CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

Critical reflection on the process of validation of a framework for person-centred practice

Jane Christie* and Jane Camp

*Corresponding author: Independent Nurse Consultant, Edinburgh, Scotland
Email: christiejane1@aol.com

Abstract
Background: Demonstrating safe, effective, person-centred practice is a constant challenge for health and social care practitioners. A framework has been developed to highlight the values underpinning person-centred practice in terms of the actions required, the positive outcomes and the risks should person-centred practice not be achieved.
Aims and objectives: To analyse the process of developing a framework for person-centred practice using Mezirow's critical reflection; to demonstrate our learning during this development and to share the findings with others.
Conclusion: Enabling practitioners to participate in the validation process highlighted the importance of listening to others rather than imposing our own experience. Changing our approach demonstrated an improved process with the potential for further development of person-centred practice in health and social care settings.
Implications for practice:
- Healthcare leaders should consider this participatory approach as an innovative way to improve understanding of the experience of person-centred practice
- Finding time in the workplace to experience person-centred practice is an essential part of enabling individuals, teams and organisations to develop a better understanding of working together to improve the experience of care
- This approach to facilitation, reflection, action and analysis can be applied by others in different health and social care contexts

Keywords: Practice development, person-centred practice, facilitation, reflection, evaluation, values

Introduction
The focus of this paper is a critical reflection on the development and validation of a framework to evidence person-centred practice (Christie et al., 2012) and our learning during this process. The method taken demonstrates two cycles of action: reflection and evaluation. Mezirow's critical reflection (1991) provided the analytical tool that helped organise and evidence our learning.

The person-centred approach (Embleton et al., 2004) has been developed in a number of health and social care settings and is argued to be an essential component of healthcare policy and the quality agenda (Scottish Executive, 2002, 2005, 2007; Department of Health, 2005; Healthcare Improvement Scotland, 2009, 2010; Scottish Government, 2010; Goodwin et al., 2012). This approach has been explored in terms of meeting individual needs and concerns, improving interactions between patients

and care providers and developing quality cultures (McCormack 2003a; Scottish Executive Health Department, 2003; Beach et al., 2006; McCormack and McCance, 2006; McCormack et al., 2008; Hobbs, 2009; Christie et al., 2012).

In an evidence-based workplace, the priority is for knowledgeable, competent professionals to deliver patient-centred care within agreed targets. This is often taken as being the same as person-centred practice, however, there are subtle differences. Although it has been shown that evidence of clinical effectiveness must be sought from different perspectives (Rycroft-Malone et al., 2004), it is increasingly challenging in the busy workplace to ensure that the values underpinning the policy culture are actually experienced in practice (Titchen and Manley, 2006).

Being person-centred encourages involvement and enables choice (O'Brien and O'Brien, 2000; Sanderson et al., 2004). The focus must be on the person, with the aim of creating a positive learning environment of trust, flexibility, mutuality and respect (McCormack et al., 2002; McCormack, 2003a; 2003b). This needs time for reflection and the development of shared understandings (Kline, 1999; Eagger et al., 2005). Consequently, demonstrating person-centredness in a busy health or social care setting can be difficult. Christie et al. (2012) have developed a framework for evidencing person-centred practice that defines the attributes in terms of risks, actions and outcomes. Figure 1 shows the outcomes of this framework.

Figure 1: The outcomes from the framework for person-centred practice (From Christie et al., 2012)

	Positive	Feelings/thoughts
1	Accepted	• Person feels welcome and safe • Team is welcoming and reassuring • Organisation feels safe
2	Listened to	• Person can express emotions; feels heard • Team makes time to listen • Organisation gives time for everyone to be listened to and heard
3	Understood	• Person feels valued and respected • Team knows, understands and cares • Positive culture of learning and support
4	Informed	• Person feels connected, senses rapport • Team is aware of the impact of self on others • Fewer complaints, more compliments
5	Involved in choices	• Person's choices are respected and accepted • Team collaborates and has shared values • Organisation has less sickness and absence
6	Flourishing	• Person feels satisfied and content; holistic needs met • Team works together and experiences a sense of satisfaction • Organisation promotes a healthy sense of wellbeing

Reflecting on the process of validation

A two phase approach was taken to validate this framework, with one workshop in phase one and a series of five in phase two. We conducted this series of workshops with an international group of healthcare professionals from acute and primary care, including from education and practice development. After each workshop, time was set aside for debriefing and analysis of the themes and evaluations created on the flipcharts used during the workshops. The application of Miles and Huberman's (1994) conditional matrix enabled us to capture the detail of the development process, to evidence our decision-making and subsequent actions, and to demonstrate the process of building theory from practice.

