International Practice Development Journal

Online journal of FoNS in association with the IPDC (ISSN 2046-9292)

ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Finding the hidden heart of healthcare: the development of a framework to evidence person-centred practice

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Abstract

Background: In the present healthcare climate of performance management it has become increasingly challenging to ensure there is a balance between evidence-based practice and person-centred practice. Policy documents lead us to believe that the persons' understanding of the care process and satisfaction with the care experience is important. However, in many healthcare settings evidence of person-centred practice often remains hidden behind the delivery of target driven, research-based care.

Aims: The aim of this development was to develop a shared understanding of person-centred practice.

Design: A collaborative enquiry approach was taken as it valued action, reflection and meaning making between participants who work in different healthcare settings.

Method: A self-selected group of seven practice development nurses met to share stories and developed insights into evidencing person-centred practice. Dialogue interspersed with critical reflection enabled us to validate our experiences. Ideas shared were grouped into a framework of values, themes and sub-themes. These were validated by practitioners locally, nationally and internationally.

Results: The framework is comprised of six values: accepted, listened to, understood, informed, involved and flourishing. For each value there are themes and sub-themes that illustrate the outcomes for individuals, teams and organisations of person-centred practice; the risks if person-centred practice is not achieved and the actions that promote person-centred practice.

Conclusion: Implementing this framework for evidencing person-centred practice develops mutual trust and understanding of collective knowledge. It gives a sense of purpose amidst the uncertain, stressful, complexity of the present healthcare context. Interpreting evidence in a participatory learning environment can raise awareness of the values underpinning person-centred practice.

Implications for practice: Facilitated appropriately this process has the potential:

- To raise awareness of the meaning of 'being' person-centred
- To support managers and leaders in understanding and valuing person-centred practice
- For further research to develop evidence of person-centred healthcare cultures

Keywords: Person-centred practice, working together, shared values, evidence, practice development, flourishing

Introduction
Like many countries, Scottish healthcare is faced with an increasingly ageing population; persistent health inequalities and a continuing need to shift towards the care of people with long term conditions and chronic disease. The traditional illness focussed medical model has influenced healthcare for many years. This approach has made outstanding progress in tackling ill-health. The difficulty is that, despite the implementation of a variety of continuous quality improvement initiatives, healthcare continues to focus on efficiency, standards, systems and the needs of the professionals working in medical specialities. Collaborative working has developed in some healthcare communities encouraging teamwork, partnership and self-care. However, an enormous cultural change is needed to find the evidence that healthcare professionals are making the transition to person-centred practice.

Increasingly, person-centred terminology is used but the meaning can be vague and difficult to understand. This is partly due to the practice of person-centred care being influenced by the context in which care is carried out. This approach to healthcare practice can be interpreted differently in each care setting which can create confusion, discomfort and anxiety. Person-centred practice can be achieved but is often hidden behind the present priorities of target driven, evidence-based practice. Healthcare teams should be looking to demonstrate evidence of person-centred practice. This is a challenge that demands urgent attention.

This paper details the development of a framework for evidencing person-centred practice that illustrates the shared understanding of the values that underpin this approach to care, the risks should these actions not be achieved and the actions required by the individuals, teams and organisations to ensure that person-centred practice can be experienced by all.

The policy context
In the present healthcare climate of performance measurement and with the national drive to improve targets it is increasingly challenging to ensure there is a balance between implementing evidence-based practice and meeting the individual's health needs. Policy documents lead us to believe that people should be first and that their understanding of the care process and satisfaction with care is paramount (Scottish Executive Health Department [SEHD], 2003; Scottish Executive, 2005; Department of Health, 2005b; Scottish Executive, 2007).

In 2005, an evolving model of care was proposed that would move away from episodic, disjointed and reactive hospital focussed care, towards integrated, continuous community-based care, based on partnership and collaboration (Scottish Executive, 2005). Policies stated that person-centred practice should be central to decision making in healthcare, enabling patients to have 'choice' and to be partners in their care (SEHD, 2003; Department of Health, 2005; Health Improvement Scotland, 2009; Scottish Government, 2010). Healthcare Improvement Scotland (HIS) working in collaboration with NHS Education for Scotland, (NES) suggested that practice development, involving innovative and creative approaches to sustainable change, would enable the development of person-centred practice (Healthcare Improvement Scotland, 2009). Furthermore, the NHS Scotland healthcare quality strategy outlined the need for safe and effective person-centred care (Scottish Government, 2010). The policy context demanded that carrying out and providing evidence of person-centred practice was an essential part of quality healthcare delivery and needed to develop at every level to be effective.

Person-centred practice
During the late 1940's Dr Carl Rogers (1902-1987) created the idea of person-centred practice as an approach to psychotherapy. Rather than depending on the therapist to be the expert or authority figure, a safe psychological environment was created where people could develop greater self-

awareness and overcome their own difficulties (Rogers, 2004). The presence of empathy, unconditional positive regard and congruence gave an individual complete psychological freedom therefore fostered creativity and therapeutic change. The person-centred approach has since been applied in other settings including healthcare (Embleton Tudor et al., 2004).

