 Contemporary Nurse (2009) **32**(1–2): 92–104.

Practice development: Realising active learning for sustainable change

Brendan McCormack
Professor of Nursing Research, School of Nursing, University of Ulster, Jordanstown, Northern Ireland

Jan Dewing
Honorary Research Fellow, University of Ulster/Independent Nurse Consultant, Visiting Professor, University of Wollongong, Wollongong, NSW, Australia

Liz Breslin
Development Officer, Nursing/Midwifery Planning and Development Unit (HSE North West), Donegal, Republic of Ireland

Ann Coyne-Nevin
Assistant Director of Nursing/Programme Facilitator, St Patrick's Hospital/Nursing/Midwifery Planning and Development Unit (HSE South East), Waterford, Republic of Ireland

Kate Kennedy
Nursing and Midwifery Workforce Planner, Nursing and Midwifery Planning and Development Unit (HSE South), Cork, Republic of Ireland

Mary Manning
Practice Development Facilitator, Older Persons Services, Nursing/Midwifery Planning and Development Unit (HSE Mid-Leinster), Offaly, Republic of Ireland

Lorna Peelo-Kilroe
Regional Practice Development Facilitator, Older Persons Services, Nursing/Midwifery Planning and Development Unit (HSE West), Limerick, Republic of Ireland

Catherine Tobin
Post Graduate Diploma Coordinator/Programme Facilitator, Centre for Nursing and Midwifery Education/Nursing/Midwifery Planning and Development Unit (HSE North East), Ardee, Republic of Ireland

ABSTRACT

This paper explores the concept of practice development in the context of professional development and strategies for facilitating learning in practice. In this paper we present the background to the methodology of emancipatory and transformational practice development. Key concepts underpinning a contemporary definition of practice development are unravelled and nine principles for effective practice development proposed. An example of a large-scale national practice development programme with older people residential settings in the Republic of Ireland is presented to illustrate the processes in action. The findings of the first year of the programme are offered and these findings demonstrate the ways in which practice development systematically uncovers the deeply embedded characteristics of practice cultures – characteristics that often inhibit effective person-centred practice to be realised.

Keywords: practice development; active learning; evaluation; change; facilitation

Introduction

Practice Development is a well established international movement. Over the past 10 years significant conceptual, theoretical and methodological advances have been made in the development of frameworks to guide practice development activities. During that period, the relationships between practice and professional development have been deliberated so that greater clarity can be achieved around their relationship with each other. In this paper, some background to practice development will be presented, including an overview of the key concepts within practice development and current evidence underpinning the methodology of emancipatory practice development. We will then use the processes and outcomes arising from the first year of a 2-year national practice development programme being undertaken in the Republic of Ireland to illustrate core practice development processes in action.

Background to practice development

All innovations have their roots in what has preceded them and practice development is no exception. Practice development (PD) is a systematic approach that aims to help practitioners and healthcare teams to look critically at their practice and identify how it can be improved. It not only works with concrete projects or initiatives but also seeks to first deconstruct and then reconstruct the different types of patterns within the workplace and enable staff to better understand and facilitate their workplace cultures. Thus, its purpose is to develop more effective workplace cultures that have embedded within them person-centred processes, systems and ways of working. Unique to practice development is its explicit person-centred focus. Person-centredness is about respecting and valuing each individual as a unique being with rights, and engaging with them in a way that promotes their dignity, sense of worth and independence. This is the essence of caring, fundamental to nursing, and core to health care business. The delivery of effective healthcare is significantly dependent on the staff who deliver the care. It is they who create and sustain the climate and culture within which patients are cared for and therefore the culture that is most directly experienced by patients and families. Corporate culture also plays a role in how practice development is viewed. Practice development facilitators help staff and managers to get underneath the surface and patterns of their immediate cultures, to critically reflect on the values and beliefs they hold about patient care and their workplace cultures. Teams are challenged to consider if the behaviours, systems and processes used in practice are consistent with person-centred values. They are enabled to identify what needs to change and the part they need to play in effecting continuous improvement. This needs staff to be able to reflect on and evaluate evidence from practice, enhance their ability to implement evidence into practice, to be consistent and sustain new initiatives. Processes that: (1) enable staff to learn about and take control of their own practice, (2) integrate work-based active learning, and (3) develop new knowledge, skills and ways of working are vital to achieving sustainable change.