Phase one

The aim of the first phase of the validation process was to enable the participants to find evidence of person-centred practice in stories told by patients and carers. This approach is a recognised method for improving practice (Gullick and Shimadry, 2008). Permission was obtained for these stories to be used anonymously.

The workshop in the first phase was time limited to one hour. Twenty-five participants were expected and were to be divided equally into six working groups. We were well prepared but had not anticipated that this workshop would be as popular and over-subscribed as it was. The large room accommodated everyone but the start was delayed and the working groups had to be larger than anticipated.

Each group was given an outcome name from the framework and a story. During the introduction, the practitioners were invited to participate and it was made clear that they were free to leave at any time if they wished to. The aim was to provide a safe learning environment with an opportunity to share experiences while valuing and respecting everyone's contribution. We gave a two minute slide presentation to introduce the aims and instructions for the practitioners present. This directed the groups on their activities and a bell was set on the presentation as a reminder to the presenters to prompt the groups to move to the next activity. The practitioners were asked to work in groups and answer some questions, in order to find evidence of the framework outcomes in the patient's and carers' stories.

Phase one – reflections

Our reflections from phase one can be found in Table 1, on page 4.

Table 1. Phase one: finding the framework domains in stories told by patients and carers

Critical reflection (Mezirow, 1991) → Conditional matrix (Miles and Huberman, 1994) ↓	Descriptive — What happened, what is important, who is it important to?	Affective — Awareness of our thoughts and feelings about the situation	Judgemental — Awareness of value judgements What was good and bad?	Conceptual — What concepts or ideas are being used or could be used?	Discriminate — Awareness of decision making and actions	Psychic — What has been learned? How could the situation be developed?	Theoretical — Using experience to generate own theories – to make sense of things. What principles or strategies have we derived from this?
Cause	•Needed to test validity of framework with practitioners •Application of stories to find evidence of person-centred practice	•Enthusiastic about process and opportunity	•Process well prepared •Involved participants	•Validating research findings	•Opportunity arose to share our experience and developments so far	•Enthusiasic about process, wanted to involve others •Don't assume others have same experience	•Ensure that approach to validation matches the values
Context	•Large conference room; attendance was good •Opportunity to learn about framework	•Many enthusiastic healthcare professionals wanting to participate	•Asked groups to participate. •Gave information and asked them to apply this to stories	•Participatory	•Stories will raise awareness	•This is a popular, relevant topic •Enable participants to share own experience	•Healthcare professionals have much knowledge about person-centred practice that they need opportunity to share
Leadership/ facilitation	•Introduction, aim, ground rules and timed activities •Gave each group one framework domain and a story. Guided process	•Well prepared, controlled process	•Dividing framework would ease process •Stories raise awareness of experience	•Transactional	•Created discomfort and chaos	•Stories raised awareness of problems but gave little time to find solutions •Made assumptions; need to ask perception not 'tell' our perception	•Our approach valued the patient and carers' experience and enabled practitioners to apply framework domain to a story
Phenomena	•Reductionist approach; divided up the framework: lack of information about whole picture	•Emotions released, raised anxiety and reduced trust	•Anger, frustration, uncertainty	•Stress and coping	•Problem solving or defence mechanisms	•Hidden stress that influences behaviour •Listen to practitioners experience	•Giving a reality that the participants did not own created a stressful environment
Action	•Answer reflective questions •Create themes and group them •Strength and limitations of session	•Scrutiny •Distress •Inconsistency •Mixed messages •Criticism •Chaos	•Gets tasks done •Appears to lack caring •Confusion •Lack of information •Lack of understanding	•Task orientated •Loss of dignity and respect •Communication	•Focused on domain, not person	•Led to unintended confusion and competition •Professionals know best •Needs values clarification •Listen to the experience	•Healthcare professionals experienced conflict as a result of insufficient information or conflicting reality; unable to work effectively together
Consequences	•Many different perceptions •Discomfort, dissonance •Did not feel listened to •Conflicting values •Fuzziness	•Some stories appeared uncaring and disrespectful •Frustrated •Critical	•Act as advocate for patient •Wish to reduce conflict •Professional knows best	•Defence mechanisms •Dissonance and anxiety = projection and rationalising	•Blame others •'Them and us' •Competition between groups	•Unintentional impact •Behaviour due to release of feelings, lack of support or lack of self-awareness	•Defence mechanisms used to cover up concern and to share concerns; all want to be heard
Reflection and change	•Raising awareness of problems and leaving them unresolved leads to stress and competition between groups	•Needs attention; need to change our approach	•Criticism and monitoring increases anxiety and the problem	•Psychodynamics •Social systems as a defence against anxiety	•Transactional – social critique and management control are not going to improve this	•This is a stressful experience that needs collaboration, support and action. •Develop new approach	•Our style was not holistic and not perceived to be person-centred •Taking a different approach will help raise awareness and improve understanding