Person-centred practice has been explored in terms of meeting physicians and patients' needs, promoting individual care, respecting values and improving satisfaction with care (Mead and Bower, 2000; Coyle and Williams, 2001; McCormack, 2003b; Beach et al., 2006, Hobbs, 2009). A number of definitions of person-centred practice have emerged over time (McCormack, 2003a; NHS Education for Scotland, 2011; Morgan and Yoder, 2012) but there is no obvious consensus about its meaning in healthcare. Mead and Bower (2000) recognised that being person-centred required the practitioner to understand the needs of the patient while creating a therapeutic climate that offered genuine choices in care. McCormack (2001) argued that person centeredness is concerned with the right to have individual values and beliefs respected; the values that give each individual their uniqueness and authenticity. This is reinforced by Slater (2006) and Leplege (2007) who identified dignity, autonomy and respect to be vital to person-centred practice.

McCormack (2003a) suggested that being person-centred requires an agreement between professional and patient that is built on mutual trust and a shared understanding. When a person's feelings, anxieties and needs are accepted unconditionally, they can then express how they are, or are not coping with their circumstances (Rogers, 2004). Person-centred practice shifts the focus from the practitioner to the person being cared for thus giving the person responsibility for their own health (Leplege et al., 2007; Slater, 2006). This approach is argued to be most effective when organised around the person's needs and preferences rather than institutional standards or routines (Leplege, 2007; Morgan and Yoder, 2012). This is difficult to achieve in workplace cultures that value paternalistic approaches to the delivery of evidence-based care.

Person-centredness is a different way of thinking and working together (Sanderson et al., 2004); it is a way of 'being' rather than doing or telling. O'Brien and O'Brien (2000) and Sanderson et al. (2004) suggest it is the balance between professionals understanding the feelings, anxieties and needs of people they are caring for, as well as supporting the people in having responsibility and ownership of their care. It involves practitioners in the development of moral reasoning, moral responsibility and moral sensitivity (Ford 2000, McCormack, 2003b). Person-centred practice requires a commitment to develop a deep understanding of others as thinking and feeling beings that have the potential to learn, develop and grow (Sanderson et al., 2004). This is done by creating a positive learning environment that enables the person to use their own resources to develop themselves and others in a positive way (McCormack et al., 2002). By ceasing to form judgements and accepting people as they are, enables individuals to take responsibility for their own health and development (Rodgers, 2004). However, for these therapeutic conditions to be effective there needs to be supportive infrastructures at every level of an organisation (Embleton Tudor et al., 2004; Sanderson et al., 2004; Slater, 2006). This approach needs to be embedded in norms, mores and values and beliefs of the workplace culture.

Developing a culture of improvement and innovation
Creating sustainable change in healthcare culture is an active process, not a passive one (Pickering and Thompson, 2003). Organisational systems are made up of structures, processes and outcomes (Department of Health, 2005a). When improvement is required the first action has been to change the structure, which time and time again has shown to have very little impact. The second action has been in the improvement of processes. This has resulted in some excellent advances in care pathways, recruitment and procurement. The introduction of pathways has centred care on the patient's journey, however, service delivery has continued to be fragmented and task focused. Also,

there have been difficulties with collaboration, involvement and sustainability (de Luc, 2000; Renholm, Leino-Kilpi and Suominen, 2002; Zander, 2002; Van Herck, Vanhaecht and Sermeus, 2004; Guthrie et al., 2010).

The national drive to reduce risks and improve the outcomes of healthcare practice has resulted in the introduction of a variety of interrelating projects with discrete objectives (Department of Health, 2001; Scottish Executive, 2002; Healthcare Improvement Scotland, 2010; Gullick and Shimadry, 2008; NHS Education Scotland (NES), 2008; NHS Institute for Innovation and Improvement, 2008; SEHD, 2006; Scottish Government, 2008a; Scottish Government, 2008b; NHS Institute for Innovation and Improvement, 2010; Nolan et al., 2004; Smith, 2010; University of Edinburgh, 2008). These projects have taken a variety of creative approaches to improving the quality of the healthcare experience. Early evaluations have used objective methods to establish effectiveness rather than seeking the individual views of those involved. Consequently, the rigour, objectivity and measurement of the evidence-based world continued to dominate and the more subjective practical knowledge is ignored. Local problems with additional workload were reported as quality initiatives were perceived to be 'bolted on' rather than integrated into daily work. In our experience for Senior Charge Nurses and their teams, reconciling the tension between improving the experience of care for patients while meeting the ever increasing demands of productivity, fiscal restraints and quality initiatives was an on going challenge.