Key concepts in practice development

There have been significant advances in our understanding of the key concepts underpinning practice development work irrespective of methodological perspectives being adopted. For example, workplace culture, person-centredness, facilitation; practice context; evidence, values and approaches to active learning (Bellman, Bywood, & Dale, 2003; Clarke & Wilcockson, 2002; Dewing, 2004, 2008a; Fink, 1999; Manley, 2004; McCormack, 2004; Rycroft-Malone et al., 2003; Titchen, 2004). In a concept analysis of practice development, Garbett and McCormack (2004, p. 29) articulated the interconnected and synergistic relationships between the continuous process of improvement; development of knowledge and skills; helping or facilitation and systematic, rigorous and continuous processes of emancipatory change in order to achieve the ultimate purpose of evidence-based and

person-centred care that reflects the perspectives of users. Manley and McCormack (2004) articulate these elements of practice development in a model called 'emancipatory practice development' (ePD). Whilst the Garbett and McCormack definition makes explicit the interconnected and synergistic relationships between the concepts stated above, the definition fails to capture some of the more contemporary developments in health care services and within practice development or the notions of creativity and active learning. Contemporary practice development has embraced creativity and indeed some of the most recent exciting advances in practice development methodologies relate to the way creative and cognitive processes are integrated (McCormack & Titchen, 2006; McIntosh, 2008; Titchen & McCormack, 2008). It is becoming apparent that active learning can make a significant contribution to practice development. Practice developers in an 'International Practice Development Collaborative', recognising the need to provide theoretical and methodological frameworks to guide development activities, have proposed a new definition of practice development as:

> …a continuous process of developing person-centred cultures. It is enabled by facilitators who authentically engage with individuals and teams to blend personal qualities and creative imagination with practice skills and practice wisdom. The learning that occurs brings about transformations of individual and team practices. This is sustained by embedding both processes and outcomes in corporate strategy – (Manley, McCormack, & Wilson, 2008, p. 9)

Consequently the key concepts that currently influence practice development are: sustainable person-centred cultures; enabling facilitation (Shaw et al., 2008, p. 147); authentic engagement; blending personal qualities and creative imagination with practice skills and practice wisdom; active learning; transformations of individual and team practices and corporate strategy. These concepts can be translated into nine principles that can then be used to guide practice development activities in health care settings and in academia (Table 1, adapted from Manley et al., 2008). These principles are particularly intended to help commissioners, funders, policy makers (for example) about what practice development is and what it is not. These principles can provide the criteria or standards by which any activity presented as practice development could be judged as such and differentiated from other activity that may be similar or different. Similarities and

TABLE 1: NINE PRINCIPLES FOR PRACTICE DEVELOPMENT ACTIVITIES

1. Aim to achieve person-centred and evidence-based care that is manifested through human flourishing and a workplace culture of effectiveness in all healthcare settings and situations
2. Direct attention at the micro-systems level – the level at which most healthcare is experienced and provided, but ensure coherent support from interrelated mezzo and macro-systems levels develops
3. Integrate work-based learning with its focus on active learning and formal systems for enabling learning in the workplace
4. Integrate and enable both the development of evidence from practice and the use of evidence in practice
5. Integrate creativity with cognition in order to blend differing energies, enabling practitioners to free their thinking and allow opportunities for human flourishing to emerge
6. Recognise the complexity of the methodology and its many uses across health care teams and interfaces to involve all internal and external stakeholders
7. Utilise key methods that are consistent with the methodological principles being operationalised and the contextual characteristics of the PD programme of work
8. Utilise a set of processes including skilled facilitation that can be translated into a specific skill-set required as near to the interface of care as possible
9. Integrate evaluation approaches that are always inclusive, participative and collaborative

differences with, for example, service development, are important where the latter is focused on systems and processes compared with practice development which focuses on people and practices. We will now expand on each of the key concepts.

Person-centred cultures: are for everyone. Staff must experience a person-centred culture as part of the process of them offering this to patients and families. The systematic development and empowerment of staff is a deliberate purpose inter-related with creating a specific type of culture, termed a *transformational* culture. This is a type of culture where quality becomes everyone's business; positive change becomes a way of life; everyone's leadership potential is enacted; and, where there is a shared vision apparent in numerous ways, including service management (Dewing, 2008b), investment in and valuing of staff (Manley, 2004).