In the workshop we were enthusiastic and welcoming. There was evidence that we created an environment where participants could contribute but, for some, our approach was frustrating. The stories we had chosen were varied and not all of the examples painted a positive experience. The workshop participants noted that it was difficult to see 'person-centred care' as 'issues [appeared to be] mismanaged' and 'it was difficult to see positives'. When person-centred practice was not obvious in the story the participants expressed frustration.

Our facilitation approach impacted on how the participants responded. In order to facilitate the process, it had been easier to divide up the framework. We observed that the groups worked separately and unintentionally competed with each other to portray their interpretation of person-centred practice. In the feedback, each group argued that their outcome was the most valuable. This showed that the outcome and stories supplied subconsciously influenced the behaviour and attitudes of the participants, as would the words used in the workplace. Our style helped maintain control and ensure completion of the task but did not support the groups to work together effectively.

The participants described the themes that had emerged from the group work, reporting back on the strengths and limitations they had identified and sharing what they had learned. The absence of the whole framework affected the way in which they worked and responded. Not having the whole framework meant they could not see the whole picture; they 'needed to have all [the] domains'. In protecting anonymity and providing brief excerpts of complete stories of care for the groups to explore, we had removed the full context of care, inadvertently taking a reductionist approach. This approach is often experienced in the healthcare workplace and can lead to fragmented care and a lack of understanding of the bigger picture.

The feedback confirmed that the feeling of fragmentation of the whole experience had made it 'easy to make assumptions' and had made interpretation of the stories more difficult. It was evident that the participants cared and were passionate about person-centred practice; however, being individuals they all had different ways of showing this. The challenges and limitations of this initial approach had caused concern for the participants but had given them a chance to participate and to share expertise. Overall, the participants recognised that this approach could be developed to promote the delivery of safe, effective, person-centred healthcare and they welcomed our attempt at the 'creation of physically and psychologically comfortable spaces in which to work'.

Phase two
As a result of the evaluation and our analysis of the first phase, an experiential approach was adapted from 'Becoming (familiar with the) person-centred (nursing framework)' (Cardiff, 2008), incorporating ideas from 'Creating a vision' (Dewing, 2007). This new design was piloted with volunteers from a local practice development forum. A series of five participatory workshops followed, enabling 168 participants to experience and understand the framework as a whole. The workshop sizes ranged from 12 to 100 healthcare practitioners.

During this series, individual participants were invited to choose from a selection of narratives, words, pictures and toys to create a collage that illustrated their own interpretation of person-centred practice. Consideration was given to the ethics, ensuring an open, honest negotiation of ground rules. Consent was obtained from participants at every stage of the process and it was made clear to them that they could withdraw at any time (Christie et al., 2012).

