?**

Care that is geared up to and centred on what the person needs.

#### **What would that include?**

Personal Cares, Meal times – we can't always offer flexibility

What they normally do at home, getting to know the person

#### **How does that happen?**

Past notes, admissions

Relatives, background, family, home, work, hobbies

#### **Can you give examples of when PCC has been good?**

On this ward (Stroke) don't always manage to give PCC as strict routine and different professionals need to see the patient

On another ward I know of the patients may get up at any time – much more geared up to the individual and would be more conducive to PCC

Where we do get it right is with the family and getting to know them personally, this helps us be able to reassure them. One lady I am caring for at moment I know about her family and background and it helps when she gets upset

#### **What is the average length of stay for stroke rehab patients?**

Can be up to a year max, 3 months or even as little as 1 month, which seems a long time but not for stroke rehabilitation needs Average would 6- 8 weeks

#### **How do NHS targets affect this?**

They would like it to change but it has to be individual – rehab potential home care

Gives us more chance to work with them and their family

#### **Good things happening here - good relationships. How does the other ward help PCC happen?**

I did a study day with some of their nurse and they said that the day revolves around patient and their own pace

Tea, Toast, Cereals etc. ready for patients to get up

Therapists are there on the ward all day so much more flexibility and more casual than our therapists. Their speciality is dementia care

#### **How could that transfer to stroke care?**

Difficult as therapists have set number of people to care for during the day, some patients may be reluctant to have therapy at a certain time during the day and this may be more difficult to accommodate.

If you know the person is better later in the day we can be flexible, but too much flexibility may be detrimental to their care

**Can you give an example of when you have seen PCC care work well?**

We have a lady at the moment with a Learning Disability, from supported living needs very individual had to get to know her and she has had to get to know us too – quite distressing for her to be in strange environment with different people

She has been here a few weeks and she now has a relationship with us and knows who she can wrap around her little finger

**Would it be usual for same nurses to care for the same group of patients regularly?**

Yes we have Ladies and Gentleman team so the patients get to know the nurses and named nurse helps too. This helps when building relationships with patients and family

**Can you give an example from your experience in nursing when PCC hasn't happened?**

I worked on MAU when first qualified – incredibly difficult, you have to deal with medical problem and the person comes second to dealing with problems.

Much better here where you can get to know the person

The person is discovered when they get moved to a ward.

It becomes the norm on MAU which is sad

**Can you give an example of where PCC could have worked better?**

Discharge is very important

One example early on I my time working here was a lady with a complex discharge.

I thought everything had been covered arrived back 2 hours later – no access to key to get into the house – I was devastated and felt it was and all my fault. I felt really sad that I hadn't followed this up – only delayed 24 hours – issues about communication with everybody, MDT, Family, Ambulance crew etc. in complex discharges

**How does the MDT contribute to PCC?**

We have strong MDT it is well established and stable so communication is good

The consultants are down to earth and approachable. This shows with the family as they know the therapists

**How do you involve the family?**

Get involved in decisions and therapy to learn how to care for the person with the nurses and therapists.

Some relatives are anxious and this helps if they can get involved. It helps them and the patient to see their progression.

**What impact does it have on rehab?**

Definitely positive, as relative understands rehab and patient can see their progress

**How would you know if someone was providing PCC?**

A lot of things – personal cares, hair brushed, shave if a man, clean clothes, no food round their mouth, catheter s empty, no dirty tissues, medication, empty bags

**What would atmosphere be like?**

Cheerful, no patients crying or buzzers going off unanswered

**What helps you deliver PCC?**

A good team, all the main jobs done and then time to care for little things (which probably matter most to the person), such as hair washing, curlers.

If you are organised you can usually dedicate time to the little things that make a difference – taking a walk having a chat with others

**What would support you in providing PCC?**

Obvious thing is more staff – we get taken away from the patient by paperwork etc.

**Is it about delegating to others?**

If you have a good relationship with Support Workers and they know you will do it too, they will usually get on with things anyway

**What advice would you give to others about facilitating PCC?**

Main things is to get to know your patient to see what sort of things they would find valuable. For example a lady had been in hospital a few weeks and had been quite poorly and we were tidying up one day and found a bag of makeup in her locker. A different person emerged when she had her makeup on – maybe only took 5 min to do after her wash, after a while she could put the makeup on herself and it made a real difference to her wellbeing.

People noticed the difference in her and said how well she looked

**What do you think the barriers are to PCC?**

Time

Being observant – e.g. making sure you tidy lockers before relatives come and have a cup of tea later rather than the other way around

Sometimes you just run out of time

**Anything else you wish to say?**

For me it is about thinking how you would want to be cared for or how you would want a family member to be cared for. Just going that extra mil, just pushing yourself a bit further and making sure you have covered everything you have done everything up to my satisfaction and hopefully my standards are up to everyone else's.