Enabling facilitation: PD relies on skilled holistic facilitation. Facilitators aim to help staff become aware of and freed from taken-for-granted aspects of their practice, their roles in creating and sustaining culture in the workplace and the organisational systems constraining them. Facilitators foster a climate of critical intent through multiple methods and assist enlightenment and empowerment through various high challenge and high support strategies. Although facilitator's roles in practice development vary depending on the facilitator's role within the organisation, they are generally responsible for enabling a culture to develop where practitioners can bring about changes. Thus facilitators do a lot of 'behind the scenes' work in practice development (Shaw et al., 2008).

Authentic engagement: drawing on Titchen's (2001) concepts of 'authentic use of self' and McCormack's (2001) framework of 'authentic consciousness' the concept of authentic engagement requires practice development facilitators to engage in reflexive engagement with others. Working authentically, a facilitator has a heightened awareness and a deep understanding of the assumptions that they and others make. This awareness and understanding enables perspectives to be challenged and supported and different assumptions to be blended for the purposes of rigour.

Blending personal qualities and creative imagination with practice skills and practice wisdom – creativity: McCormack and Titchen (2006) have articulated the way in which cognitive and artistic processes can enable critical engagement to happen, new and novel solutions to be identified and alternative perspectives to be realized.

Active learning: this is an approach to in-depth learning that draws on, creatively synthesizes and integrates numerous learning methods (Dewing, 2008a, p. 273). It is based in and from personal experience of practitioners and patients in the workplace. Being open to, engaging with personal experience and learning from experience are central activities in emancipatory and transformational practice development work and to achieving its purpose. Active learning draws on multiple intelligences; critical reflection; learning from self; from dialogue and shared experiences with others, enabling facilitation and action and primarily takes place in the workplace. Central to active learning is both the translation of learning into practice, so that the practitioners' own practice is experienced differently and secondly, the enabling or facilitating of active learning with others. Everyday doing – and often taken for granted – aspects and patterns of practice are critical markers for Active Learning. For example: active learning methods can be used to explore language and discourse; values and beliefs; the environment and who it privileges; signage; routines and rituals; team work and facilitation and so on. Facilitating staff to learn how to evaluate the processes and outcomes of practice and to demonstrate the impact of

practice development for patients, families and staff is also a core activity.

Transformations of individual and team practices: transforming the cultures of practice is a key focus of practice development. With its focus on working with people, the systematic and integrated practice development processes enable individuals and teams to explore and realize practice alternatives and change practice cultures.

Corporate strategy: as part of embedding practice development within organisations it must be visible within corporate strategy (Dewing, 2008b). Practice development needs to provide evidence to demonstrate sustainability (would it work?), feasibility (can it be made to work?) and acceptability (will 'they' work it?). In the classic three stage model proposed by Johnson and Scholes (1984) strategic options are evaluated against the three key success criteria just mentioned. Strategic thinking is not always easy as many practice developers are more comfortable working at the micro level of the organisation which tends to lead to tactical thinking instead.

In summary, with this advancement in practice development methodology comes both increasing complexity with regard to the theoretical ideas underpinning it, but also increasing clarity about how the methodology is translated into practice. Thus it has been possible to develop a set of principles that articulate the activities involved in practice development.

Practice development: The evidence

The first systematic review of practice development was undertaken by McCormack, Wright, Dewer, Harvey, & Ballintine (2007a, 2007b, 2007c, 2007d). The study was underpinned by a method of systematic review of a diverse range of evidence called Realist synthesis (Pawson, Greenhalgh, Harvey, & Walshe, 2004). This methodology enables the study of complex interventions in response to the perceived limitations of traditional systematic review methodology. Practice development with its multiple methodological and method perspectives is considered to be a complex intervention and thus the use of realist synthesis was appropriate. The purpose of the review was to identify approaches adopted to practice development and critically examine the evidence base that supports them, drawing on both empirical data and expert opinion.

