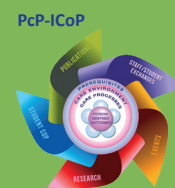


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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

The impact of implementing person-centred nursing key performance indicators on the experience of care: a research evaluation

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Abstract

Background and aim: This study reports the outcomes from an international study that implemented a set of person-centred nursing key performance indicators across a range of services provided to sick children. It aims to explore the factors that influenced the successful implementation of those indicators, and assess the impact of the evidence generated on person-centred practice across the children's services.

Methods: Twelve organisations across Australia and Europe participated, with data collected in 2015 and 2016 and analysed using thematic analysis. Semi-structured interviews and focus groups were conducted with staff, including executive sponsors, managers, facilitators and clinical nursing teams. The COREQ guidelines were considered in the conduct and reporting of this study.

Results: The results describe the impact of implementing the key performance indicators from the perspective of nurses operating at different levels within organisations. The following six themes became apparent: credibility of the key performance indicators; uncovering the whole picture; embracing nursing; engaging in the process; connecting with others; and achieving healthful outcomes.

Conclusion: The findings from this study confirm an emerging relationship between the nature of evidence generated by the person-centred nursing key performance indicators and its use in practice. Also highlighted was the importance of facilitation in the process of data collection and in understanding the data and the context in which it is used.

Implications for practice:

This study will be of interest to clinical nurses, educators, managers and facilitators of cultural change.

- The data generated through the implementation of the person-centred nursing key performance indicators evidences the global contribution of nursing across services provided to children and their families
- Engaging staff at all levels in an organisation enhances implementation of evidence that is meaningful for nursing practice
- The triangulated evidence generated by the key performance indicators and accompanying measurement tools offers feedback that can drive improvements in nursing practice

Keywords: Nursing, person-centredness, key performance indicators, quality improvement, evidence, facilitation

Introduction

Globally, there is increasing scrutiny of the challenge of improving the patient experience in complex, changeable healthcare environments, particularly against a backdrop of economic constraint. Policymakers have called on healthcare organisations to establish universally applied transparent metrics and introduce quality measures to identify the safe, effective and compassionate elements of nursing care (American Nurses Association, 1995; Department of Health, 2008; Health Information and Quality Authority, 2013; NHS England, 2014). This article reports the outcomes from an international study that implemented a set of person-centred nursing key performance indicators (KPIs) and a related measurement framework in supporting the development of person-centred practice across a range of services provided to sick children.

Background

Universally recognised KPIs have been implemented across nursing, although such metrics are primarily aligned to organisational priorities of patient safety and access targets (Varkey et al., 2007; Griffiths et al., 2008). While they provide important information, these indicators do not necessarily measure what matters most to patients, families and nurses. This has resulted in a drive to identify alternative nursing metrics using consensus methodology that more accurately reflects the contribution of nursing (McCance et al., 2012; Sim et al., 2018; Murphy et al., 2019; Kock et al., 2020). Furthermore, KPIs cannot provide a means of problem solving or improving quality of care without analysis of the data that they produce and subsequent action. Nurses and midwives are ideally placed to inform the extent to which KPIs are used in practice, yet policymakers and researchers continue to be concerned about the barriers to healthcare professionals implementing evidence in practice (Bucknall and Rossum, 2015; van der Zijpp et al., 2016).

There is a need to involve staff in localised improvement initiatives (Haines and Warren, 2011), and to develop evidence-based metrics that can measure both nurse-delivered outcomes and patient experience (Griffiths et al., 2008). Earlier research (McCance et al., 2012) aimed to address this, resulting in the development of eight KPIs that were sensitive to the unique contribution of nursing, focusing on improving patients' experience of care. Those KPIs (see Table 1) were novel and, when considered in the context of the existing evidence base, were different from the other metrics traditionally cited (for example, the incidence of pressure ulcers, infections and medication errors), with an explicit focus on person-centredness. A measurement framework was developed to accompany the KPIs, and comprises four data collection methods: a patient survey; an observational tool; patient and family stories; and a review of sample patient records undertaken in conjunction with nurse interviews (McCance et al., 2015).

