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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Development and evaluation of a new model for person-centred goal setting using practice development and appreciative inquiry approaches in a rehabilitation unit

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Abstract

Background: This article explores the use of a mixed-methods participatory approach to bring about transformative change to goal setting in an 18-bed, subacute rehabilitation unit in New South Wales.

Aim: To use a blended approach underpinned by practice development and appreciative inquiry approaches, to develop and evaluate a model of person-centred goal setting for rehabilitation clients.

Methods: Evaluative methods were co-designed and co-agreed by members of the rehabilitation team, based on what the team hoped to achieve in terms of establishing goals for clients in their care and what this meant to clients and each other. Data sources included team discussions, semi-structured interviews with individual team members and clients, a survey and stories using emotional touchpoints. Interpretation of the data involved content analysis for generation of themes and the use of Statistical Package for Social Science software for analysis of the survey.

Results: Nine themes emerged. Clients highlighted: barriers to goal achievement; incorporation of goals into daily care; goal achievement; and a sense of purpose. The rehabilitation team highlighted: becoming person-centred; their role in goal setting; and barriers to establishing goals. The survey responses showed the team used person-centred approaches to achieve person-centred goals.

Conclusion: Changes to goal setting allowed staff to feel person-centred in their care delivery and gave them the satisfaction of knowing they were doing something meaningful for those in their care. There was strong agreement that a unified team approach to goal setting was key to client satisfaction and achievement of the goals. Clients felt valued and included in making decisions surrounding their care.

Implications for practice:

- Using the practice development principle of developing collaborative partnerships among healthcare teams leads to greater involvement of clients in their care
- Involving clients in goal setting leads to greater success and improved client satisfaction
- Appreciative inquiry and practice development approaches are effective in developing partnerships between team members
- Staff who treat clients with dignity and respect improve participation in goal setting by the clients
- Creating a space in which the emotional needs of clients can be heard and acted on is crucial for success in goal achievement
- Appreciative inquiry generates a greater appreciation and understanding of how to deliver person-centred care

Keywords: Rehabilitation, person-centred goals, transformation, person-centred care, practice development, appreciative inquiry, collaboration

Introduction

Rehabilitation is concerned with increasing quality of life following an injury or illness, and there is broad agreement that goal setting is a key component of rehabilitation process (Playford et al., 2009; Black et al., 2010). The main principles of rehabilitation begin on admission and continue beyond discharge (Stott and Quinn, 2016) and each client will have differing needs throughout their journey. Input from an multidisciplinary team is a crucial element of successful rehabilitation for older adults (Evans, 2020), with staff who have different areas of expertise working with the client to enable individualised care. The desired outcome is for the clients and their carers to enjoy the best possible quality of life. In this study, a rehabilitation team in New South Wales set out to co-create and evaluate a new model of person-centred goal establishment, using a mixed-methods approach underpinned by practice development and appreciative inquiry.

This article presents the processes, shared learning, new understandings and findings from the project.

Background

In 2016, New South Wales Health released recommendations for new models of care in rehabilitation settings (NSW Government Health, 2015). The models were designed to enable flexibility for individual healthcare settings to develop approaches to care that aligned with the uniqueness of their teams. For this project, the rehabilitation team identified an opportunity to co-create a model of care that aligned with its values and vision of providing person-centred care. The team's vision statement was: *'Together as a team, our care and your commitment will maximise independence and achieve personal goals.'*

The team had been involved with a practice development-based programme, known as Essentials of Care (EoC; NSW Health, Nursing and Midwifery Office, 2014) for 10 years. This provided the necessary framework for the team to transform aspects of its clinical practice through multiple projects over the years. The EoC programme, underpinned by practice development principles, provides a six-phase cyclical framework to guide the creation of person-centred cultures and generate innovative ideas for change in nursing practice and person-centred care (NSW Health Nursing and Midwifery Office, 2014; Hennessy and Fry, 2016). The six phases are:

1. Preparation – engaging teams
2. Assessment – gathering information about care and culture
3. Feedback – critically reflecting and identifying themes
4. Planning – prioritising and actioning themes
5. Action, ongoing – implementing and evaluating actions
6. Re-assessing, every two years – re-gathering information about care and culture at the end of each cycle

Two staff in the rehabilitation unit were trained as EOC facilitators to support team members in engaging in practice development methods, such as critical reflection, creativity, dialogue and critical inquiry, to bring about transformational change (Hennessy and Fry, 2016). The intention was to co-create and evaluate a new model of client-centred goal setting, with person-centred approaches that would help clients identify goals that were important to them and foster greater team engagement in discussing progress towards these goals. Initial discussions identified that team members felt goals were healthcare professional oriented rather than being based on clients' expressed needs. A greater emphasis on a unified team approach, inclusive of all disciplines, was highlighted as necessary to improve goal setting with clients; this was to be the first time that all healthcare disciplines in the unit would work together on a project. The literature suggests collaborative partnerships between professionals and clients fosters a holistic approach that encourages a focus on setting person-centred goals (Leach et al., 2010; Jesus et al., 2016; Cameron et al., 2018). This is strengthened through person-centred approaches that enable clients to share what is important to them, what they value and how they understand the care they are receiving (McCormack and McCance, 2006).