Using a traditional top-down approach to continuous quality improvement has aimed to influence ways of working that shape the person's experience of healthcare by moving towards the new model of partnership and involvement (SEHD, 2003). There was little evidence that policy making, protocols and clinical decision-making were necessarily promoting person-centred practice (Rycroft-Malone et al., 2002, 2004) or asking if the experience was satisfactory. The management systems along with the objective, quantitatively measured evidence-based guidelines and the need for efficient care delivery have resulted in an environment where the needs of the individual invariably get lost. The danger of this approach to improvement was that healthcare professionals believe that they have to do as they are told. Therefore, they were not necessarily in a position to think through the complex ethical dilemmas of daily practice. In the drive to develop learning programmes, provide information, monitor progress and improve outcomes it appears that this top-down culture perpetuated the paternalistic medical model. The underlying values and beliefs that promote person-centred practice have remained hidden.

An effective workplace culture in healthcare not only involves providing care that is effective and evidence-based, but also needs to be person-centred (RCN, 2006). The difficulty is that the rigour, objectivity and measurement that are essential for credibility in the evidence-based world, are difficult to apply in the humanistic, person-centred world. This is not about valuing one type of evidence over another but realising that together they offer a much more accurate and richer picture. Being person-centred involves valuing thoughts, feelings and beliefs and showing the willingness to accept the person as they are. It requires listening and responding to each person in an individual way (Sanderson et al., 2004). This cannot be achieved through an objective, measured, standardised package. Consequently, it is our belief that evidence-based practice and person-centred practice have potentially conflicting perspectives and values.

In developing human services for people with a disability, it was recognised that person-centred practice needed to be liberating rather than regulatory and controlling. To make a positive impact on people's lives required a change in perceptions; encouraging involvement, developing new understandings and enabling choice (O'Brien and O'Brien, 2000; Sanderson et al., 2004). Person-centred practice improved quality and satisfaction as it focuses on the person, so increasing feelings of satisfaction and wellbeing (McCormack, 2003a; McCormack and McCance, 2006). To successfully

improve the care experience for all involved, leaders in healthcare need opportunities to combine quality initiatives, with learning and development programmes to enhance person-centred practice. Differences need to be discussed openly in order to build and sustain an effective, evidence-based, person-centred healthcare culture that aspires to partnership and involvement. To complicate matters, evidence for effective person-centred practice must be established and applied carefully taking into consideration the culture and context of care (Rycroft-Malone et al., 2002, 2004; Slater, 2006). The natural diversity inherent in workplace cultures makes this a difficult task. Also, there was the wider challenge of developing a research culture that would value a variety of ways of evidencing the effectiveness of these new ways of thinking (McCormack et al., 2006).

Developing a culture that promotes person-centred practice
The most immediate culture experienced by patient, families and staff refers to how things are thought about and done in the workplace (Dewing, 2007). Zachary (2006) uses the term; context, which is the circumstances, conditions, and contributing forces that affect how we connect, interact with, and learn from one another. It is a difficult concept to grasp since it can be seen from different perspectives and is influenced by different competing contexts that often happen simultaneously (McCormack et al., 2002). As a result of these different perceptions the healthcare context can hinder the delivery of effective person-centred practice (Titchen and Manley, 2006; Edvardsson et al., 2009).

Building and nurturing a culture that promotes person-centred practice involves recognising the value of learning, respecting the person who is central to the care process and developing an environment where risk taking is safe. However, there is often an enormous difference between the actual culture experienced by those involved and the espoused culture, explaining why so many organisational cultures appear confused and contradictory (Brown, 2007). To overcome these contextual problems the values underpinning person-centred practice need to be clarified (Department of Health, 2005a; McCormack and McCance, 2006) with the aim of giving a sense of purpose, direction and guidance in uncertain, stressful times.

Making values and beliefs explicit is the first step to making them a reality in the workplace (Eagger et al., 2005; Brown, 2007). Developing an understanding of the match between what we say, what we believe and what we do is one of the characteristics of effective individuals, teams and organisations (Manley, 2000). Comparing stated values with what people are actually doing in practice helps increase awareness of inconsistencies and gives a sense of what to aspire to and how to change and develop practice. Evidence has shown that making time for reflection and values clarification in a safe, trusting confidential environment can enable the transition in thinking and the development of shared understandings (Kline, 1999; Burnard, 2002; Freshwater, 2002; Johns, 2002; Manley et al., 2008).

The impetus for the development of a framework for evidencing person-centred practice in healthcare stemmed from the need to develop a shared understanding of the hidden values underpinning person-centred practice. Our aim was to develop a framework of shared meanings that would highlight the outcomes of person-centred practice; the risks if person-centred practice was not achieved and finally, the essential interactions for individuals, teams and organisations that results in a positive outcome.

Developing the Framework
This development emerged from the work of the multi-professional forum known as Professional and Practice Development Nurses, Midwives and Allied Healthcare Professionals (NMAHP) Forum (PPDNF) Scotland. This was an independent support network for healthcare professionals from all over Scotland who worked in Practice Development in a variety of settings; NHS, independent and

voluntary sectors. Practice development is a methodology known to promote sustainable cultural change and to develop person-centred practice in healthcare (Dewing, 2007; Manley et al., 2008). The forum had identified an uncertainty about the values underpinning person-centred practice that needed clarification. Ethically it was unacceptable to ignore this disquiet (Bray et al. 2000; Brydon-Millar, 2008).