Working in small groups, each person gave their interpretation of one collage. The person whose collage it was then had a chance to be listened to and heard as they described their own understanding of person-centred practice. This process was repeated for each collage. Working together, the participants then themed their thoughts and meanings. These themes were then grouped into three categories: risks, actions and outcomes. The category headings can be found in Figure 2.

Figure 2: The three categories: risks, actions and outcomes

The **risks** for individual, teams and the organisation should person-centred practice not be experienced

The **actions** required by the individuals, teams and the organisation to enable person-centred practice to be experienced

The **outcomes** if person-centred practice is experienced by individual, teams and organisations

Phase two – reflections

In the second phase, the participants felt more involved and the workshops were described as 'proactive'. It was perceived to be 'helpful to discuss person-centred practice at the heart of healthcare provision'. The sessions gave valuable time to explore an important issue that was a priority and involved looking at attitudes and feelings that are not easily measured. Our reflections from phase two can be found in Table 2.

Table 2. Phase 2: enabling participants to share their own understanding of person-centred practice

Critical reflection (Mezirow, 1991) → / Conditional matrix (Miles and Huberman, 1994) ↓	Descriptive	Affective	Judgemental	Conceptual	Discriminate	Psychic	Theoretical
	What happened, what is important, who is it important to?	Awareness of our thoughts and feelings about the situation	Awareness of value judgements What was good and bad?	What concepts or ideas are being used or could be used?	Awareness of decision making and actions	What has been learned? How could the situation be developed?	Using experience to generate own theories – to make sense of things. What principles or strategies have we derived from this?
Cause	•Workshop where participants could share own meaning of person-centred practice	•Accepts diversity •Values contribution •Welcomes individuals	•Accept as it is •May be seen as unrealistic or a burden	•Therapeutic relationship	•Being helpful and welcoming •Creates safe environment	•Feels valued •Can value others •Role models person-centred practice	•Accept and welcome people the way they are; everyone is different
Context	•Opportunity to tell story and be listened to	•Integration of participants stories [evidence] into practice – blending	•Time to share •Limited to those present	•Respect •Values clarification •Listening	•Can see whole picture •All perspectives are included	•Need time to listen and hear •Make time in practice to listen to others	•Listen to and respect peoples' views
Leadership/ facilitation	•Sharing values and beliefs •Taking time to understand •Role modelling person-centred practice •Showing that people matter	•Being true to self and others •Honest and realistic; links different perspectives	•Calm, informative facilitative process; involving others, valuing all perspectives; led by group ideas; creative	•Role-modelling •Validating practice development	•Recognising when people don't know, giving appropriate information and checking understanding	•Develop shared meaning and plan for practice. •Develop leadership roles in practice	•Facilitating an environment that accepts diversity, listens to and respects views, takes time to understand and enables action
Phenomena	•Safe, valued, understood and informed, able to ask, 'door always open', can share information	•No division between participants; promotes equity	•Comfortable and challenging •Values individual perspectives •Reduces threat	•Person-centred practice •Collaboration	•Risks, actions and outcomes •Development of a framework	•Shared meanings •Actions for practice •Practice development	•Being a person working in partnership developing cultural awareness
Action	•Welcome, inform of process, gain consent •Collect creative materials •Listen to others then share own meaning of person-centred practice •Generate themes, apply to framework; values participants' contribution	•Motivation •Values-based •Personal choice autonomy, acceptable to all •Person as team member •Never had this experience before	•Therapeutic, creative, alternative, different •Valued views of participants •Finite	•Participatory practice development	•Focus on shared values through participation and action •Facilitated process •Shares evidence •Allows creativity •Models person-centredness	•New experience, that captures thoughts and feelings of all and transforms attitudes •Approach could be carried out in any setting	•Exchange of evidence and sharing of values while taking time to understand
Consequences	•Seeing the whole experience from the person's point of view •Shared understanding •Feeling unique, valued and seeing that little things matter	•Confidence Sense of value, informed, calm, choices respected, Pleased, interested	•Positive evaluations •Actions to practice Raised awareness •No further development due to end of study	•Values clarification and shared vision	•Know ourselves and others; •Framework to test in other settings •Feedback to service	•Value of practice development approaches •Some ownership and sustainability •Possible future investment and research	•Working towards the future involves willingness to see whole picture, take responsibility, reflect, learn from each other and work together to promote person-centred practice
Reflection and change	•Balance of person-centred practice, evidence based practice and performance	•Satisfied •Mutual growth	•Journeyed together •Finite	•Person-centred practice	•Clarifies values •Promotes closure with individual action and group framework	•Tested locally, nationally internationally •Roll out programme to develop values	•This process needs to be experienced by all working in health and social care settings

