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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme

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Abstract
Background: The promotion of person-centredness in practice has the capacity to make a critical difference to the care experience of patients and staff. While there is growing international evidence to suggest that emancipatory practice development programmes can develop person-centred cultures, understanding of how person-centredness is effectively operationalised in practice remains an underdeveloped area.
Aim: The research aim was to explore how the culture and context of acute care practice settings impacts on the engagement of practitioners in a facilitated practice development programme.
Methods: The methodology used was programme evaluation, using multi-methods including process evaluation, reflective accounts and focus group interviews. Data analysis was undertaken using a creative hermeneutic approach.
Findings: The findings highlighted that the programme enabled a level of engagement that was characterised by positive ways of working, building relationships and maintaining momentum. This in turn impacted on the ability to embrace person-centred values in practice and reflected nurses' confidence and competence. Person-centredness in practice was also impeded by conflicting priorities characterised by a sense of feeling pressurised, limited staffing and resources, and the challenges of an evolving context, particularly within the provision of services in acute hospitals.
Conclusions: The findings are confirmatory and add to the existing evidence regarding the effectiveness of practice development as an approach that facilitates teams to explore their own practice. The findings, however, add to existing evidence by highlighting new insights that should be taken into account when delivering a facilitated practice development programme. These insights reflect the tussle between the impact of context and the development of cultures that support person-centredness in everyday practice.
Implications for practice:
- There is a need to further explore the impact of the contradictions of espoused values of person-centredness on the experience of patients and staff and how further refined interventions can contribute towards workplace cultures that are healthful and that enable human flourishing for all

Keywords: Person-centredness, context, practice development, acute care, programme evaluation

Introduction

Improving the patient experience is not solely about providing good clinical care; it is also about being cared for with 'kindness and compassion' (Goodrich and Cornwell, 2008; Dewar and Mackay, 2010). There is evidence to suggest that while organisations might aspire to a standard of care that reflects these components, the reality of the quality of care delivered is often something different (Department of Health, 2008; Care Quality Commission, 2010; NHS Confederation, 2010). This brings to the fore the need to focus on attitudes, behaviours and relationships, and reflects the importance of engaging in new ways of thinking and working that promote a person-centred approach. Person-centredness is a term that is becoming internationally recognised within health and social care. McCormack et al. (2010) describe person-centredness as:

'An approach to practice established through the formation and fostering of therapeutic relationships between all care providers, people and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.' (p 13)

It has been argued that the promotion of person-centred cultures has the capacity to make a critical difference to the care experience of patients and staff (Binnie and Titchen, 1999; Pope, 2012). The challenge, however, is the consistent delivery of this standard in practice. McCormack et al. (2011) suggest that contextual factors such as organisational culture, the learning environment and the care environment itself, pose the greatest challenge to person-centredness and the development of cultures that can sustain person-centred care. There has been significant conceptual and theoretical advancements in the area of person-centredness with the development of frameworks (Nolan et al., 2004; McCormack and McCance, 2010), alongside the application and testing of these frameworks in practice (Ryan et al., 2008; McCance et al., 2010). This has in turn gone some way towards enhancing our understanding of how we can effectively operationalise person-centredness in practice.

Furthermore, there is growing international evidence to suggest that facilitation through emancipatory practice development programmes can develop person-centred cultures, but more importantly this approach moves away from one-off change events to continuous reflection and development of critical relationships that can be sustained over time (McCormack et al., 2006). Practice development is described as an approach to sustained and continuous quality improvement, where the focus is on learning and the freedom to implement care and work differently with the aim of promoting effective person-centred practice (Manley et al., 2008). Central to this approach is the development of transformational leaders and skilled facilitators, the ability to learn in and from practice, and the use of systematic, rigorous and continuous change processes (Dewing, 2010).

McCormack and McCance (2010) argue that our understanding of how person-centredness is effectively operationalised in practice remains an underdeveloped area and requires the use of 'creative strategies for evaluating complex processes that underpin person-centredness in practice' (p 114). The study reported in this paper aims to contribute to the knowledge base in this area. The paper describes the implementation and delivery of a practice development intervention, which targeted a cohort of nursing teams working within acute care settings within one healthcare organisation, with the aim of evaluating its impact. Acute care settings within this paper refer to inpatient hospital wards, covering a range of specialties, which are described in more detail in the following section.

Study aim

The aim of this study was to explore how the culture and context of acute care practice settings impacts on the engagement of practitioners in a facilitated practice development programme. More specifically, there were three related research questions. How does a facilitated programme focusing on exploring the concept of person-centredness:

- Impact on nurses' and midwives' understanding of person-centredness in practice?

- Increase nurses' and midwives' understanding of the emerging challenges to providing person-centred care?
- Impact on outcomes for staff as a result of practice change?

