Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Office of the
Nursing & Midwifery
Services Director

University of
ULSTER

The Implementation of a Model of Person-Centred Practice In Older Person Settings

FINAL REPORT

THE IMPLEMENTATION OF A MODEL OF PERSON-CENTRED PRACTICE IN OLDER PERSON SETTINGS

FINAL REPORT

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ACKNOWLEDGEMENTS

- Margaret Buckley, Regional Facilitator NMPDU South and Seamus McCaul, NMPDU North East who worked as NMPDU facilitators in the first year of the programme.

- Julie Cummins, Administrator, Institute of Nursing Research, University of Ulster for her attention to detail in the final editing of this report.

- The residents, families, friends and other colleagues who participated in a variety of ways in this programme. We dedicate this work to them as without their participation none of the developments would have happened. Their contributions and participation will enable others to benefit from their insights, challenges and support. Thank you.

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EXECUTIVE SUMMARY

BACKGROUND AND CONTEXT

This national two year practice development programme in the Republic of Ireland (2007-2009) has significantly built on the learning and recommendations of a pilot practice development programme that was undertaken in the Midlands Region (2005-2007).

The national programme was also influenced by broader international theoretical and methodological developments in practice development, especially those within the International Practice Development Collaborative. In particular, the programme has built on the findings of the first systematic review of practice development. In this review the authors identified nine key issues that need to be addressed in order for practice development to have a desired impact.

The programme was managed and delivered by the University of Ulster. The funding for the programme came from the National Council for the Professional Development of Nursing & Midwifery and the six participating NMPDUs. The budget was managed by the NMPDUs. Recognition is also made that all the programme sites found ways of releasing staff to contribute to the programme within their existing budgets. It should be noted that as this programme took place during a prolonged period of wide scale financial pressures on the HSEs, it had to be seriously modified in year 2 in order to be sustainable.

PROGRAMME AIMS AND OBJECTIVES

The overall aims of the programme were to: implement a framework for person-centred practice for older people across multiple settings in Ireland, through a collaborative facilitation model and to carry out an evaluation of the processes and outcomes. For the purposes of this programme, the team defined person-centredness as:

"an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, older 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"

Programme 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 and 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 multi-professional model.

6. Utilise a participant generated data-set to inform the development and outcomes of person-centred practice (already designed and tested tools will be used to produce data set).

7. Enable local NMPDU facilitators to work with shared principles, models, methods and processes in practice development work across older people's services.

PROGRAMME METHODOLOGY

The programme drew on numerous principles from different yet complementary theories and approaches; emancipatory practice development, co-operative inquiry and a specific person-centred practice framework. Additionally, through the programmes' activities another methodology emerged, namely 'Active Learning'. Within the emancipatory practice development approach, for the aims of this programme, particular emphasis was placed on evaluation and on learning. Within the programme, the active learning methodology was systematically tested refined and expanded.

PROGRAMME STRUCTURE AND PROCESSES

Eighteen residential units for older people were involved in the Older Persons Services National Practice Development Programme for the development of person-centred practice. The programme commenced in September 2007. Practice

development programme groups were established. The groups represented staff from different areas within the units and different grades i.e. Clinical Nurse Mangers, Staff Nurses, Health Care Assistants, Housekeeping, Catering and Administration staff.

The participants from the sites met 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. As the first year progressed a range of interim meetings and discussions groups were established within the workplace in between these days. In year two these session evolved into project working and action plan implementation groups. The programme had a number of visible activities that took place on a regular basis. Overarching these 'events' the programme activities principally involved: (i) developing an understanding of what the work/practice development involves and the competence and confidence to role model the processes to be used (ii) becoming familiar with the Person Centred Framework and Practice Development Model as the frameworks used for the programme and for achieving the above (iii) developing an understanding of workplace culture and 'change' processes (iv) awareness raising activities for different staff groups, older people and families in the programme sites (v) developing a shared vision using Values Clarification Exercises involving the Residents/Patients Families/Carers and all staff within their work place (vi) Active Learning in the workplace (vii) structured reflection (vii) facilitation skills development (viii) developing greater appreciation of skills in effective group and team working and (iv) working with evaluation methodology and methods.

PROGRAMME EVALUATION

The processes and outcomes from the practice development programme were evaluated within a framework of cooperative inquiry. In addition, a number of 'evaluation instruments' were used. These instruments have been developed as components of previous research and development in person-centred practice and have established validity and reliability. The project leaders, lead facilitators and project participants all acted as co-researchers in the collection and analysis of the data. Thus this programme has the added benefit of developing evidence gathering and research skills among participants. Data were collected at three time points during the programme: approximately between December 2007 - March 2008 and again at two more time points (January-February 2009 and August-September 2009).

Data collected using the Context Assessment Index, Environment Awareness & Impact, and the observation of care tools were analysed at a local level only and the data used to inform the development of local action plans.

Data collected using the Person Centred Care (PCCI) and Nursing Indices (PCNI), Culture observation tool (WCCAT)l and user (older people) narratives were analysed at a local level to inform the development of action plans and collectively at a national level to inform the effectiveness of process and outcome achievement across the programme as a whole. All the data was analysed using a participatory approach with programme participants, programme facilitators and programme leaders.

In addition to this data, stakeholder perceptions of the programme have been gleaned throughout the first year of the programme through various stakeholder events. This data collection ceased in year 2 as a consequence of the national HSE embargo. As an alternative method, at timeline 3, data was collected through a questionnaire with key stakeholders (for example Directors of Nursing from the sites and NMPDUs, service and general managers). However, the response to this was very low thus limiting the usability of the data. The notes from the programme days across all the sites detailing learning evaluations and feedback to Directors were also collated and analysed for evidence of progression. The evaluation of this specific part of the programme identified a variety of active learning activities that were utilised. Many of the activities are now being replicated and refined in an Australian practice development program, again indicating their usefulness within practice development.

SUMMARY OF FINDINGS

The personal and professional growth for individuals across different roles and within the health care teams was evident in the analysis of the programme day notes, thus active learning activities were found to be acceptable to the participants and utilised throughout the programme day and in practice. Further, the acceptability and usability of active learning across all the sites and throughout all the days was high, further indicating its usefulness.

The outcomes from this program also demonstrate that practice development programmes can be led from a distance and that a group of facilitators can be

coached to locally lead and deliver complex practice development activity. It also shows that practice development offers work based and work place learning and skills development that will produce improvements in care and the workplace culture/context.

The summary of findings is presented against each of the key objectives of the programme.

Coordinate a programme of work that can replicate effective Practice Development processes in care of older peoples' settings

This objective has been achieved. A programme was developed, coordinated and delivered. Once the programme began, interest was shown by other sites who wished to become involved. HIQA inspections are prompting other sites to explore practice development activities to achieve their action plans.

Enable participants/local facilitators and their Directors and 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)

Staff and managers became familiar with the Person-centred Practice and practice development frameworks, and learnt a set of core practice development methods and processes. The ground work for embedding practice development within the organisation has taken place. It is now up to others to sustain and nurture this. Given the changes across the NMPDUs it is unclear how successful this will be.

Develop person-centred cultures in participating practice settings.

Significant progress was made in achieving numerous attributes of a person-centred culture. There is no end point to person-centred cultures, thus further development is still needed. If this is not systematically planned and nurtured then the new cultures will begin to fall apart.

Systematically measure or evaluate outcomes on practice and for older people

I. The PCNI and PCCI data demonstrated significant **outcomes for nursing and care staff** and were statistically proven. These changes relate to the 'pre-requisites' of person-centred practice within the person-centred practice framework. These changes are significant in terms of developing a person-centred culture. Statistically significant changes included:

- Preparation for the role
- Staff support
- Knowledge of treatment decisions
- Communication and support
- Career development
- Role satisfaction
- Staffing and resources
- Commitment to the setting
- Workload
- Intention to stay in role

II. There was significant change in nurses perceptions of caring' as assessed using the Caring Dimensions Inventory (CDI). The data analysis showed that staff had shifted their views from one of seeing technical' aspects of nursing as caring, to a view that the 'non-technical' aspects of caring were more important. This was at a statistically significant level.

For residents and families, the data demonstrated significant changes in care practices that resulted in an impact on four key areas of care experiences for older people and their families, with each of them showing qualitatively a change in the practice culture:

- *Hope and Hopelessness*: This was also a theme in the analysis of the first round of evaluation (and reported in the Year 1 report (October 2008). However on this occasion the data shows a shift towards increased hopefulness in the way that residents are cared for, including the range of activities available for residents, their involvement in decision-making and the quality of engagements between staff and residents. However, hopelessness among residents continues to be an issue and one that needs further work.

- *Choice:* The data demonstrated that residents were provided with a greater range and number of choices. Specific activities (such as resident and family groups) have been initiated and established in the majority of settings as methods of enabling more choice for residents.

- *Belonging and Connectedness*: There was evidence of staff 'knowing the person' in a more meaningful way in this data set compared with Year 1 data. A range of activities have been initiated to enable greater knowing of residents as persons with 'histories' and these can be seen to have had an impact on the quality and quantity of meaningful engagement with residents. A lot of attention

has been paid to improving the environment in many of the participating sites and this has been viewed positively.

- *Meaningful relationships:* The attention paid to such issues (which are overt demonstrations of being more person-centred) as language, team-work, reducing ritual and routine, facilitating more choice, intentionality and the development of meaningful relationships have had a positive impact on resident experience.

In the Year 1 observation data there were <u>as many</u> poor practice examples as there were good practice, in the year 2 data set there were <u>significantly less</u> examples of poor practice, demonstrating a change in culture and supporting the findings of the PCNI and PCCI. The table below shows examples of the way in which the 'residents' narratives were more positive at the end of the programme compared with Year 1 data, again reinforcing the change in the overall findings:

Year 1	End of Programme
• "It is communal living and I accept it" • "I hate not being independent and having to stay here. I'd like to leave here but I can't" • If I have a problem? – I just stay quiet – "a shut mouth catches no flies". • "Do you think they would let Bella (dog) come in here? I don't know if Bella is still alive, ah, just leave it" • "I miss the smell of silage – was part of my life for so long" • "Its great here as long as she's not around (meaning a particular nurse)" • "Can't remember the last time I had a Guinness – now that would be a treat"	• "The staff are friendly and they would do anything for you, even back a horse". • "I love to get up at six. When I was at home I would go to bed at midnight and get up at 6 a.m. I would hate it if someone told me I couldn't get up till 10 a.m. - I like my routine". • "Feels like a hotel here, you have everything you want. It is the staff really, they leave their troubles behind and focus on you, have a laugh and a joke and attend to your questions, you can ask them anything and they are very attentive". • "We made cream slices and were barely hot out of the oven before they were eaten". • "I like my own room and love watching the telly. I am a real telly addict". • "I like the company in here, you always have someone to talk to when you want. The nurses are brilliant, especially the wee blonde Sister"

An evaluation framework has been introduced that could be continued at a local regional or national level. We believe this framework can support HIQA and other quality initiatives nationally across older peoples' services

Further test a model of person-centred practice in long-term care/rehabilitation settings and develop it as a multi-professional model.
The model has been tested and will be reported elsewhere in more detail. The testing in this programme demonstrated the need for the physical care environment to be included.

Utilise a participant generated data-set to inform the development and outcomes of person-centred practice.
The programme has enabled local NMPDU facilitators to work with shared principles, models, methods and processes in practice development work across older people services in Ireland. A range of learning and evaluation tools have been introduced through this programme that can be continued. The data set informed the development of local action plans in the programme and has been used to demonstrate outcomes in person-centred practice across the sites over three time periods.

RECOMMENDATIONS

For future practice development programmes and for the development of residential care for older people in Ireland a number of issues need to be addressed and these are set out below under 6 themes.

Theme 1: Role of NMPDU and NMPDU facilitators
• Establish leadership role of NMPDUs in taking forward emancipatory/ transformational approaches to practice development work
• Review of the effectiveness and value for money in staff input into training and short term training and practice development initiatives
• Review/map the skills sets of NMPDU staff working in practice development
• Plan for the ongoing development of facilitators who can enable emancipatory practice development processes to be realised in practice in line with the National practice development strategic framework

Theme 2: Practice/Workplace Based Learning

- Address low levels of reflection and underdeveloped skills in critical reflection
- Consider further Active Learning or other similar experiential based approaches to learning in and from practice
- Generate opportunities for observations and feedback activities to become a regular feature in the workplace
- Consider provision of more mixed groups for learning
- Create learning spaces rather than teaching places
- More work is needed on learning alongside older people and families
- Review investment in classroom-based training and explore creative means of resourcing work-based learning

Theme 3: Leadership and Facilitation Skills

- Develop more learning opportunities for the development of facilitation skills
- There is a need for continued support for those who have already developed facilitation and practice development skills through this programme
- A new national network for facilitators has been created by NMPDU and internal facilitators of this programme – there is a need for ongoing support for this new national network
- There is a need to maximise opportunities to enhance the leadership capability of all staff

Theme 4: Directors of Nursing and Managers

- Managers need to be formally introduced to PD processes prior to the commencement of a programme
- Develop a 'contract' between managers, funders, facilitators and evaluators that makes explicit roles and responsibilities and support requirements

Theme 5: Audit and Evaluation of Practice

- Practitioners to be actively engaged in designing and collecting data/evidence at local levels
- Observation of care should be an ongoing peer review process in all sites
- All sites should measure and evaluate their workplace culture and benchmarking across sites should be encouraged
- All sites should have formalised action plans based on insider led practice development priorities

Theme 6: Older People and Families

- Older people and their families should be considered to be active participants in all practice development programmes in residential care settings
- Methods of developing practice should be mainstreamed and integrated into everyday care processes, and reflective and development processes
- Ways of informing older people and their families about ongoing advancements in practice need to be established and evaluation data made public to them alongside other data sources such as HIQA review findings

CHAPTER 1
INTRODUCTION, BACKGROUND AND METHODOLOGY

INTRODUCTION

This detailed report is organised into 5 chapters. In this first chapter we begin by introducing and setting out the background to the Older Persons National Practice Development Programme in the Republic of Ireland (2007-2009). This is then followed by an overview of the programme aims and objectives. The methodology is described before the programme structure and methods/processes are presented. In Chapter 2 the findings from the individual regions and their sites are set out. As this chapter is written by the different programme team members, readers might like to note the style differs throughout. In the third chapter the overall quantitative and qualitative findings from the evaluation research are presented. In the following chapter (Chapter 4) there is a discussion in which the significant learning from the programme is discussed and finally, Chapter 5 sets out the recommendations for future practice development priorities in Older Peoples Services across the Republic of Ireland.