Choosing the approach
The collaborative enquiry approach was chosen as it sits in the evolving paradigm of human enquiry that values adult education, participation, democracy and transformative learning (Bray et al., 2000). This approach was appropriate as it valued action, reflection and meaning making between group members who shared a common experience.

A self-selected group of seven experienced nurses within the forum agreed to work on the project. As a group of people who shared a common interest we formed a community of practice (Wenger et al., 2002). The community of practice created space for us all to share our different views of healthcare and to have an equal say in the decision-making process. Through sharing knowledge, expertise and experience we worked towards developing a framework for person-centred practice.

Ethics
This group were collectively responsible in working together to define an area of practice to develop, to establish a set of meaningful questions and to determine ways of gathering pertinent information. The fundamental underpinning value was the genuine respect for each other and a long term commitment to working together (Bray et al., 2000; Brydon-Millar, 2008). Beneficence was achieved through the ongoing discussion to develop a greater understanding of the ethical issues we faced on a day to day basis. In practice development the concern for justice extended to our involvement in decision making, the generation of ownership and taking an agreed approach to the dissemination of new knowledge (Brydon-Millar, 2008). The risks were managed through the collaborative style of working together that enabled us to challenge the process should there have been any ethical concerns.

Method
Due to work commitments, between three and five of us were able to attend each of the 12 meetings that were held over two years. Meeting dates were planned in advance and dates were circulated to all involved. Each meeting built on the previous one. Records of each meeting were made in the form of flip charts and meeting notes and were circulated to all group members.

The first meeting was spent discussing the topic and focussing our questions. The next meetings involved clarifying the values underpinning person-centred practice, as described by Dewing (2007). We reflected on our values and experiences as nurses, patients or carers, carefully considering the meaning of person-centred practice, the enablers, inhibitors and the actions required. This involved looking back at situations, thinking critically and carefully about ourselves and our practice and gleaning new meanings from it (Burnard, 2002; Freshwater, 2002; Johns, 2002). The thinking and reflection time was beneficial. Working together and sharing experiences develops and conveys more richness and authenticity than those obtained by a detached observer (Kline, 1999; Bray et al., 2000).

Storytelling and dialogue also provided the medium in which to define 'evidencing person-centred practice'. Telling stories of our personal and professional experiences while hearing stories of others was valuable in the search for tacit knowledge. As in active learning (Dewing, 2007), reflective questioning was used to clarify values and focused questions were used to gain understanding. The dialogue interspersed with critical reflection was kept focussed by our questions and the limited

timeframe of the meetings. At the start of each meeting the notes of the last meeting were agreed and built upon. This valued everyone's contribution enabling participation and sharing of common understandings. This provided an important source of validity (Bray et al., 2000).

Analysis
Analysis was integrated into the process of development. Flip charts were reviewed over three or four meetings to ensure that everyone's thoughts were included and further information was added where necessary. Subsequent meetings involved grouping and theming the information. Although we recognised that some of these themes were similar or the same in meaning we began matching the statements to the themes. The themes were in no particular order but we gave them numbers to ease the process. The values clarification process and analysis (Dewing, 2007) continued until a framework was developed with key statements of outcomes, risks and actions along with how they could be evidenced.

Validation of the framework
While these were the ideas of a group of experienced nurses, the framework required wider validation. The PPDNF membership and conference workshops provided triangulation and further understanding of the values in the framework. Validation was accomplished at a national and international level by attending three conferences. The development group facilitated a variety of workshops, attended by ninety people overall, using creative practice development methods (Dewing, 2007).Meanings and evaluations from these workshops were integrated into the framework.

A final series of five participatory workshops enabled a total of one hundred and sixty eight participants to experience and understand the whole framework. Our approach was developed from a person-centred workshop experienced at an international conference (Cardiff, 2008) with ideas integrated from 'creating a vision' (Dewing, 2007). The interactive workshop involved 'being' person-centred. Participants were invited to choose creative materials and narratives to create collages to share meaning of person-centred practice. By listening to others, sharing experiences and then grouping and theming their thoughts, ideas were built into the framework. The process enables the participants to experience person-centred practice; to see the risks should this not be achieved, to understand the actions required by the individuals, teams and organisations, to ensure that person-centred practice can be experienced by all and to see that the values that underpin person-centred practice are a valuable part of everyday work.

In the spirit of participatory practice development, ethical aspects were achieved through the open, honest negotiation of ground rules, obtaining consent from participants at every stage of the process and ensuring group members were able to withdraw at any time (Brydan-Millar, 2008). The strengths were in the creative working that enabled participation, valued experience and enabled learning through the experience of 'being' person-centred.

At each workshop the ideas and experiences shared by the participants corresponded with the words and phrases in the current framework further strengthening the common values. In addition to this their clear understanding of the organisational impact of person-centred care was reflected in their statements and the risks, actions and outcomes they identified, which have now been added to the current framework, have added further strength and value to this development.