**Thanks – END OF INTERVIEW**

## Appendix 14 – Report from Time Out days

### Introduction

During January 2012 a series of three 'Team Building' events were held at xxxx Training Centre. The purpose of the events was to find out what matters to the staff who worked on xxx and the values and behaviours that should underpin everything they do for work colleagues and patients in their area. The Department of Health has set out a pledge that all staff who work in the NHS should expect

*"To engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families".*

Nursing staff were selected by the acting ward manager. A total of **33** staff were invited over the 3 days. The acting ward manager and two senior sisters attended each event. In addition the matron for xxx was also invited to attend the events.

Although different issues were raised through out each day there were some consistent themes which emerged. All of the workings for each day were captured on flipcharts/ post it notes and discussions and these were later transcribed and analysed. Despite a wealth of data there was remarkable consistency across the themes.

The next part of this paper describes the emergent themes, and provides some narrative to put the analysis into context. Each theme concludes with a number of suggestions that the Xxx may wish to consider for further action.

The Practice Development Team has gleaned a wealth of information from the 3 events and is grateful to the staff of xxx that have made suggestions for improvement so far.

### Themes

#### Communication and Staff Experience of Working on xxx

Nursing staff are not unrealistic about the challenges of working on a busy acute ward and many were quick to say they loved their jobs and wouldn't change it.

*"There are nice people around you"*

*"I like the people I work with"*

*"I like the patients"*

Staff did recognise however they did not laugh together enough and tended to focus on the negative.

Numerous frustrations were expressed about internal communications within the ward. However most poor experiences of working on the ward could be attributed to poor or inconsistent communication practices, coupled with a lack of acknowledgement for work well done. A general feeling of a lack of team work was expressed at all sessions:

*"There is a lack of consistency among staff"*

*"Some people do not take responsibility"*

*"Too many secrets between staff"*

*"Blaming one another", "Grumbles"*

*"Work as a team regardless of who is on"*

*"Too much of people saying it's not my job"*

*"People not knowing their roles"*

*"Some staff not willing to help each other with washes"*

*"Other ward staff calling us a "sinking ship""*

There were some comments about being taken for granted and that staff will not get their breaks or leave duty on time.

Staff did not always feel supported when dealing with dying patients and relatives and would like to see more support and training.

Many staff felt that the workload pressures had increased over the last few years and this was increasing pressure and stress on staff, which was impacting on the health. This also may have an effect on how staff viewed some patients and their relatives and also the perceptions of other ward teams.

Staff also felt bank staff and new starters, including student nurses needed better information about the ward. This may include ward routine, who's who, ward philosophy, staff values and beliefs and expectations of care. Staff often felt frustrated by working with staff who did not know the routine or staff not knowing how to care for respiratory patients (Bank Staff).

## **Suggestions**

Hold lunch time information sessions

Compare how other wards work and function - time management and organisation of care to see if anything can be gained from sharing ideas. This is with the aim of improving workload and stress for the team.

Look at the roles staff do and how they work on an early shift e.g. should the bank nurse work on their own?

Develop a welcome leaflet for new starters/bank staff

Bereavement training/reflection/debriefing

Raise awareness of staff stress during breaking bad news, caring in complex and end of life situations and dealing with death and bereavement on the ward.

Be aware of each other's needs and give support and a bit of 'time out' when needed, often just after dealing with the situation to allow staff to gather themselves. (Since client group changed this has become an issue which is affecting staff more)

Be more open with each other in the team if you are struggling with your work load generally, to ensure the team can offer support, which will enhance care and job satisfaction.

## **Patient Care (24/7 service)**

The general feeling was that the staff on xxx are aspiring to be a caring and dependable team, they did recognise that they needed to improve their customer service to ensure that they met the needs of all their patients and relatives.

The volume of paperwork and documentation that has to be completed is also a source of frustration for many staff because although there is a recognition that records have to be kept there is duplication of effort and the time taken to complete documentation impacts on the quality of patient care.

It was recognised that there was a need to improve the quality of patient information that patients were given and that this needed to present a more professional image –

*“Staff shouting down the ward”*

*“Be more welcoming”*

*“Help each other out- ask for help”*

*“Some staff not willing to help each other with washes”*

### **Suggestions**

Customer care training to be provided for staff

Offer more choice and flexibility when offering personal care, think about individual needs and preferences e.g. shower vs. wash with a bowl or hair washes offered more frequently.

Be aware of need for debriefing within the whole team when a complex case has occurred and try to consider this as a priority to help the team to continue to deliver high standards of care.