Overview of the programme

The focus of the practice development programme was to enable nursing teams to explore the concept of person-centredness within their own clinical setting, in order to improve care delivery. The programme was delivered over two years and the structure comprised facilitated activities in line with a practice development approach. Figure 1 illustrates the methods used, mapped onto the practice development framework that uses the concept analysis undertaken by Garbett and McCormack (2002). The methods were drawn from the recommendations arising from the realist synthesis undertaken by McCormack et al. (2006, pp 124-125), which is considered best evidence in relation to delivering a practice development programme. The programme was delivered through a series of facilitated workshops (n =5), with ongoing monthly support provided through a project team. Each workshop focused on key themes including:

- Promoting an understanding of person-centredness
- Developing a shared vision
- Determining the quality of the user experience
- Systematically developing practice
- Celebrating success

Each workshop profiled relevant activities as presented in Figure 1 to enable teams to engage with the processes more widely back in their own clinical areas. The methods used are standard to systematic practice development work, as reflected in key resources such as those of the Royal College of Nursing (2007).

Figure 1: Overview of the programme
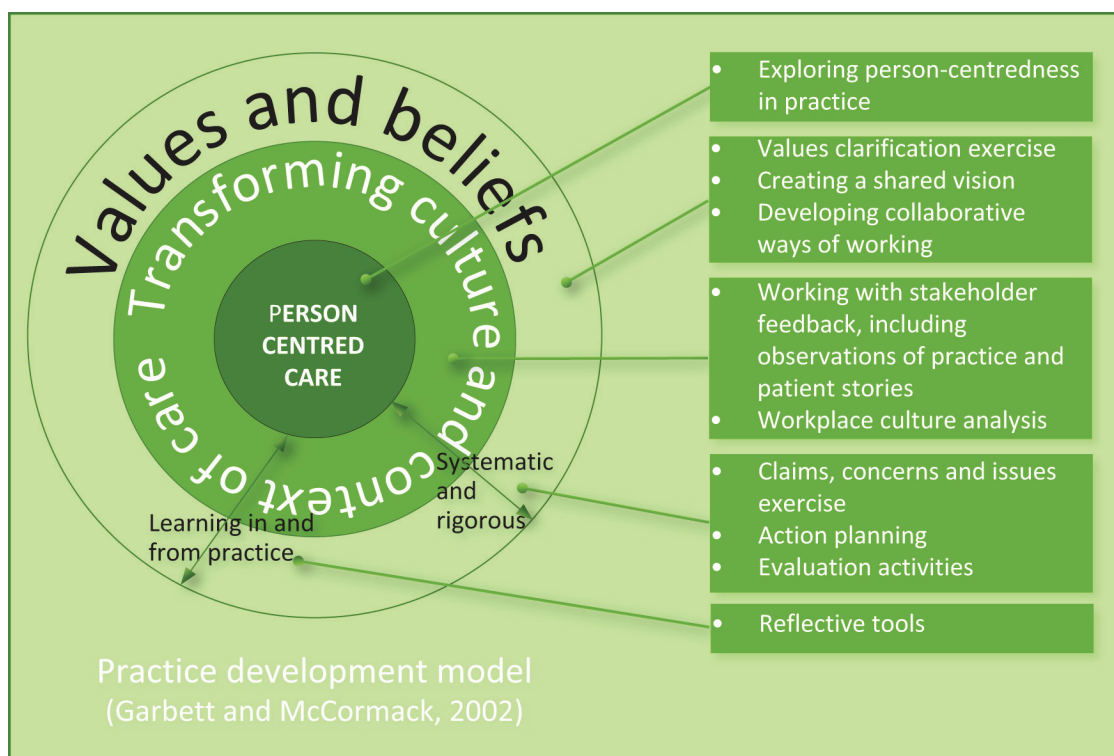
The Person-centred Practice Framework developed by McCormack and McCance (2010) provided the theoretical underpinning for the programme. The framework was developed as a tool that enables

nurses to explore their practice. It acts as a lens to offer greater insights and understanding of person-centred practice, and is presented in Figure 2. The framework was used in multiple ways by participants across the range of programme activities; examples include to support critical reflective activities in order to make explicit links to person-centredness, to analyse data collected at local level and as part of the programme evaluation, and to inform practice changes.