BACKGROUND

This programme has significantly built on the learning and recommendations of a two year pilot practice development programme in two sites within the Midlands region of the Health Service Executive (HSE) and also incorporated a smaller scale practice development programme across three sites that had started in 2006 across three older peoples services in the Mid West (as it was then).

Between 2004 and 2006 a team of practice development and research staff from the Midlands HSE Nursing and Midwifery Planning and Development Unit (NMPDU) and the University of Ulster collaborated on a practice development (PD) programme, funded by the National Council for Nursing & Midwifery. The project utilised an internationally tested model of emancipatory practice development (Garbett and McCormack 2004; Manley and McCormack 2004; McCormack and Titchen 2006), incorporating 4th Generation Evaluation (Guba and Lincoln 1989) and emancipatory facilitation (Harvey et al 2002). The project took place in two care settings and the team worked with internal facilitators to facilitate the development and evaluation processes. This initial project had a range of successes with clear evidence of cultural change (Dewing and McCormack 2007).

Key lessons learnt from the pilot project included the need to, further develop, streamline and expand the role of trained local facilitators; approaches; increase PD knowledge and engagement with Directors and Assistant Directors of Nursing; secure greater commitment for practice development as core to day-to-day work among project participants/internal facilitators and have a systematic process in place for increasing 'buy in' and active participation among all clinical staff; locate the developments undertaken within a person-centred model to shape decision-making and developments in practice and management; and actively involve older people. See Appendix 1 for the executive summary of this project.

The current programme was also influenced by broader international theoretical and methodological developments in practice development, especially those within the International Practice Development Collaborative. In particular, the programme has built on the findings of the first systematic review of practice development. In this review McCormack et al (2006) identified nine key issues that need to be addressed in order for practice development to have a desired impact (see Chapter 5).

The funding for the programme came from the National Council for the Professional Development of Nursing & Midwifery and the six NMPDUs. The budget was managed by the NMPDUs. Recognition is also made that all the programme sites found ways of releasing staff time to contribute to the programme within their existing budgets.

PROGRAMME AIMS AND OBJECTIVES

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

For the purposes of this programme, the team defined person-centredness as:

"an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, older 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"

Programme objectives

1. Coordinate a programme of work that can replicate effective PD processes in care of older people's settings.

2. Enable participants/local facilitators and their directors and 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 multi-professional model.

6. Utilise a participant generated data-set to inform the development and outcomes of person-centred practice (already designed and tested tools will be used to produce data set).

7. Enable local NMPDU facilitators to work with shared principles, models, methods and processes in practice development work across older people's services.

PROGRAMME METHODOLOGY

The programme drew on numerous principles from different yet complementary theories and approaches: emancipatory practice development, co-operative inquiry and a specific person-centred nursing framework (McCormack and McCance 2006; 2010 in press). Additionally, through the programmes activities another methodology emerged, namely 'Active Learning' (Dewing 2008 and 2009; McCormack et al 2009). Within the emancipatory practice development approach, for the aims of this programme, particular emphasis was placed on evaluation and on learning. Within the programme, the Active Learning methodology was systematically tested refined and expanded. The methodology will now be described in more detail.

Practice Development

Practice development is often conceptualised as a continuous multifaceted journey (McCormack et al 2004). The term practice development is widely used within the nursing profession in the United Kingdom and Australia. Given it is a relatively young field, it is evolving rapidly and becoming increasingly theoretically complex. Manley

and McCormack (2004) contend that practice development is focused on achieving improved and ultimately effective care based on quality patient-focused care through personal development. This includes developing knowledge, skills and values. The emphasis in practice development is on increased effectiveness of patient or person-centred care through the application of new knowledge and skills that individuals and teams have developed. The learning and the freedom to implement care and work differently contribute to longer term more deeply embedded transformations within the culture and context of care. Central to this approach is skilled facilitation, particular types of learning opportunities and systematic, rigorous and continuous change processes. Practice development is also very explicit about valuing the experience of service users as evidence.

This description of practice development has since evolved. 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 (Dewing 2004; Dewing 2008 and 2009; Manley 2001; Manley, 2004; McCormack 2004; McCormack et al 2002; Rycroft Malone et al 2002; Titchen 2004). Practice developers in the 'International Practice Development Collaborative', in 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 and Wilson 2008; p9)

Practice development is therefore not only concerned with increased effectiveness in patient and person-centred care, with the application of values, knowledge and skills, it is also concerned with the interface between practice and management and between the operational and corporate layers in organisations.

Technical and emancipatory practice development

The technical approach is regarded as a top-down approach and is based on the assumption that once practitioners have evidence, often policy based, they will find it compelling and their practice will change (Manley and McCormack 2004; Sanders 2004). It also usually focuses on one aspect of practice, often a clinical concern (such as pain assessment, catheter care, end of life care) and addresses it in isolation from other aspects of practice and what is going on in the context. Therefore, significant development of staff, if it occurs, is a consequence of practice development rather than a deliberate and intentional purpose of the technical change (Manley and McCormack 2004). This approach tends also to emphasis a stop-start mentality to improving practice. The mind set tends to support the notion that once the evidence has been put into practice then best practice has been achieved and there is then no further need to attend to that aspect of care or practice.

It is vital that practice development activities contribute to professional and personal development of practitioners and managers for longer term sustainability. Every short term initiative should add to and enhance broader contextual and cultural transformation. Manley and McCormack explain that emancipatory practice development, on the other hand, has an explicit focus on the empowerment of the practitioners. The practice development literature demonstrates that this is closely related to the creation of a specific culture, termed a 'transformational culture'. Emancipatory practice development believes in learning and transformation in its broadest sense. However, it also recognises the demands from organisations who want value for money and visible outcomes in regard to service delivery and quality.

Emancipatory practice development explores concerns around oppression and empowerment. These purposes are consistent with and reflect the influences of key theoretical principles within critical social science. A critical social science perspective suggests that social phenomena cannot be understood unless other than through the history and structure within which they are founded (Fay 1987). Therefore, central to emancipatory practice development is enabling practitioners to understand their context and culture and to positively influence it rather than it controlling them.

Practice development and associated research based on critical social theory requires researchers to take an inherently critical stance and ask 'how' questions (McNiff and Whitehead 2006). This implies not only a theoretical position but also a

desire to act to change something, which may include oneself. Thus critical social theory seeks to expose oppressions in whatever form they take. Furthermore, emancipation must free not only the individual but also deconstruct any oppressive social structures and replace them with a more equitable structures and systems (Holmes 2002). In health care this generally implies a more flattened management hierarchy along with increased decision making by teams of practitioners. Inherent in this movement, practitioners often need to learn new ways of feeling, thinking and relating – of being.

Enlightenment, empowerment and emancipation

Many critical social scientists draw on the work of Fay (1987), who argues critical social science is concerned with enabling a process of enlightenment, empowerment and emancipation. As will be described in later chapters, the journeys for many people in this programme had an emancipatory aspect. Enlightenment is concerned with people seeing things differently or becoming aware of things they previously did not know existed or have taken for granted. Manley (2004) states that, according to Mezirow (1981) and Fay (1987), enlightenment is an antecedent to empowerment, and involves identifying taken for granted aspects in everyday life and working through consciousness-raising and awareness to make them obvious. Empowerment as defined by Kreitner and Kinicki (2007) implies not only the sharing of (some) power but also creating other related opportunities to enable workers to release their full potential. People who work in conditions that enable empowerment tend not to feel constrained by rules, controls and policies and at the same time feel they have a wide degree of freedom and responsibility for their own decisions. Empowerment for example, is described by Johns (2000) as a sense of freedom to do something significantly different. Manley (2004) drawing on work by Giroux (1988) argues that there is a need to generate knowledge that will enable a person to see new possibilities, or a vision of what is possible or how things can be in the future. Emancipation can emerge from empowerment. Emancipation is the ultimate achievement on the continuum. Emancipation is active when practitioners are engaged in freeing themselves from the things they take for granted in their everyday practice and the context in which they work and take action to be more creative and do things differently.

Reflection

Practice development emphasises the centrality of learning. Reflection has been widely used to enable practitioners to critically reflect on their experiences in their work in the belief that this would evolve into informed action or praxis. Burns and Bulman (2000) for example consider praxis is an important concept to critical theories developed through the reciprocal relationship between action and critical reflection. In addition, Johns (2000) drawing on Fay (1987) considers reflection is a critical social process that enables practitioners to overcome forces that prevent them from evolving through enlightenment, empowerment and emancipation. Reflection is therefore a process that is concerned with the growth of a more emotionally intelligent and powerful person. This person comes to better understand complex situations and is willing to take action to reconstitute taken for granted patterns relating to more powerful others in ways that enable them to realise a desirable and effective practice. However, many practice development initiatives, including the pilot project to this programme, report on the difficulties many practitioners have in learning how to critically reflect and especially in acquiring the discipline of regular and structured critical reflection.

Active Learning

Active Learning (Dewing 2008a; McCormack et al 2009) is an approach for in-depth learning that draws on, creatively synthesizes and integrates numerous learning methods. It is based in and from personal emotionally connected experience of practitioners and patients/residents in the workplace. Being open to, engaging with personal experience through critical reflection and learning from experience (seeing and doing) with others are central activities in this approach. 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. Active Learning takes knowledge, in its many forms, and looks at how it can become (emotionally) meaningful for individuals and teams. Thus it expands on what is known about knowledge translation activity. 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.

Co-operative inquiry

The theory of co-operative inquiry suggests that people examine their own experience and action carefully in collaboration with people who share similar concerns and interests. It is often described as being a way of working with other people who have similar concerns and interests in order to understand make sense and develop new and creative ways of looking at things. This inquiry is also concerned with learning how to act to change things that the inquirers may want to change and find out how to do things better. One aim is to produce knowledge and action directly useful to a group of people through research, adult education and socio-political action. The second aim is to empower people at a second and deeper level through the process of constructing and using their own knowledge: they `see through' the ways in which they are limiting themselves or being limited, work out and try out new and more creative ways of working. The core principle drawn on for this programme was the notion of collaboration within a framework of inquiry (Heron and Reason 2001). This, it was hypothesised at the beginning of the programme, should contribute to increasing ownership of the programme and its evaluation research.

The Person-centred Practice Framework

The Framework for Person-centred Practice (McCormack and McCance 2006 and 2010) has four constructs – or prerequisites, which focus on the attributes of the nurse; the care environment which focuses on the context in which care is delivered; person-centred processes which focus on delivering care through a range of activities and expected outcomes which are the results of effective person-centred practice. The relationship between the constructs suggests that in order to deliver person-centred outcomes, account must be taken of the prerequisites and the care environment, which are necessary in providing effective care through the care processes. It is also acknowledged that there are relationships within, and across, constructs.

The 'Person-centred Practice Framework' (Figure 1) which formed the theoretical framework of the programme of work was adapted from the original 'Person-centred Nursing Framework' developed by McCormack and McCance (2006) for use in the

intervention stage of a large quasi-experimental project that focused on evaluating the effectiveness of the implementation of person-centred nursing in a tertiary hospital setting (McCormack et al 2008; McCance et al 2008). Recently, McCormack and McCance (2010) have made refinements to the framework in order to deemphasize the focus on 'nursing' and locate each construct of the framework in a multidisciplinary context. This adjustment makes the framework suitable for both nursing and multidisciplinary research, development, education and practice. The person-centred practice framework has four constructs:

1. Prerequisites focus on the attributes of the care worker and include: being professionally competent; having developed interpersonal skills; being committed to the job; being able to demonstrate clarity of beliefs and values; and knowing self.

2. The care environment focuses on the context in which care is delivered and includes: appropriate skill mix; systems that facilitate shared decision making; effective staff relationships; organisational systems that are supportive; the sharing of power; the potential for innovation and risk taking; and the physical environment.

3. Person-centred processes focus on delivering care through a range of activities and include: working with patient's beliefs and values; engagement; having sympathetic presence; sharing decision making; and providing holistic care.

4. *Outcomes,* the central component of the framework, are the results of effective person-centred practice and include: satisfaction with care; involvement in care; feeling of well-being; and creating a therapeutic environment.

The relationship between the constructs suggest that in order to deliver positive outcomes for patients and staff, account must be taken of the prerequisites and the care environment, which are necessary for providing effective care through person-centred processes. The framework has been used previously to analyse underpinning barriers to change, to focus particular developments and to evaluate practice change (Masterson 2007; McCormack et al 2008). In this programme it was used in multiple ways including to create awareness about new possibilities (i.e.

visioning), critical reflection, for data analysis especially with structured observations using the Workplace Culture Critical Analysis Tool.