Table 1: Person-centred nursing key performance indicators (McCance et al., 2012)

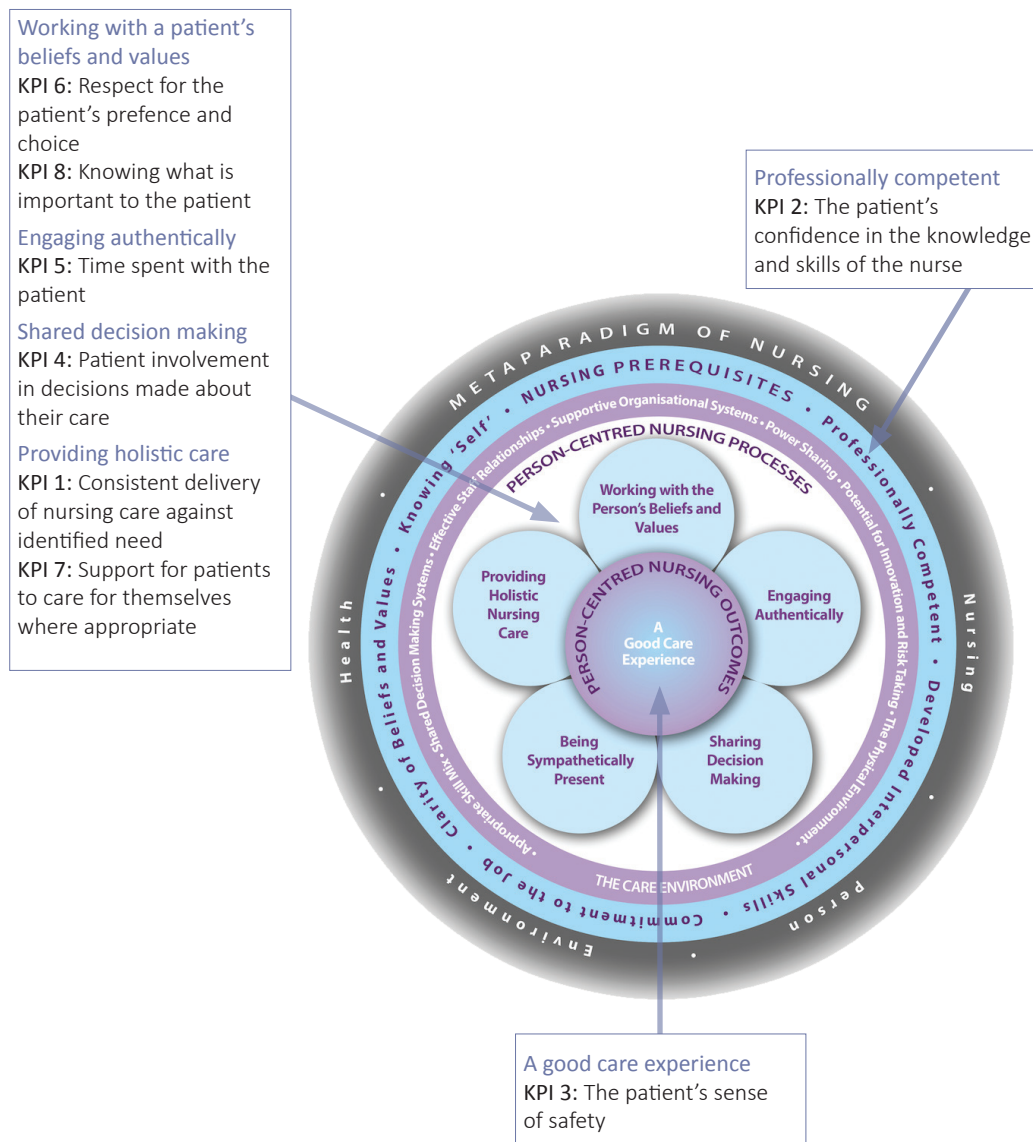
KPI 1: Consistent delivery of nursing care against identified need
KPI 2: Patient's confidence in the knowledge and skills of the nurse
KPI 3: Patient's sense of safety while under the care of the nurse
KPI 4: Patient involvement in decisions made about his/her nursing care
KPI 5: Time spent by nurses with the patient
KPI 6: Respect from the nurse for patient's preference and choice
KPI 7: Nurse's support for patients to care for themselves where appropriate
KPI 8: Nurse's understanding of what is important to the patient and their family

The KPIs are considered a measure of person-centredness and are theoretically underpinned by the Person-centred Nursing Framework (McCormack and McCance, 2021). This comprises four main domains:

- Nursing prerequisites, focusing on the attributes of the nurse
- The care environment, focusing on the context in which care is delivered
- Person-centred nursing processes, focusing on delivering care through a range of approaches
- Person-centred nursing outcomes, summarised as a good care experience

The relationship between the four domains is indicated by the pictorial representation (Figure 1). To achieve the outcomes at the centre of the framework, the attributes of the nurse must first be considered as a prerequisite to managing the care environment, in order to provide effective care through the person-centred processes (McCormack and McCance, 2010). The eight KPIs are largely aligned to the person-centred processes illustrated in Figure 1 and are a valid indicator of the desired outcome from person-centred nursing – that is, a good care experience from the perspective of the patient.