Blending the EoC framework and appreciative inquiry

A mapping exercise was used to consider carefully how the phases of the EoC framework (NSW Health Nursing and Midwifery Office, 2014), alongside appreciative inquiry approaches, could guide the project to design a new model of care. One of the research team members (ND) had been working with visiting Professor Belinda Dewar and EoC coordinators from across NSW Health to learn about appreciative inquiry and develop skills as a co-inquirer. The collaboration between NSW Health, the Nursing and Midwifery Office and Professor Dewar built on the skills of EoC facilitators to explore and enhance student midwives' experience (Dewar et al., 2020). This encouraged the team to try the appreciative inquiry approach.

Practice development and appreciative inquiry are complementary approaches to the collaborative generation of new knowledge. Appreciative inquiry is grounded in constructivism and aspires to create knowledge through collaborative processes (Coghlan and Brydon-Miller, 2014; Sharp et al., 2017). Practice development supports this exploration through interventions that empower and enlighten clinicians to bring about change that increases clients' involvement in decisions surrounding their care (Manley et al., 2014). Methods of reflection, values clarification and critical inquiry guide these processes (Boomer and McCormack, 2010), while the use of facilitators in both areas of work enhances meaning and understanding about the area under investigation. Facilitative processes are dynamic in nature, supporting and actively working with teams as they seek to embed change (Dewar and Sharp, 2013; McCormack et al., 2013).

The project's aligning of the EoC framework and appreciative inquiry phases was based on deciding which appreciative inquiry approaches would best support each stage of the project and provide a deeper level of inquiry. The theoretical stance of constructivism is that each individual constructs their own social reality. This was evidenced in practice in this study as the health professionals worked to support clients in setting and achieving their goal of a return to independence in the community through shared decision making. Building relationships with clients enabled staff to individualise care to each client's needs, with the client's unique perspective on how they construct their route towards rehabilitation being a necessary component in achieving this. Communication with regard to goal setting was valuable for staff and clients, and the co-creation between the two provided synergies for person-centred care – although in practice the health professionals, especially the nurses, found this work was somewhat limited by the amount of quality time they had available to spend with clients.

Methods

A mixed-methods approach was adopted: practice development and appreciative inquiry approaches were used to guide, facilitate, support and evaluate the process at all phases of the project (Table 1).

Table 1: Project phases aligned to EoC framework and appreciative inquiry

Essentials of Care framework (NSW Government Health, 2014)	Appreciative Inquiry phases (Sharp et al., 2017)	Practice development and appreciative inquiry approaches	Participants	Time frame
Preparing Engaging all stakeholders	Discover (what gives life to organisation, appreciating and valuing what works well)	Monthly team sessions (icebreakers used at the beginning of every session). The focus was on discovering what is occurring in practice via: • Reflection • Team strengths • What is working well • Samoan circle*	Doctor (1) Occupational therapists (5) Physiotherapists (7) Nurses (20) Nurse unit manager (1)	Four months
Assessing (gathering information about care and culture)		• Client semi-structured interviews • Team sessions • Corridor conversations • Observations	Clients (6) Doctor (1) Physiotherapists (3) Occupational therapists (1) Nurses (4)	
Feeding back (critically reflecting and identifying themes)	Envision (envisioning what might be, affirmative exploration)	A focus on what changes needed to occur to develop a new person-centred model. What would this look like? • Claims, concerns and issues • Circle of concern, circle of influence	Doctor (1) Physiotherapists (3) Occupational therapist (1) Nurses (7)	Four months
Action planning (prioritising and actioning themes)	Co-create (co-constructing what the ideal should be)	• Team sessions	Doctor (1) Nurses (4) Occupational therapist (1)	
Implementing (ongoing, implementing and evaluating actions)		• Team sessions • Reflections	Doctor (1) Nurse unit manager (1) Physiotherapists (4) Occupational therapist (1)	Four months
Re-evaluating (care and culture at the end of each cycle)	Embed (sustaining what will be, the envisioned future)	• Interviews- story collection using emotional touchpoints • Team sessions • Reflections	Client survey (60) Clients receiving care (6) HCP (6) Doctor (1)	12 months

**A Samoan circle is a facilitated activity aimed to generate discussion among teams*

Setting

This project was conducted in an 18-bed, subacute rehabilitation unit in a regional hospital in New South Wales, between 2018 and 2020. The participants were clients from the rehabilitation unit, alongside nursing and medical staff and allied health professionals, including physiotherapists and occupational therapists, all working in the unit. The research team consisted of two nursing members (KB, TG) from the rehabilitation team, both practice development-trained facilitators who had been part of the EoC programme (NSW Health Nursing and Midwifery Office, 2014). They had a rapport with the team, having co-facilitated multiple clinical change initiatives over a 10-year period. The researchers had received facilitation training through the International Practice Development Collaborative's Practice Development School and had engaged in ongoing commitment to build on their skills as practice developers since the EoC programme. The facilitators had also recently been introduced to appreciative inquiry. The third researcher (ND) held a different role as a practice development manager for the local health district and had worked closely with the rehabilitation team and the nursing facilitators as a mentor and co-facilitator during many of their initiatives.