Look at the handover process- include support workers

Generally, to ensure the team can offer support, which will enhance care and job satisfaction.

### **Environment**

Staff took pride in where they worked and felt they did this well

*“We keep the ward clean”*

However they were frustrated with:

*“Staff from other wards “helping themselves” to stock without asking”*

Poor surroundings may also have a negative effect on the morale of staff who work on xxx.

The day room was seen as a place that could be improved as it was viewed as a *“general store room”*.

### **Suggestions**

Better use of shared space such as the dayroom, tidy it up, move stored items and make it more welcoming and relaxing.

Try setting up the dining table and offer choice to appropriate patients to have meals there as desired.

### **CONCLUSION**

Be more open with each other in the team if you are struggling with your work load

Although there are clearly a number of different areas causing frustrations to many staff there were also positive comments at every event.

*“We have good leadership”*

*“I love my job – I just want to do a better job for the people, we are all here for –the patients”*

*“The best thing about xxx is the people who I work with”*

What was apparent at every event was the enthusiasm of the staff and the willingness to want to improve services for patients and colleagues. Although staff felt that they had been listened to and the evaluations showed that they appreciated the opportunity to 'have their say', they were very concerned that the investment in the Time Out events would result in little change.

#### **Actions taken following Time Out days**

1. ...has spoken with ... (End of Life Care Professional Development Coordinator) who is going to put Ward Sister on mailing list for education and training re: End of Life Care, Counselling Skills etc. This will give the team access to study days at *Another Hospital*.
2. ...has spoken with ...Sister on Palliative Care Unit, who has offered to talk with Ward Sister or alternatively she may contact ...Ward Manager Palliative Care Unit. The aim of this would be to discuss staff support, debriefing etc.
3. ...has spoken with ...Link Lecturer for *Another Ward* who has done research study on how nursing staff deal with death in acute ward settings. She agreed that the above will help and that even just talking about these concerns on the time out days will have helped. She is also willing to talk to Ward Sister about her research findings if thought it may be helpful.

**In addition to this the main suggestion which came from the person-centred care session was:**

*It would be really helpful for the team to have a weekly meeting for half an hour (maybe on a set day of the week to help it become routine).*

**The purpose of this meeting would be** to talk about care issues which have arisen during the week or any concerns in the team. It could also be time for reflection or debriefing following complex cases.

**The Ward Sister agreed this would be an excellent way forward**, particularly in the early days and that it could be any members of staff which could attend the meeting to maintain the momentum of these time out day suggestions. The discussions in the meetings would be fed back to the team.

**She also plans to display the comments made from staff during the time out days to allow the team to decide their priorities for development within the team.**

LOOK CLOSER.

What do you see nurse, what do you see ?  
What are you thinking when you look at me ?  
A crabbit old woman, not very wise,  
Uncertain of habit with far away eyes.  
Who dribbles her food and makes no reply:  
When you say in a loud voice, "I do wish you'd try."  
Who seems not to notice the things that you do,  
And forever is losing a stocking or shoe.  
Who quite unresisting lets you do as you will;  
With bathing or feeding the long day to fill.  
Is that what you're thinking, is that what you see?  
Then open your eyes nurse, you're not looking at me.  
I'll tell you who I am, as I sit here so still,  
As I move at your bidding, as I eat at your will.  
I'm a small child of ten...with a father and mother,  
And brothers and sisters who love one another.  
A girl of sixteen with wings on her feet;  
Dreaming that soon a true lover she'll meet.  
A bride soon at twenty..my heart gives a leap;  
Remembering the vows that I promised to keep.  
At twenty five, I have young of my own,  
Who need me to build a secure and happy home.  
A woman of thirty, my young now grow fast,  
Bound to each other with ties that should last.  
At forty, my young ones have grown up and gone:  
But my man stays beside me to see I don't mourn.  
At fifty, once more babies play round my knees;  
Again we know children, my loved one and me.  
Dark days are upon me, my husband is dead...  
I look at the future, I shudder with dread;  
For my young are all busy with young of their own,  
And I think of the years and the love that I've known.  
I am an old woman now, and Nature is cruel,  
'Tis her jest to make old age look like a fool.  
The body, it crumbles, grace and vigor depart,  
There now is a stone where I once had a heart.  
But inside this old carcass a young girl still dwells,  
And now and again my battered heart swells.  
I remember the joys, I remember the pain,  
And I'm loving and living life over again.  
I think of the years...all too few, gone too fast,  
And accept the stark fact that nothing can last.  
So open your eyes nurses, open and see..  
Not a crabbit old woman,  
Look closer...see..ME.