Figure 1: The Person-Centred Practice Framework
(McCormack and McCance, 2010)
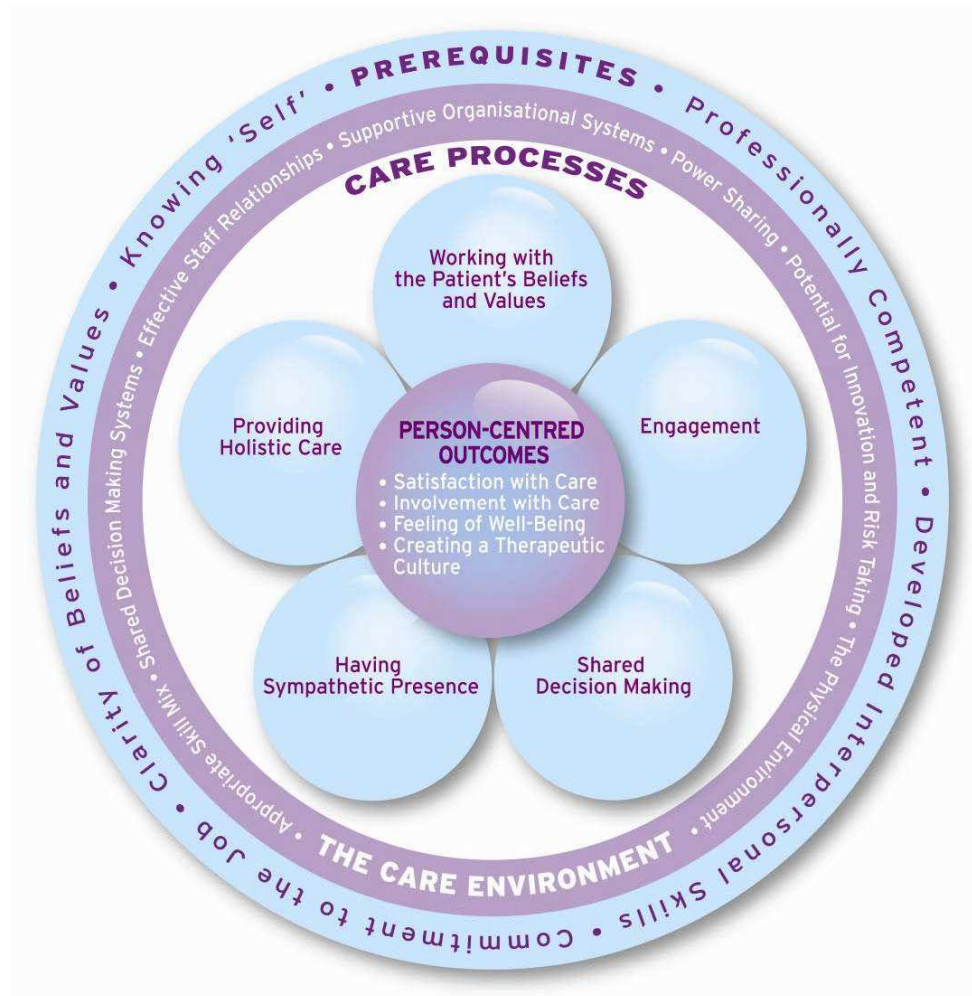
The challenge for the programme team was to bring alive the methodological approaches for the whole range of staff that were facilitating and delivering new ways of working across all the programme sites within the programme structure and processes.

PROGRAMME STRUCTURE AND PROCESSES

Eighteen residential units for older people are involved in the Older Persons Services National Practice Development Programme for the Development of Person-Centred Care. 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. Although there was some similarities in what events took place, there were also local differences according to context and the creativity of staff for how they went about creating and building awareness about the programme. 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 Mangers, 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 approximately. As the first year progressed a range of interim meetings and discussions groups were established within the workplace in between these days. It should be noted that the interim meetings and groups although initially taking place, gradually become less successful due to staff release issues and other issues related to the ongoing national HSE embargo. In year two these sessions evolved into project working and action plan implementation groups. Overall, the programme days were well attended and the rate of engagement with workplace activities designed to enable learning and model changes in practice has been high. This is discussed in more detail by the NMPDU facilitators in Chapter 2 in the individual region reports.

Programme Activities

The programme had a number of visible activities that took place on a regular basis. These were:

- Day long workshops or programme days at each site (approximately 12 over two years)
- 2 hour interim sessions
- Other related sessions for learning in year 1
- Project working groups or action implementation groups
- Managers Stakeholder Group

• National Reference Group meetings

• Meetings with NMPDU Directors

• Programme team development and planning days

• Site visits by the programme leads

Overarching these 'events' the programme activities principally involved:

• Developing an understanding of what the work/practice development involves and the competence and confidence to role model the processes to be used.

• Becoming familiar with the Person-Centred Framework and Practice Development Model as the frameworks used for the programme and for achieving the above.

• Developing an understanding of workplace culture and 'change' processes.

• Awareness raising activities for different staff groups, older people and families in the programme sites.

• Developing a shared vision using Values Clarification Exercises involving the residents/patients families/carers and all staff within their work place. Clarifying values and beliefs and agreeing common or shared values and beliefs is the first step in collaborative practice development work. Using values clarification exercises to give a sense of direction a common vision for the future. Developing and working with shared vision statements.

• Active Learning in the workplace. Examples included:
  o Cats, Skirts, Lipstick' exercise: This activity was originally developed by a previous participant in St Mary's, Mullingar as part of the pilot programme. This activity was repeated with as many of the patients/residents as possible and the information gleaned is now reflected in their plan of care. This has become a regular activity on some sites involving staff from different areas e.g. catering staff, who in the past would not have had the opportunity to get to know the patients in a person-centred way.
  o Person-Centred Language: 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 the programme groups. The posters were then displayed throughout the units, which again promoted 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.

- o <u>Observations of Practice</u>**:** Participants were all involved in carrying out several short observations of the care setting and what goes on and then of care practices. This 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. 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.

- o <u>Environmental Walkabouts</u> by the participants took place at all the sites. 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 was used to inform the development of action plans in year two. Participants facilitated additional walkabouts with other staff. In some sites older people and family members have also been involved in this activity and in a few sites photography was used.

- • Structured Reflection: Participants were introduced to a model of reflection and the use of reflective questioning which they were encouraged to use at all programme events and every day. Participating in structured reflection showed some signs of assisting participants in both their personal and professional learning. At the end of year one a representative sample of written reflections were analysed. As a consequence more attention was given to this method in

year two. We have discovered that, for all groups, developing skills in reflection would require more work in year 2 of the programme. The data has not been included in the evaluation research because of the low levels of reflectivity. See the discussion chapter for further consideration.

- Facilitation Skills Development: Listening, the use of enabling 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 were 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. Active learning methods were used to enable participants to enhance their skills in a focused way.

- Developing an understanding and gaining direction on how practice development processes will impact positively on the achievement of the National Standards for Residential Care developed by the Health Information and Quality Authority (HIQA). All the objectives and development processes have been mapped to the HIQA Standards and these are being used to explore the findings from the evaluation data collection and inform action plans developed.

- Developing greater appreciation of and skills in effective group and team working.

- Introduction to the evaluation methodology used for the programme and involvement in the collection of the evaluation data. A range of evaluation tools and processes have been used in this programme (detailed later in this chapter). Wherever possible programme participants have been involved in collecting and analysing this data and informing the identification of outcomes. This intention further contributed to changing the social power within their workplaces.

Programme Evaluation

The processes and outcomes from the practice development programme were evaluated within a framework of co-operative inquiry as outlined earlier, primarily drawing upon reflective dialogue data between lead facilitators, project participants and the project leaders; interview data with all participants and records of developments. In addition, a number of 'evaluative instruments' were used. These instruments have been developed as components of previous research and development in person-centred nursing and have established validity and reliability data. The project leaders, lead facilitators and project participants all acted as co-researchers in the collection and analysing of data. Thus the framework has the

added benefit of developing evidence gathering and research skills among participants.

Data were collected at three time points during the programme: approximately between December 2007 - March 2008 and again at two more time points (January - February 2009 and August - September 2009). The tools used, and listed below, 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 et al 2009): This tool assesses the practice context and its receptivity to person-centred ways of working.

2. Person-centred Nursing Index (PCNI) (Slater & McCormack 2007): 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). It was piloted in sites within the North West region prior to national use.

4. Cultural observation tool (WCCAT) (McCormack et al, in press): 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 peoples' 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 acted 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 only and the data used to inform the development of local action plans.

Data collected using the PCNI, PCCI, Cultural observation tool and user narratives were analysed at a local level to inform the development of action plans and collectively at a national level to inform the effectiveness of processes and outcome achievement across the programme as a whole. All the data was analysed using a participatory approach with programme participants, programme facilitators and programme leaders.

In addition to this data, stakeholder perceptions of the programme have been gleaned throughout the first year of the programme through various stakeholder events. This data collection ceased in year 2 as a consequence of the national HSE embargo. As an alternative method, at timeline 3, data were collected through a questionnaire with key stakeholders (for example, Directors of Nursing from the sites and NMPDUs, service and general managers). However, the response to this has been disappointingly low. The notes from the programme days across all the sites detailing learning evaluations and feedback to Directors have also been collated (see Chapter 3).

Ethical Approval

Ethical approval was given by the appropriate body in all the regions involved in the programme. Approval included the use of process consent (Dewing 2002, 2006 and 2008) which enabled the inclusion of older people with a dementia into the evaluation research. It should be noted that all the ethical committees across the country had variations in the submission process and requirements.

CHAPTER 2
FINDINGS PART 1: INDIVIDUAL SITE REPORTS

THE MIDLANDS AREA

Participating Sites

In the midlands region there were three participating sites.

- St Vincent's Hospital, Mountmellick
- St Brigid's Hospital, Shaen
- Community Nursing Unit, Birr

All three sites are residential units for older people.

St Vincent's Hospital is a Health Promoting Unit, committed to enhancing the quality of life and health status of older residents in their care. The Unit provides a total bed capacity of 162 incorporating long-stay, respite, rehabilitation and special care rooms for hospice residents. The specific age range for the Unit is over 65 years of age. There are 7 wards: 1 ward temporarily closed, 3 female, 2 male, and a specialised unit for older people with dementia. The catchment area for the Unit is mainly Co Laois but with a small number of beds for Co Offaly.

St Brigid's Hospital Shaen is a Care Of the Older Person 45-bedded unit. The residents' conditions include dementia, psychiatric and general medical conditions. The unit provides residential and respite care to male and female residents. The Unit is situated in the countryside close to the towns of Portlaoise, Mountmellick and Portarlington.

Birr Community Nursing Unit is a 90 bedded unit providing care and services to older people, including residential, respite, rehabilitation, palliative care, and day care services. It is a modern and well planned building. The Unit was purpose built to provide the highest quality care for older people. The Unit comprises of three individual suites of 30 beds. The suites are identified as and comprise of the following bed numbers:

- Camcor - 26 long term care and 4 respite.
- Sandymount - 24 long term care and 4 respite & 2 rehabilitation.
- Laurel – 24 long term and 4 respite, 1 rehabilitation and 1 special care/hospice room.
- Day care – 30 places daily.

Residents are admitted to the Unit for a variety of reasons i.e. long term care, rehabilitation, respite care and special care/hospice services. The Unit also provides a structured day care service, physiotherapy, occupational therapy, dietician, and the services of a very enthusiastic Activities Team.

Programme group

The programme participants from each of the sites were representative of the following groups; nursing, health care attendants; housekeeping catering staff. Programme groups size ranged from 7-16. Having representation from all care groups was a very significant positive contribution to the programme. It enriched the contributions from the participations on programme days.

Each of the sites had named internal facilitators (IF). In St Vincent's the IF was at assistant nursing director level; St Brigid's the clinical nurse specialist for activation therapies was the lead. In BCNU for the first year of the programme, the IF was the acting director of nursing. She left to take up a new post at the end of year one. The group were very anxious that the programme should continue, two of the participants stepped forward to take on the role of the internal leads for the programme. The change in roles, while very positive did create new tensions and challenges for the IFs and the participants. It did however highlight the importance of the sustainability of the programme and was an acknowledgement of the achievements within the unit to date. During that time there was also in BCNU a change in leadership with the appointment of a new director of nursing and a new assistant director of nursing. The new director was somewhat familiar with the programme and was fully supportive from the very beginning.

Achievements

There were similarities across all three sites from the findings of the observations, narratives and environmental walkabouts throughout the programme. However there were specific findings from the observations and environmental walkabout from St Brigid's that were not applicable to the other sites. A detailed action plan to address issues identified was developed in collaboration with the key stakeholders in all units.

Emerging themes from the qualitative data collection identified were:

- Developing a more person-centred culture around the use of everyday language
- Creating a more homely environment
- More meaningful engagement of staff with residents
- Creating a care environment that is supportive of power sharing and creates the potential for innovation
- Shared decision making
- Team work and communication
- Loneliness and boredom
- Creating more meaningful connections with the community
- Issues relating to end of life care for residents and their families

The process of conducting the narratives with the residents in the units provided the participants with an opportunity to really get to know the person. Having the opportunity to share their story gave staff the chance to really connect with the person and come to know them in a different way. When residents shared stories about important aspects of their lives with the staff, this helped them to identify meaningful activities and ways to help personalise care routines.

Actions identified for development from the analysis of the narratives focused in BCNU on

- *Getting to know the individual.*
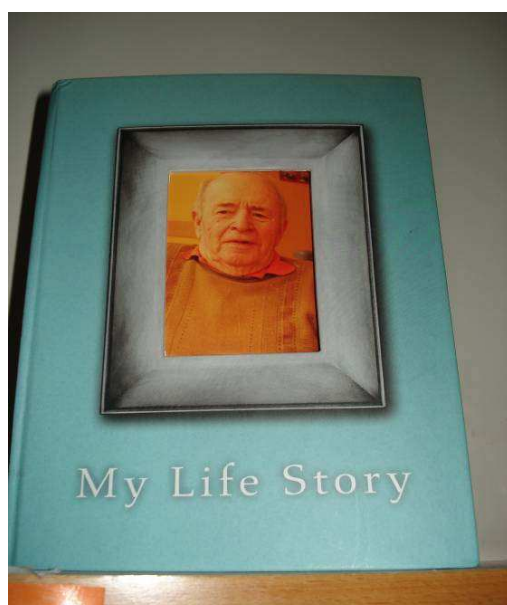
Through getting to know the person and understanding their biography, staff working with the residents and families developed individuallife stories (Image 2.1). These stories are displayed throughout the building in different ways for example as a collage, in book form or in a individualised display box. They are a source of pride and joy for the community within the unit. This is an ongoing project with all residents, staff and families who wish to get

Image 2.1 'My Life Story' Example

involved being given the opportunity to partake.