Two methodologies were intertwined for the project. The EoC framework uses practice development principles to enhance team relationships, build a shared vision for practice and ensure practice change occurs at the micro level. This is achieved through skilled facilitators who actively engage team members in reflection, critical dialogue and strategies for change, all while working with the CIP principles of collaboration, inclusivity and participation (McCormack and McCance, 2006; Manley et al., 2013). These guiding principles are essential for contributing to teamwork and shared learning (Hardy et al., 2012; Eriksen and Heimestol, 2017).

Appreciative inquiry was included for its key principle of bringing to life the experiences of clients and staff. As a practice, it is built on the discovery of what gives life to an organisation, taking a strengths-based approach to bring about effective change (Cooperrider and Whitney, 2006; Cooperrider et al., 2008). Further development of appreciative inquiry in the field of nursing and midwifery uses a four-phase inquiry process of discover, envision, co-create and embed, with collaborative inquiry methods to focus on what works well, challenge assumptions and develop strategies for practice change (Sharp et al., 2017; Watkins et al., 2020; Stulz et al., 2021).

Appreciative inquiry and practice development both use participatory active learning in the generation of practice change (McCormack et al., 2013; de Witt et al., 2020). They were interwoven into the exploration, development, design and implementation of the project. Appreciative inquiry approaches enhance practice development principles used to support change processes by focusing on what works well (Trajkovski et al., 2013).

Design

Within the mixed-methods approach, a range of data sources was used to represent staff and client perspectives, experiences and outcomes. Members of the rehabilitation team played an active role in co-designing and evaluating the project and clients' perspectives also informed the design. Ethical approval was granted by the local health district.

The research and facilitation team spent time exploring and discussing their individual and collective roles on the project, as well as their perspectives, worldviews and opinions on what it means to be involved in research. The team used a reflexive approach to ask one another questions about their hopes and fears for the project, past experiences on other projects, what working with the team looked like and what their personal hopes were. This is important in practice development and appreciative inquiry work for challenging prior assumptions, establishing ways of working and agreeing on the project's purpose (Manley et al., 2008; Dewar and Sharp, 2013).

Evaluation

Evaluation focused on exploring existing goal-setting processes and newly developed ones. Three methods were used for data collection, which were informed by the team's and clients' hopes for the project: the collection of field notes during team sessions provided representation of the team's voices; semi-structured interviews added richness to the data collection through clients' stories and staff experiences; and the team strongly expressed a desire to have a quantitative representation of outcomes. They also wanted a formal process for clients to evaluate the delivery of care. An exploration of the literature uncovered the client-centred rehabilitation questionnaire (Cott et al., 2006) – a validated tool specifically designed to enquire about rehabilitation goals. The team agreed this closely related to the desired aims of their model and that there was no need to develop an individualised survey.

In this phase, stories were collected through semi-structured interviews with six clients and six healthcare professionals using the appreciative inquiry tool emotional touchpoints (Scottish Health Council, 2014). This is a way of interviewing that elicits a person's experience in a balanced way, which can identify a time when the person felt emotionally about an interaction relating to their care (Dewar et al., 2009). The method enables interviewer and interviewee to focus on the emotion, with a view to gaining a greater insight into the human experience of the person's journey (Dewar et al., 2009). The team identified the touchpoints they wanted to explore with the clients as focal points of evaluation: the experience of setting their own goals; feelings around goal achievement; and support from the rehabilitation team in working towards the goals. The team wanted to know how clients connected emotionally with changes to the model of care and felt this was a way to capture their stories and feelings towards setting their goals. A collection of positive and negative words was presented in the interviews to help clients and team members describe their emotions, including happy, frustrated and hopeful. Clients selected the words that best described their experiences, which provided the basis for further elaboration (Dewar et al., 2020).

The interviews lasted between 30 and 60 minutes. Notes were taken, transcribed following the interviews and returned to the client within 24 hours. They were given time to read the transcript and invited to add or retract any information. When the researcher collected these, clients were asked if they wished to clarify any parts of their story. No one wished to withdraw their story.

Data analysis

Qualitative data

Qualitative data from the stories were transcribed verbatim and analysed using content analysis (Elo and Kyngas, 2008); this supports theme development, data consolidation and interpretation. All researchers engaged in a process of reading and re-reading the transcripts. A reflexive process was used throughout to discuss the connections and themes until consensus was reached. The reflexive aspect involved the researchers meeting at regular intervals to revisit the data, engaging in an inquiry process of sharing of their interpretations and then asking each other questions in order to develop a deeper understanding. The questions were framed to encourage thinking: 'How do we know this?' 'What do we believe the data tell us?' and 'How does this contribute/add to our focus?'