Figure 1: The eight person-centred KPIs aligned to the Person-centred Nursing Framework (McCormack and McCance, 2021)



The eight KPIs and accompanying measurement framework were initially tested in three organisations across the UK and the Republic of Ireland (McCance et al., 2015). Findings revealed the value placed on the evidence generated from the implementation of the KPIs, and reflected a strongly held belief among clinical staff that this approach had focused on measuring what mattered most to patients, and indeed to nurses and midwives. This was linked to the nature of the evidence generated by the KPIs using multiple methods and privileging the patient voice. There was a high level of engagement in the processes and outcomes generated from the measurement framework, and a recognition that this evidence drives changes in practice and informed the development of person-centred cultures. This

article reports the outcomes from an international study, the Paediatric International Nursing Study (PINS), which further tested the person-centred nursing KPIs across a range of services provided to sick children (McCance and Wilson, 2015; McCance et al., 2016).

Aims and objectives

The overarching aim of the study was to explore factors that influence the successful implementation of a set of person-centred nursing KPIs, and the impact of the evidence generated on person-centred practice across a range of services provided to sick children. This article specifically focuses on the experience of implementing the KPIs and accompanying measurement framework from the perspective of key stakeholders, paying particular attention to the research objectives, set out in Table 2.

Table 2: Research objectives

1. To explore staff's views on using the KPIs as a focus for quality improvement
2. To establish the views of key stakeholders on the appropriateness and relevance of the evidence generated from the KPIs as a measure of the quality of service provision
3. To review the effectiveness of data collection mechanisms

Methods

The study is part of a programme of research that focuses on the implementation of the person-centred nursing KPIs used to evidence and develop person-centred practice. The theoretical positioning of this work is underpinned by the Person-centred Nursing Framework (McCormack and McCance, 2021). An evaluation approach, derived from the work of the Medical Research Council (2006), guides the research methodology for the programme. The MRC's guidance describes a phased approach to the development, evaluation and implementation of complex interventions to improve health (see Table 3).

Table 3: Phased research process (Medical Research Council, 2006)

1. **Development:** focuses on identifying the evidence base, and modeling process and outcomes in advance of the actual project/intervention
2. **Feasibility/piloting:** focuses on preparatory work to establish any problems with acceptability, engagement or buy-in with key stakeholders, to assess the degree to which the intervention is meeting the aims set out in the development phase and to select methods to collect evidence
3. **Evaluation:** focuses on assessing effectiveness and determining the adequacy of the intervention for the needs of its target users
4. **Implementation:** involves dissemination using methods that increase the likelihood of getting findings translated into practice, as well as surveillance, monitoring and long-term follow-up

This specific study sits within the feasibility and piloting phase and contributes to the evidence generated from ongoing evaluation. The SRQR (Standard for reporting qualitative research) guidelines and COREQ (Consolidated criteria for reporting qualitative research) checklist were considered in the conduct of this study. This was a largely unfunded study; one organisation secured funding for external facilitators, but all other organisations contributed mainly by allowing staff time to engage in the process.

Setting and sample

The study involved a convenience sample of 12 organisations: seven specialist children's hospitals and five paediatrics wards in general acute care hospitals. There were six sites across three states in Australia and six across four countries in Europe. This article reports qualitative data, obtained through taped semi-structured interviews with executive sponsors (n=11), managers (n=14), and facilitators (n=17). Focus groups (n=14) were also conducted, involving more than 60 clinical nursing staff across all sites. Data saturation was reached before completion of the interviews/focus groups, but it was considered important to give all stakeholders the opportunity to contribute.

Ethical considerations

Ethical approval was sought and granted in line with research governance framework requirements across all jurisdictions, with the exception of the hospital in Denmark, whose regulations did not require formal ethical clearance. The approval process was led by Ulster University for the UK sites, and in Australia by the health research and ethics committee for each state involved. The ethical challenges in relation to the wider study were covered in an earlier article (McCance and Wilson, 2015).