Findings
The evidencing person-centred practice framework is comprised of six values: accepted, listened to; understood; informed; involved and flourishing. These values are illustrated in terms of outcomes, risks and actions. The outcomes are the thoughts and feelings of the person and those close to them

if the care experience is positive. The risks are the harm and cost to the person and those close to them should the outcome not be positive. The actions are the attitudes and behaviours expected from the healthcare team in order to ensure a positive outcome in terms of experience.

The values are expressed in chronological order as one value is a prerequisite to the next. The action of one value without the actions of another will not necessarily contribute to a positive experience. The interpretation of these values will be specific to the context in which they are experienced and can be applied in any healthcare setting. By highlighting the risks, actions and outcomes this framework can help raise awareness of the little things that can make practice person-centred. Table 1 illustrates the six values in terms of outcomes, risks and actions.

Discussion

Healthcare professionals are working in stressful complex environments striving to deliver the best care for people and those close to them. National policies indicate that there is a need for person-centred evidence-based care where people are partners in their care and that they understand the care process and are satisfied (Scottish Executive, 2005; Department of Health, 2005b). There is drive to implement guidelines, standards and other quality improvement and learning projects in order to improve healthcare practice (Scottish Executive, 2002; SEHD, 2006; NHS Institute for Innovation and Improvement, 2008; Scottish Government, 2008; NHS Education Scotland (NES), 2008; NHS Institute for Innovation and Improvement, 2010).

There are multiple groups of people working away carrying out the assigned projects, teaching new ways, delivering care and monitoring the progress and performance. All this work is important in the context that it is happening, however it remains disjointed. Reports are prepared delivering results and outcomes that endeavour to show that practice is effective. Each project, person and team has aims and a purpose to aspire to. All may value person-centred practice, deliver evidence-based care and believe that their work is effective. However the outcome is interpreted differently by those involved as it is influenced by the context in which they are working. Quite often the values that are talked about do not necessarily have a bearing on what is actually happening in practice (Titchen and Manley, 2006). In our experience if teams are repeatedly scrutinised and stressed through performance and fiscal measures, the focus on the requirements of their workplace and person-centred values, that are more difficult to measure, become hidden.

Person-centred care is an essential component of the Scottish policy and the quality agenda (Scottish Government, 2010). We recognised that the fundamental part of the jigsaw was missing. There was a difference between the actual culture experienced by those involved and the policy culture. Brown (2007) explains this is why cultures often appear confused and contradictory. As Manley (2000) suggested by taking time to share and compare our experiences, challenging our thinking and confirm our values, gave direction and inspiration for evidencing person-centred practice. Making time for thinking, reflection and values clarification in a safe, trusting confidential environment enabled us to develop shared understandings (Kline, 1999; Burnard, 2002; Freshwater, 2002; Johns, 2002; Eagger et al., 2005; Brown, 2007).

Developing a framework for evidencing person-centred practice has drawn on the qualities outlined by McCormack (2003) of mutual trust, understanding and a sharing of collective knowledge. The focus moved from institutional standards or routines delivered by the practitioner to the needs of the person being cared for (Slater, 2006; Leplege et al., 2007). Experiencing the framework in action has shown practitioners how important they are in improving the experience for those they are caring for. It awakens in them an understanding of person-centred practice and a moral

Table 1. A framework for evidencing person-centred practice

	Positive OUTCOME (Feelings/thoughts)	RISKS if outcome not positive (Harm, cost)	ACTIONS of the individual, team and organisation that results in a positive outcome (Behaviour and attitudes)
1.	**Accepted** Feels greeted, welcome and safe Relaxed, appreciated and safe Welcoming and reassuring Reduced stress Safe environment	**Person** Anxiety, fear, lack of trust, lack of importance **Team** Burden or nuisance Judgemental **Organisation** Discrimination Unwelcoming	• Accepts differences and diversity • Values people's uniqueness and contribution to their own health • Is warm-hearted, selfless and non-judgemental • Reassures and puts at ease • Shows good faith and honest intention
2.	**Listened To** Allowed to express emotions Clarity was agreed Feels heard Feelings and opinions are important Gives time for everyone to listen and be heard	**Person** Frustrated* Rushed* 'Slipped through the net' **Team culture** Busy and unavailable **Organisation** Poor communication Inequity	• Allows time for emotion to be expressed and heard • Shows genuine interest • Uses senses • Acknowledges thoughts and feelings • Takes problems seriously • Reflect and ask questions to clarify