Figure 2: Person-centred Practice Framework
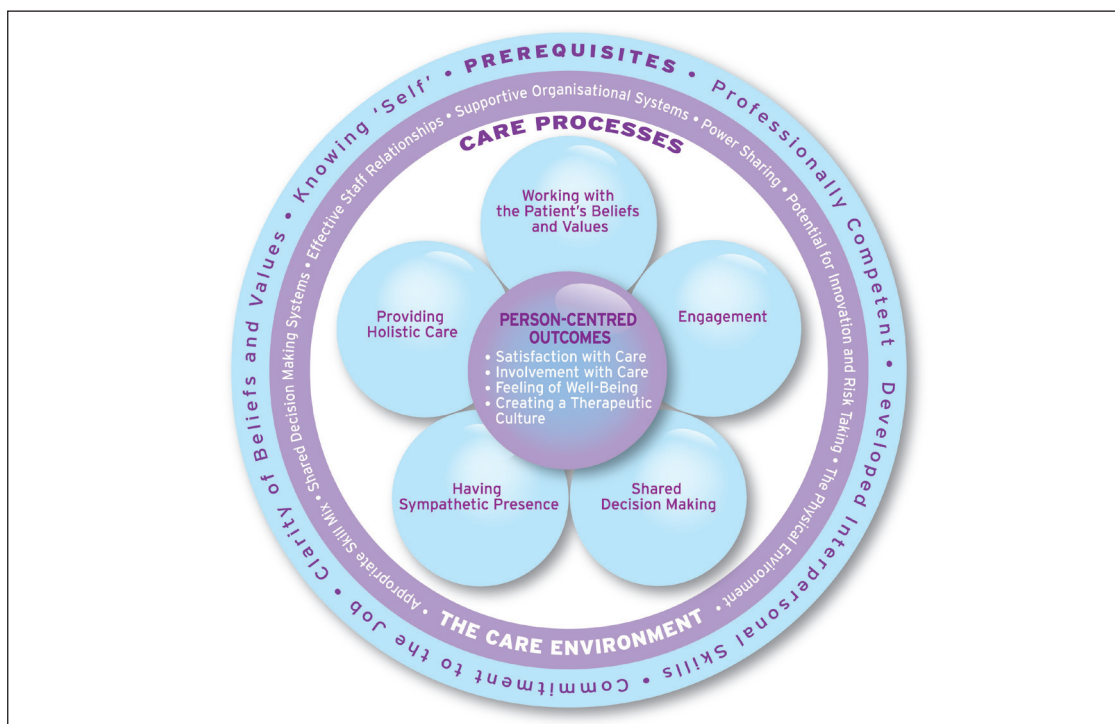
Methods

The approach used was programme evaluation using qualitative methods to assess the effectiveness of the programme components, identify contextual issues that impact on its delivery and implementation, and identify outcomes and practice changes. According to Patton's (2002) typology for evaluation, which runs along a continuum from theory to action, the evaluation reported in this paper would fall under the 'formative category', which serves the purpose of improving a specific programme. Furthermore, this study would align to what Patton describes as 'developmental' evaluation, a type of formative evaluation, where the focus is on organisational development and learning, empowering local groups through participation, and using processes of evaluation to inform continuous improvement.

Setting and participating sites

The person-centred care programme was delivered in a large health and social care organisation, with approximately 20,000 staff, of which almost 6,800 are nurses and midwives. The organisation serves a local population of 340,000 people but also provides regional services. The programme was undertaken at a time of unprecedented change, when services for health and social care in this region were being reorganised. The organisation in which the programme was delivered was the result of a merger with several other organisations and at the time of commencement of the programme was less than one year established. Ten nursing teams were recruited from across the organisation, with the ward sister/charge nurse plus two other staff members participating. Each team was also accompanied by a local facilitator attached to their area, whose role was to support the ward sister/charge nurse. These individuals attended the formal programme events but were expected to lead all aspects of the programme back in the workplace. The inclusion and exclusion criteria applied for selection of teams

is presented in Table 1. The teams selected to participate in the programme spanned a range of clinical specialities and were located across four different hospital sites within the organisation (see Table 2).

Table 1: Inclusion and exclusion criteria		
Target sample	**Inclusion criteria**	**Exclusion criteria**
Teams	• Previous practice development involvement or programme activity focused on developing practice • Agreement of ward manager/team leader to participate • Evidence of service support from associate director of nursing and senior manager • Access to a nursing development lead (a facilitative support post) linked to the selected area, who has experience of using a practice development approach	• Currently involved in other service/ developing practice initiatives • Areas where there are significant performance issues
Nursing development leads	• Responsibility for supporting the area • Knowledge and skills required to facilitate a developing practice activity or access to appropriate support to undertake facilitation of the team	• Currently involved in other significant service/ developing practice initiatives

Table 2: Participating sites*
Participating acute hospital sites
Cancer inpatient unit
Mental health inpatient unit
Brain injury unit
Specialist and general medical inpatient wards • Chest medicine • Cardiology intervention • Medical/respiratory • Medical/hepatology • Neurology
• Eyes and ear, nose and throat theatre department
One of the original ten sites withdrew before completion of the programme