Quantitative data

Quantitative data were analysed using the Statistical Package for Social Science (SPSS). These data were analysed descriptively, using frequencies and percentages. Spearman's bivariate correlations were used, which are non-parametric analyses that can determine relationships between certain variables or questions. In this case, they enabled associations to be established between: expectations; information sharing; communication between staff, clients and family; respectful care; treatment; emotional needs; and interdisciplinary and community care.

Results/findings

Preparing, assessing, feeding back and action planning

Key questions directed towards what was working well or not so well offered insights into two aspects of current practice that staff strongly felt needed to be changed if any new model was to be successful: the role of the healthcare professional in goal setting, and establishing person-centred goals.

The role of the healthcare professional in goal setting

Nurses acknowledged and expressed the importance of supporting clients to identify goals that were important to them. They described not feeling involved in this aspect of the clients' journey as it was predominantly conducted by allied health professionals, including physiotherapists and occupational therapists: *'Nurses don't tend to be involved in goal setting.'* This was confirmed by allied health professionals, who said it was their role to set goals with clients. However, this was not openly communicated or shared with the other healthcare professionals in the rehabilitation team: *'The nurses and physiotherapists don't work closely together – to be person-centred we need to stop with individual discipline goals, we need to discuss this together.'*

Establishing person-centred goals

Team members expressed a view that their approach did not encourage clients to choose goals that were meaningful to them: *'We don't ask the patient what they want; we have expectations of what we want them to do, but often it's not relevant to their home, not relevant to them, not person-centred at all.'* Conversations in the interviews with clients revealed they felt guided by healthcare professionals towards what their goals should be. They felt their goal was to be able to transition towards going home, whereas the professionals might set smaller, more incremental goals. The key for working with clients in setting their goals was to establish a unified approach: *'The clients' goal should be a focal point throughout their journey.'* In developing the new model of care, team members felt successful client engagement could be achieved if there was clear communication and identification of the goals: *'At every point of care we should be discussing their goals to motivate and encourage them towards getting home.'*

This initial project phase established connections among the team, which was significant in the collaborative design and the final phases of the project.

Implementation, re-evaluation

Development of the new model of goal setting

It was agreed that the new co-created model of goal setting should begin with allocation of a member of the rehabilitation team to each new client on admission. The team member's responsibility was to orient the client to the unit, provide an explanation of the aims and purpose of rehabilitation, establish and document the clients' goals, communicate these goals with the rehabilitation team and maintain regular and consistent communication with the client on progress.

Themes from clients

Barriers to goal achievement

Time constraints were cited as the biggest barrier by clients. They felt the allocation of more time to discussing their goals would offer the opportunity to have a meaningful conversation about their wishes, needs and concerns.

> *'I've just had a stroke so cognitively things are confusing. What would be helpful is having the time to sit down with my case manager and discuss my plan'* (C1).

> *'It would be good to have a deliberate time of knowing when the nurse is coming so we can discuss our goals'* (C2).

Discussing goals during daily care

The clients noticed that discussion of goals tended to happen during moments of care. This felt natural as the staff noticed potential areas of concern for the patient and were able to talk about these while providing care.

> *'I found discussing my goals happens in the moment, for example when they are helping me to shower, this helps me to raise any concerns'* (C1).

Communication with and feedback from staff helped clients build confidence; paying attention and giving the client cues was important.

> *'The nurses always feed back on my progress, it helps me to focus on the good things that are important to me'* (C2).

> *'Even when we work on my goals, it's good to have a laugh and joke. For example, the tap in my room always splashes when the nurses get me to turn it on; both me and the nurse get drowned and we laugh'* (C4).

Goal achievement

Achieving their goals or even taking small steps along the way made the clients feel proud in the knowledge they were making progress. When staff acknowledged these small improvements it made clients feel more positive and motivated.

> *'When I got back from my first home visit the nurses were so excited for me, they wanted to hear all about it. I found this to be very encouraging'* (C5).

> *'The nurses make me hopeful, they are like your little cheer squad'* (C1).

Building confidence in this way was significant. Although rehabilitation was described as painful and difficult, encouragement from staff helped clients believe they could succeed.

> *'I was given a lot of encouragement, which made rehab more bearable and gave me the confidence to continue doing the exercises, which has helped me achieve my first goal'* (C4).

Sense of purpose
Clear communication in relation to the purpose of rehabilitation gave the clients a clearer understanding of the process, lessening their anxiety.

> *'I am really determined to leave here, and setting goals has helped me. It has been a learning experience seeing others like me. I felt confident to set my goals and value that the staff know what they are doing. They are patient with me to get me to where I need to be'* (C3).