• *"My Day My Way "*

The Importance of getting to know the person not just the resident and what is important to them in their daily care is central to the concepts underpinning PCC. As part of the Person-Centred Care Programme an innovative exercise "My Day My Way" was developed by participants in BCNU (Figures 2.1 and 2.2). This getting to know me exercise can be carried out before a resident is admitted to the unit, when they are admitted as part of their admission procedure or now as part of their ongoing assessment. All staff at unit level are involved, which has greatly enhanced team work.

BIRR COMMUNITY NURSING UNIT

"My Day   My Way "

Towards Developing Person Centred Care for Residents

The Importance of getting to know the person not just the resident and what is important to them in their daily care is kernel to the concepts underpinning PCC. How can we help staff be more person-centred in their care for the individual person?

As part of the Person Centred Care Programme an innovative way "My Day My Way" was developed by participants.

- This getting to know me exercise can be carried out before a resident is admitted to the unit, when they are admitted as part of their admission procedure or now as part of their ongoing assessment.
- This can be completed with the resident by a family member care staff named nurse.
- It should be kept in the residents care plan which is accessible to all staff.
- It should be reviewed and updated as part of the ongoing evaluation of the residents care
- All new staff should familiarise themselves with the plan

Figure 2.1: My Day My Way (Process)

I would like to share with you what is important to me when caring for me

Name: Mary Kelly   **Suite:** Sandymount

What makes me Happy ?

- I like to put my own makeup on in the morning please don't rush me. If you leave the mirror and the makeup bag I will work away at it. I am not in a hurry

- I love to get fresh air every day, if you can assist me to go to the garden

- I love a lie in on a Saturday morning I always did it at home. If you can put my radio on and put RTE 1. I love the chat on the radio

- I don't like to eat my meals with other people. Please let me sit on my own to have my meals. I eat better that way.

What Makes me Unhappy

- Tea. . I hate tea, always have and I am not going to change now please let staff know that.

- Trousers, I have never worn a pair and I would prefer not to at this stage of my life

- Loud music and the TV on at the same time. If you bring me in to the day room, keep the noise level down please!

- Not to be consulted when planning my care. I hate when people talk over me like I am not there!

Figure 2.2 My Day My Way (Example)

• *Development of more individualised meaningful activities*

Across all three sites, programme facilitators at unit level worked with residents and staff on the development of individualised activity plans. These plans were based on activities/programmes the resident wanted to partake in. For some residents, trips to the local pub, local cinema, the resident's home place, local matches has now become the norm. Other activities have been introduced within the units based on the specific identified need of individual residents.

In St Brigid's Hospital, a trip to Lourdes for one of the residents was facilitated. This resident through her narrative shared a lifelong dream to travel to Lourdes but because of her medical condition never thought this could be possible. In collaboration with the family staff and members of the multidisciplinary team, this was organised. She fulfilled her lifelong dream accompanied by members of her family and staff members from the hospital.

A similar theme that emerged from the narratives across the three areas, highlighted how the residents were lonely and missed the connection with the outside community. For some they found the day really long with little to do, in particular the evenings for some were very lonely and boring.

Several actions arose from this across the sites. In St Vincent's Hospital an action plan was developed to address the establishment of a volunteer programme. This would involve the local community and link in with the national volunteer project. A series of communication strategies were identified to invite local people of all ages to get involved in volunteering. This included a visit to the hospital from former Taoiseach Albert Reynolds to promote the programme. A volunteer programme is now established with all the required protocols in place from Garda vetting to education and training programmes for volunteers.

Music evenings for the residents are now facilitated by members of the active retirement group in St Vincent's. A kitchen has been developed for the diversional therapy department in St Vincent's this is now used by for cookery sessions where the residents are actively involved in cooking/baking, using their own recipes. This time provides a great opportunity to socialise and reminiscence about times past and has become very popular.

Plans are under way to install a new computer into the diversional therapy unit where the residents will have access to the computer and have the opportunity to learn new skills. Gardening has also been included into weekly activities; this was highlighted by one of the residents in his narrative.

In St Brigid's Hospital, one resident in his narrative expressed a desire to have more autonomy and control at meal times. In particular he wanted to have his own tea pot. While it appeared to be a very simple and normal request, it proved a challenge for the team to implement. There were issues raised initially from staff around health and safety. The IF along with the team developed a plan of action addressing the concerns of the staff. The resident along with others now have their own tea pots at meal times. This achievement has led to other initiatives being introduced where staff in the past would have resisted, citing concerns around health and safety.

Daily activity programmes for the residents have become much more focused on providing activities that are appropriate and meaningful to the residents. Such new activities included the availability of a minibus and driver one day a week to facilitate outings for the residents in two of the sites. This service is provided free of charge from a local community organisation. Innovative trips have been organised from going on boat trips, trips to the theatre to attend their 'Elevenses club' that shows old time movies in the morning followed by a trip to the local "McDonalds"

In St Brigid's they have developed community links, this was something that had not happened previously. Visits from Foroige youth club, local traditional and folk groups are now a regular feature. Other activities include involvement in an inter care setting Boccia league organised by Mountmellick Development Association in conjunction with Sport Le Cheile. St Brigid's have two teams involving 10 residents.

Using Person-centred Care Planning formats and processes, the internal facilitator along with the residents and staff has completely revamped the activity programme to include many more meaningful activities: we use Cats Skirts Lipstick exercise, Poole Activity Level, activity questionnaires, My Way My Day and talk with family members also. Residents have requested more social afternoons/evenings, social's are now organized in the revamped dining room where everyone is invited to attend.

Facilitating Residents to have a voice and to be involved in decision making was identified from the observations and narratives across the sites.

In St Brigid's, the residents action group was well established and running very well with regular meetings. In BCNU while a resident's forum had been established for the unit, an evaluation of its effectiveness identified the need to re-view it. Following consultation with the residents and staff it was agreed to establish a residents forum on each of the three units. In St Vincent's Hospital a forum was set up at ward level which was facilitated by a programme participant and the ward manager. Meetings are now held every 4-6 weeks and residents have identified areas for development and action. For those residents who are unable to communicate a relatives/advocate has been invited to attend. The hospital volunteer advocate also attends some of these meetings. All three sites have the groups up and running and are now an established part of life in the sites.

In St Vincent's Hospital and BCNU linkages were made with the National Advocacy programme to participate in it. In St Vincent's they now have introduced an advocacy service to one of the wards and plans are in place to extend that service. Environmental changes have been made in different sites to promote/develop a more homely person-centred environment that reflects the vision statements. Action plans were developed around numerous areas for improvement. At each data collection phase, further improvements were made to the environment. Some improvements identified, needed to be incorporated into the overall service plan. Décor in general needed to be improved, some areas had a complete makeover. In St Brigids hospital the observations of care and environmental walk about highlighted in particular the dining area as not very conducive to a homely environment. Practices at mealtimes were identified as somewhat institutionalised and routinised.

A project team involving residents, family/carer and members of the Multidisciplinary Team (MDT) was established to look at the whole mealtime experience from the practices to the environment. This project was completed throughout the programme. The dining room area was completely transformed. As well as changing the environment, education and training programmes were delivered to all staff on nutrition, assessment, assisting residents at mealtimes and other specific issues related to nutrition. Facilities are now available within the dining area for relatives to come and have refreshments with the residents at any time of the day. Ongoing auditing and observation of mealtimes have become an integral part of staff development and practice development in the unit.

Other areas of improvement in all the units include:
- Art work done by the residents is now displayed throughout the units on the walls
- Signage was changed to facilitate the residents
- Entrance areas to the units were enhanced and made more welcoming
- Throughout the units changes were made to improve and enhance the environment
- Residents were facilitated to personalise their bed areas if they wished
- Sitting rooms were made more homely
- Development of a quiet room
- Development and enhancement of existing enclosed garden spaces

In St Brigid's Hospital the internal doors were locked to prevent residents with cognitive impairments wandering out of the building. The programme group identified the need to address this issue. An action plan was developed involving the residents' family members, risk management, senior management both within the hospital and at a higher level with the HSE. The aim was to improve residents' freedom of movement around the building, thus restoring their dignity and rights.

The objectives were to:
- explore process and timescale for opening doors throughout the building.
- to include individualised risk assessments and guidelines for staff
- facilitate learning sessions to support residents, staff and families plan for the changes to the environment to be delivered
- establish a process for ongoing review monitoring for sustaining the changes involving all the key stakeholders

This culture change challenged staff; it raised issues around accountability for the safety of the resident. Staff, residents and family needed education and reassurance in relation to the new systems in place. Opening the doors within the hospital has been phased in and proposals submitted to the finance department for funding to change some of the external doors. Residents now have much more freedom to mobilise throughout the building and the feedback from ongoing observations of care indicate that it is now a more homely welcoming environment. The project very clearly identified that introducing change can be slow and needs to be planned well involving all stakeholders at every stage of the process.

Issues in relation to improving communication and teamwork amongst staff were identified from observations of care, the PCNI and PCCI along with evaluation data on programme days in all three units. Action plans were developed to address the issues highlighted. Named programme participants took on the responsibility of leading the groups. For some participants this was the first time they ever were involved in chairing a group. Action plans were developed from auditing current practice, using questionnaires, feedback from staff meetings along with observations of care. Throughout the programme, progress has been made in improving communication and developing teamwork in the management and delivery of care.

Some achievements include:
- Regular unit meetings were established involving all care groups
- Daily communication meetings where staff are updated on ongoing issues. This takes place for an agreed time every morning with the lead person rotating each day.
- Introduction of a communication book for staff at unit level
- Quarterly Newsletter
- Re establishment of the social club
- Bi annual staff well being weeks
- Implementing reflective practice and problem solving frameworks in everyday work
- Development of protocols on giving and receiving feedback in the units
- Implementation of clinical supervision for staff

Developing person-centred care was as much about staff as it was about the residents. Across the three units the programme participants in consultation with all staff, identified what the staff wanted. A five day programme of events was organised for staff covering areas such as:
- talks on health care issues relevant for staff with experts offering advice and support to staff
- relaxation, and beauty therapy sessions offered to staff throughout the day; social outings and in-house events
- The staff well being weeks have evaluated very positively in particular in relation to staff morale. These events are now incorporated into the yearly planner with events organised bi-annually.

Information from narratives with one resident identified the need to improve end of life care practice in the unit. One resident spoke about how he would like to think that he would be remembered in some way in the unit when he died (Image 2.2). He felt the unit was very much his home and the staff and residents part of his new family. A multi disciplinary team group with representatives from the key stakeholders including pastoral care and medical staff was established. An action plan was developed with specific areas identified for action. Some of the achievements to date include:

- the development of a memory book to celebrate the lives of residents and staff who have died was introduced to each of the units. Any thoughts, special moments or events staff, residents and carers would like to recall either in pictures poems or story to share memories of the person are invited for inclusion in the book.

- introduction of the Liverpool Care pathway with staff receiving education on its implementation from staff who have received training in the UK

- introduction of person-centred practices around end of life care

- education programmes for staff on palliative care
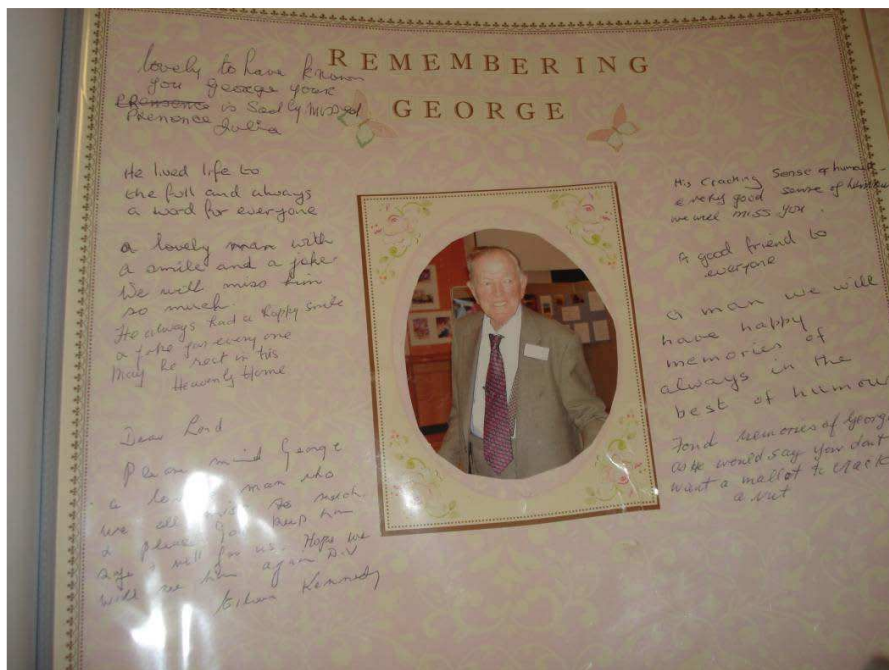
Image 2.2: "Remembering George" as an example of using narratives in end of life care

Programme participants in the participating sites along with the IFs have had the opportunity to present posters on person-centred care at national conferences, talk on the subject at both in-house education programmes and externally at conferences (Figure 2.3 is an example of a poster presented at a conference).

Figure 2.3:   Example of a poster presented at a national conference by participants

Celebrating the National Programme in 2009

The three sites had a celebratory event towards the end of the programme in 2009. The events were organised as a way of celebrating and showcasing all the achievements and successes from the programme. The celebratory events ranged from one day family/community days to a week long event in CNU Birr involving residents, their families, and staff both in unit and in the community. The feedback was very positive and generated great enthusiasm and pride for the units. It highlighted for all involved the importance of celebrating what we do well and the need to embed that positive attitude of 'can do' into our everyday practice and culture.