Data collection

Data were collected in 2015 and 2016 by two experienced researchers after each site had generated at least two cycles of KPI data. Executive sponsors, managers and facilitators were interviewed individually, but there were also a number of interviews conducted with facilitators and managers together. Focus groups comprised between two and eight clinical staff and participants were invited via email to respond to key questions such as:

- Tell me about your experience with PINS?
- What worked well for you?
- What do you think could improve the KPIs?

Interviews and focus groups lasted between 20 and 60 minutes, and were audiotaped, transcribed and de-identified in preparation for analysis.

Data analysis

A thematic analysis of each of the four datasets was undertaken individually by each of the researchers, starting with the first three steps of Braun and Clarke's (2006) six-phase thematic analysis. This included becoming immersed in the data by reading and re-reading each transcript to get a sense of the overall picture, then generating preliminary codes highlighting interesting, meaningful and thought-provoking aspects. The next step involved interpreting the codes and combining them to establish connections, themes and subthemes. The four datasets were combined, looking for similarities and differences and creating a thematic data map for discussion among the research team. At the fourth stage – reviewing themes – consensus was established between the researchers, with few differences in the shared analysis. The themes were refined and subthemes confirmed, and quotes to support each of these were extracted and a data evidence file was created. This enabled the overall story to emerge from the shared perspectives of executive sponsors, managers, facilitators and clinical nursing staff.

Ensuring rigour

Attention was given to suitable strategies aimed at enhancing the rigour of the findings, using the seminal work by Lincoln and Guba (1985), which considers rigour in relation to credibility, transferability, dependability and conformability. The data collection and analysis processes were undertaken by the two senior researchers on the project team (VW, TM). Key strategies employed included peer debriefing within the project team, thick description to highlight contextual factors that would enable transferability, and a clear audit trail in terms of data collection and analysis.

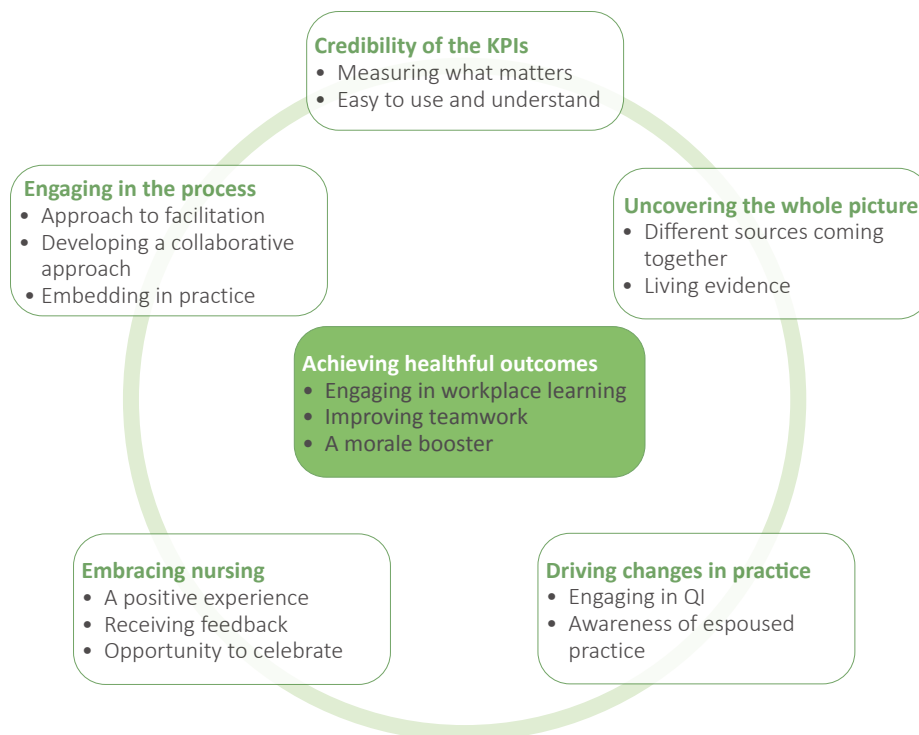
Results

Six key themes emerged from the analysis:

1. The credibility of the KPIs
2. Uncovering the whole picture
3. Engaging in the process
4. Embracing nursing
5. Driving practice change
6. Achieving healthful outcomes

The themes and subthemes are presented in Figure 2. All participants' names used in the following section have been changed to preserve anonymity.