3.	**Understood**		
		Person	• Poses pertinent questions to check understanding
	Feels valued and respected	Loss of dignity and respect	• Checks assumptions that limit ideas
	Dignity maintained	Feels a product –lack of worth	• Check understanding and interpretations
		Annoyed, angry, confused	• Use touch and/or verbal assurances to give confidence
			• Agrees understanding
		Team culture	
	Has confidence in team	Dismissive, complacent	
	Believes they know and care	Blame; 'You don't understand'	
		Nobody cares, depersonalised	
		Organisation	
	Positive culture of learning and support	No learning culture; just work Hospitalised; institutionalised	
4.	**Informed**		
		Person	• Recognises the need for information
	Feels connected	Ill-informed, misled	• Gives information thoughtfully and sensitively
	Senses rapport	Undermined, defensive, aggressive	• Follows up with written information that is appropriate, relevant and up-to-date
		Loss of motivation	• Refers to other people or other sources of data
		Uncooperative, non compliant	• Checks understanding and evaluates learning
		Team culture	• Records information understood
	Physical and psychological needs met	Lack of, wrong or inappropriate information that is not useful	• Ensures records are secure and confidential
	Aware of impact of self on others	Controlling doing to, creating dependence, mismanagement	
		Organisation	
		Errors, accidents and readmissions	
	Less complaints	Increased length of stay	
	Less readmissions	Increased complaints	
	More compliments		

	Quicker turnover		
5.	**Involved in choices** Choices are recognised, respected and accepted Supported Partnership and ownership Autonomy; feels in control Collaboration and equity Shared values Meets physical, psychological and social needs Earlier discharge Less sickness and absence	**Person** Unimportant, unwanted, uneasy, uncertain, isolated, unsupported, disempowered, withdrawn Inappropriate choices Lack of ownership Team culture Team knows best; persons' experience not valued Isolation, dependency Organisation Low team morale, poor staff retention, poor reputation	• Invites personal commitment and engagement from those concerned • Encourages dialogue, problem-solving and negotiates level of involvement • Facilitates participation and teamwork • Understands, accepts and agrees the rights and position of all involved • Gives person and those close to them space and time to make sense of all the information and to consider the best way forward • Negotiates conflict areas • Supports and enables autonomous decision-making • Recognises and respects choices; agrees and accepts decisions • Continuously reinforces the value of these decisions • Prepare for next stage of care, be honest about expectations and realistic in goal setting
6.	**Flourishing** Feels satisfied Happy, confidence and content Self-actualisation Holistic needs met Journeyed together to agreed destination; experienced mutual growth Has healthy sense of wellbeing, and inner strength	**Person** Sad, unhappy, self-centred Depression, exhaustion, despair Dissatisfaction, bad memories Team culture Static, unchanging, loss of continuity Lack of development and learning Fear of change, passive behaviour Organisation Oppression, targets not achieved Poor outcomes, negative press	• Aspires to values and agree ground rules that enable individuals and those close to them to value, listen to, understand, inform and involve others • Aware of self; recognises limitations, seeks support when needed. • Takes responsibility for actions • Gives constructive feedback; learns from mistakes • Creates an environment that says to people – 'you matter' • Is creative, facilitative, supportive and enabling • Seeks permission for the discussion and sharing of the experience with appropriate others • Participates in evaluation; mindful of the quality agenda • Promotes closure at each stage of journey and makes transitions • Able to grow and develop

responsibility for their actions (McCormack, 2003b). This awakening helps them see a different way of thinking and working together (O'Brien and O'Brien, 2000; Sanderson et al., 2004) balancing their professional understanding with the feelings, anxieties and needs of people they are caring for.

As expressed by Sanderson et al. (2004) it has enabled participants to develop a deep understanding of others as thinking and feeling beings with the potential to learn, develop and grow. We have been able to involve healthcare practitioners locally, nationally and internationally in sharing their ideas and experiences to develop a framework of shared values. By creating a positive learning environment (McCormack et al., 2002) and accepting people as they are (Rogers, 2004) can give a sense of purpose, direction and guidance amidst the uncertain, stressful, complexity of healthcare practice.

In the busy life of healthcare quality and improvement, performance management and the delivery of learning programmes the development of a framework of shared values has appeared to develop slowly. Some have questioned the purpose of this development, others have had difficulty understanding the process, others have wanted an audit tool that can be used to measure performance and many have urged us to publish this work at each stage of the process. We have listened to all on the journey, shared our experiences and learned from them, enabled others to understand the process and strengthened the framework through the integration of new ideas and interpretations gleaned through the workshop process.

Testing and refining the framework

Along this journey the group discovered that we had to move from a fragmented to a holistic approach. Initially we had used a process of validating the individual components. The framework was divided and each group was asked to share their ideas about only one value from the framework. The result was that the groups' acted competitively as if their single value was the most important, for example "listened to" or "involved". This led us to understand that the framework must be treated as a whole, just as the person must be treated as a whole person and all their needs taken into consideration (Morgan and Yoder, 2012). We also found that by sharing the framework through a participatory workshop, using a person-centred approach that involved listening and accepting others, views changed the individuals thinking and influenced their patterns of behaviour. At the end of the workshop we are able to show the participants that their findings and interpretation matched the framework. This validated their experience and increased their awareness of the practice of 'being' person-centred.

The person-centred workshop supports participants by raising their awareness of attitudes and behaviours within practice. This influences their thinking and guides the future actions they need to take to develop person-centred practice. In a safe environment, people see another view. They see how the little things matter and make a difference. Values of person-centred practice are shared and a greater understanding developed. It is only through this process that practitioners can understand how to evidence person-centred practice. The participants feel the value of being welcomed, listened to, informed, and involved. They are able to understand the actions needed to provide person-centred practice and the risks to all if person-centred practice is not achieved. As a result, we realised that we had not developed just another audit tool but a method by which teams can safely share their experience and understanding of the risks and benefits of person-centred practice in their workplace. The values that emerge we believe are the hidden heart of healthcare.