The study was designed in two phases: *Phase 1* focused on reviewing the published practice development literature using the review methods of realist synthesis as outlined by Pawson et al. (2004). The phase was operationalised through 3 stages of work from explicitly agreeing the focus of the study, the identification of contributory theories to practice development that would shape the review questions (the review was structured around 13 areas of theory reflecting 4 broad theoretical perspectives of practice development). One hundred and sixty-nine papers were selected for review following various stages of refinement of the search strategy. Of these papers, 71 explicitly used practice development as a study methodology or studied the experience of involvement in practice development; 30 were scholarly reviews of practice development literature; 6 were concept analyses; 29 papers were studies where practice development was implicit to the work and 33 were empirical research studies that related to practice development but did not focus on practice development processes or outcomes. *Phase 2* was informed by the outcomes of phase 1 and undertaken in two stages – stage 1 included the review of the grey practice development literature using the same review processes as phase 1 and stage 2 involved the conducting of telephone interviews with key informants internationally. A total of 41 items of grey literature were reviewed and in addition four books were reviewed that are widely referenced in the literature because they add to an understanding of practice development methodology (Bellman, 2003; Bryar & Griffiths, 2003; McCormack, Manley, & Garbett, 2004; Page,

Allopp, & Casley, 1998). A total of 47 interviews were undertaken with key informants representing strategic, organisational, unit and academic roles in the UK, Republic of Ireland, Sweden, The Netherlands, New Zealand, Australia, Canada and the USA.

The findings

From the findings of the systematic review, McCormack et al. identified nine key issues that need to be addressed in order for practice development to have a desired impact:

1. Decisions about practice development being uni or multi-disciplinary should reflect the overarching intent/desired outcomes of the development work itself. Currently there is no evidence to suggest either one or the other approach works better.
2. The involvement of managers in practice development is crucial to the successful implementation of practice development processes and the sustainability of outcomes.
3. There is universal acceptance of the need for patient/service user involvement (or engagement) in practice development work.
4. Practice developers in 'formal' practice development roles need to have skills in expert holistic facilitation.
5. Collaborative relationships with Higher Education Institutions (HEIs) can provide an important means of reducing isolation for practice developers, but also a way of extending the potential for systematic and rigorous processes to be adopted.
6. If practice development processes and outcomes are to be sustained beyond the life of particular project timeframes, then there is a need to embed practice development activities in learning strategies within organisations. Therefore practice development and learning are inextricably linked.
7. Effective practice development requires the adoption of three key methodological principles – collaboration, inclusion and participation.
8. There are a number of methods that are effective in ensuring participatory engagement and in bringing about changes in the culture and context of practice (Table 2).
9. Outcome measurement in practice development is complex and does not lend itself to traditional methods of outcome evaluation. Outcome measurement needs to be consistent with the espoused values of 'participation and collaboration' where data collection and analysis is an integral component of the development itself.

TABLE 2: METHODS THAT ARE EFFECTIVE IN ENSURING PARTICIPATORY ENGAGEMENT AND IN BRINGING ABOUT CHANGES IN THE CULTURE AND CONTEXT OF PRACTICE

1. Agreeing ethical processes
2. Analysing stakeholder roles and ways of engaging stakeholders
3. Person-centredness
4. Clarifying the development focus
5. Clarifying values
6. Clarifying workplace culture
7. Collaborative working relationships
8. Continuous reflective learning
9. Developing a shared vision
10. Developing critical intent
11. Developing participatory engagement
12. Developing shared ownership
13. Developing a reward system
14. Evaluation
15. Facilitating transitions
16. Generating new knowledge
17. Giving space for ideas to flourish
18. Good communication strategies
19. Implementing processes for sharing and disseminating
20. High challenge and high support
21. Knowing 'self' and participants
22. Use of existing knowledge

In summary, practice development has as its explicit intent, the development of cultures that can sustain continuous processes of improvement and innovation with a focus on the development of person-centred cultures. The explicit intention of practice development is the empowerment of all practitioners to take responsibility for the quality of their practice, develop practice and learn about the processes involved. Thus professional development is a necessary partner to practice development, although, we would argue that practice development is the overarching approach.

We will now move on to present a case study in order to illustrate much of the previous content. In particular, we want to illustrate the methodological principles and methods of practice development in action, woven together in a large scale practice development programme.

A 'CASE STUDY' OF PRACTICE DEVELOPMENT

The 'Older Persons Services National Practice Development Programme' is a 2-year programme involving older people, families and staff in eighteen older person service residential sites across the four Health Service Executive [HSE] Administrative Areas in the Republic of Ireland. It is a collaborative programme between the University of Ulster and six Nursing and Midwifery Planning & Development Units (NMPDU), HSE[1]. It is jointly funded by the NMPDUs and the National Council for the Professional Development of Nursing and Midwifery[2]. The ultimate aim is to improve the experience of care that older people receive through the implementation of a model of person-centred practice (McCormack & McCance, 2006). A formal programme of work is in place in each of the sites, directed nationally by two programme leaders from the University of Ulster (BMcC and JD) and led locally by six NMPDU facilitators (the other co-authors of this paper).