One client revealed how knowing their role and understanding the importance of being an active participant in their healthcare journey provided hope and normalised the rehabilitation process.

> *'I came to rehab after my total knee replacement, because of Huntington's chorea I often get treated differently. I was told I could do my rehab like the other people, it made me feel positive about getting back to my normal life'* (C4).

Themes from staff
Becoming person-centred
Healthcare professionals said changes to the new model of care made them feel more person-centred in their delivery of care. Their experience was that giving clients a voice in choosing their goals encouraged progression towards those goals.

> *'This new approach in being person-centred engages the person in taking smaller steps, progressing towards their goal and giving them a say'* (P4).

> *'It gives us a link to the family, we can ask for support; it gives us a way to have a conversation with the person about getting back to daily living'* (P1).

> *'The clients receive the information when they first arrive and this is followed up in a timely way by the case manager to discuss goals'* (P2).

> *'Having a staff member when they first arrive is a good communication opportunity for us to recognise where the patients are at; it helps to us to work with them on any alternative goals* (P3).

The new model of goal setting also improved the engagement of families and others important to the clients. Staff felt they were able to develop more meaningful relationships with them.

The shared value of goal setting
Goal setting provided the space to find out what was important to clients and their families. The new way of thinking that staff needed to take the time to connect with the client as a person made the difference.

> *'It's so nice when we can make the time to spend with the person. Recently I had time with a person showing her photos of her cat, and she loved it'* (P5).

> *'It is important the person knows someone is taking the time to find out what matters to them and what they want from their recovery'* (P1).

Working together as healthcare professionals

There were consensus and similarities in the healthcare professionals' experiences and views on establishing person-centred goals, despite the diversity of roles in the rehabilitation team. A unified team approach was seen as vital for promoting positive person-centred outcomes and helping clients understand the rehabilitation process.

> *'It's important for the person to see all healthcare professionals working together, they need to know we all do different bits but we are all working towards the same goal'* (P2).

Knowing the client as a person was also seen as a key component of the healthcare professional role and one that made it easier to establish therapeutic relationships.

> *'It is important we know the person individually, we are pushing them through really difficult times, through new barriers and grief'* (P3).

Staff saw themselves as advocates for the clients, acting as a conduit for information between family members and other healthcare disciplines.

> *'It can be confronting for a client to talk about their goals. Nurses act as a buffer to help explain gently what the aim of the goals are'* (P4).

The importance of providing care that was both compassionate and made the client safe was reflected throughout the interviews. There was a desire to ensure the client experienced as little fear or anxiety as possible about working towards their goals.

> *'Clients in rehabilitation get scared about not being able to go home. Sometimes they don't always tell the truth, for example about being able to dress themselves – they have fear if they can't do the task, they won't be able to go home'* (P6).

Barriers to establishing goals

Healthcare professionals said time constraints were their biggest barrier. They described feeling frustrated at not being able to spend sufficient quality time with the client to discuss goals.

> *'It is hard to find time to have meaningful conversations with the client, and the generosity of time is difficult'* (P4).

They described needing time for more in-depth communication to be able to discuss meaningful, rather than task-oriented, goals.

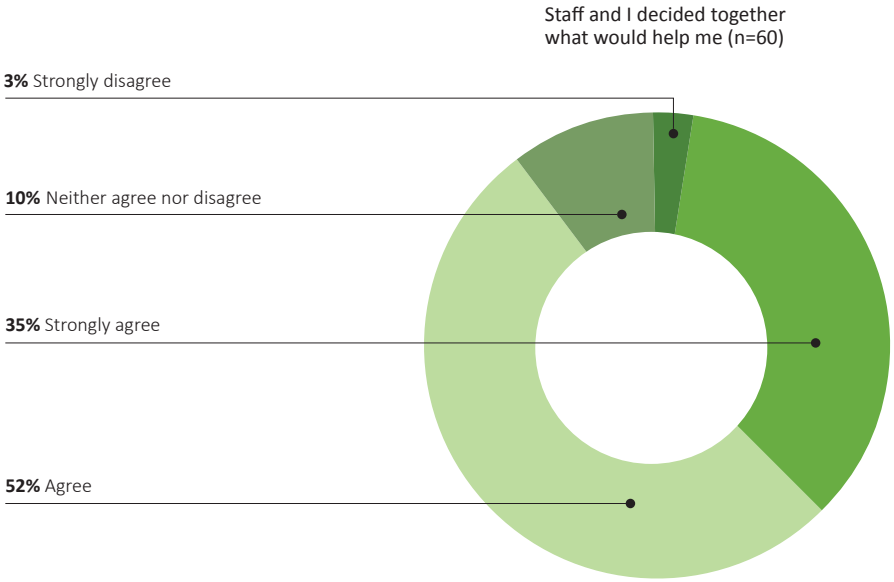
> *'Discussing and setting goals with the client needs to be realistic as it can influence therapy'* (P3).