By facilitating a supportive environment the participants had a chance to experience person-centredness. By taking a person-centred approach we valued the participants' experience, encouraged participation and enabled learning. This reduced any risk of conflict and enabled the participants to share their experiences openly and honestly:

> '…creativity reduces stress and the small group activity enables individuals to be part of the activity… we all know the risks of not practising person-centred care and the natural consequences thereafter. Everyone knows what it is but are rarely given the time to talk about it.'

Meeting different people, who were initially strangers, was a good opportunity to share thoughts about healthcare. It gave practitioners:

> '…the opportunity to meet colleagues, to listen to different perspectives, to share common thoughts and views while developing own understanding.'

In the process, the participants discovered that they all had similar ideas about person-centred practice:

> '…broadly speaking, we all have the same thoughts and problems and have the enthusiasm and willingness to address issues. Finding out that it doesn't matter where we work; we all share the same ideas about what is meant by person-centred care.'

By using imagery in the form of narrative, pictures, words and toys to stimulate thought, we valued different learning styles and gave the practitioners a chance to hear other perspectives. It gave them an 'opportunity to think outside the square [box]' and challenged their thinking through 'not taking things at face value'. The sharing process was motivating as it was perceived to be 'beneficial to patients, staff and the organisation'. The process not only developed 'self-awareness' and 'leadership' but challenged everyone to 'live the change you are looking for'. Simple, clear messages were shared, such as:

> 'Don't label people – see the person not the patient… value individuality and celebrate this… take time to reflect…'

The approach promoted teamwork, improved communication and was perceived to be 'achievable'. The practitioners thought that the interaction and discussion could be used in the workplace by incorporating the process into team meetings and agreeing actions to implement in practice. They considered promoting person-centred practice to be:

> '…everyone's responsibility… everyone needs to take action to ensure it is done.'

Our learning
Our approach in the first phase helped maintain control and enabled the participants to share views about each of the six domains but it did not help them work together effectively. This was not dissimilar to the busy workplace where, despite the numerous policies and initiatives espousing healthcare quality improvement, there is often an enormous difference between the values of the policy culture and what actually happens in practice (Titchen and Manley, 2006). We learned that communication, particularly listening and understanding, was important and that the values underpinning person-centred practice need to be modelled and facilitated by leaders in healthcare. While we had planned to be interactive and person-centred, our style had not been perceived as such.

Using patient, carer and staff stories helped demonstrate the value of seeking evidence from a variety of sources (Rycroft-Malone et al., 2004). However, the stories presented a reality to the participants that they didn't own and caused discomfort. The response was to defend their position and to explain the factors that might be contributing to the situation. As a result we gained a lot of useful information about the leadership style and context of care.

Taking a more holistic, person-centred method in the second phase drew on the qualities outlined by McCormack (2003a) of mutual trust, understanding and sharing of collective knowledge. Practitioners were invited to participate by listening to others and sharing their own experiences of person-centred practice. Taking time to listen and to share and compare experiences challenged thinking, confirmed shared values and gave participants the direction and inspiration to explore person-centred practice in greater depth.

By creating a positive learning environment (McCormack et al., 2002) people were accepted as they were and gave a sense of purpose and direction. Working together in a supportive environment enabled the participants to explore current practices critically. Giving everyone an opportunity to speak reduced anxiety, ensured equity and valued diversity. Difficult issues were able to be discussed and positive solutions explored. Acknowledging the risks first *'raised everyone's awareness'* of the serious issues that needed to be tackled. The process of being listened to and being heard raised awareness of practices that prevent person-centred practice and of the values that underpin it.