PHYLLIS McCORMACK

## **Appendix 16 - Search Strategy and Matrix**

### ***Approach used to select the literature for the initial review***

In order to prepare for the review several databases were accessed:

Cumulative Index for Nursing and Allied Health Professionals (CINAHL Plus with full Text)

MEDLINE, Psych Info and PubMed Central

All databases were searched using the search terms person-centred (to include patient-centred). In CINAHL Plus and MEDLINE this identified 651 papers. A further search was performed combining the search terms person-centred (to include American spelling and patient-centred) and care, this identified 542 papers. By adding in the term hospital this reduced the number to 47. A separate search was performed using the terms person-centred and practice and this identified 198 papers. In total the papers reviewed in this initial stage were 245.

Psych Info identified 529 papers when using only the term terms person-centred (to include patient-centred). When 'in hospital' was added this reduced to 99 papers which were reviewed and a further 9 papers were added. Repeating this process in Pub Med Central added 11 papers. Furthermore, incremental searching was used by following up the references from key papers. These were supported by key theoretical texts and relevant policy and guidelines. Searches covered the time period January 2000 – January 2012 as explained on page 11 of the research report.

### **Outcome of the literature search**

Abstract and executive summaries of 364 of the retrieved articles were read. Those that related specifically to person-centred or relationship care / practice were retained. This resulted in a total now of 67 papers to review in-depth. Seminal theoretical papers / books were also included.

Finally 21 significant papers were selected for the review, 17 of these had been cited in each of the databases independently, which gave confidence in the findings. Only papers written in English were reviewed, although these included work from Sweden, North America, and Australia in addition to the United Kingdom.

## **Inclusion and exclusion criteria for the initial literature review**

It was decided to present the literature review chronologically, which comprised of initially reviewing seminal work to outline the core theoretical principles underpinning person-centred care. In addition to reviewing the core principles more contemporary papers were included, this covered literature which reported on research, education, clinical practice and health care quality and policy. This approach was designed to set the scene for the study and provide a context for the work, rather than to present a systematic review of the literature.

Because of this focus, setting the inclusion/ exclusion criteria was challenging. However parameters were set for the inclusion of the contemporary literature. This included research published within the last twelve years (2000 – 2012), which was reported in English. The papers had to have a focus on valuing patients as individuals, person-centred or relationship-centred care / practice within research, education, clinical practice and health care quality and policy. Initially, the papers were related specifically to inpatient care. However, as the review expanded papers were included to reflect care delivery in community and residential settings as the principles of person-centred care were applicable to the aim of the review and gave an opportunity to draw comparisons between differing care settings, including the recognition of possible barriers to person-centred care. In addition to original (mostly qualitative) research papers, grey literature was also accessed. For example, national policy and guidelines were reviewed in order to understand the social and political background within healthcare.

## **Overview of the methods for managing the literature**

Once the literature had been retrieved it was important to manage it effectively (Crookes and Davies 1998); therefore each paper was assigned to the matrix according to the category it fitted into.

The rationale for this was to ensure that the papers used within the review were truly relevant to the study and added to the understanding required to set the work in a contemporary framework.

The critical appraisal of the papers was guided by Greenhalgh and Taylor (1997) who provides questions to examine the quality of the studies. Three simple questions are asked:

- Why was the study done and what was the research aim?
- What type of study was done?
- Was the design appropriate?

These questions allowed a more detailed analysis of the studies in order to provide the context and back ground to the study. The Critical Appraisal Skills Programme (CASP) (2013) qualitative research checklist was also used to guide critical analysis of the papers.

**Literature Review - Matrix of Mixed Literature (Abbreviations used: PCC – Person-centred care, Pt - Patient)**

No	Author	Type of Publication	Title	Method	Data Collection	Data Analysis	Findings
1	Coyle, Joanne & Williams, Brian University of Dundee	Journal of Advanced Nursing (2001) 36 (3) 450-459 Based on previous qualitative research	Valuing people as individuals: development of an instrument through a survey of person-centredness in secondary care	Cross-sectional survey Personal identity threat as a key concept	97 patients from general wards medical / surgery / otolaryngology	Proportions calculated along with 95% confidence intervals. Differences in responses men vs women & Spearman's rank correlation coefficient to test for relationship with age	Many positive sentiments but threats to power/control, involvement in care, approachability & availability of staff. Women more at risk of threats to identity
2	McCormack paper 2001	Ageing and Society (2001)	Autonomy and the relationship between nurses and older people.	Guided by hermeneutic philosophy	Recorded conversations of 4 hospital nurses with patients, doctors and healthcare team for at least 3 shifts for 1 year. 14 case studies of nurse – patient interactions	Conversational analysis as theoretical framework for initial descriptions of data.	Complex interactions, blurred boundaries between paternalistic and beneficence in the relationships. Centrality of honesty communication skills, knowledge and experience of nurse and patient's personality knowledge and experiences. Autonomy hindered by many factors; contextual and attitudinal.