Results from client-centred rehabilitation questionnaire

The quantitative findings resonated and aligned with the qualitative findings, showing the rehabilitation team took a multidisciplinary, person-centred approach to helping clients reach their rehabilitation goals. Bivariate correlation analyses identified relationships between the staff and the client deciding together what would help and positive achievements in working towards rehabilitation goals.

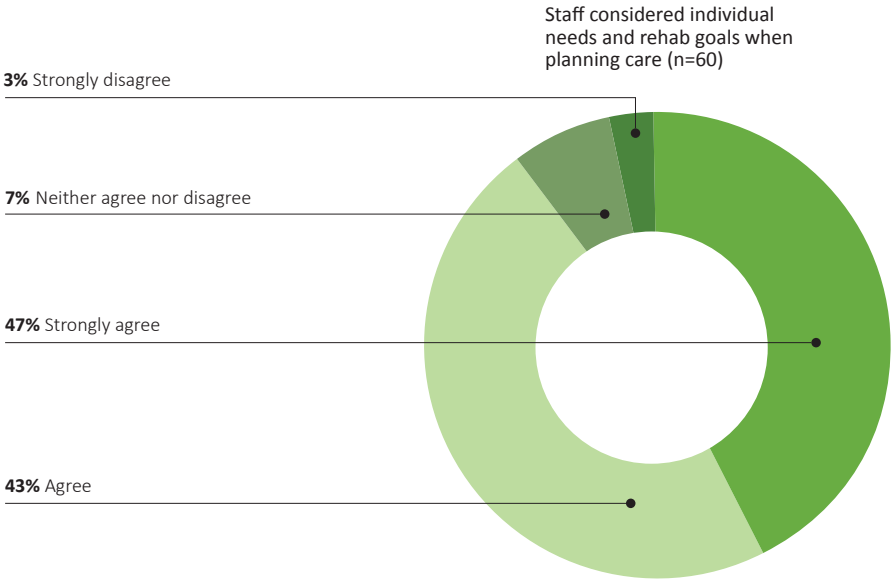
The majority of clients' responses were positive about their rehabilitation journey. There is evidence of working together with staff, as the majority of clients (87%) agreed joint decisions were made over what would assist them in their journey (Figure 1).

Figure 1: Staff and client deciding what would help



The majority (90%) of clients receiving care reported that staff considered their individual needs when planning their care towards reaching rehabilitation goals (Figure 2).

Figure 2: Staff considering individual needs for planning rehabilitation



Bivariate correlations demonstrated significant relationships that were important for the clients' rehabilitation goals (Table 2).

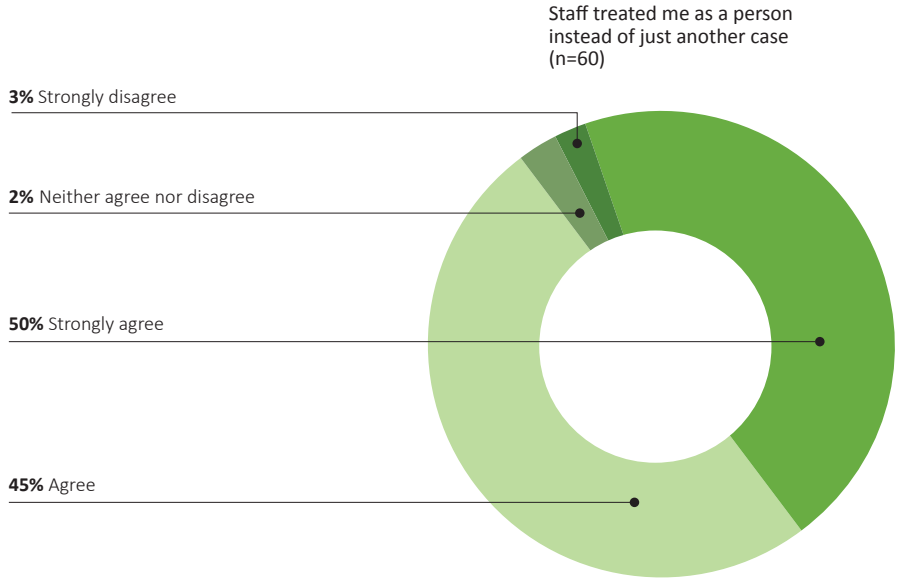
Table 2: Relationships between family, friends, client information and clients' emotional needs and bivariate correlations