Figure 2: Overview of themes



Credibility of the KPIs

Participants indicated a high level of positivity and support for the KPIs and the measurement framework. The indicators were seen as credible and resonated with staff, who believed they were **measuring what matters**. The facilitators reinforced their value, with Amelia commenting: *'I think they're on the money, if I can say that. I don't think there's any that's missing, or that there's too many'* (Facilitator 4) and Sharon stating: *'Quite simply, I love them'* (Facilitator 5). The KPIs were not only measuring what matters, they had value in evidencing the *'caring aspect'* of practice. Barbara commented: *'...if you can improve these eight KPIs you've done a great job for your patient ... this is about the caring aspect'* (Manager 11). She also noted they were capturing data not generally collected: *'From my point of view, we weren't able to evidence it before. Like parent's satisfaction, very different'* (Manager 11). Annalise went a step further saying: *'I think it has affirmed what perhaps we knew but were perhaps using the excuse of, well hey, we can't gather that data so we are just going to ignore it'* (Manager 12).

A number of staff talked about the KPIs being **easy to use and understand**. As Maree noted: *'When we started this project we had thought this was going to be very complex and what it really is for us is that this is not rocket science'* (Facilitator/manager interview 6). This was supported by Hannah when she discussed the whole process: *'... the simplicity of it, it's not overly onerous, it's achievable, and you can have actions from it'* (Facilitator 1). Clinical staff indicated that it was easy to interpret the reports and understand what they meant for their practice: *'The different ways it was shown in the pie graphs or the other graphs, and written out as well, so multiple ways of showing results, which was good to understand'* (Focus group 5).

Uncovering the whole picture

A strong message in the data was that staff valued the role of different components of the measurement framework in creating or uncovering the whole picture of clinical practice. This was achieved by **different sources coming together** and was reflected by Annalise, who stated: *'I think it has to be a multifaceted approach to gather this data and I think for me it has vindicated and validated that actually we cannot just do one sort of data collection...'* (Manager 12). This is a strong indicator of the

value that different types of data hold for staff. Clinical staff suggested: *'I guess they all look at different aspects, really. One is documentation, and a visual one, and there's interviews – yeah, so they all kind of bring (together) different areas, in a way. I guess they all come together'* (Focus group 9).

The data generated from the KPIs were referred to by Daisy, as **'the living evidence'** (Facilitator/manager interview 6). The patient's voice was valued highly in this respect, as Carla indicated: *'Patients' stories were really useful, because it's that real patient voice ... stories speak volumes, and I sense that the staff were quite sensitive to, you know ... the patients' stories'* (Facilitator 2). Leah suggested that for staff it *'triggered their minds a little bit more ... changed a lot of the girls' practice'* (Manager 7), while Ashleigh said: *'It's the comments that give you the meat, in a way. How you can actually improve'* (Manager 2). While all the data had value, the patient stories had more power in connecting to staff and leading to improvements in care.

Embracing nursing

The implementation of the KPIs across all clinical sites resulted in staff feeling that the indicators supported nursing practice and embraced the value of nursing. There was a clear sense that being involved in the project and having the opportunity to use the KPIs was **a positive experience**, as highlighted by clinical teams: *'I think we're also very lucky just to be part of it ... I think it's opened our eyes a lot to what's important, and I think that's been beneficial'* (Focus group 1). This was further supported by Ashleigh: *'I think it's been very valuable for all of us to be involved in this. It's a wonderful opportunity ... I think it's been great for our staff, and ultimately our families as well. I think it's been very positive'* (Manager 2). She makes the point that the positive experience goes beyond the staff and contributes to improved care. Similarly, Lyndal saw *'some real transformations within individual people and teams'* and felt *'really positive and encouraged by what that's achieving'* (Executive sponsor 2).

A significant process of this study was the way in which the collated data were fed back to staff. In the early stages of **receiving feedback** Sharon indicated that staff *'were defensive'* (Facilitator 5). Judy, a manager, said staff were *'reactive'* in the beginning, but noted: *'One of the biggest changes that I've seen ... we had discussions'* (Facilitator/manager interview 2). This was a move beyond being reactive to embracing the data as a positive mechanism to generate discussion about nursing practice. Clinicians also noted that: *'Positive feedback is naturally going to make you more inclined to keep doing things, because ... it's encouraging feedback ... it's really good to get a positive as well, because sometimes you only see and hear the negative'* (Focus group 1). Lyndal described this as *'the transformational aspect'* of the process (Executive sponsor 2).