Context

Like many countries internationally, the Republic of Ireland has a mixed economy of residential care provision. Residential services are provided through a network of local community hospitals, publically and privately funded nursing homes, but with a large proportion of residential care funded and provided by the health service. The modernisation of services is a key priority of the HSE and since 2007 a transformation programme has been in place (See http://www.hse.ie/eng/HSE_FactFile/FactFile_PDFs/Other_FactFile_PDFs/Transformation/Transformation%20Programme%202007-2010.pdf for further information). Six priorities underpin the transformation programme and these comprise structural, systems and behavioural changes. A major focus in the transformation programme is the development of services for older people with a particular focus on developing integrated and 'joined-up' services. In the residential care sector newly developed 'National Quality Standards for Residential Care Settings for Older People' (Health Information and Quality Authority [HIQA], 2007) are being introduced and these have person-centred practice as a central strategic direction of service delivery.

Programme aims

The overall aim of the programme is to implement a framework for person-centred nursing for older people across multiple settings in Ireland, through a collaborative facilitation model and an evaluation of the processes and outcomes.

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[1] There are eight Nursing and Midwifery Planning and Development Units [NMPDU] in the Republic of Ireland. The NMPDU is an integral component of the Health Service Executive, coordinating continuing professional development, practice development, quality improvement and workforce developments in the Health Service Executive areas.

[2] The purpose of the Council is to promote and develop the professional roles of nurses and midwives in partnership with stakeholders in order to support the delivery of quality nursing and midwifery care to patients/clients in a changing healthcare environment.

Objectives

1. Coordinate a programme of work that can replicate effective Practice Development processes in care of older people's settings.
2. Enable participants/local facilitators and their Directors[3] and other managers to recognise the attributes of person-centred cultures for older people and key practice development and management interventions needed to achieve the culture (thus embedding person-centred care within organisations).
3. Develop person-centred cultures in participating practice settings.
4. Systematically measure or evaluate outcomes on practice and for older people.
5. Further test a model of person-centred practice in long-term care/rehabilitation settings and develop it as a multiprofessional model.
6. Utilise a participant generated data-set to inform the development and outcomes of person-centred practice.
7. Enable local NMPDU facilitators to work with shared principles, models, methods and processes in practice development work across older persons' services.

Ethics

Ethical approval for the programme of work was received from six individual ethics committees. The university facilitators developed a 'core protocol' and supporting letters, information sheets and guidance notes. They then worked with each NMPDU facilitator to contextualise the core materials to each participating facility. The protocol took account of development activities, individual site evaluation activities and the overall programme evaluation framework.

Programme of work

The programme commenced in September 2007. An awareness campaign was initially held in each participating site with an open invitation to attend extended to all staff, older people and their families. Following on from these sessions, practice development programme groups were established. The groups represent staff from different areas within the units and different grades; i.e. Clinical Nurse Managers, Staff Nurses, Health Care Assistants, Housekeeping, Catering and Administration staff. The participants from the sites meet with the internal facilitator from within their unit and the external facilitator from the NMPDU for a formal programme and skills development day every 6 weeks. A range of interim meetings, project working groups and discussion groups have also been established. The university facilitators provide direct facilitation support to the NMPDU facilitators as well as leading the design of the facilitation activities in the different settings, coordinating the programme of work across all sites to ensure consistency and managing the evaluation of the programme. The rate of engagement by participants with workplace active learning activities designed to enable learning and model changes in practice has been consistently high. Some sites have since recruited new programme members as the programme has progressed. Across all sites there have been key activities which have included (for example):

- Developing an understanding of what the work/practice development involves and the processes used. Becoming familiar with the Person-Centred Framework (McCormack & McCance, 2006) and Practice Development Model (Garbett & McCormack, 2004; McCormack, Manley, & Walsh, 2008) which are the central frameworks used in the programme.
- Developing a shared vision using Values Clarification Exercises involving the Residents/Patients' Families/Carers and all staff within their workplace. Clarifying values and beliefs and agreeing common or shared values and

[3] Directors of Nursing are Nurse Managers responsible for overall site and clinical management and are equivalent to a Band 8 in the UK and in Australia to a Nursing Co-Director.

beliefs is the first step in collaborative practice development work. In order for this exercise to have meaning everyone had the opportunity to become involved and forward opinions and suggestions that may be helpful in identifying a common vision for their service. Using values clarification exercises has helped give a sense of direction and a common vision for the future. Vision statements have been completed and are used on a daily basis in various ways.