3	McCormack Brendan <b>See also Book:</b> Negotiating Partnerships with older People: a person centred approach (2001)	International Journal Of Nursing Practice (2003)	A conceptual framework for person-centred care with older people	Derived from original work on the meaning of autonomy for older people in a hospital setting based on hermeneutic philosophy	Description of recorded discussions and conversations between 4 nurses & patients; nurses & doctors; nurses & PAMs over 1 year	Interpretation and understanding – follow up reflective conversations and interviews to discuss coded transcripts Conversational analysis to describe and derive interpretive themes	Effect of institutional discourse, dynamics of power & control, Pt access to knowledge, impact of professional authority. Devised 23 principles for action
4	McCance, Tanya. Northern Ireland Practice and Education Council for Nursing & Midwifery	Research and Theory for Nursing Practice: An International Journal (2003) Vol. 17, No 2 101-116	Caring in Nursing Practice: The Development of a Conceptual Framework	Hermeneutic phenomenological approach using narrative method	One to one interviews purposive sample of 24 patients in their homes shortly after discharge	Thematic analysis followed by in-depth analysis of identified narratives using Denzin's (1989) definition of narrative (although specific criteria not shown) Donabedian's framework of structure process and outcome used to develop conceptual framework from emerging themes & subthemes	Structures: Nurse attributes, Organisational issues, Patient attributes. Process: Providing for patient physical and psychological needs Being attentive, getting to know, taking time, being firm, showing respect, the extra touch. Outcome: Feeling of wellbeing, patient satisfaction, effect on environment. Link between caring and quality

5	Clarke Amanda, Lecturer University of Sheffield Hanson Elizabeth, Senior Lecturer University of Kalmar Sweden & Ross Helen, Lecturer University of Sheffield	Journal of Clinical Nursing (2003) 12: 607- 706	Seeing the person behind the patient: enhancing the care of older people using a biographical approach	Practice development, collaborative approach	Focus groups- hospital staff (new to PCC) , with nursing home staff, (already using life story approach), patients and relatives	Focus groups and interviews transcribed; Two of research team independently identified themes looking for similarities and differences until consensus met.	Biographical approach encourages seeing person & can build & strengthen relationships with patients & relatives. Not suitable for everybody
6	McCabe Catherine Lecturer Trinity Centre for Health sciences Dublin	Journal of Clinical Nursing (2004) 13,41-49	Nurse-patient communication: an exploration of patients' experiences	Hermeneutic phenomenology. Purposeful sample	Unstructured interviews – 8 patients in general teaching hospital	Reflective process, description & interpretation of themes and sub themes	4 themes – lack of communication attending, empathy & friendly nurses. Nurses communicate well when using PCC, however organisations do not recognise value of PCC

7	McCormack Brendan (Professor of Nursing Research University of Ulster)	International Journal of Older People Nursing in association with Journal of Clinical Nursing 2004 13, 3a,31-38	Person-centredness in gerontological nursing: an overview of the literature	Literature review 42 articles and 6 books Jan 1996-December 2003	Literature search using terms person-centred (patient-centred) combined with elderly care	Critical analysis of papers and described under four emerging concepts	Being in relation, being in a social world, being in place and being with self. Central themes: knowing the person, centrality of values, biography, relationships, seeing beyond immediate needs & authenticity. Important to remain 'driven' by the person rather than models.
8	West Elizabeth (London School of Hygiene and Tropical Med), Barron David (Oxford) & Reeves Rachel (Picker Institute, Oxford)	Journal of Clinical Nursing (2005) 14, 435- 443	Overcoming the barriers to patient- centred care: time, tools and training	Survey developed using previous qualitative research - how patients evaluate their care	Postal Questionnaire – employee survey (based on USA prototype) 2880 usable (47%) responses returned	Basic statistics used - %	Majority overworked (64%) not enough time for essential nursing (pt & rels anxieties, fears, concerns, info) Lack of staff, space, equipment and cleanliness. Desire for training social & interpersonal skills
9	McCarthy Bridie Lecturer University College Cork	Journal of Clinical Nursing (2006) 15,629-638	Translating person- centred care: a case study of preceptor nurses and their	Case study design aimed to explore whether and if so how PCC is translated into	Participant observation, review of nursing records and semi- structured interviews	Two stage analysis 1 identifying themes 2 Analysis against theoretical propositions	Preceptors - limited understanding of PCC & limited appreciation of what learning involves and