Issue of significance	Rho*	Effect of positive relationship
Family and friends being involved in client's rehabilitation as much as they wanted	.912	• Client learning what they needed to know in order to manage their rehabilitation goals at home
	.950	• Client being told what to expect when at home
	.910	• Family and friends being given the information they needed when wanted
Client being told what to expect when at home	.929	• Client being given adequate information about support services in the community
Client's emotional needs (worries, anxieties, and fears) being recognised and taken seriously by the staff	.937	• The staff and client discussing their progress and rehabilitation goals together and the client making changes as necessary
	.910	• Client receiving the information they needed when they wanted it
	.927	• Learning what the client needed to know in order to manage their rehabilitation goals at home
	.947	• Client knowing who to contact in their rehabilitation journey
	.925	• Client accomplishing what they had expected in their rehabilitation journey
	.934	• Client's treatment needs, priorities and goals being important to the staff
Therapists, nurses and doctors working well together	.976	• The therapy programme being explained to the client in a way they could understand
	.971	• Staff taking the client's individual needs and rehabilitation goals into consideration when planning their care
	.909	• Client's family and friends being given the information they wanted when it was needed
Client being encouraged to participate in setting their own rehabilitation goals	.942	• Client being treated with respect and dignity

** Rho measures the strength of association between variables. All values p<0.01, 2-tailed*

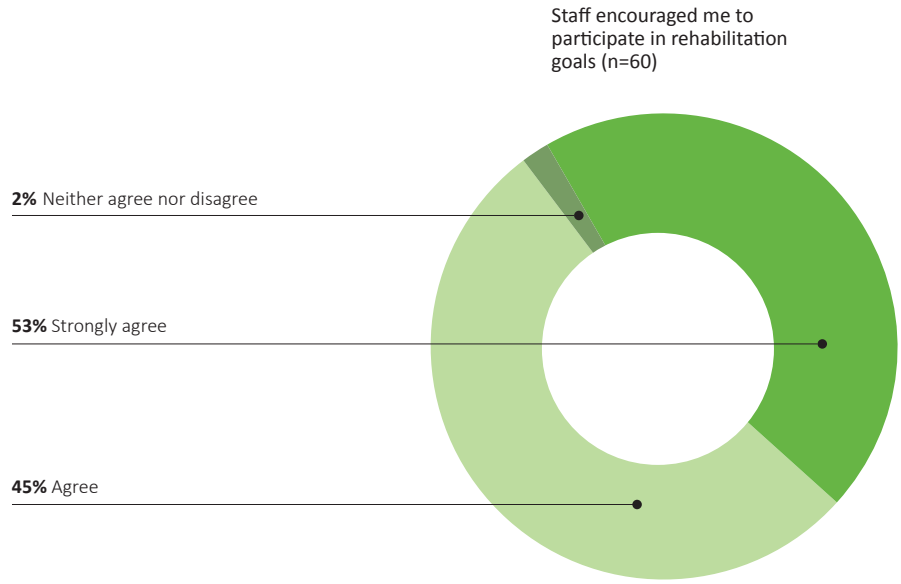
Encouraging clients to participate in their own rehabilitation goals had a significant relationship with: being treated with respect and dignity ($r=0.942$, $p < 0.01$); the staff treating them as a person ($r=0.934$, $p < 0.01$); pain being acknowledged by staff ($r=0.917$, $p < 0.01$); and feeling comfortable expressing feelings to staff ($r=0.951$, $p < 0.01$).

The majority (95%) of individuals reported that they were being treated as a person rather than as just another case. This offers evidence that staff were providing person-centred care and taking clients' emotional needs seriously (Figure 3).



The majority (98%) of clients receiving care felt encouraged to participate in their rehabilitation goals (Figure 4).

Figure 4: Feeling encouraged to participate in rehabilitation goals



Discussion

This study's findings show that a change in practice from an individual healthcare professional approach to goal setting to one that uses a cohesive team approach and person-centred methods can lead to greater involvement of the client and those important to them. One of the key factors in achieving such a collaborative team approach was the use of appreciative inquiry methods that incorporated a positive outlook for staff and clients, focusing on improvements in the rehabilitation journey. The value of staff getting to know clients as individuals was also found to be beneficial for team dynamics and client engagement, supporting the findings of previous studies (McCormack et al., 2013; Health Innovation Network, 2014).

Having a process to establish person-centred goals, and inform ongoing achievement throughout the clients' journey, was deemed necessary by healthcare professionals. The valuing of clients' treatment needs, priorities and goals by staff was associated with better recognition of the clients' emotional needs, which underlines the importance of individual goals (Figure 2). The first stage of the process, whereby a team member connects with a client on admission was seen as crucial for building rapport, as was discussion of goals between nurses and clients during daily care. Staff acknowledged small improvements along the way and building clients' confidence in this way was important in motivating them; this links to the importance of appreciative inquiry to recognise each individual's perspective – in this case, of how each client constructed their own ideas towards rehabilitation. The skills of listening and asking the right type of questions are supported by other studies that emphasise the importance of this in establishing person-centred goals and care (Dewar and Sharp 2013; Cameron et al., 2018). Dewar and Nolan (2013) found making connections through finding out what matters to clients helps the development of positive relationships. Communication with clients about the purpose of their rehabilitation journey gave them confidence and a sense of security, and encouraging them to participate in establishing their own rehabilitation goals made them feel they were being treated with respect and dignity. However, the healthcare professionals said they were not able to devote as much time to these aspects of communication with clients as they would have liked.