Data collection methods
Multiple methods were used to establish the impact of the programme, which are summarised below.
- Process evaluation was collated throughout each phase of the work and was drawn from fourth-generation evaluation (Guba and Lincoln, 1989), which involves the repeated use of claims (favourable assertions about the topic), concerns (unfavourable assertions) and issues (questions that reflect what any reasonable person might ask about the topic). This was undertaken globally at monthly project team meetings, but data was also collated for the individual participating sites on an ongoing basis, giving rich insight into the experience of teams engaging in the programme over time.
- Reflective accounts were provided by programme participants and were undertaken at the

beginning of the programme and following completion of the themed workshop activities. A simple reflective tool was used drawing on the work of Johns (1993), with key questions such as:
  – How would you describe your experience of the programme so far?
  – How do you feel about the experience?
  – What have you learned about yourself and your practice?
- Qualitative interviews using focus groups with programme participants and facilitators (n=7) were undertaken by external evaluators. The format for the focus groups comprised key questions relating to the participants' experience of the programme. Focus groups were undertaken with the local facilitators and the ward sisters/charge nurses at the beginning and end of the programme, which was delivered from January 2009 to April 2010.

Data analysis

A creative hermeneutic approach was used, drawing on the work of Boomer and McCormack (2010), who describe this approach as 'the hermeneutic analysis of multiple data sets in groups that brings together hermeneutics, staged facilitation and creativity'(p 638). This approach to data analysis reflects Gadamer's (1993) philosophical perspective on hermeneutics, and the use of the arts to support new ways of working and learning (Simons and McCormack, 2007). The creative process involved building images of impressions (intuitive grasp) of the data through paint and collage, and story writing. Within the programme evaluation the hermeneutic creative analysis was conducted by the implementation team, comprising programme leads, wards sisters/charge nurses from participating sites and local facilitators. External evaluators co-ordinated the data collection and analysis in relation to the evaluation. Data analysis following completion of the hermeneutic analysis involved a review of the data and discussion and further refinement by the project team. This led to a clear set of identified themes and subthemes, which were then tested with the programme participants and finalised.

Ethical considerations

This study was subject to governance approval in the healthcare organisation and was also submitted to the local research ethics committee. The main ethical considerations related to:
- Ensuring informed consent
- Ensuring anonymity and confidentiality, where possible
- Ensuring participants experienced no distress or harm as a result of taking part in the study
- Having mechanisms in place to deal with unforeseen issues that may arise in practice during the conduct of the research

The project team secured all relevant approvals before commencement.

Results

Our main findings highlighted that the practice development programme described in this paper enabled a level of engagement that was characterised by positive ways of working, building relationships and maintaining momentum. The impact of the programme, however, was affected by conflicting priorities that reflected a sense of feeling pressurised, limited staffing and resources, and the challenges of an evolving context. This in turn impacted on how participants were able to live out person-centred care within their own practice through embracing person-centred values and being confident and competent (see Table 3).

Table 3: Summary of findings		
Enabling engagement	**Conflicting priorities**	**Living person-centred care**
• Ways of working • Building relationships • Maintaining momentum	• Feeling pressurised • Staffing and resources • Evolving context	• Embracing person-centred values • Being confident and competent

Enabling engagement

Engagement with the person-centred care programme, at a conceptual level and at an operational level, was key in both a personal and team journey towards a better understanding of person-centredness in practice. At the outset there was recognition from participants that engaging staff in the programme would be challenging but there was also an enthusiasm at an early stage that the essence of person-centred care was at the heart of nursing.

'Why I was excited by the project was that in the midst of all we are having to deal with, this is giving credence and recognition to the core principles of why I became a nurse...' (Focus group, round 1)

'Person-centred nursing is what nursing is about – delivering high standards to each individual, consider their needs, thoughts, concerns and the concerns of family/carers. How do I engage staff to participate and recognise their good work?' (Reflective account, workshop 1)

Using a practice development approach grounded in the principles of collaboration, inclusion and participation promoted positive ways of working. In addition, the facilitation approach of the programme and the support structures and processes put in place were to enable participants to engage fully with the programme. While there were two lead facilitators delivering the programme, each participating site had a nursing development lead to facilitate its delivery in the practice setting. Establishing and sustaining local facilitation also presented challenges. The knowledge and skills of facilitators ranged from little experience of facilitation within a practice development context, to significant insight into emancipatory practice development. For some, access to support was central to how they were enabled to continue to facilitate engagement with their own teams.

'Support of the facilitators and the way in which they [referring to the lead facilitators] ensure clarity through revisiting and questioning understanding.' (Reflective accounts, workshop 2)

'I have support structures to access... others look to me for guidance, which can be stressful as I don't have all answers but that's ok as I can access my facilitation skills and trust the process.' (Reflective accounts, workshop 2)

The importance of *building relationships* between different stakeholder groups in promoting effective person-centred care was also highlighted. This focused on challenging and influencing the established ways of working in a respectful manner that could contribute to team culture and developing relationships, and sometimes this stretched beyond traditional boundaries.