An important part of the feedback process was creating the **opportunity to celebrate** the positive aspects of nursing practice. Amelia commented: *'You see it on their face when it's presented. They like hearing not just that they did a good job [but] specifically what they did well'* (Facilitator 4). Feedback was specific about their practice, opening the way for further improvement and creating the opportunity for celebration, as Margaret stated: *'It's not just looking at what we could do better, but looking at how well we are doing as well, and moving forward and celebrating what people had done well'* (Manager 13). Julianne summed this up, saying: *'I think it put the sparkle back into nursing'* (Manager 14).

Engaging in the process

It was clear that pivotal to the success of this research, which was largely unfunded, was the level of engagement in the process of undertaking the study; there was no attrition across the 20 international sites. Engagement was supported through different **approaches to facilitation**, such as securing external support and identifying champions at local level to support the process. External facilitation was used at a number of sites, and as Leah, a nurse manager, said: *'It's great to have that support from an external source who is involved with research on a regular basis'* (Manager 7). At times, there was tension between getting the facilitation help, *'prompting staff and reminding them about our action*

plan...' and the potential for this to bring a sense that *'staff aren't really that involved because it's ongoing'* (Manager 1). External facilitators were aware of this possibility and reacted accordingly after, as Amelia stated: *'Well, it's theirs. It's not actually ours. We support and enable, but it does belong to them, and that's what we try to deliver more that second time'* (Facilitator 4). A shift from relying on external facilitation to a collaborative approach was thought by Diana to *'need a lead champion in each ward'* (Facilitator 6). Having internal champions helped support the process and engaged staff in discussions around the nature of the data and what needed to be done to achieve outcomes. Hannah explained the role of the champions: *'When I think back to the first and the second one [cycles] ... we needed a champion ... just even to set up the PINS board, and then to challenge behaviour that maybe was in conflict with what the ward was trying to achieve ... I think it's vital'* (Facilitator 1).

Julianne spoke about the need to **develop a collaborative approach** as the work progressed *'to involve people more internally'* as a way to gain traction with the work (Manager 14). There was also an element of providing opportunities for staff on the ward *'enabling them and showing them how to do the observations of practice, how to undertake these small activities themselves to evaluate their practice ... trying to get staff involved that second time, and hopefully this third time, they can lead this and do it'* (Facilitator 4). This was linked to the importance of staff taking ownership of the study to give it a better chance of longer-term success: *'They're wanting to drive it, but maybe needed the leadership and support of how to drive it'* (Facilitator 1). This was not always achieved, as this clinician pointed out: *'So the ward needs to own it to be able to take it forward ... to embrace it and to say, right let's do this and make changes ... I think my feeling is that we don't own it at the minute, that's where we are'* (Focus group 11).

There was acknowledgement that the implementation process needed to be **embedded in practice**: *'The concept is not really embedded'* (Facilitator/manager interview 7), but while the implementation *'worked incredibly well'* there was a need *'to see it embedded'* (Facilitator/manager interview 5). This was linked to the time needed to build momentum. While initially *'it took a little while to get the ball rolling'* as time progressed and staff got to the second cycle *'it was just done. It was so much more smooth in the process'* (Facilitator/manager interview 1). To support the process of embedding it in practice, participants suggested that: *'The principles could be embedded into, so things like appraisal, supervision, you know, different strands of work and research'* (Facilitator/manager interview 7) and that it could be embedded *'as business as usual'* (Executive sponsor 3).

Driving changes in practice

It was clear that the data generated from the KPIs were driving change and providing useful information on ways to improve the care experience: *'The KPIs really pinpoint what area you need to improve on ... they were very specific and it was very easy to pinpoint to what you needed to improve'* (Focus group 14). The process itself also helped to drive change and supported staff **to engage in quality improvement**: *'It was something they'd wanted to do for a long time ... simple little changes make that journey better'* (Facilitator 5). The process also raised staff **awareness about espoused practice**: *'We weren't actually doing bedside clinical handover in its full capacity and expectation'* (Facilitator/manager interview 1), and despite it being noted that *'there was a lot of resistance about involving the parents'*, when staff had the evidence from the KPIs they *'were a lot more receptive to it [the change]'* (Facilitator/manager interview 1). There was acknowledgement from managers such as Annalise: *'You see the evidence of that on the wards, I think that's great, you know we've changed things'* (Manager 12) and Trish: *'The other thing I'm very, very proud of is the information booklet, that was one of our action plans from the first cycle ... we took nothing to do with the development of that ...staff... completely owned it'* (Facilitator/manager interview 5).