Sharing knowledge with clients and families on the aims and expectations of rehabilitation created a space where goals could be discussed. A positive relationship was also demonstrated between allowing families to be as involved in the client's rehabilitation as they wished and the client learning what they needed to know to manage their rehabilitation goals at home. McCormack and colleagues (2015) emphasise that a person-centred culture is needed for staff to work in person-centred ways; in this study, shared decision making, creating ways for clients to be heard, and involving clients and family were essential for establishing person-centred care.

Clarifying clients' expectations when they return home included consideration of access to support services in the community. Studies show that incorporating goal setting into nursing models of care leads to enhanced client involvement and increased goal achievement (van de Weyer et al., 2010; Dalton, et al., 2011). Identifying goals in the early stages after admission establishes a platform for those goals to become a central part of care provision, although it was acknowledged that this is dependent on the whole rehabilitation team being familiar with the goals.

The members of the healthcare team noted that a collaborative approach to goal setting promotes clients' active involvement in their care and in choosing goals that have meaning to them. Co-creation between staff and clients has been shown to lead to improved satisfaction levels and better healthcare outcomes (Levack et al., 2006). A unified approach was identified as crucial by the rehabilitation team and was associated with the team considering the clients' individual needs and rehabilitation goals when planning their care. Effective multidisciplinary teamworking was also shown to reduce clients' emotional concerns and fears. This supports the findings of other research showing the benefits of a multidisciplinary rehabilitation team working together for clients' health-related quality of life, including a reduction in levels of anxiety, depression and burnout (Jacobs et al., 2020).

Team members found increased involvement in discussing clients' goals had a positive influence on their mood, confidence and satisfaction. This created an environment where clients felt they were part of a family, and could share their achievements with the healthcare professionals. This concurs with other research describing how the attitudes and personalities of staff impact on how clients experience care (Tyrrell et al., 2012). The same authors report that where nurses find ways to encourage and motivate patients to engage in rehabilitation activities, it leads to an increase in nurses' confidence and participation in learning new skills. Receiving emotional support and encouragement from staff leads to a greater level of participation from clients; this study found that recognition of the emotional needs of the client and the joint creation of goals and discussion of progress were associated with

the client making changes as necessary. Clients who feel valued and listened to are confident they can get the help they need (Angel et al., 2011). Creating positive relationships is crucial for human connection and relationship-centred care (Dewar and Nolan, 2013) and further research to explore how teams create an environment of positivity to influence client outcomes is recommended.

Despite a desire to focus on their clients' goals, healthcare professionals felt challenged and frustrated by time constraints; both staff and clients valued having quality time for discussion. Other studies emphasise that creating a space where clients can voice their concerns is vital for building rapport and empowering clients to express their needs (Papadimitriou and Cott, 2014; Cameron et al., 2018). Having the time to be empathetic and respectful of the clients' goals helps staff feel they are developing rapport and being person-centred (Cameron et al., 2018). The importance of designated protected time and ways to enable effective connection with clients through meaningful communication is key to staff perceptions of achieving person-centred care (Leach et al., 2010; McCormack et al., 2013; Papadimitriou and Cott, 2014).

Other authors argue that the burden of workload on staff is viewed as a barrier to providing person-centred care (Papadimitriou and Cott, 2014; Cameron et al., 2018). It would be valuable to understand from a client perspective the type of conversations/language that encourages people to feel confident in communicating their goals, especially given the time constraints.

Limitations

Our study took place at a single site and it would be beneficial to conduct the same study in other rehabilitation areas or clinical settings in which clients are encouraged to take an active role in goal setting. Healthcare professionals who volunteered to participate could potentially have been those who regularly engage with client goal setting. We did not include family members in the collection of stories; doing so could have provided different perspectives and added to the level of understanding about the client experience.

Conclusion

This study provides insight into how clients and healthcare professionals experienced changes to a new model of client goal establishment and argues that identifying rehabilitation goals from the point of admission helps them become a primary focus of the clients' care. The themes that emerged provide insight into the reality of working in a subacute rehabilitation setting, and give voice to the views of clients and staff. Appreciative inquiry and practice development methods and approaches were valuable in establishing a safe and creative space for team members to build positive relationships to enable clients to participate in setting their goals. The new model helped staff feel person-centred in their care delivery, and they derived satisfaction from knowing they were doing something meaningful for their clients.

The study contends that a collaborative approach from all members of the healthcare team is essential for enhanced client experience and staff satisfaction; clients described feeling valued and reassured by knowing everyone was working together. This was reinforced by quantitative evidence showing that clients being treated with respect and dignity was associated with their being empowered to participate in setting their own goals. Allowing the family to be involved in the client's rehabilitation as much as they wished showed a positive relationship with the client learning what they needed to know to manage their rehabilitation goals at home. Assigning quality time to discuss and plan goals was emphasised by clients and staff as key to success in goal achievement and it is suggested that further research in this area would be beneficial.

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