'The programme is about developing respect and good relationships between everyone to try and improve patient outcomes.' (Focus group, round 1)

'Another challenge for participants was dealing with what some perceived to be "some of the old guard from the medical side of things who are still clinging onto some of the old power struggle", and I think some of this does pose a challenge for nursing, but interestingly some of the newer staff and newer medics... recognise there is a change to the culture, a change to the environment...' (Focus group, round 1)

Maintaining momentum was a theme that arose consistently throughout the programme. There were times when there was a high level of commitment and energy and this was reflected in the level of engagement across the participating sites. However, there were times when maintaining momentum was a challenge due to the organisational context.

'Difficult to keep momentum and energy going. It needs an awful lot of energy and this is often hard to find. Takes an enormous amount of time from working day. Sometimes this is difficult because it

is so busy on the ward. The end product will be good but difficult to institute.' (Reflective account, workshop 3)

The leadership role within the ward was considered pivotal in maintaining momentum, particularly in areas where there was a high staff turnover. There was, however, a more fundamental message that was about developing person-centred cultures and also relates to living out person-centred values in everyday practice.

'But they can role model it and keep it going so that people can learn from it because staff change, especially the senior leaders... and the ward managers that is a big part of their role but staff change, staff come and staff go so before you know it in six months' time six people have gone from your ward and you sort of feel like you are starting all over again but if it's continuous and built into everyday practice, and it's part of the ethos of the ward, it becomes part of the culture.' (Focus group, round 2)

Conflicting priorities
Feeling pressurised within the environment was a strong theme arising from the data. This was described in the context of multiple organisational priorities and the pressure to deliver within specific deadlines. This created a real sense of frustration for participants, where on the one hand they recognised and valued the importance of person-centred care but on the other the reality in practice made this way of working unobtainable.

'Mixed feelings today. I know that the theory is an excellent one and that in a "Utopian" world it would be perfect, but I feel bogged down with lots of other things at the moment, like high impact bundles. Frustrated at times as cannot achieve what I perceive I need to do due to time constraints, workload, and other perceived priorities.' (Reflective account, workshop 3)

Feeling pressurised was further compounded by the continual challenge of adequate *staffing and resources*. This played out at every level in the programme, from staff attendance at workshops and project team meetings, to the delivery of aspects of the programme in practice. Some areas managed this dynamic and continued to engage in the programme, while others struggled to keep the project moving forward.

'Because of staff shortages... I know for a fact the staff haven't got near the information files to read them because they just don't have the time, it's a way down the list and trying to put our action plan into place is really difficult, we are wanting to move forward with it and we are wanting to get the morning sessions sorted out so that we can talk to staff about this and bring them on board but we don't have the time.' (Focus group, round 1)

Participants were keen to stress significant workload pressures amid a changing organisational context. The focus on strategic review of services was leading to different models for care delivery and changing roles. All of this, they reported, led to increased demands and greater workload.

'Volume and conflict, each person's project is expected to take priority, and if each of us had applied for a specialist post in whatever field, that would be our priority. But for the people who are delivering the care, it's all funnelled down and we have to feed all these projects, as well as meet the patient's needs. We agreed the principles... however somebody... has to recognise that it has become impossible to address each patient in a person-centred way.' (Focus group, round 1)

'Disseminating information about person-centred care in the ward was considered to be more difficult, because ward meetings were rare. When meetings did occur, these are described as one-way communication from the ward manager to disseminate what staff perceived as copious

amounts of information about projects and targets all of seemingly equal priority to the Trust.' (Focus group, round 1)

As previously mentioned, the organisation was undergoing significant change, which resulted in a *context that was constantly changing and evolving*. All the participating sites were experiencing the impact of this and, as noted above, some areas continued to be able to function in this context and engage in the programme, while others struggled to keep the project moving forward. One participating site, however, embraced the person-centred care approach of the programme to manage the potentially negative impact of the changing context within their service, which was requiring staff to work in quite different ways. The approach and resultant outcomes achieved by this team are summarised in Figure 3. This level of engagement has an impact on how relationships are formed within and across teams.

Figure 3: Case study - applying a person-centred approach to organisational change

This theatre unit comprised a suite of four operating theatres and one five-bedded postoperative recovery unit caring for those from both ends of the age spectrum and everyone in between. The core team of 38 staff had varying degrees of perioperative experience; some had previous insight into the person-centred concept and framework, having taken part in a pilot in 2002-03.