			teaching practices in acute care areas	nursing practice and teaching	with 6 preceptors (mentors)	from literature	ill prepared for the role and unconvinced about classroom learning. Care - medical model.
10	Innes Anthea, McPherson Suzie & McCabe Louise Joseph Rowntree Foundation (Innes from University of Stirling)	Joseph Rowntree Foundation Full Report (2006)	Promoting person-centred care at the front line	Literature review on the role of frontline workers within community care services (older people, disabled people & people from ethnic minorities) - 'What are the barriers & opportunities in providing high-quality frontline care?'	Researchers also spoke with frontline workers (discussion groups) and service users	Used remit from JRF to explore: <ul style="list-style-type: none"> <li>management issues</li> <li>staff recruitment</li> <li>disempowerment and devaluing of frontline workers</li> <li>training/qualifications for frontline workers</li> <li>qualities of frontline workers</li> <li>working with families</li> <li>views on person centred care</li> </ul>	Lack of focus on specific roles of frontline workers in changing policy & practice. Difference in quality of care between specialist / generic services Policy change can have an impact on quality of care delivered ?service user consultation
11	McCormack, Brendan Prof. Nursing Research University of Ulster and Director of Nursing Research & Practice Dev.	Journal of Advanced Nursing (2006)	Development of a framework for person-centred nursing (PCN)	Framework developed iteratively by combining two existing conceptual frameworks taken from empirical studies	Mapping of original conceptual frameworks against the literature on PCC & caring. Focus groups with practitioners & researchers.	Identifying similarities and matched aspects of the two frameworks, critical dialogues with co-researchers and lead practitioners to reach agreement of elements of	The PCN Framework = 4 constructs; prerequisites, the care environment, PCC processes & expected outcomes. Further testing of the framework needed.

	Royal Hospitals Trust, Belfast McCance, Tanya, Nursing R&D Director Ulster University and Ulster Hospital, Belfast					match. Testing framework – Not sure what this entailed fully; but focus groups discussed analysis of barriers to PCC, developments and evaluation of changes made to care environment	
12	Peek, Carmel, Higgins, Isabel & Milson-Hawke, Sally, McMillan, Margaret & Harper, Deborah Australia, NSW.	Contemporary Nurse (2007)	Towards innovation: The development of a person-centred model of care for older people in acute care	Developed a model of care after reviewing international literature (best practice)	The Older Person Acute Care (OPAC) model uses practice development to implement change. Involves critical reflection with support of Clinical Nurse Specialist in OPAC	Respect, for everyone encouraging open debate and critical reflection resulted in nurses identifying need for improved palliative care, pain and symptom management	A philosophy of person-centredness is hoped to encourage shared vision, better understanding of the needs of older people, respect, dignity and choice in care.
13	Goodrich, Joanna, Researcher, King's Fund Point of Care programme and Cornwell, Jocelyn, Director (As above)	The Point of Care review paper (2008)	Seeing The Person in the Patient	Qualitative research + Literature review	Interviews with patients, families and staff. Focus groups with junior doctors, nurses, HCAs, mixed support staff AHPs. Nine individual & paired interviews with	Interviews / focus groups recorded and transcribed, analysed to draw out common themes (unclear what this involved)	Difficult to make generalisations from the data. <b>Importance</b> of seeing the person. Pt experience relate to organisational & human factors, leadership in

						consultants, non – executive and executive Trust board members.	actions, words & behaviour, compassion, empathy, responsive to needs, values, expressed preferences, co-ordination, communication & education. Physical comfort, emotional support, involvement of family & friends
14	Goodrich Joanna Senior Researcher, Point of Care, Kings Fund	Nursing Times (2009) 105, 20 14-17	Exploring the wide range of terminology used to describe care that is patient- centred	Qualitative approach to explore language used	Literature review, focus groups, paired and single In-depth interviews. Use of prompt cards	Description of responses (no clear analysis described in this article)	Language of research & policy doesn't translate well into everyday language in healthcare. Ordinary words such as dignity, understanding & comfort resonate well. Seeing the person.
15	Wheeler Nicola (Clinical Research psychologist) and Oyebode Jan (Consultant Clinical Psychologist) Birmingham &	Nursing Times 22 <sup>nd</sup> June 2010 106, 24 18-21	Dementia care 1: person centred approaches help to promote effective communication.	Nine Care homes specialising in Dementia care (Mixture of privately owned, owned by chain and charity)	Focus groups (Total 36 people, average of 4 in each) Range of staff – nurses, healthcare assistants and activities co-ordinators	Thematic analysis (unclear <b>what this involved</b> ) Identified 3 types of communication staff to staff, staff to resident and staff to family	<b>Refers to Gold Standards Framework (2009)</b> – staff should empower residents by PCC, Spend time interacting & getting to know residents. Act as a team with shared goals,