Achieving healthful outcomes

It was evident from the data that staff, facilitators, managers and executive sponsors who participated in the PINS study viewed the work as making a significant contribution to outcomes for staff and

patients. It was noted that there were opportunities to engage in workplace learning. Bianca stated: *'I think it's been a good learning curve for staff members who would not necessarily have been involved with quality improvement projects beforehand, so I think that's been a really positive thing'* (Manager 7). Clinical staff suggested: *'We can also use what we've learned about data collection and what's important to families'* (Focus group 1). Sharon supported this, saying: *'I really do believe that a lot of learning's gone on from my perspective, as well as from the ward staff'* (Facilitator 5). There was a sense of learning about the process and about data collection, and then about learning in and from practice at all levels.

An outcome of engaging in the work identified by Carla was **Improving teamwork**: *'Just that collaboration with as many people as possible. The whole teamwork thing is important'* (Facilitator 2). Jillian noted that *'it brought out teamwork, it brought out mateship within the workplace'* (Manager 2). This supported the idea that undertaking work like the PINS study can have outcomes beyond the project itself. Staff have an opportunity to work together on something that is shared, meaningful and establishes a sense of mutual support: *'It's almost a change in culture, as well, from an individual person doing a job to a team effort, whereas you don't feel like you're all alone'* (Focus group 9).

It was evident across all the sites in the study that this work created something really positive for all who participated, which links to the 'embracing nursing' theme. Diana, speaking about the staff, stated: *'They're so proud that they did it ... were able to prove how good they are ... it worked really as a staff morale booster'* (Facilitator 6). These thoughts were echoed by a clinical team in another country: *'It definitely boosted our staff morale on the ward, to get better comments from parents'* (Focus group 3). Speaking about her team, Kristy said: *'I think people are quite chuffed that we're part of that. So that's been quite good for kind of morale to see that, gosh yes, this is quite a big deal'* (Manager 10).

Discussion

This study set out to explore factors that influence nursing teams' implementation of eight person-centred KPIs and an accompanying measurement framework. The findings reported from PINS were confirmatory, validating key findings from the original study that tested the utility and feasibility of the KPIs as an approach to evidencing the patient experience (McCance et al., 2015). Findings that were reinforced include: the credibility of the KPIs in measuring what matters; the ability to uncover the whole picture through the use of multiple data sources; the high level of engagement in the process aligned to the ability to use the data to improve practice and evidence the positive contribution of nursing; and the positive experience of engaging in the process. Similar findings were reflected by the implementation of the KPIs in a community nursing context (McCance et al., 2020).

Generating robust evidence is insufficient on its own to effect change in practice; supporting the generation and implementation of evidence in clinical practice requires input from a facilitator (Dogherty et al., 2010). It is acknowledged that the engagement of executive sponsors, managers, facilitators and staff within this study promoted continuity and momentum. However, various models of support were implemented across the participating sites and the effectiveness of these are reflected in the findings, which focus on how participants engaged in the process. The findings suggest that working with facilitators to gather and analyse data and implement changes, following feedback and benchmarking activities, is a good mechanism in clinical environments. Working with a key facilitator responsible for co-ordinating activities, initiating and supporting the cycles of work at a unit level and keep nursing teams motivated was considered an important factor for success. This is consistent with a scoping review (Cranley et al., 2017), who identify nine different types of facilitator role, concluding that 'facilitation has become an important aspect of implementing research into practice, and has potential to be an effective innovation' (p 13). In exploring issues of facilitation with participants, it was clear that having that one clinical person who was able to lead and was respected by the team was as important to managers as it was to clinical nurses. This suggests the professional, personal and leadership skills of the key facilitator are crucial, and reflects the importance ascribed to the role of facilitation (by whom

and how) in implementing evidence into practice by the PARIHS framework (Kitson et al., 2008; Harvey and Kitson, 2015a). Furthermore, in a re-conceptualisation of the constructs of this framework, Harvey and Kitson (2015b) developed the integrated PARIHS (i-PARIHS), which positions facilitation as the active component in guiding individuals and teams through complex contextual and change processes. Harvey and Kitson (2015b) identify the 'key facilitator' as the change agent who is generally internal (insider) to the organisation with the central role of co-ordinating activities, initiating work at a local level and 'generally keeping everything going' (p 13). The findings from this study reflect that.