The unit decided to consider person-centeredness from a staff perspective as there was a significant challenge from a high level of vacancy control required as part of efficiency savings. Staff were required to undertake inter- and intra-site perioperative work across three acute hospital sites, which was generating anxiety and dissatisfaction. Therefore, the team decided to focus on facilitating cross-site movement of staff in a person-centred way. It was essential that staff movement contributed to safe and effective patient care, but also that staff felt that movement was fair and equitable and, where possible, tailored to suit their own personal and professional development needs.

The practice change focused on the collaborative development of a protocol, which reflected the Trust policy on staff movement. Staff were encouraged to share their personal thoughts regarding this relatively new requirement to move outside their immediate clinical area and how it could be a more positive experience for those involved. This contributed to the development of a protocol, which all staff signed up to. Following its implementation, staff were encouraged to provide feedback using a structured questionnaire to determine to what degree the protocol had been successful.

This approach to changing practice achieved a number of significant outcomes, which included:

- Staff engagement in changing practice, resulting in willingness and acceptance to move inter/intra site
- A significantly enhanced experience for staff who moved inter/intra site
- Evidence that staff were more receptive to change
- Increased understanding within the team of the principles of person-centredness and the Person-centred Nursing Framework
- Transferability of the learning to other organisational changes, for example, the successful merger of two independent teams into one using person-centred principles
- Opportunities to share learning and celebrate success, for example, the team won the Siobhan Rankin Perioperative Team of the Year National Award for their person-centred work

Living person-centred care

While the values that underpin person-centred care were not new to participants, the significance was in how they *embraced person-centred values* in practice, even in the challenging context described above. Participants acknowledged the difficulty of recognising how person-centred values are reflected in practice, both in support of best practice and in recognising aspects of practice that needed to change. There was also a fundamental shift during the programme when some participants began to recognise the meaning of 'person' in person-centred care, a central tenet of this way of working.

'It's about getting back to recognise those very important things... it doesn't always have to be hi-tech, it's just sometimes the most simple things can matter an awful lot to a patient lying on a bed. So to me that's what I feel about it, fundamental is almost like that.' (Focus group, round 1)

'Being person-centred with each other, your colleagues, your peers, multidisciplinary team... that is something that the staff didn't necessarily understand and it's only because they did the values clarification... to be honest with you... it just would have been patients and relatives.' (Focus group, round 2)

Being confident and competent was also key to this way of working. Many participants described their experience of the programme as a personal journey characterised by the development of knowledge and skills, or indeed an increasing awareness of personal limitations or barriers to working differently.

'Feel excited, bit daunted. Made me consider my own capabilities and skills.' (Reflective account, workshop 1)

'Engagement with staff is very rewarding, not only for me but also for them. Sharing the journey and supporting staff to develop new skills, ie facilitation. I strive to role model person-centred care. Recognise I don't always get it right. Importance of reflection. I have learned what kind of learner I am and it has refocused my attention to what nursing is and should be.' (Reflective account, workshop 1)

Discussion
The findings from this programme evaluation do resonate with what is already published in the international practice development and evidence-based practice literature, but they also provide new and important insights for promoting person-centredness in practice. Three key areas will be discussed in the context of the existing evidence base and the resulting implications for ongoing work in this area.

Enabling engagement through practice development
There are key findings within this evaluation that are confirmatory and add to the existing evidence on the effectiveness of practice development and the delivery of practice programmes. The first relates to the value of the processes used within practice development that ensure participation as presented in Figure 1, prioritise working collaboratively with a range of stakeholders and promote shared ownership. Such processes enable engagement, which has a positive impact on relationship building and team effectiveness. These findings support the key messages from the realist synthesis of the evidence relating to practice development undertaken by McCormack et al. in 2006, but are also noted in several studies reported in the international literature (Wilson, 2005; Boomer and McCormack, 2010; McCormack et al., 2010). The second finding relates to the knowledge and skills of the practice development facilitator and the centrality of this role in enabling engagement at a local level. Consensus within the practice development literature would suggest that developing capacity for facilitation can be a significant challenge for organisations, and for individuals who are embarking on a journey that will hopefully lead to personal growth and professional development (van der Zijpp and Dewing, 2009; Boomer and McCormack, 2010; Crisp and Wilson, 2011; Hardy et al., 2012). The third finding reflects the challenge of maintaining momentum, which again would appear to be a characteristic of practice development programmes in general (Wilson, 2011) and which is often linked to culture and context, which is discussed further below.