Summary

Values and behaviours are changing slowly to reflect a more person-centred culture. Practices have changed to embrace new ways of working, staff are becoming more resident focused as opposed to staff focused. There is more focus on the processes and not just outcomes and a realization that a lot of unlearning had to be done first before a shift to the new culture of care could happen. There is a greater emphasis on participation, choice and inclusion in decision making and practice has become more thoughtful. Staff who in the past felt they had no voice have now through the development of new skills begun to challenge the culture and status quo. While the changes may appear small, there is a definite shift in culture. It is the beginning of setting the seeds of change for older person services, both for the older people and the organisations as a whole. We have started the journey. Sustainability plans have been developed for all units in consultation with the Director of Nursing, internal facilitator, unit managers and programme participants. The challenge for the future will be to keep the momentum and motivation sustained in the current climate of change and uncertainty.

Evidence of the Programme Continuing

A volunteer programme for Residents has recently (May 2010) been launched in St Vincent's Hospital Mountmellick by the former Taoiseach Mr Albert Reynolds. This is the first HSE unit nationally to officially launch a volunteer programme. The concept of developing a volunteer programme was identified as a direct result of findings from research undertaken by the participants involved in the person-centred programme. Findings from the residents' narratives clearly indicated that often resident's felt

lonely and cut off from the community, when they went into residential care. Volunteers are now an integral part of the unit, visiting individual residents on a regular basis.

THE NORTH WEST AREA

Two community hospitals participated on the programme from the North West. The following section describes each of the sites, the practice development groups who were involved in the programme and a summary of their action plans and achievements.

Participating Sites

St Patrick's Community Hospital

St Patrick's Community Hospital is situated in Carrick-on-Shannon, County Leitrim. The hospital was built in 1841 and has been used as a care facility since 1928. There are a range of services provided to the local community including, residential care, respite, a day centre, an X-ray department, physiotherapy and occupational therapy and specific outpatient clinics. The building is located in a residential area on the periphery of the town a short drive off the N4 national Dublin/Sligo roadway.

The community hospital has a bed capacity for 112 residents. There are 14 beds allocated for convalescent care, 10 for respite and one bed for rehabilitation. The remaining 87 beds are allocated for long term residential care. Accommodation is organised over two floors with three units on the ground floor. The Sheemore ward is a 20 bedded female unit, the Dr McGarry, a 28 bedded male unit and the Monsignor Young an 18 bedded dementia specific unit which was built in 1998. The Rivermeade unit on the upper floor provides care for 36 male and female residents. A nurse's station and pharmacy area is located on each of the units.

There is a reception area located at the entrance foyer with a small coffee shop, and seating area. A church is also located on the ground floor and is used on a regular basis by residents, staff and the local community. A quiet room for residents and their families is also located on the ground floor.

The Programme Group – St Patrick's

The group consisted of multidisciplinary members as detailed in the table below. Two internal facilitators – a CNM and a staff nurse - were recruited at the outset, one worked on the Sheemore ward, and the other worked on the Dr McGarry Ward. One of the internal facilitators (Staff Nurse) left the programme after approximately 8 months and was replaced by an Assistant Director of Nursing who was already a

member of the PD group. The Director of Nursing worked with the programme group in relation to the practice development work.

Registered Nurses	Grade	Non Registered Care Workers	Areas Of Work
2	CNM11 x 1 Staff Nurse x 1	8	• Healthcare Assistants (5) • Catering Assistant (1) • Support staff from Housekeeping (2) • Occupational Therapy Assistant (1)
			• Resident Volunteer Worker
2 Internal Facilitators	CNM1 Assistant Director of Nursing		

Falcarragh Community Hospital is one of 11 Community Hospitals and Nursing Units in County Donegal. The hospital was purpose built in 1980 and all accommodation is organised on one floor. There are 35 in-patient beds and a day hospital; also on the grounds is a primary care centre that provides a General Practitioner and MDT service to the wider community of Falcarragh. Within the hospital there is a small church which is used daily by the residents and also widely used by members of the community. The range of services offered in the Community Hospital over the last number of years has expanded in response to client need, service development and reconfiguration of the health services. As well as the ability to provide continuing care beds there is also an allocation for respite, rehab/convalescence and palliative care. Community Mental Health Services in Donegal also use an area within the hospital as a day facility for their clients. The hospital is located in North West Donegal and is situated in a rural area, the nearest large urban town is Letterkenny which is approximately 30 miles away. The geographical area is a Gaeltacht area, where the Irish language is the first language for many of the older people and healthcare staff utilising the service.

The Programme Group – Falcarragh Community Hospital
Two internal facilitators were recruited to work with the NMPDU facilitator and programme group. One of the IFs is a Staff Nurse working in the ward area and the other IF a CNM 2 who is mainly based in the day hospital, although alternates to the

ward for periods. The programme group was multidisciplinary and expanded from the early programme days to include more registered nurses and support staff although a core group remained constant over the period of the programme. The Director of Nursing worked with the programme group in relation to the practice development work.

Registered Nurses	Grade	Non Registered Care Workers	Areas Of Work
3	CNM11 x 1 Staff Nurse x 2	6	• Healthcare Assistants • Physiotherapy Assistant • Occupational Activity Assistant • Support staff
2 Internal Facilitator	CNM11 Staff Nurse		

Programme Achievements from both sites

In Falcarragh Community Hospital formal data collection as part of the PD programme took place at two timescales including observations of care, environmental observations and patient narratives, PCNI/PCCI and CAI. In St Patrick's the data collection process took place over three timeframes. As well as the formal data collection, a continual process of analysis from group process evaluation, discussion among the participants of the PD group and also at individual ward level has contributed to the ongoing work of the programme in both sites.

The action planning and achievements from the programme in both sites were very similar in many respects and the following is an overview.

Communication

The development of resident group meetings led by nursing and healthcare assistants is now established in both sites. This was identified as a need after dialogue with residents through narrative work. This provided a method to involve residents in a more meaningful way in their care. This was a positive achievement for residents, families and staff; the process was also a positive learning and personal growth experience for the facilitators of the meetings which included registered nurses and healthcare assistants. A formal process was agreed by the PD groups where the information collected at the resident group meetings which are

held on a regular basis is documented, solutions sought and feedback provided to the residents and all the staff.

In St Patrick's there has been a long standing resident committee established with an independent chairperson, the development of smaller resident group meetings on each of the individual wards has further enhanced this process of communication. In both sites it was found that the information collected at these meetings contributed to and provided more evidence to support implementing change in other ways by bringing to the fore issues such as, choice around meal times, the exploration of more meaningful activities for residents, getting to know the residents likes and dislikes and issues they wanted to highlight. One of the residents in St Patrick's, through the resident group meeting, expressed a wish to try to return to live in her own home. A process was put in place with the resident which was facilitated by the CNM, a participant on the PD group and MDT to explore if this was possible. This was progressed over a long period, although it was not possible for the resident to return on a permanent basis because of many different reasons. The resident was at the centre of the decision making process and all efforts were made to meet the person's needs.

Action planning as a result of consultation with residents in Falcarragh Community Hospital through the resident group meetings included the following:

- Excursions to areas of interest in the local community that are meaningful for the resident.
- Going out shopping both locally and travelling to Letterkenny.
- Having 'fish and chips' for tea.
- The establishment of a hairdressing salon in the hospital, a similar service was established in St Patrick's.
- The attendance of regular chiropody service for the residents.
- The expansion of social activities based on resident's choice and requests.

Person-centred language activity was explored by the participants in both groups over the two years. This resulted in raised awareness of using person-centred language, the participants facilitated this through active learning activities and work based learning, such as, role play, developing listening skills and observing. There

was definite improvement and change in the way staff relate to residents and also to each other.

Quality of life exercises were carried out as part of the programme days and the information collated was used to find out more about residents and provide a more person-centred approach. In both sites notice boards were established in the sitting rooms and main corridors as a result of communication with residents and staff; these are updated with important news and events on a regular basis.

In Falcarragh Community Hospital the introduction of mobile phones for residents was successfully facilitated through action planning. The overall intention is to enhance communication for the resident. This initiative was led by the activity assistant and support by the programme group.

The introduction of a quarterly newsletter (St Patrick's News) was successful in St Patrick's with the aim of providing news and information for both residents and staff. Over the previous years there had been a consumer newsletter issued on a quarterly basis but it had ceased and was no longer published. Through the data collected and evaluated from the various sources it was decided after dialogue with the residents that reactivation of this newsletter would provide a forum to improve communication and share information. The programme group worked collaboratively to re-establish this newsletter and it is now issued quarterly, it is led by one of the CNMs. This publication has now been renamed 'St Patrick's Magazine' after consultation with residents and staff.

Environment
There were a wide range of environmental changes identified overall from the data collected from both sites; this included narratives, observations of care and environmental observations. Collective themes emerged from the data analysis including the need to explore and address the following:

- The need to re-decorate and creative furnishings that are person-centred and where residents have choice
- Signage not appropriately placed or highlighted enough for older people
- Furniture needing to be replaced
- Areas used as storage space instead of living space

Action plans were put in place to address these issues and improvements made in collaboration with residents and staff contributing to a more person-centred environment.

In Falcarragh Community Hospital one of the early observations of care was carried out in the dining room and analysis of the data identified the need to change the environment and make it more homely and pleasant. A small working group consisting of the DON, activity assistant and CNM2 was established to progress the action planning process. The outcome of this for residents was a more 'homely' and person-centred environment. Soft furnishings, tables and chairs were purchased and the area was completely re-decorated. The emphasis of the group was to focus on creating a person-centred environment in the dining room; this area is used daily by residents and day visitors at mealtimes and also is used as a large recreational facility on occasions. The sitting rooms were also refurbished as a result of formal observations of care with the purchase of new televisions placed at appropriate levels to enable residents to view comfortably. Overall the observations of care and formal environmental observations identified many aspects that required further work and change to enable a person-centred approach to be realised.

Meaningful Activities
The need to identify activities that were meaningful, interesting and that each resident had choice and access to was identified through all stages of the data collection with specific reference to analysis of resident narratives and observations of care and in dialogue with residents through day-to-day conversations. Suggestions from residents and staff were similar in both sites and included facilitating residents to attend music sessions both in the hospital and outside in the community, the inclusion of the community in birthday parties here appropriate, and also the attendance at social events outside of the hospital.

In St Patrick's an area on the Rivermead Ward was identified which could be converted into a games/activity room and action planning put in place with the inclusion of residents and staff. This work is a long term project and some aspects have been completed and some are ongoing.

One of the residents in St Patrick's specifically requested a wish to visit Knock Shrine this was identified through participation at a resident group meeting. The CNM2 on

the ward facilitated a process to find out if other residents would be interested in making the trip to knock which is approximately 50 miles from Carrick on Shannon. The outcome was that five residents, three of whom were accompanied by their families and staff members went on a day trip to Knock Shrine in 2008. Feedback was very positive from everyone, one of the residents has since died and the family have specifically expressed how they enjoyed the experience and how much it meant to their mother and also to them to be able to make this trip.

Nutrition and Mealtimes

During the programme, development work commenced in relation to nutrition and mealtimes for residents in both sites. This was identified as a result of observations of care, environment observations and patient narratives and staff/resident discussion and also in response to HIQA standards. Action plans that include the establishment of working groups are currently in progress in both sites, this is long term work involving the MDT and has many different perspectives. Providing choice around particular foods has been achieved at the request of residents, the following example demonstrates this, one resident identified that his relative brought him strawberries every year and it was a special treat, he was unaware that he could have strawberries everyday if he wanted, but he didn't know and it was only through dialogue with residents in a meaningful way that this resident was able to voice his opinion and choice to a staff member. The learning achieved demonstrated that by utilising PD process and the Person-centred Care framework person-centred outcomes can be achieved.

End of Life Care

End of life care issues were introduced and linkages to the resources from the Hospice Friendly Hospitals (HfH) Programme were accessed by both sites. In Falcarragh the introduction of 'Hospice Friendly Handover Bags' and sympathy cards for relatives of the bereaved was successful and is now a firmly established practice and was initiated by the PD group.

The PD group in St Patrick's are involved in action planning in relation to end of life care and have established two multidisciplinary sub groups and have been expanded to include members of staff outside of the PD group including community representations for example, spiritual leaders, General Practitioners, volunteer representatives, HSE estates and funeral directors. The sub groups work

collaboratively with the Pastoral Care Group in the hospital. The groups established represent the following:

1. Spiritual and psychological issues in relation to end of life care
2. Clinical and environmental issues in relation to end of life care

The following is an overview of the PD work as a result of action planning that has been completed and in progress in relation to end of life care in St Patrick's.

- Completion of the church renovation and the installation of a video link throughout the hospital.
- The introduction of specific personal property bags and sympathy cards to families is now current practice.
- Clear linkages have been made with the national HFH Programme.
- The development of the healthcare teams' professional needs in relation to end of life care is ongoing through education, support and in collaboration with the HfH, Hospice and Centres of Nurse and Midwifery Education.
- The creation of a 'black bow' in the event of a death of a resident. This is a symbol attached to each ward door on the day of a death of a deceased person that gives respect and dignity.
- The introduction of the shroud for the vehicle that removes the body of the deceased to the mortuary.
- New white linen was purchased for each ward to be used when laying out a resident who has died.
- The introduction of aromatherapy diffusers for ward areas.
- Recently, access to the mortuary has been reviewed and renovated. A new access route has been established through the construction of a new ramp system. Consultation with relevant people and organisations (HSE, HfH, residents and staff) has been part of the development work. This will ensure dignity and privacy for the transportation of the deceased person from the hospital to the mortuary.
- Plans are in progress to develop a sensory garden; an area has been identified at the side of the community hospital which is accessible for residents.