Schein (2010) argues that the strength of cultural data only becomes relevant when the members of the organisation feel they have something to gain. Therefore, it was important that staff using the person-centred nursing KPIs and a measurement framework saw themselves as having some ownership of the data and actions arising as a consequence of the data. Working collaboratively, they became fully immersed in the problem-solving process, meaning the data became a joint responsibility. Viewing the data, this was most evident for those working in units with an insider/insider facilitator. It is interesting to note that some areas that started with an insider/outsider facilitator defaulted to having an internal champion due to the pressures of competing demands in their roles. Balancing the positive aspects of understanding the organisational culture against the challenges of working in individual ward micro-cultures offered a challenge for insider/outsider facilitators (Coghlan, 2019). Some external facilitators discussed the challenge of gaining access to wards and there being a lack of ownership, as nursing staff considered the work they were doing to be a 'directive' driven by facilitators. This was reiterated by clinical nurses, who commented that they felt they did not own the work because a facilitator was brought in from outside and it was considered their job. However, insider/insider facilitators also experienced challenges when they did not show strong, consistent leadership: for example, in one area a leader was present in cycle one but not in cycle two, which staff found difficult. This reflects the findings of a recent qualitative study conducted by Baloh et al. (2018), who similarly identify leadership and buy-in as important internal facilitation activities when implementing evidence-based interventions in hospitals. They conclude that understanding the types of facilitation activities and their distinguishing characteristics can support managers in implementing evidence. The findings from this study would suggest that, whoever is nominated to be a key facilitator, there is a requirement to communicate effectively and be able to support colleagues in implementation work, if healthy workplace cultures are to be built.

Finally, the study findings highlight the impact of implementing the KPIs on the experience for staff. Participants described how engaging in the process provided opportunities for workplace learning, created a sense of improved teamworking and boosted staff morale. These outcomes are reflective of effective person-centred cultures and are in line with the expected outcomes described in the Person-centred Nursing Framework – namely, a good care experience (McCormack and McCance, 2021). The experience of good care reflects the evaluation that patients, or indeed nurses, place on their care experience and reflects a workplace that enables human flourishing. This is a key determinant of how healthcare is experienced and McCormack and McCance (2017) would argue that the extent to which the environment supports and maintains person-centred principles is critical to the development of person-centred practice. Furthermore, McCormack et al. (2021) describe a healthful culture, the key outcome of person-centred practice, as one in which staff are supported and enabled to maximise their potential in line with their values. This reflects the impact of implementing the person-centred nursing KPIs as evidenced by the findings from this study.

Limitations of the study

This was a large international study with multiple sites across Europe and Australia, the challenges of which have previously been reported (McCance and Wilson, 2015). An important limitation of working across the international landscape was the challenge of monitoring consistency in the implementation processes across sites. Furthermore, as in many studies that have an action-oriented component, the turnover of staff is always problematic, particularly in terms of sustaining momentum. However, it should be noted that all 20 units completed the study.

Implications for practice

This study reaffirms the importance of generating evidence for practice that is meaningful for nursing teams, as opposed to collecting multiple sources of routine organisational data. It challenges organisations to consider what evidence is generated through KPIs and other metrics, and the impact on improving nursing practice. The evidence generated from the KPIs provides a stimulus to drive improvements in practice that contribute to the development of person-centred cultures. Furthermore, having the ability to generate data that evidences the contribution of nursing creates a positive work environment that encourages a culture of celebrating success. The challenge to effective implementation, however, is the engagement of staff at all levels in an organisation, from clinical teams through to executive leaders. Investment in this process, however, does have the potential to impact on the care experience for patients and their families and for staff.

Conclusion

Using evidence to implement change is a multi-layered and complex process in day-to-day clinical practice (Greenhalgh and Wieringa, 2011; Brown and McCormack, 2016). Researchers argue this relates to the debate on what constitutes evidence and the ways in which micro, meso and macro contexts affect practice, which influence healthcare professionals at individual, team and organisational levels (Ferlie, et al., 2009; Brown and McCormack, 2011; Harvey and Kitson, 2015a). The findings from this study reaffirm the value of the evidence generated by the person-centred nursing KPIs and the ease with which they can be implemented within practice. There is also a clear relationship emerging between the nature of evidence generated and its use in practice, alongside clarity over the need to be assisted (or facilitated) to collect and understand the data and the context in which they are used. This reflects the interplay in the PARIHS framework between the elements of evidence (research, clinical, patient, local), context (culture, leadership, evaluation) and facilitation (by whom and how) (Kitson et al., 2008; Harvey and Kitson, 2015a). Most importantly, however, implementing the KPIs and the accompanying measurement framework is a process that leads to positive outcomes for staff, and creates the conditions for the development of effective person-centred cultures.

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