Impact of context on person-centred practice
Conflicting priorities, as described in this study, reflect the context in which care was being delivered. Rycroft-Malone (2004) describes context as the environment where people receive healthcare services, and identifies three key elements that form a context: culture, leadership and evaluation. The findings

from this evaluation reflect an evolving context indicative of an organisation immersed in major reform. Furthermore, the diversity of the ten pilot sites in relation to their particular local context was a significant factor in enabling engagement in the programme and re-emphasises the impact of contextual factors, which according to McCormack et al. (2011) 'pose the greatest challenge to person-centredness and the developments of cultures that can sustain person-centred care' (p 1). The readiness of each team to engage in a practice development programme of this nature was reflected not only in maintaining momentum, but also in the areas targeted for improvement activity, which in the majority of cases targeted initiatives with staff, with only two focused directly on the patient's experience. An explanation for this can be offered from the relationships within the Person-centred Practice Framework (McCormack and McCance, 2010), which proposes that first and foremost, staff require the necessary attributes (for example, developed interpersonal skills, clarity of beliefs and values, and commitment to the job) to be able to manage the care environment and deliver person-centred processes.

The idea of assessing the practice context to establish 'context readiness' is a key discussion point. Evaluation of the context of practice and the presence of person-centred values and behaviours is an important first step in undertaking development work of this nature (McCormack and McCance, 2010). Wilson et al. (2005) present a similar argument, highlighting the need to understand the culture of the individual workplace before implementing innovations or developments. McCormack and McCance (2010) offer a number of approaches and tools for evaluating practice context, for example the Context Assessment Index (McCormack et al., 2009a) and the Workplace Culture Critical Analysis Tool (McCormack et al., 2009b). A practice development approach encourages individuals and teams to explore their own context in a non-judgemental and transparent way and to be explicit with others about the stage they are at in terms of their journey towards person-centred practice. Furthermore, the focus on readiness identified within this programme, which was delivered within acute hospital settings, raises questions about transferability to other care settings. While context readiness has been identified as particularly important, the use of a practice development approach can take account of this and support teams at whatever stage they are at.

Developing cultures that support person-centredness in everyday practice
The constant tussle between conflicting priorities as described above and the desire to live out person-centred values in practice is evident from the data. McCormack et al. (2011) argue that while acknowledging that everyday practice is challenging, often stressful, sometimes chaotic and largely unpredictable, it is important to ask how we can ensure person-centredness becomes an everyday cultural norm. How we embrace person-centred values in everyday practice relies on knowing self, an attribute identified within the Person-centred Practice Framework (McCormack and McCance, 2010). Through being authentic we can embrace person-centred values in the way we work with patients and staff. This, however, links back to having the confidence and competence to work differently and with clear principles that promote participation and collaboration, and also how we use our experience to manage the care environment to help ensure that delivery of care reflects person-centred values (Christie et al., 2012). The need for everyday person-centred practice reinforces the importance of establishing a learning culture and developing reflective learning strategies that are delivered in the workplace (McCormack et al., 2006; Dewing, 2010).

Manley et al. (2011) emphasise the interplay between corporate, organisational and workplace cultures and the impact of this on achieving consistent standards. They articulate the essential attributes of a workplace culture, which include the ability to realise core shared values such as person-centredness in practice. Being able to work in this way leads to outcomes such as human flourishing for all, and indeed we can see from the data relating to living person-centred values the desire of staff to deliver this standard of care in their everyday practice.

Conclusion

First and foremost, this report reaffirms the value of using a practice development approach to promote person-centredness in practice. The key findings, however, reinforce the interplay between enabling engagement and living out person-centred values in practice, and the impact of contextual factors on delivering safe and effective care. Preparedness and readiness to engage was considered an essential precursor for involvement in practice development. This conclusion has important implications for the development of the workforce, at individual and team level, and the knowledge and skills required to enable practitioners to engage in a critical dialogue about person-centredness in practice, and to use approaches that will create person-centred cultures. Furthermore, the acknowledgement of contradictions in practice highlights the need to continue to develop practice using participatory approaches if our goal is to improve the experience of patients and staff in health and social care.

Implications for practice

The findings from this programme offer new insights into how person-centredness can be supported in everyday practice. There is value in assessing context readiness as an essential precursor to involvement in a practice development programme and in light of this, delivering an intervention that takes account of this information, but has as its core active learning. Active engagement with managers is also vital to ensure a collaborative approach to recognising and managing the context in which care is delivered so the team can work towards creating an effective workplace culture. Finally, we need to explore further the impact of practice contradictions on the experience of patients and staff, and consider how we can develop further tailored interventions that contribute towards cultures that are healthful and enable human flourishing for all.

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A commentary by Jackie Crisp appears on the next page.

COMMENTARY

Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme

Jackie Crisp

The opportunity to write this commentary caused me to reflect on several issues to do with my own experiences with similarly complex programmes of work and dissemination of findings, including the challenges that at times have overwhelmed those of us involved and slowed or even stopped our efforts to share our findings and learning. Some of those reading this commentary may be familiar with workplace conversations that end with the agreement that 'we are too busy doing the work to write about it'. The invitation to write the commentary also led me to reflect on the drivers of decisions concerning what to publish: specifically, the question of which stories get told, which sit implicitly in the background of those that are told, and which stories are only shared locally or remain forever within the research team. The following commentary is a little different to the norm in that it has its origins in questions that arose out of the paper at hand, but seeks to stimulate more general thinking related to decisions concerning publication of our research/evaluation work.