Making time for reflection in a safe, trusting, confidential environment improved communication and enabled the development of shared understandings (Kline, 1999; Eagger et al., 2005). It made it safe to acknowledge the risks while there was a chance to highlight actions that could improve practice. The process helped participants see a different way of thinking and working (O'Brien and O'Brien, 2000; Sanderson et al., 2004) and enabled them to balance their professional understanding with the feelings, anxieties and needs of the people they care for (McCormack, 2003b). Working collaboratively valued different perspectives and improved understanding, thereby lightening the burden of implementing person-centred practice. The participants developed their awareness of the value of listening to peoples' experiences, of developing shared understandings, of *'looking for patterns in behaviour'*, and developing realistic actions that could be implemented in practice. There was evidence that the process transformed thinking.

Conclusion

Enabling practitioners to participate in this validation process highlighted the importance of listening to others rather than imposing our own experience. Learning together and agreeing actions transformed participants' thinking and attitudes about the real world of practice. Developing a table of evidence demonstrates a detailed systematic analysis of the process of generating theory from reflective practice. The table gave us structure, clarity and evidence at each stage of the change process. Developing our approach demonstrated an improved process with the potential for further development of person-centred practice in health and social care settings.

Implications for practice
- Healthcare leaders should consider this innovative, participatory approach as an initial stage in raising awareness of the process of finding evidence of person-centred practice in the workplace
- This approach to facilitation, reflection, action and analysis can be applied by others in different health and social care contexts, enabling individuals, teams and organisations to develop a better understanding of working together to improve the experience of care
- Finding time in the workplace to experience person-centred practice is an essential part of learning to listen, accept and to understand the perceptions and experiences of others

References

Beach, M., Saha, S. and Cooper, L. (2006) *The Role and Relationship of Cultural Competence and Patient-Centeredness in Health Care Quality*. New York: The Commonwealth Fund. Retrieved from: www.commonwealthfund.org/publications/fund-reports/2006/oct/the-role-and-relationship-of-cultural-competence-and-patient-centeredness-in-health-care-quality (Last accessed 15th May 2014).

Cardiff, S. (2008) Becoming (familiar with the) person-centred (nursing framework). Conference workshop, *International Practice Development Collaborative Conference: Enhancing Practice 8*, October 2008, Veldhoven, The Netherlands.

Christie, J., Camp, J., Cocozza, K., Cassidy, J. and Taylor, J. (2012) Finding the hidden heart of healthcare: the development of a framework to evidence person-centred practice. *International Practice Development Journal*. Vol. 2. No. 1. Article 4. Retrieved from: www.fons.org/library/journal/volume2-issue1/article4 (Last accessed 15th May 2014).

Department of Health (2005) *Self Care - A Real Choice: Self Care Support – A Practical Option*. London: HMSO.

Dewing, J. (Ed.) (2007) *Workplace Resources for Practice Development*. London: Royal College of Nursing.

Eagger, S., Desser, A., Brown, C. (2005) Learning values in healthcare? *Journal of Holistic Healthcare*. Vol. 2. No. 3. pp 25-30.

Embleton Tudor, L., Keemar, K., Tudor, K., Valentine, J. and Worrall, M. (2004) *The Person Centred Approach: A Contemporary Introduction*. Basingstoke, UK: Palgrave Macmillan.

Goodwin, N., Smith, J., Davies, A., Perry, C., Rosen, R., Dixon, A., Dixon, J. and Ham, C. (2012) *Integrated Care for Patients and Populations: Improving Care by Working Together*. London: The King's Fund and Nuffield Trust.

Gullick, J. and Shimadry, B. (2008) Using patient stories to improve quality of care. *Nursing Times*. Vol. 104. No. 10. pp 33-34.

Healthcare Improvement Scotland (2009) *Integration, Collaboration and Empowerment: Practice Development for a New Context*. Edinburgh: Health Improvement Scotland. Retrieved from: www.healthcareimprovementscotland.org/previous_resources/policy_and_strategy/practice_development_framework.aspx (Last accessed 15th May 2014).