Programme Group - Growth

The means to achieving a person-centred philosophy is not only concerned with the residents and day visitors to both community hospitals but also includes how the whole team works together. Communication and teamwork were identified by the PD participants as being critical to implementing change and providing an effective working environment. The identification of improving communication and valuing different roles were identified through work based activities, such as group process review, discussing with other colleagues and getting to know each other's role better. There was a resident volunteer on the PD group in St Patrick's; this was found to be positive for the group. The development of team meetings involving all of the healthcare team was introduced in Falcarragh, this was considered positive and this work continues.

The participants themselves were introduced to many different skills over the two years, including, reflective practice, high challenge/high support and giving and receiving feedback. It was acknowledged that these processes are difficult and are not short term learning but require sustained effort to achieve a person-centred culture. Though a group review at the end of the programme, individuals in the programme group identified that they were 'open to new ideas', its little things that matter' 'teamwork is important' and 'residents are at the centre'. Education and training were identified as important to personal and professional development for the participants in the groups. Overall the groups felt they had moved closer to their vision (see for example Figure 2.4)
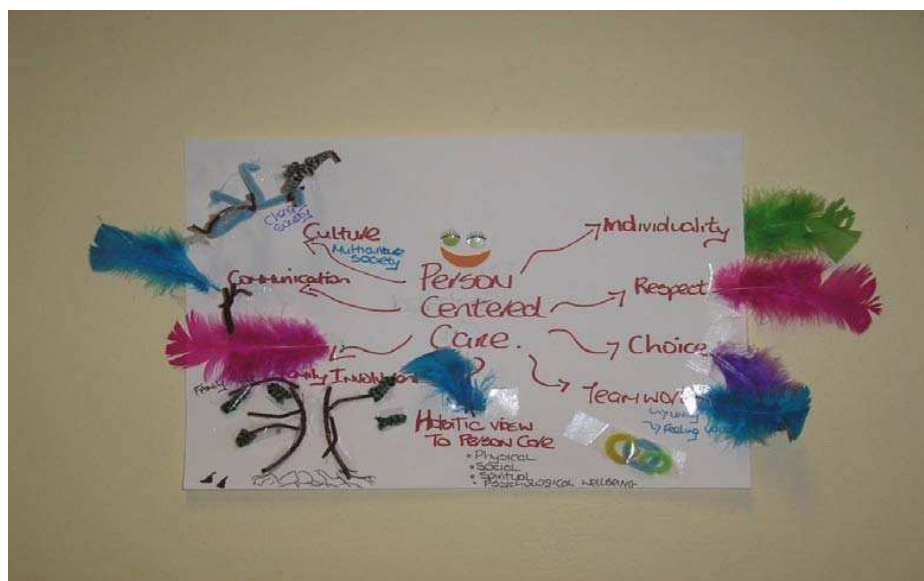
Image 2.3: Person-centred Practice Image

Celebrating the National Programme in 2009

The two sites had a celebratory event towards the end of 2009, the purpose of the event was to celebrate with residents, their families, and staff both in the hospital and in the community the achievements over the two years. Both were successful events and provided a foundation to evaluate work ongoing and plans to sustain the PD work.

Sustainability of the Programme

The programme group on both sites are keen to continue to work towards implementing a person-centred philosophy and plans are in place in both sites to progress this work. The increased involvement of residents/families and the wider healthcare team over the next year is part of the sustainability plan.

Summary

The PD programme resulted in many achievements and changes for residents and staff in both sites in the North West. There was significant growth in the strength of the group and this was demonstrated in many ways. Increased interaction between residents, families and staff has occurred due to cultural change brought about by changing the way things are done – being part of the programme has contributed directly to this. The implementation of action planning through the process of collecting the evidence from practice and analysing the data has promoted choice and independence for residents and increased the knowledge and skills of the care providers. Over the timeframe there were many challenges that required sustained effort. The introduction of the HIQA standards was important and further reinforced the need to continue this work.

The next stage is to sustain the programme of work and continue to expand the knowledge and skill-base of the core programme group and extend that growth into the wider team. Keeping the resident at the centre is critical to the process.

THE SOUTH EAST AREA

Participating Sites

- St Columba's Hospital, Thomastown, Co Kilkenny - 142 bedded Care of the Older Persons Facility.

- Sacred Heart Hospital, Carlow - 138 bedded Care of the Older Persons Facility (101 beds Sacred Heart and 37 beds Bethany House). In 2009 Bethany House was closed and the residents were relocated to facilities of their choice.

- St John's Hospital, Enniscorthy, Co Wexford - 169 bedded community hospital based over 3 sites. The old hospital building (former workhouse) has two wards with 37 beds, the new building has 108 beds (20 of which are rehabilitation beds and 1 respite bed) and St John's Ward which is located in Ely Hospital has 24 beds (1 respite).

Baseline findings and action plans arising from baseline findings

The programme commenced in September 2007 with an awareness campaign in each participating site with an open invitation to attend extended to all staff, residents/patients and their families. Following on from these sessions a Person-Centred Care Practice Development Working Group was established. The timing of this National Programme was significant as it provided a "road map" for all involved in working with older people in conjunction with the proposed National Quality Standards for Residential Care Settings for Older People in Ireland (HIQA Standards) to transform residential facilities into home like environments where the holistic needs of each person would take precedence. 'Buy in' into the programme was immediate as it provided an opportunity for all to benefit from living and working in an environment that promotes and practices a person-centred culture. Through a series of planned/agreed programmes and work place learning activities, the participants continued to develop their skills and knowledge and build confidence to enhance the experiences of care that older people received through the implementation of a model of person-centred practice. The programme actively supported the participants to challenge custom and practice/assumptions, beliefs and values that fell short of what patients and their families expected from care providers.

The programme days were well attended demonstrating the participants' commitment to increase effectiveness in person-centred care through enabling others to transform the culture and context of care. Nurse Management supported the programme by

providing feedback to the participants, however, the participants felt that the demonstration of that support/commitment needed to be visible and consistent throughout the hospital by engaging others in dialogue about the programme and initiatives that were been undertaken.

The programme emphasised the value of working with a shared vision based on collective values and beliefs together with the need to work systematically, evaluate processes and outcomes, develop action plans, develop reflective skills (in and on action) and empower others to be "leaders of something" within the workplace.

Working with the Terms of Engagements provided the groups with the 'norms'/rules of behaviour on how they behaved and interacted with one another. It provided them with the means to affect interventions if behaviours became dysfunctional and comment on such behaviours without sounding critical or judgemental.

Working on the development of a shared vision and purpose statement in each hospital was a starting point for cultural change in the workplace as values and beliefs influence behaviours. According to Manley (2002) a match between what we say we believe and what we do is one of the hallmarks of effective individuals, teams and organisations and so a values clarification exercise took place resulting in a formal launch of their Vision Statement in each site.

In implementing cultural changes there were many barriers to overcome, in particular the long term effects of institutionalised practices. An awareness campaign within each hospital was undertaken and it aimed at putting dignity at the heart of everything that the healthcare providers did. One such example was challenging non-person-centred language in the workplace. This work was ongoing by raising awareness through the display of posters, dialogue and displaying a poem written by one of the participants. Monitoring this and other practices involved the participants developing the skills of "high challenge" and "high support" which was often achieved through the strategies of "graceful care".

Quality of Life Exercise "Getting to Know You" using an activity called "Cats, Skirts and Lipstick" that gathers information about the person rather than the "patient label" proved to be very informative and assisted the staff to individualise their approach to the residents/patients.

Re-evaluation of findings, action plans and achievements (Second Phase)

The process of gathering and evaluating data (formal and informal) informed the participants about the culture of their organisation and the direction that was required to improve health and social needs and end of life care for residents/patients. With regards to the patients it was planned to ensure that the initiatives would contribute to the delivery and achievement of some of the HIQA standards and the action planning explicitly addressed actions relating to them.

- The use of patient's "Life Stories"/"Narratives" was one such example of how information could be utilised to move towards a new culture of care. This new culture, while involved in the physical aspects of care is concerned equally with the promotion and maintenance of personhood, in which a person is actively involved and lives a meaningful life. According to Kitwood (1997) biographical knowledge about a person is essential if their identity is to be protected, and one way of contributing to this is through the development of life-story work. The stories included both happy and sad memories, and in many cases assisted the staff in forming a more emphatic, therapeutic relationship with the residents/patients. Furthermore, one could go so far as to recommend, "story sharing" between residents and staff. According to Heliker (2009) unlike "story telling" in which one person is the focus, story sharing assumes an equal and mutual exchange and honours the space "in between" teller and listener, one speaking and one listening reflectively and interpreting the significance of the story being told.

- Another tool used in the gathering of data that impacted on the participants regarding the need for cultural change was the Workplace Culture Critical Analysis Tool (WCCAT). Seeing practice, raising consciousness about taken-for-granted practices and assumptions and reflecting on them were key components of the observations. Stepping outside their usual role of 'doing' and trying to observe the environment from a different perspective and its possible impact on resident/patients was enlightening. Providing feedback to the staff in the form of a "critical dialogue" was essentially to challenge 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 could be sustained and thus transform healthcare delivery. According to Person and Marsh (2002) transformative change calls for new ways of "thinking", "being" and "doing".

- Structured reflection was an integral part of the programme whereby the participants could reflect in and on experiences and explore the environment in which they work and see themselves in the context of their practices. This provided the participants with the opportunity to stand back and try to make sense of the experience and to question what it is they do and what they would like to do better.

- Following the analysis of both the quantitative (questionnaires) and qualitative data (observation of care and patients narratives) and the interpretation of the findings the participants identified and prioritised their action plans. The emerging themes from the three sites centred on improving quality of life issues and included:
  - Privacy and respect
  - Choice
  - Loneliness/family/connectedness
  - Improved communication
  - Maintaining identity
  - Creating a homely environment
  - Meaningful activities
  - Meal times and choice

These themes mirrored the national themes (7) towards the end of year one of the programme (McCormack et al 2007 and 2009):
  - Privacy and Dignity
  - Choice and Power
  - Hope and Hopelessness
  - I'm just a Task (Task Orientation)
  - Environment
  - Communication and Interaction
  - Staffing and Team Work

The term 'person-centred' was not only concerned with the care older people received, it focused on the management and organisational systems available to all

care workers to support working in person-centred ways. The themes that emerged from the quantitative data (Person-Centred Nursing Index (PCNI) and Person-Centred Caring Index (PCCI)) regarding staff were:

- o Work related stress
- o Job satisfaction
- o Organisational culture
- o Empowerment
- o Organisational commitment

And from the Context Assessment Index (CAI) were

- o Leadership
- o Cultural
- o Evaluation
- o Context

The findings from these were discussed using reflective questioning and the challenge was to make initiatives/innovations tangible and relevant to residents/patients, families and staff and a starting point was to challenge the taken–for–granted perceptions of care and caring and to build on the existing body of best practice. The following were the proposed local action plans based on the data gathered:

- Hospital greeting cards (welcome cards) (Image 2.4) for new patients and staff were designed by the participants and printed. One site sent sympathy cards on behalf of the staff and management to the family of residents following their death. Christmas Cards were designed by the participants in one site and given to the residents/patients from the staff and management.
- Effective communication between service users and service providers were fostered and care plans were modified to take account of the Activity of Living (Working and Playing). Communication was enhanced by including Healthcare Assistants at handover in one hospital that did not previously engage in this process.
- Residents/patients were facilitated to become more active in their daily life, participate in decision-making about their care and have choices with regards to their preferences and needs. Residents' bed spaces were personalised with their

belongings etc. where possible. Cognisance was taken of both lighting and colour-being aware of the effects of both on some residents/patients.

- Outdoor space: some sites made their gardens more accessible to residents/patients and indeed staff.
- Seating assessment for residents confined to wheelchairs was undertaken in one site resulting in the residents getting new chairs.
- Families and friends were encouraged to maintain their connection and relationships through frequent visits etc.
- Social calendars were developed with a programme of meaningful activities for residents/patients. Some of the sites invited voluntary musicians and artists from the local communities to come in and provide entertainment over the Christmas period. These activities created a special atmosphere for the residents/patients and for the students, scouts and choirs it enhanced the links with and involvement of local community groups.
- Staff held Person-Centred Care mornings.
- Hairdressing services were improved and included a Barber Service in one site.
- Biographical Life Story's for residents in conjunction with their families involvement lead to new stories and memories been created within the walls of the hospitals. Taking time to capture memories etc became a treasure trove of family folklore and a rare insight into a personal history for those that participated in the activity.
- Reality Orientation Boards were utilised in some areas.
- Meals and mealtimes lead to choice, menu cards, improved table layout etc and in some sites improved interaction between staff and residents at mealtimes.
- The establishment of a Residents Council in two sites empowered older people through the provision of quality information and a forum to have a voice on matters that were of concern to them.
- The creation of a homely environment in some areas was made possible from feedback from the environmental walkabouts undertaken by staff, residents and their families. The redesign of some day rooms, improved signage, décor at the entrances to wards and main entrances took place and created a more homely atmosphere.
- HfHs - End of Life Care and working with the Liverpool Care Pathway enabled one of the areas to develop a dedicated end of life care room that offers more privacy to the dying resident/patient and his/her family/carers at this difficult time. This has been a very welcome initiative from the relatives and involved all

members of the Nurse Management team and the Medical Officer working with the staff to provide the service

- Hospital Newsletters: capturing the life and stories within the hospitals were launched with enthusiasm and success. Hospital Information Booklets/Folders were been developed or reviewed by the participants in all sites with a more person-centred approach to meeting patient's and relative's information needs.

- The participants were actively encouraged to network/liaise with other working groups/committee members within the hospital i.e. Partnership, Essence of Care, Ten Steps Programme etc. to share their experiences and learning

- Hospital Day: for both residents/patients and staff were organised

- An unexpected achievement was the final move towards pet therapy - overcoming the barriers to the implementation of pet therapy has taken place in one site since the completion of the programme.