- Active Learning on Language and Discourse: At the beginning of year 1, participants were asked to reflect on how person-centred the language used every day is. This not only applied to the language used when speaking to older people but also to each other and language used in documentation. Participants developed posters to generate group discussion amongst their colleagues. The posters were displayed throughout the units, which again promoted wide scale discussion about person-centredness and workplace cultures. Staff are now much more aware of the language they are using and how language can impact on how they behave and view older people. Moreover, it is more acceptable for staff to challenge each other if language is not person-centred.
- Active Learning with Observations of Practice: Participants have all been involved in carrying out several short observations of the care setting, team relationships and care practices. This has helped the participants get a greater understanding of how person-centred the care is for the older person within their units. Seeing practice, raising consciousness about taken-for-granted practices and assumptions and reflecting on them are key components of the observation activities. Observations were then formalised into one of the evaluation methods (see below). Providing feedback to the staff in the form of a 'critical dialogue' was essential to challenging practice by highlighting the differences between values espoused and those observed in practice. These activities highlighted the need to see things from a different perspective and to facilitate therapeutic/relationship-based care that can be sustained and thus transform healthcare delivery. It has enabled participants to reflect on how they practice and the things they take for granted. It has been a powerful tool which the participants are now engaging in with other staff to facilitate them carrying out observations of care to inform practice. Participants have also facilitated other team members to undertake these activities for themselves.
- Active Learning with Environmental Walkabouts by the Participants: The purpose of these is for participants to look at how person-centred or not the environment is for older people. The basis for this is that unless we offer older people an environment that compensates for impairments and disabilities, as far as is possible, they are being made to be more disabled and dependent than is needed. The data collected is being used to inform the development of action plans in year 2. Participants have facilitated additional walkabouts with other staff. In some sites older people and family members have also been involved in this activity.
- Structured Reflection: Participants have been introduced to a model of reflection and the use of reflective questioning which they are being encouraged to use at all programme events and everyday. Participating in structured reflection is assisting participants in both their personal and professional learning. It is helping them value practice: identifying and building on what they do well, exposing contradictions, identifying and addressing what they could do better, managing conflict and stressful situations.
- Facilitation Skills Development: Asking questions, high challenge, high support, giving and receiving feedback are all components of facilitation that have been explored and developed in the programme. Participants have been introduced to these skills and are being encouraged to further develop their confidence in using these skills in their every day work and across their workplaces to help develop a more person-centred culture.

- Introduction to the evaluation methodology used for the programme and involvement in the collection of the evaluation data for phase one. A range of evaluation tools and processes have been used in this programme. Wherever possible programme participants have been involved in collecting and analysing this data and informing the identification of outcomes.

Evaluation process

Processes and outcomes are being evaluated within a framework of cooperative inquiry (after Heron & Reason, 2001) primarily drawing upon reflective dialogue data between the NMPDU Facilitators, Internal Facilitators, Programme Participants and the Programme Leaders; interview data with all participants and records of developments. In addition, a number of 'tools' are being used to systematically evaluate the processes and outcomes of the activity and to measure the existence and growth of person-centred care. Data has been collected between December 2007, March 2008 and January 2009 and will be collected again in August 2009. These tools have been developed as components of previous research and development in person-centred care and have established validity and reliability data:

1. Context Assessment Index [CAI] (McCormack, McCarthy, Wright, Slater, & Coffey, 2009): This tool assesses the practice context and its receptivity to person-centred ways of working.
2. Person-centred Nursing Index [PCNI] (McCormack et al., 2008): This tool measures the processes and outcomes of person-centred nursing from both nursing and patient perspectives.
3. Person-centred Caring Index [PCCI] (Slater & McCormack, 2007): This tool measures the processes and outcomes of person-centred caring from healthcare worker perspectives (including healthcare assistants and other care workers in the care setting who contribute to patient care).
4. Cultural observation tool (WCCAT) (McCormack, Henderson, Wilson, & Wright, 2009): this recently developed observation of practice tool explores the culture of a workplace at a number of levels in order to inform the degree to which changes in practice are achieving a change in culture.
5. User Narratives: Utilising a framework developed by Hsu and McCormack (2006) for collecting and analysing older people's stories about the quality of care, this data would serve to bring richness and depth to the other data sets.