Strengths of the framework
- The framework outlines the:
    - -Outcomes of person-centred practice
    - -Risks if person-centred practice is not achieved

- o -Actions for individuals, teams and organisations that result in person-centred practice
- 'Being' person-centred can be experienced by everyone
- The experience involves a creative, participatory approach that blends individual stories and imagery to create collective messages that match the framework. This combined with agreed action can develop practice
- Exploring risks, actions and outcomes raises awareness of the important role each individual has in developing person-centred practice

Limitations of this framework
- You need to experience the awakening within a psychologically safe environment. This can be accomplished in a half day creative workshop
- Gathering the evidence and conducting the workshop requires experienced support and facilitation
- For some the process is deeply uncomfortable and ground rules and consent issues are fundamental to a safe, successful experience
- There are participants who clearly experience flourishing and feel the awakening
- In the world of micro-management and control there are leaders who believe they are already doing person-centred practice so do not need to participate as no change is required
- Taking this learning back into practice presents challenges as the workplace culture has not necessarily changed

Key messages for the future
Strong messages have emerged from the evaluations.

> '……………..imagine standing in the shoes of another seeing through his/her eyes'

> 'Person-centred practice means positive outcomes for all involved'

> 'The process of agreeing common themes is amazing and satisfying and more time needs to be taken so we can better understand our shared direction'

> 'The risks of not achieving person-centred practice have far reaching consequences for individuals, families, teams, health services and communities'

> 'Leadership that values the fundamentals of care will result in a culture that supports and demonstrates person-centred care along with the skills of the staff to deliver'

Haiku, a short naturalistic form of traditional Japanese poetry that combines form, content, and language in a meaningful way (Toyomasu, 2001), was used in one evaluation to capture the essence of the experience.

Exploring risks first	*Create partnership*	*G♡♡d experience*
inspires better solutions	*Identify shared vision*	*For staff and patients alike*
and awareness	*Listening to all*	*Public confidence*

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Reawakening the individual 'humanness' in everyone – needs to be experienced by all working in healthcare contexts whether the NHS or independent sector. Not just those who have direct interface with patients and public but it needs to include support services, managers, executive teams and politicians. Those participating in the development of evidencing person-centred practice in the future need to be supported within the organisation. This needs to be high on the agenda for learning and development in every healthcare organisation. For an effective, healthy, therapeutic learning organisation the values need to be experienced by the person and those close to them, the interprofessional team and the organisation.

Conclusion

The development of this framework has taken us on a journey from standard setting and audit of practice to 'experiencing' person-centred practice. The challenge for the future is to enable everyone involved in healthcare to experience and understand this journey. This needs to happen at all levels of the organisation. While it may appear difficult to implement, we have demonstrated that in a very short time, with critical questions and narratives prepared in advance that evidencing person-centred practice can raise awareness. Experiencing the workshop enables others to use narratives collected from their own practice. This makes the experience real and relevant to their workplace and generates actions that can be implemented and evaluated. Developing understanding and shared vision with established teams in managed clinical networks maybe the next step. Through this, person-centred practice can then be implemented in every healthcare setting supporting a shared, agreed and visible, caring, quality agenda with far reaching development opportunities for healthcare practice, leadership, education and research.

Implications for practice

- Greater communication between executive level and healthcare workers

The whole workforce should feel valued and have pride in the organisation. Everyone should experience the person-centred values that they are expected to deliver. Crisis management can lead to profound dissatisfaction. Working under severe pressure without insight into the organisation's objectives or direction can lead to underperforming teams who in their struggle to survive a working day do not experience, and so perhaps do not know, the values underpinning person-centred practice. If an organisation takes a top-down approach to change then a top-down approach must be taken in terms of experiencing person-centred practice. By starting with the executive teams it can be agreed how the experience can be rolled out through each healthcare setting.

- Experiencing person-centred practice for all clinical leaders

Middle managers are often pressurised from above without real understanding about how to engage staff at the patient/public interface. This results in orders being given rather than discussion and development of ways in which to support the organisation to achieve a safe and effective evidence-based person-centred workplace.

- Raising awareness of the hidden values of person-centred practice

Creative workforce planning is required to integrate protected time at all levels to ensure all those working in healthcare have time to experience person-centred practice. This could promote transformational change at all levels of the organisation.

- Refocusing the priorities for Lead Nurse/AHP role

Within the current financial climate these Lead nurses and AHP's become deputy business managers rather than leaders of evidence-based person-centred practice. Those in leadership posts who manage clinical teams should have the freedom and skills to lead their teams in the improving quality and promoting person-centred practice in a way that transforms the experience of care.