Your family and friends are welcome to visit you and become involved in your day to day activities if you so wish.

These activities include health and social care needs which can be discussed and planned with the staff as they plan your care.

Welcome To
The Sacred Heart
Hospital

Ward:
Address:

Vision Statement

Our ultimate purpose is to deliver person centred care in a caring and homely environment that embraces the privacy, dignity, respect, values and beliefs of all.

We are committed to building on our experiences, skills and knowledge and working with older people and their families to promote a culture of continuous improvement.

We the Staff and Patients welcome

_____

to

_____

ward

Please let us know if there is anything we can help you with.

Our team is made up of

Nursing Staff

Healthcare Assistants

Household Staff

Catering Staff

Hospital Chaplin

Consultant

General Practioner

and

Allied Health Professionals

Image 2.4: Welcome Cards

Final evaluation of findings, action plans and achievements (Third Phase):

Following the analysis of data and the interpretation of the findings, the emerging themes from the three sites were similar and centred on improving quality of life issues:

- o Choice, no voice
- o Respect
- o Routines
- o Powerlessness
- o Meals and mealtimes
- o Caring (being cared for and acceptance and dependence)
- o Meaningful activities, boredom, outings etc
- o Environment, space, noise,
- o Family connections, loneliness, depression, isolation, visitors
- o Attitudes
- o Finance

These themes mirrored the national themes (presented in Chapter 4). The participants continued to work with their action plans as they were ongoing and at different stages of development.

Summary of achievements

The site visits by Dr Jan Dewing (January 2008) and Professor Brendan McCormack (January 2009) were one of the highlights of the programme for the participants. Presentations on Person-Centred Care, workshop on aspects of dementia care, environmental walkabouts, group discussions, meeting staff and residents in all three sites proved to be both popular and informative to staff. The information obtained provided new ways of "thinking" and "doing" for example in caring for people with dementia. One IF obtained new knowledge about how the environment can impact on residents with dementia and influenced the management team on how best to maximise the planned decor of their proposed new building. Being person–centred relies on getting close to the person going beyond traditional notions of routine care etc. Even with the concept of "team nursing" participants have articulated how in today's climate of healthcare "reforms" and "transformation" even the notion of individualised care is at times compromised. Moving towards person-centred care in some of the initiatives highlighted, means providing care and services that are

compatible with individual's values and beliefs and enabling the rights of the residents to a quality of life in a caring and respectful environment.

Plans to sustain the work long term

Prior to the completion of the programme, the groups identified a number of ways to continue working with some of the processes (observation exercises, patient narratives, high challenge and high support and using Claims Concerns and Issues for evaluation purposes). The group plan to use some of the processes in rolling out the HIQA Standards and keeping the PCC/PD model/framework on all relevant agendas within their hospitals. The internal facilitators have been instrumental in developing a supportive and challenging climate to implement person-centred care and promote new ways of "thinking", "being" and "doing" in their sites.

THE MID WEST AREA

Participating Sites

Three sites in the HSE West, Mid West area took part in the national practice development programme - Community Hospital of the Assumption, Thurles; Cappahard Lodge Residential Unit of Old Age Psychiatry, Ennis; and Carrigoran House Nursing Home. These sites had already completed one year of a practice development programme to introduce person-centred care before joining the national programme. This programme was led by Jan Dewing and Lorna Peelo-Kilroe, thus merging it into the national programme was relatively uncomplicated. All three sites provide residential care for older persons in different settings - a mental health unit, a general residential hospital and a voluntary nursing home. All three sites had their own challenges with the programme both from within the group, the workplace and the organisation but all three continued with the programme until it finished. Many practices have changed in all three sites and routines altered or disbanded because they are no longer justifiable in terms of good practice. It is possible to list many developments and changes that have taken place during the course of this PD programme relating to meals and mealtimes, changes to the physical environment, changing work practices that are more in line with international thinking and evidence based. However the most significant changes are in work practices and the values and beliefs that staff hold about their care, in other words the cultures and contexts of care. This report will focus on these developments which are seen by the facilitators in this area as having the most significant impact on personal and practice development and ultimately on the care experiences by service users. Brief examples from the practice area will be used to support these developments mainly as a means of inspiring and informing other sites not currently involved in a similar programme.

Active Learning

In the final year of the programme in the Mid West all three sites focused on developing capacity within their settings. The realisation grew within the PD groups that changing a culture requires the involvement of everyone. This necessitated a shift in priorities for the groups to becoming more inclusive with their colleagues and the organisational structures they had to work in. With this insight, came further understanding that the level of engagement with colleagues and ultimately the amount of impact that the programme would have in their sites depended on their

effectiveness when sharing knowledge and skills from PD sessions and how they strategically planned for changes in the systems in which they worked.

In the early to middle stages of the programme, many individuals looked outside their group for external support to drive changes in their sites. Developing a belief that they all had the capacity now to bring about cultural and practice change was a slow process of realisation that they could do this. This was in marked contrast to the perception when the programme started that many changes were beyond their scope of authority and outside their circle of influence. In essence PD groups started to become active learners where they looked beyond learning-by-doing, to learning from theoretical constructs, PD methods and methodologies, and from practical activities and critical reflection. With this significant development came an appreciation of the need to structurally plan their PD work with colleagues. Project work identified at the beginning of the programme and embraced enthusiastically, became a chore very quickly because in some sense there was a disconnect between what was envisioned and how that would happen. Obstacles within the system disheartened groups quickly and a defeatist attitude made progressing with some project plans very difficult. When the groups started to understand PD methodology in its totality as it applied to them they started to understand that they could not change their practice or system alone and had to start engaging in a real level with each other and colleagues. This is best illustrated by the 'tea-bags event' – based on resident feedback, the group identified the need to improve the quality of the tea-bags used in the setting, but the manager refused to support the change:

"The issue with the quality of the tea bags floored us at first and we thought that we couldn't do anything about it because it was the system we had to work in. Now we are not prepared to take no for an answer from anyone without questioning it. This is just a system and systems can be changed".

Practice development processes such as environmental walk-abouts and observations of practice helped staff to start to appreciate what life may be like for residents/guests[1] when living in an environment that has no frame of reference for them to their life before entering residential care. For one group member the profoundness of the experience following an observation of care exercise in a residents lounge area for 20 minutes was deeply meaningful. She commented that,

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[1] In one of the participating sites an activity was undertaken to establish how the older people residing there wished to be referred to. They chose the term 'guest'.

although there were residents present in the lounge at the time, the loneliness and isolation she felt was very disturbing for her. This prompted a discussion with staff and residents about how they could make the unit more homely.

The picture below (Image 2.5) shows a residents lounge in the Community Hospital of the Assumption redecorated following a PD exercise known as 'structured conversations' on how to create a homely environment' where staff engaged with residents and colleagues to find out what constituted a homely environment for them. This exercise followed an environmental walk-about undertaken with the PD group during a programme day.

Image 2.5

Image 2.6

All lounge areas were transformed from minimalist design with contemporary furniture and décor that may not adequately equate with the residents' experiences of a homely room, to areas that were inviting and homely for residents and their visitors. This transformed the atmosphere in the area both for residents and staff. There are focal points such as the fireplace and a cabinet with ornaments that contribute to creating topics of conversation and areas of interest for residents and visitors. The layout has influenced staff where it is conducive to a less clinical approach to care.

The importance of spirituality to older persons is well documented and Carrigoran House have a small church incorporated in their building so that guests can visit whenever they wish and regular services are held during the week (Image 2.6). Developing an appreciation of the person as a whole individual, in other words the personhood of the individual was a challenging concept in reality as opposed to espoused thinking on individuality. No person in the three PD groups would have denied the individuality of the residents/guests and in fact at times talked passionately about the right of the resident/guest to be treated as an individual. But the reality of this was not always evident and the slow realisation that the fundamental way that care was planned and delivered had to be reviewed before

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espoused values became a visible reality. There is an ongoing process in the three sites of questioning and challenging rituals and traditions that took precedence over individual wishes. Instead of church times being seen in some cases as an inconvenience to the work in the units, work was organised so that there were no obstructions to guests/residents in attending church.

In Cappahard Lodge the environmental walk-about exercise identified many options to create a more stimulating and homely environment. Residents were directly involved in ideas about what constitutes a home following a focused conversations exercise between staff and residents – 'What makes a Home'. Although it was accepted that a home means different things to different people the common themes from these conversations were identified. In many of the conversations residents talked about homeliness and feelings of safety and security. Food was important to the feeling of homeliness with the environment having lesser importance. The choices and flavours of food were seen as very important and many residents/guests said that they had favourite meals that they would like to have available more often.

"I like a nice potato with my dinner, it is very important to me. The potatoes here are not often nice and not the way I like them. I just like simple food"

In an effort to reduce the level of institutionalisation around food, staff in the Community hospital of the Assumption developed a daily menu board (Image 2.7) for residents who can read and are designing pictures of meals for residents with cognitive impairment or who are unable to read.

Image 2.7: Daily menu board

Work was focused on adding more variety into the daily menus as part of the meals and mealtimes project that some staff were involved in. Staff also focused on their approach to residents' mealtimes and started to realise the value of this time as a social occasion for residents and that to facilitate this they would have to review their attitudes about mealtimes. It was generally acknowledged among staff that mealtimes were hurried occasions where there was little emphasis on the social needs of residents/guests and more emphasis on getting the task over with quickly so that other important work could continue in the units.

The environment in all three sites was clinically focused and the balance was heavily in favour of the staff needs rather than the residents needs. To support this work staff in all, three sites involved residents in designing their living environment to make it more personalised, cosy and user friendly and to redress the imbalance.

Image 2.8: hospital corridor

Image 2.8 shows a corridor in Cappahard Lodge where bedrooms are on the right of the picture. This corridor used to be quite dark and every room looked the same both outside and to a greater extent inside as well. Since engaging a local artist to paint the corridor each bedroom looks different from the outside. The necessary clinical additions such as hand wash dispensers, gloves and aprons faded into the background and the whole corridor was transformed into a street theme. An unanticipated outcome of the project to paint the walls in the unit was the engagement that took place between the artist and some of the residents. Many of the residents were fascinated with the work and spent a lot of time talking together with the artist.

Image 2.9: Resident's Bedroom

Residents are encouraged to personalise their bedrooms and this work is currently underway (Image 2.9).

Active learning for residents

Active learning was identified as important for residents/guests and staff started to think of ways to create a more stimulating environment for residents. Meaningful activities which were often viewed as an added extra if work wasn't too busy became accepted as part of the necessary day-to-day experiences for residents/guests. Residents/guests notice boards (Image 2.10) were created to supply information on what is new in the home, activities planned for the week, notices about staff development work that is of interest etc. Structured activities are based on assessments carried out with the residents where they are documented on activity assessment forms. This adds credibility, is inclusive of the individual and becomes part of the overall individual care plan.

Image 2.10: Residents' notice board at Carrigorn House

Image 2.11: Cookery session with residents

Structured activities are now tailored to residents/guests wishes rather than based on what staff think residents need. This has at times tapped into skills that residents had prior to entering residential care such as baking. The example in Image 2.11 is a cookery group established in the Community Hospital of the Assumption. The group is organised and run by the residents and day centre members with the hospital supplying the facilities and ingredients. In this photo a service-user of the day centre is leading the cookery group. The advantage of this group is that people come together to share skills and recipes, and reminisce and chat in a relaxed atmosphere. The members plan and own the group and topics of conversations. One of the members has quite an advanced stage of dementia but can participate in the cooking and storytelling along with the rest of the group.

Pet therapy has become recognised by staff as beneficial and all three sites have resident dogs and other animals. Image 2.12 shows Josephine, a guest from Carrigoran House, with a pet guinea fowl.

Image 2.12

Outings are planned according to the wishes of residents rather than where staff thought might be appropriate. Photos are taken and displayed in the units to generate topics for conversation and as a reminder of the event for residents and staff.

Supportive Challenge

The impact of staff break times, meal times and therapy services that dictated what time residents had to get up and dressed, along with many other aspects of care planning appeared to be too daunting initially to challenge. Being able to critically look at how work was planned gave insight into how routinised it was, but this process of reflection took a lot of time. The importance of discourse enabled individuals to agree that something had to give, and that they could no longer be comfortable with going back to how things were. Although this was a gradual process within the groups, some members were unable to let go of their traditional views about care and gradually left the groups, mainly because they didn't believe in the relevance of the work to their practice and the challenge was too strong.

Changing the focus of care from task orientated to being more person-focused, meant that the PD groups had to engage with their colleagues and ultimately challenge them about what they were doing and why. In one site in particular, but to a great extent in all sites, this was seen a daunting and dangerous. The amount of resistance initially to challenge meant that there was little sustainable change and group members became disheartened at the slowness of change. Even the word 'challenge' was disputed and many thought it was inappropriate and too aggressive a term to use. Although colleagues were engaging in PD activities they were having little impact on the culture of care. At this stage groups were waiting for someone other than themselves to 'fix' things so that they could proceed without challenging or upsetting any colleagues. As the programme proceeded the level of challenge during PD sessions was increased and this in itself was a learning exercise. Groups needed to start challenging each other in the group before they could effectively do this in the workplace. The tensions in the workplace that restricted developments in practice continued and in two of the three sites in particular, this tension only increased over time until some resolution was found. This required engagement with the individuals by asking questions rather than accepting things as they were. The questions initially were gentle but increased in intensity as confidence grew.