Healthcare Improvement Scotland (2010) *National Patient Safety Programme*. Edinburgh: Health Improvement Scotland. Retrieved from: www.patientsafetyalliance.scot.nhs.uk/programme (Last accessed 15th May 2014).

Hobbs, J. (2009) A dimensional analysis of patient-centered care. *Nursing Research*. Vol. 58. No. 1. pp 52-62.

Kline, N. (1999) *Time to Think - Listening to Ignite the Human Mind*. London: Ward Lock.

McCormack, B., Kitson, A., Rycroft-Malone, J., Titchen, A. and Seers, K. (2002) Getting evidence into practice: the meaning of context. *Journal of Advanced Nursing*. Vol. 38. No. 1. April. pp 94-104.

McCormack, B. (2003a) A conceptual framework for person-centred practice with older people. *International Journal of Nursing Practice*. Vol. 9. No. 3. pp 202-209.

McCormack, B. (2003b) Researching nursing practice: does person-centeredness matter? *Nursing Philosophy*. Vol. 4. No. 3. pp 179-188.

McCormack, B. and McCance, T. (2006) Development of a framework for person-centred nursing. *Journal of Advanced Nursing*. Vol. 56. No. 5. pp 472-479.

McCormack, B., McCance, T. and Slater, P. (2008) Person-centred outcomes and cultural change. Chp 10 *in* Manley, K., McCormack, B. and Wilson, V. (Eds.) (2008) *International Practice Development in Nursing and Healthcare*. Chichester, UK: Blackwell. pp 189-214.

Mezirow, J. (1991) *Fostering Critical Reflection in Adulthood*. San Francisco: Jossey-Bass.

Miles, M. and Huberman, A. (1994) *Qualitative Data Analysis: An Expanded Sourcebook*. (2nd edition). Thousand Oaks, California: Sage.

O'Brien, J. and O'Brien, C. (Eds.) (2000) *The Little Book About Person-Centred Planning*. Toronto: Inclusion Press.

Rogers, C. (2004) *On Becoming a Person: A Therapist's View of Psychotherapy*. London: Constable.

Rycroft-Malone, J., Seers, K., Titchen, A., Harvey, G., Kitson, A. and McCormack, B. (2004) What counts as evidence in evidence-based practice? *Journal of Advanced Nursing*. Vol. 47. No. 1. July. pp 81-90.

Sanderson, H., Kennedy, J., Ritchie, P. and Goodwin, G. (2004) *People, Plans and Possibilities: Exploring Person-Centred Planning*. Edinburgh: SHS Trust.

Scottish Executive (2002) *Beyond Boundaries: A Development Approach to Improving Inter-Agency Working*. Edinburgh: Scottish Executive. Retrieved from: www.scotland.gov.uk/Publications/2002/06/15025/8292 (Last accessed 15th May 2014).

Scottish Executive (2005) *Building a Health Service Fit for the Future*. Edinburgh: Scottish Executive. Retrieved from: www.scotland.gov.uk/Publications/2005/05/23141307/13104 (Last accessed 15th May 2014).

Scottish Executive (2007) *Better Health, Better Care: Action Plan*. Edinburgh: Scottish Executive. Retrieved from: www.scotland.gov.uk/Publications/2007/12/11103453/0 (Last accessed 15th May 2014).

Scottish Executive (2003) *Partnership for Care: Scotland's Health White Paper*. Edinburgh: Scottish Executive. Retrieved from: www.scotland.gov.uk/Publications/2003/02/16476/18730 (Last accessed 15th May 2014).

Scottish Government (2010) *Healthcare Quality Strategy for NHS Scotland*. Edinburgh: Scottish Government. Retrieved from: www.scotland.gov.uk/Publications/2010/05/10102307/0 (Last accessed 15th May 2014).

Titchen, A. and Manley, K. (2006) Spiralling toward transformational action research: philosophical and practical journeys. *Journal of Advanced Nursing*. Vol. 14. No. 3. September. pp 333-356.

Jane Christie (PhD, MSc, PGDE, RN), Independent Nurse Consultant, Edinburgh, Scotland.
Jane Camp (MPC, RN), Independent Nurse Consultant, Glasgow, Scotland.