- Future research and development

Further participatory action research using this framework could help reduce risks and to move away from a 'blame culture' towards the development of a culture that promotes evidence-based person-centred practice. Ownership and sustainability can be achieved by enabling teams, who have

a shared interest, to work towards the actions that enhance of person-centred practice while collecting evidence of improvement and satisfaction. This would give an opportunity for the framework to be tested more widely and against the existing theories of practice development.

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COMMENTARY

Finding the hidden heart of healthcare: the development of a framework to evidence person-centred practice

Fiona Cook

I was delighted to be invited to comment on this particular piece of work, not least because I know each of the authors personally through the PPDNF network, the Scottish Practice Development Forum through which we have been able to support and challenge each other over many years; but also because of my personal interest in this very high profile topic. I am also proud to have been one of the many participants who have contributed to the process used by the authors to identify the themes identified in the framework described.

Having confessed to a number of biases which might potentially sabotage my critique, there is something very positive about this paper for all the practice development community. Firstly, the notion of person centred practice is and has been at the very heart of our values based practice for a long time. I commend the authors on their collaborative approach, which really sought the *shared* understanding of the meaning of person-centered practice through their own dialogue, and then through the process of the building of the framework itself. Their creative process of working with the participants is mentioned in the narrative and I am sorry that more about this approach was not described in further detail, as practice developers should be as interested in the process used as the outcome gained. There is much to be learned from their process, which role modelled the 'how to' of being person centred which would have been helpful to describe.

The authors have clearly described the challenges of being person-centred in the current context and culture of healthcare. They acknowledge the high tension and dissonance between the task focused, evidence based care provided in many clinical settings and the espoused values based care, now outlined in many policy documents.

The framework itself is particularly helpful as it not only brings together the main themes of person centeredness and actions in terms of personal behaviours and attitudes, it also lays out the potential risks at personal, team and organisational levels of not being person centred. The challenge for healthcare organisations is that they are systems made up of individuals who all have a responsibility for how they care, but as the authors have identified, the context and culture of these organisations is also crucial to the ability of the healthcare providers to actually be person centred.

The six values the authors identified are easily mapped to other current caring behaviours research evidence and are expressed in a language that is easy to understand. They appear to be interdependent but also able to stand alone in terms of transactions between one person and another, although the authors rightly stress the value of the holistic approach when using the framework.

In terms of strengths and weaknesses of the framework, the authors have honestly expressed their beliefs and values, acknowledging that in order for people to become more person-centred, a personal transformational awakening is required, which can be for some, an uncomfortable process of change. It could also be a time consuming exercise which requires skilled facilitation for the optimum results, which might in itself be perceived as challenging for some individuals, teams and organisations to consider in the current climate. However, the benefits of considering helping healthcare staff to become more person centred surely outweigh the risks in an ideal world, where small changes do indeed make a big difference to all.

I applaud the authors for holding their nerve in the long time it has taken to reach this stage, where they are convinced of the rigorous process they have adopted and the outcomes they have achieved and tested over time. They describe the range of comments they received about the time it has taken to produce the framework and the criticism of the processes used and there must have been times when they had to remain 'comfortable with being uncomfortable' as they listened and responded to each. I particularly enjoyed the haiku created which reflected well the essence of the work undertaken and the potential benefits of using the framework in organisations.

In conclusion, there are many lessons to be learned as practice developers from this paper in the current climate of task orientated, audit and data overloaded, and complex and confusing systems of care. Putting this framework into action, daring to be different, using creative techniques, offering feedback, creating safe environments to honestly reflect on practice and using our personal experiences to learn are crucial for individuals, teams and organisations. Are we up for this challenge? I hope so! It will be time and money well spent and the many personal and corporate rewards will outweigh the perceived challenges.

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International Practice Development Journal

Online journal of FoNS in association with the IPDC (ISSN 2046-9292)

RESPONSE TO COMMENTARY

Finding the hidden heart of healthcare: the development of a framework to evidence person-centred practice

Jane Christie, Jane Camp, Kate Cocozza, James Cassidy and Judy Taylor

Thank you for these honest, constructive thoughts about this development. It is reassuring to know that something we started many years ago, that stemmed from our values base, is considered relevant to today's healthcare agenda. In the busy world of healthcare, evidence-based practice, audit and performance targets are considered to be essential for efficient and effective care delivery. However, if the values underpinning person-centred practice remain hidden, the vital ingredient that can enhance the experience of care is missing. It is good to know that others involved in this collaborative venture have experienced the value of this development.

Acknowledgement of the work and the different processes involved across time has been very welcome. There is opportunity for further research that has the potential to enhance the healthcare experience for all and provide evidence of the meaning of learning, growth, health and flourishing in different healthcare contexts. The context and culture of organisations in terms of the learning environment provided, are crucial to healthcare teams in providing person-centred care. Experiencing the process is the best way to evidence person-centred practice in your workplace. It is time for healthcare organisations to rise to the challenge. We are heartened by the recognition that further development is crucial. We agree that it would be time and money well spent and that many rewards would outweigh the perceived challenges. We hope this development inspires the reader to learn more.

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