A programme such as the one presented within this paper is not to be undertaken by those who lack stamina, perseverance and the courage to deal with ongoing complexity and uncertainty, and to remain 'in it' for the long haul. Through this paper the author(s) take on the substantial task of outlining the programme and its evaluation: establishing the need for such work; providing an overview of the theoretical underpinnings of the programme; describing some of the processes involved in leadership and facilitation development and support; explaining the evaluation methods, including the approach to data collection and analysis; presenting the major themes uncovered through the evaluation; and discussing the findings and making recommendations for future work and practice.

The obvious commitment of the author(s) to their programme came through on my first reading of the paper, as did the enormity of the task of providing an in-depth account of their work. At this point I was reading with a sense of curiosity and a desire to see the story unfold. As a reader with similar interests and experiences to the author(s) I found myself nodding; some would call that the 'phenomenological nod', reflecting the extent to which what I was reading rang true for me, a different person attempting to do similar things in a different context. As the author(s) state, the findings are indeed confirmatory of previous findings within the emancipatory practice development (ePD) literature. They also rang true from my perspective as a reader with a relatively complex schema for ePD work, which underpins theory, its facilitation and common approaches, the enablers and challenges and the common experiences of those seeking to lead, facilitate or engage in true collaboration in order to impact positively on ourselves as individuals, our practice and our workplace cultures. However, the decision to tell the overall story of the work had obvious implications for the author(s)' ability to provide details across all sections of the article: for example, concerning the specific components of the programme and its evaluation.

The critical questions that arose for me as I reread the paper were, therefore:
- What are the author(s) aiming to achieve in publishing this work?
- How well does the story told within this paper fit with those aims?

Brown (1994) generated eight questions to help authors clarify content and structure of an evolving manuscript in relation to key messages and target audience (see Table 1). In common with many colleagues and students, I find that going through these questions is extremely useful. The process also creates a space in which challenging conversations are more likely to take place: conversations around authorship, intellectual property, writing workload and commitment to timelines to name but a few.

Table 1: Robert Brown's eight questions		
1		Working title of paper (20 words)
2		Authors (in order of appearance)
3		Anticipated journal/s
4		Intended readers
5		What is the central question that your paper will pose? (25 words) The central question of my paper is …
6		If your readers had only one sentence to summarise your article, what should it be? 25 words. Focus on the outcomes from the work, not the inputs
7	*a*	Why did you do the work? (70 words) Briefly outline the problem you are tackling and why it is important
	b	What did you do? (70 words) Briefly outline the methods you used to gather evidence
	c	What happened? (100 words) Briefly outline the key results. Focus on outcomes
	d	What can you add to the theory? (70 words) A research paper has to add to broader understanding. What will yours contribute? Think about how your results and conclusions will change how people see the world
	e	What can you add to practice? (70 words) Superior research also has practical consequences. What are the consequences of your work? Think about how your results and conclusions might change what people do
8		What remains unresolved? This is more for your own benefit, but will provide some guidance for your audience and some of it may be useful in your discussion

What I have come to realise – and I should acknowledge that others have probably been trying to tell me this for years – and what I attempt to share with research colleagues and research students, is that the decision to tell a particular story means that other stories remain untold. And, the many decisions we make, consciously or unconsciously, in relation to our writing are informed by a range of personal, professional, political reasons (or, if you prefer, 'practice developer', 'researcher' or 'academic' reasons) for choosing one story over another. As in life more generally, it behoves us to bring the drivers of such decisions to our conscious awareness, where we can engage ourselves and others more fully in decision-making that fits comfortably with our goals and intentions.

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RESPONSE TO COMMENTARY

Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme

Tanya McCance

This is an insightful and useful commentary that raises the important question of which stories get told and indeed which remain untold, through the evaluation of complex practice development programmes such as the one presented in this paper.

While it is suggested that decisions made to tell a particular story are influenced by a range of factors, we would contend that the only story that can be told is the one that is evidenced in the evaluation data. That said, we are not denying that there was the potential for multiple stories to be told by the various stakeholders participating in this programme; as researchers, however, we have an ethical responsibility to work with the data generated. With this in mind, the important issue for practice development researchers is the need to pay attention to evaluation strategies that give voice to multiple discourses that evidence the impact of engaging in emancipatory practice development.

The development of a robust and rigorous evaluation framework is the focus of work currently being undertaken by the International Community of Practice at the University of Ulster, and this reflects a desire to develop knowledge to support the continued evolvement of practice development within a wide range of healthcare settings.

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