The project leaders and lead facilitators all act as co-researchers in the collection and analysis of data. Thus the framework has the added benefit of developing evidence-gathering and research skills among the programme team and the programme participants.

Data collected using the CAI, environment awareness and impact, and the observation of care tools were analysed at a local level by the practice development groups and facilitators and the data used to inform the development of local action plans. Data collected using the PCNI, PCCI, WCCAT and user narratives were also analysed at a local level to inform the development of action plans and at a national level to inform the effectiveness of processes and outcome achievement across the programme as a whole. In addition to this data, stakeholder perceptions of the programme have been gleaned through events with the directors of nursing and through a questionnaire with other key stakeholders. The notes from the programme days across all the sites detailing learning evaluations and feedback to Directors have also been collated. Within the programme team, notes and reflective accounts have been collated.

Summary of findings

- Privacy and Dignity: This theme reflected aspects of practice that enhanced patient dignity and approaches that resulted in undignified

practice (such as a task approach). Issues of privacy were identified relating to the care environment and in the way care practices were carried out.

- Choice and Power: This theme reflects issues that arose regarding the involvement of older people in their care decisions and on the exercise of power by care staff. The power of older people to determine care options was also identified. From a staff perspective, the need for collaborative and inclusive approaches to management decisions was identified as a key issue.
- Hope and Hopelessness: Having a sense of hope is well documented in the literature as a key component of person-centredness with older people (Berg, Sarvimäki & Hedelin, 2006). This theme reflects perceptions of hope and hopelessness among older people in these care settings that largely arose from their narratives. The theme reflects a number of sub-themes including confusion, 'spiral of life', loneliness, invisibility and isolation.
- I'm Just a Task (Task Orientation): The contrast between espoused values of person-centredness and an orientation on the completion of tasks in every day work is reflected in this theme. The need for reflective engagement among staff to explore on a daily basis the balance of workload and skill-mix available is a key issue.
- Environment: The care environment is known to impact on person-centred practice. This theme reflects approaches to the management of the care environment that enabled a sense of 'home' to be established and aspects of the care environment that need to be addressed. Concern about infection control and health and safety being highly risk adverse also featured here as well as the need to develop care environments that embed 'high challenge with high support' in the workplace culture.
- Communication and Interaction: Boredom and a lack of activity were key sub-themes in the data. These issues and others associated with interdisciplinary team communication are reflected in this theme.
- Staffing and Team Work: The culture of care is reflected in this theme. Observed issues of team-effectiveness and ways in which this could be developed to enhance person-centred practice are important here.

The principles of this programme are firmly drawn from the practice development evidence base and they are further consolidated by linking them to the core principles of the Republic of Ireland 'National Quality Standards for Residential Care Settings for Older People' – '*the standards promote a person-centred ethos and culture that should govern the provision of residential care for older people*' (HIQA, 2007, p. 4). The action planning process in each of the sites is explicitly working with these standards.

Moving to year two

Now that the programme is into the second year a lot of the preparatory work is completed in the sites. The focus at this point is to: (1) continue to build capacity within the working groups so that each member has confidence and ability to facilitate practice development in the workplace; (2) to consolidate learning in applying practice development processes and evaluate outcomes of action plans; and (3) for internal facilitators and programme participants to take on more influencing of other practice development matters and to involve more staff in the work.

Summary

In this paper we have outlined the background, underpinning concepts and key principles of practice development. There are many approaches to developing effective person-centred practices, but the methodology of practice development with its focus on working with staff to critically explore their practice culture and bring about changes that make sense to them is increasingly recognised as of value in systems redesign. The explicit and deliberate use of active learning strategies means that the chances of sustaining practice culture changes through the collective learning among teams is greater. However, it

continues to be the case that professional and practice development are often seen as separate activities thus the potential benefits of both are not maximized. The development of strategic partnerships between higher education providers, education and research funders and senior managers is critical to the advancement of practice development methodologies, the integration and embedding of learning in practice and the transformation of practice cultures. The case study highlights the important role that higher education providers play in the facilitation of active learning strategies and ensuring that research and development processes and outcomes are embedded in workplaces.

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Received 20 December 2008 *Accepted 21 May 2009*