	Solihull Mental Health Foundation Trust						effective communication, important for all to feel appreciated and valued, holistic care, recognise key role of family.
16	Kirkley Catherine, Bamford, Claire, Poole, Marie, Arksey, Hilary, Hughes, Julian, Bond, John. Inst. Health and Soc, Newcastle University	Health and Social Care in the Community (2011) 19 (4) 438-448	The impact of organisational culture on the delivery of person-centred care in services providing respite care and short breaks for people with dementia	Mixed methods part of a larger study. This paper only reports on interviews and focus groups with service providers	Lit review, Tel interviews - key individuals of organisations giving respite, focus groups and 1:1 interviews, people with dementia, carers & front line staff.	Framework analysis – coding frame illustrated by examples from transcripts. Analysis = examining the coherence and boundaries of each code and understanding the relationships between the codes using constant comparison	5 key themes: understanding of person-centred care, attitude to service development, service priorities and valuing staff. Organisational culture has an impact on PCC. Risk adverse organisations may inhibit PCC. Recruitment staff with the qualities to share in PCC philosophy.
17	Robert, Glenn, Cornwell, Jocelyn, Brearley, Sally, Foot, Catherine, Goodrich, Joanna, Joule, Nikki, Levenson, Ros, Maben, Jill,	Project Report for the Department of Health and NHS Institute for Innovation & Improvement. The King's Fund, London and the National Nursing Research Unit, King's	<i>'What matters to patients'? Developing the evidence base for measuring and improving patient experience.</i>	Mixed methods, part of a large study over 9 months	Lit Review, Case studies of 12 different organisations. Patient and staff interviews.	More meaningful complaints analysis and information i Relational' aspects of care like dignity, empathy, emotional support are important to Pts Experiences of care need to reflect wider context of care There are poor links between staff (and resources) dedicated to measuring and improving patient experience, and education and training departments in the same organisation	

	Tsianakas, Vicki and Waite, Dick	College (2011)				NHS and HEI need to develop education about PCC more Commissioners and providers need to work together to capture patient stories The same quality criteria should be applied to measuring and improving patient experience as are brought to bear in the other domains of quality	
Practice development or professional / theoretical papers							
No	Author	Journal	Title	Aim	Approach / Implementation	Key Messages/ Outcomes	Recommendations
18	Dewing, Jan Bletchley, Nurse Consultant, Milton Keynes PCT and General NHS Trust Associate Fellow Practice RCN	International Journal for Older People (2004)	Concerns relating to the application of frameworks to promote person-centredness in nursing with older people.	Review research presented by Titchen (2000), McCormack (2001), Nolan (2001) & The Burford Model	Discussion of differing conceptual frameworks and their possible application in the care of older people.	Conceptual models need to be translated into frameworks that are user friendly. Some frameworks require a high level of experience and understanding in order to be applied. Recognition of the key role of developing relationships.	Need wide scale use in practice to prove application. Complex which remains elusive in practice. Work needs to be done re: translating complex concepts to enable practitioners to apply to practice

19	Nolan et al. Nolan – Professor of Gerontological Nursing University of Sheffield	International Journal of Older People Nursing in association with Journal of Clinical Nursing (2004)	Beyond 'person-centred care': a new vision for gerontological nursing	Critical paper exploring assumptions underpinning PCC and suggesting relationship centred (RCC) care is more appropriate.	Review of Literature related to PCC, Personhood, Valuing interdependence, emergence relationship, investment in care giving.	Critical of PCC, but seemed to lack understanding that the term related to all persons. Senses Framework proposed as way forward.	RCC is related to mutual respect as is PCC. 6 senses related to experiences of all However both PCC / RCC have elements worth noting for nursing practice
20	Ruddick Fred Senior Lecturer in mental health University of Cumbria	Mental Health Practice (2010)	Person-centred mental health care: myth or reality?	To explore how PCC came become more consistent in mental health practice	Review of core elements that affect PCC: Relationships, Spirituality, Client Need, Barriers, Personal growth, Managing change	Investment in personal development of carers is crucial to move from task orientated services. Attention needs to be given to values, beliefs and attitudes of practitioners and emphasis put on building PCC relationships for mental health recovery.	Greater emphasis on emotional intelligence. Clinical supervision should mirror PCC philosophy; focused on personal development and encouraging self-awareness. Time with service users must be seen as priority
21	McCormack, Brendan, Dewing, Jan and McCance, Tanya	Online Journal Issues in Nursing. 190913734, May 1, (2011) Vol 16, issues 2.	Developing Person-Centred Care: Addressing Contextual Challenges Through Practice development.	Paper exploring contextual and cultural aspects affecting PCC. Uses Case Study of emancipatory practice development to	Underpinned by person-centred practice framework (McCormack & McCance 2006) National 2 yr. practice development programme	Evaluations suggested staff had experience personal and professional growth. Recognising the non-technical aspects of caring. Hope & Hopefulness, Belonging and	Need to move from 'person-centred moments' and individual motivation of the practitioners to 'person-centred cultures'. Development of PC

				enhance patient-centredness	implemented across multiple settings in Ireland.	connectedness, Meaningful relationships	cultures requires sustained staff development & engagement of managers	
<b>Books</b>								
	<b>Author</b>	<b>Book Title</b>	<b>Aim</b>	<b>Structure of the book</b>				<b>Key Messages</b>
22	McCormack, Brendan, Professor & McCance, Tanya, Mona Grey Professor, University of Ulster	Person-Centred Nursing (PCN): Theory and Practice (2010)	To advance new understandings of person-centred nursing concepts and theories, using The Framework for Person-Centred Nursing.	Seven chapters: addressing philosophical and theoretical aspects of the concept of person-centredness and the Person-Centred Nursing Framework. Real examples used throughout to illustrate the application of the framework and concepts in practice settings. Critical reflection used throughout to encourage reader to consider the points raised and promote new insights into PCN.				Caring and Person-centredness important concepts, Care environments affect PCC, layers of interactive and complex characteristics related to culture, relationships, and behaviours.

**Appendix 17 Table showing consultations with healthcare staff regarding person-centred care (PCC) and the thematic framework**

No	Date	Role	Context of consultation	Comments / Questions	Outcome
1	16 <sup>th</sup> Jan 2013	Service User Development Worker in a local NHS Trust (different Trust to study)	To discuss similarities and differences between the study and work being done to audit care plans in community care looking at how person- centred the care planning and delivery is, as opposed to being problem based.	Congruent with the work being done around person-centred care planning in community mental health to encourage PCC.	No direct changes, invited further comment
2	21 <sup>st</sup> Jan 2013	Qualified Physiotherapist and Physiotherapy assistant from the study setting	Following interview about PCC, asked to comment upon the thematic framework developed after data analysis of nurses interviews.	Do you have to meet all aspects shown in the framework to be person-centred?	A feeling that the framework was reflective of the points raised in the interview however raised issues for discussion about the differing aspects of the framework.
3	21 <sup>st</sup> Jan 2013	Healthcare support workers x 2 who were interviewed in the original group of nursing staff.	To gain feedback about the ease of understanding and accuracy of interpretation of the thematic framework.	Feedback saying both could identify aspects that they had discussed in their own interviews	Positive confirmation that the framework was generated from the data

4	13 <sup>th</sup> Feb 2013	Research Interest Group within the NHS Trust where study is set x 7 staff  (6 with Nursing background and 1 Catering Manager)	To give an overview of the research process and gain insight into differing views of PCC and the application of the thematic framework	Are healthcare workers and students counted as part of the team – need to be clear about who is in the team – definitions of staff roles Need a positive environment for a positive culture. Are the parts of the thematic framework interrelated? Are patients seen as persons? Did participants come up with any negatives? Do staff measure up against the elements of thematic framework? How confident are you that you have explored all the avenues of person centred care?	Outcome
5	10 <sup>th</sup> June 2013	Formal discussion with Ward Sister and Senior Staff Nurse (participant) from the study setting	To gain feedback about the ease of understanding and accuracy of interpretation of the thematic framework.  To identify possible action as a result of the findings from data analysis	Comments / Questions Use of Complaints to identify issues and explore how to change to positive experience.  Away day for whole team - use examples of good PCC to illustrate and build upon.	Consider ways to utilise findings in positive way with all groups of staff involved in PCC
6	5 <sup>th</sup> Aug 2013	Semi-structured paired interview with Professional Development Co-ordinator and Practice Learning Facilitator	To gain feedback about the ease of understanding of the thematic framework and its possible application in clinical practice.  To consider education & training needs in light of data analysis and previous consultations	Importance of Role modelling Need to link with existing education and Trust strategies.  Themes within the framework could be used to develop materials for education and training across the Trust, not just in study setting.	Look at links between the philosophies of AR & AI. Explore existing education and Trust strategies to identify links. Discuss research findings and recommendations with Chief Nurse in Trust – Dissemination in NHS and Local Universities

7	30 <sup>th</sup> September 2013	Semi-structured paired interview with two Senior Lecturers in Nursing from local university.	<p>To gain feedback about the ease of understanding of the thematic framework and its possible application in clinical practice.</p> <p>To consider education &amp; training needs in light of data analysis and previous consultations</p>	<p>Could be used to inform education as a plan for learning</p> <p>Sets basis for minimum standards in pre-registration and could be used to explore PCC in clinical placements</p>	Discuss findings with course management team and module leaders to consider how findings may link into the curriculum
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