House of Care Principles

Carrigoran House developed a set of principles that challenged some staff attitudes and beliefs about the approach and environment that care is delivered and called them 'House of Care Principles'. The work was a culmination of structured conversations with guests on their preferences and choices about their care along with what staff were beginning to realise about the meaning of person-centredness. The house represents Carrigoran House and each individual brick in the house has a message from guests to staff. This work was undertaken during a PD programme day and shared with colleagues for their feedback and how it could be implemented. On first seeing the poster it looks simplistic and almost child-like but when each message is read and the significance of these messages to staff is appreciated it is in fact quite a complex and challenging culmination of feedback from the guests. This work built on the group's growing ability to be creative and reflective and a sense that they can make a difference. It was another means of creating a standard approach to care that works with common values and beliefs and a means of challenging staff that were, and in some cases still resistant to embracing person-centred care practices.

Group Process Review

As the work progressed, a group process review was undertaken with the PD groups. Undertaking the group process review exercise was a powerful learning activity and was the first time that the groups had to engage in feedback that was outside of their comfort zone. In essence the exercise required each group member to give each other feedback on their contribution to the group, what they liked best and least about that contribution and then each individual sharing with the group what piece or pieces of feedback had the greatest impact on them and what they had learned about themselves. When the exercise was introduced there was reluctance from the three groups to undertake it. It was obvious that there was a great deal of discomfort about doing the exercise and some members wanted to leave the group rather than take part. This required careful facilitation to unpick the issues and reassure individuals that this would be a positive experience being undertaken in a safe environment. Reluctantly everyone did engage in the activity.

During the debriefing session it was obvious that a significant change had taken place particularly in two groups. The hierarchy within one group dissolved and care attendants were comfortable with giving feedback to nurses and challenging issues

that they believed were not being interpreted accurately. This was a remarkable change especially as the nurses involved were so accepting of the feedback and challenge and the whole group were engaging as a team of equals. Interestingly this group were least resistant to undertaking the exercise.

Debriefing in another PD group highlighted the issue of members unable to identify issues they had regarding what they liked least about individual contributions. When this was discussed it became obvious the extent of the culture of reluctance to challenge in this site. This group had the most opposition to undertaking the process review exercise and some members wanted to leave the group there and then if the exercise was continued. The issue of challenge became so obvious that it became impossible to ignore and the quality of the learning from this positively influenced the quality of engagement within the group:

...”I never realised what it feels like to get feedback from a colleague” “It wasn't as bad as I thought”. “I am more aware of how to give feedback that is supportive rather than criticism”.

Facilitation evaluation – Heron's Matrix

One of the methods used to map developments in facilitation within the PD groups was the use of an adapted form of Heron's Matrix (1999) originally developed as a self-assessment guide for facilitators and used in this programme for the same purpose and adapted to suit the context. This matrix was very useful in identifying the level of facilitation and learning within the group. Evidence on how adults learn, strongly indicates that it is no longer acceptable to just impart knowledge and do things to students but to facilitate their self-directed learning (Heron, 1999).

The matrix assisted the facilitators initially and then is one site the whole group to identify where their facilitation development was in relation to six dimensions: planning, structuring, meaning/making sense, challenging/confronting, supporting/valuing and meaning under three evaluation areas: hierarchy, cooperation, autonomy with a heading for issues identified. Figure 2.4 outlines the guide used to start incorporating the matrix in the end-of-day evaluation of our PD sessions. The benefit of using this matrix is that it can give a clear picture of how the group is developing and raises awareness for facilitators of their style of facilitation so that it is varied according to the progress of the group. This matrix was used towards

the end of the programme but with the benefit of hindsight would be beneficial to use from the beginning of facilitation work as an evaluation method and a learning tool.

PRACTICE DEVELOPMENT PROGRAMME Debrief/Evaluation Template				
	Hierarchy	Co-operation	Autonomy	Issues
Planning ◆ Operational Planning ◆ Implementation ◆ Evaluation	Plan for the group in consultation	Co-operative construction of the timetable by seeking agreement and views	Delegate the planning to the group and encourage them to design own course	
Structuring ◆ Using Processes ◆ Relationship Building ◆ Decision Making	Structure learning initiatives for the group and supervise the implementation	Structure with the group, group collaborate with facilitator to design and direct exercises	They design, direct and supervise exercises as a group	
Meaning – making sense ◆ Active Listening. ◆ Understanding. ◆ Empathy	You make sense of what is happening in the group – it is your understanding	Group participants are involved in understanding what is going on then add your views	Meaning is generated within the group	
Challenging/Confronting ◆ Effective Questioning ◆ Handling Questions/Issues ◆ Resolving Conflict	Facilitator identifies the behaviour to and for the group	Raise consciousness about behaviour. Collaborate conscious raising	Group identify avoidance, defensiveness in the group. Facilitator creates the climate	
Supporting/valuing ◆ Feedback-Giving ◆ Feedback-Receiving ◆ Staying Neutral	Facilitator takes the initiative and indicates their regard for them	Create mutual value and respect within the group, collaborate to develop self-created persons	Group identify their value and personal identity and develop in their own way as a group	
Feeling ◆ Being Self Awareness. ◆ Identify and Accept ◆ Manage feelings.	Facilitator directs the dynamics of the group and decide on what they will respond to etc	Encourage views from the group and collaboration of dynamics in the group	Facilitator provides space for the group to manage own feelings and emotions	

Figure 2.4: Group Process Review Framework

Adapted by NMPDU Facilitators for Older Person Services National Practice Development Programme. (2008) from Heron's Group Matrix. Heron, J. (1999) The Complete Facilitator's Handbook, London: Kogan Page

Empowerment

Working together as a group and using group processes, practice development processes and facilitation theories along with problem solving strategies began to make more sense and therefore started to be incorporated in PD sessions. There was less need to explain connections between espoused values and beliefs and what actually happens in practice because the groups were doing these for themselves. The sense of empowerment was a slow but steady realisation that change is possible, supported by practice knowledge and a new approach to delivering care. This was a significant and powerful development for the three groups and indicated real empowerment. In gaining this confidence, the PD groups started to use the processes and really started to understand what their values and beliefs were.

When the programme commenced, each of the three sites were at varying stages of change and development and all had individual reasons why they wanted to start implementing person-centred practice although what this meant and how it would look wasn't fully understood. Anticipating a more empowered workforce was an ideal that was welcomed but difficult to vision or really comprehend. It was in the last year of the programme that this became a reality to varying degrees. One site said that:

"we thought that we were person-centred and that the external facilitators didn't really understand the way we work here". "We had no idea how complex the programme would be or we might have backed out". "I wondered what this course would do for me".

Having a sense of what the programme was about was unclear in the beginning, maybe because the three sites thought that they were already person-centred and that this was just a theoretical programme:

"we are very person-centred here", "we have always been person-centred".

The reality of the contrast between espoused values about care and what was actually happening became too obvious to ignore or defend and group members started to question their practice in a more critical way:

"we thought we were person-centred but we realise that we were not".

Pressure mounted within the groups where some staff continued to maintain that the care was good and did not require any major change. This caused various issues within the PD groups where some members continued to maintain that care was person-centred while the majority of the group acknowledged that care practices needed to change and openly challenged each other.

One of the key tools now much more appreciated and that can makes a significant contribution to unpicking the issues for team working and effective care is the Person-centred Practice Framework (McCormack and McCance, 2009).   The understanding of the importance of this framework grew slowly over the duration of the programme with a belief that this is the starting point of person-centred team and care development. It is complex in the appreciation of each prerequisite within the framework and took time to fully appreciate the importance of each prerequisite and

how they contribute to an empowered team. None the less the advantages of starting with this framework and getting to grips with the prerequisites early on in practice development provides an invaluable guide to shaping person-centred work and care cultures.

The implications of growing empowerment and the resulting assertiveness and confidence that this brought about within the PD groups proved challenging for some managers and impacted on the programme work occasionally. The evidence is showing that managers need preparation and development to prepare them for their involvement in this programme and so that they can offer the necessary support that staff need to become more empowered and knowledgeable in the very complex area of older persons care.

Resident/Guest Involvement

In the three sites, changes were more successful and sustaining when residents/guests were invited to participate and where there was real engagement. This was not a straightforward process and did necessitate shifting the power-base and many participants found this very challenging. There was a lot of over-caretaking where staff felt that residents/guests were not capable of making decisions about their environment or that they didn't like to be asked. The first 'real conversations' exercise with residents/guests was a steep learning curve where the feedback received was not necessarily the feedback anticipated. The realisation that all wasn't right in their service and that residents were not necessarily happy with everything was a shock for most participants. Hearing from residents/guests about how they felt about their care and their environment was powerful in moving on the programme goals. The ongoing difficulty for the groups was to get the same reaction from their colleagues in the workplace so that change could take place.

Undertaking structured evaluations that engaged residents/guests was new and daunting. The fear of hearing expectations that they could not meet was a big issue and the fear that workloads would increase was real. However the learning from this level of engagement was very powerful and gradually groups did not need reminding that they needed to engage with residents about proposed changes as it became automatic. This was a huge change in the three groups and learning about what was actually important to residents/guests as opposed to what staff thought was important was a steep learning curve:

"I never realised that the most important thing for some of our residents is a nice cup of tea. I thought it was about their care".

Whilst trust between staff and residents needs to be nurtured and perhaps over time residents/guests will be more confident to discuss aspects of their care priorities, none the less this was a revelation for many staff.

One of the evaluation processes that had the greatest impact on the three sites was the WCCAT (McCormack et al 2007). The process of two people observing practice reduced the subjectivity of the observations and reduced the effect of justifying practices that were highlighted. The feedback process outlined this and made the whole process effective in helping tams to consider, or reject questions raised in the observation. In one site where there are four units, nurses from two of the units refused to engage in the programme. One of the two units did have a charge nurse attend for the first few sessions, but left after that saying that they were already person-centred and could not see the relevance of the programme. The second of the two units did not have a nurse attend at all. The contrast in the care between the four units was so obvious that it could no longer be ignored. Two units had developed their practices significantly and the impact of their work was visible by the results of the WCCAT evaluation in particular. The other two sites had stood still with no real evidence of change. It was almost like having a control group and an intervention group in an experimental research study. The learning from this evaluation resulted in the charge nurse from one of the two sites joining the PD group.

Significant Issues

Each site had their own issues that at times really challenged the group to continue with the programme. One site had difficulties with gaining support and credibility for their work which was at times seen as too slow. Although the work progressed it was indeed at a slower pace as staff were free to opt out of the programme if they wished and bringing new recruits up to speed with the PD group was time consuming. The challenge for the team was to create an understanding within the organization that change was necessary, that environmental changes alone would have little effect on culture and that staff needed support to learn new ways of doing their work. For those involved in the programme their progress was obvious and a marked contrast developed between the areas that engaged in the programme and those areas that

didn't engage. The internal facilitator and PD group contributed to significant cultural changes in participating areas within the organization and have managed to sustain the cultural development work in those areas.

In another site there was such opposition from peers and unions to the PD work that it caused great pressure and distress at times for the group members. Coupled with this was also the lack of support at senior management so that there was no public affirmation or recognition of the work and achievements. This was demoralising for the group and the internal facilitator. They were under constant criticism from colleagues in other sites and because of rotating staffing systems had to cope with staff from other sites constantly undermining the work they were doing until they reached a critical mass within the unit and the undermining became less effective. They had to find their support from within the group until they became strong enough to start challenging the system.

Another site had a significant challenge with sharing power and including support staff in PD work and in the PD group. The realisation that nurses alone couldn't achieve this culture change without the involvement and participation of the support staff became more obvious as the programme progressed. However the involvement of support staff in programme days proved very challenging for some senior nurses who were uncomfortable with being challenged when support staff were present. For this group the 'group process review' was very challenging.

Conclusion

This report has focused on the broad developments of the three PD groups in the Mid West. Some of the processes in the programme may not have been as successful as others at the time and this is due in part to the nature of emancipatory practice development which is based on critical social science concepts where the emphasis is on the growth and development of the individual and the culture and contexts of the workplace to bring about sustainable change (Manley et al 2008). Deeper meaning and understanding grows within the group over time and some processes that appeared to have little meaning can become clearer as knowledge grows. It is unclear if the skills and benefits of reflection were ever fully appreciated by everyone in the three sites, as the obligation to complete reflections was a constant issue for many individuals within the groups. It would appear that in the three sites there is a greater focus on keeping the person at the centre of care and that there is greater involvement of residents/guests and their families and

recognition of the importance of this. Staff have embraced new ways of working in the three sites and are proud of their achievements. They also have a growing appreciation of the importance of evidence to support their practice and are reluctant to accept custom and practices that don't meet with person-centred principles. They all have a greater appreciation of the need to constantly evaluate their care and the idea of evaluation is no longer daunting. Two of the three sites have continued with formal PD sessions and continued to plan and monitor care practices inspite of an increasingly difficult working climate. The third site has sustained the progress made in the programme and incorporates person-centred principles into their care practices.

The ship has significantly moved in a direction that it is difficult to see any one person being able to turn it around and back in the direction it came from. All three sites have had their individual issues that could have significantly impacted on the programme but the will and vision to keep going was strong. One internal facilitator said that although they now have severe staff shortages all the staff in the unit agreed that they are not going to let this affect the residents

"we are not going to let the embargo stop us from being person-centred. All the staff have agreed that our priority is to the resident now and whatever else has to go, our person-centredness won't".

THE DUBLIN NORTH EAST AREA

Participating Sites

St Joseph's Hospital Trim (name changed to St Joseph's Community Care Unit in interim period) - a 137 bedded HSE run residential care unit in Trim Co Meath it consists of 5 units and a Day hospital.

St Mary's Hospital Castleblaney - a 144 bedded HSE run Residential care unit for older people in Castleblaney Co Monaghan. It provides a range of facilities including day care, respite, convalescence, rehabilitation, extended care and palliative care.

St Joseph's Hospital Ardee - a 34 bedded HSE run Residential Care Unit in Ardee Co Louth. It consists of a male and female unit and an extended unit called the annex. There are facilities for three respite patients.

Activities

• Vision statements have been developed at each site reflecting the values and beliefs that have emerged from the values clarification exercises. This work involved staff, residents, families and visitors. This supports the collaborative, inclusive and participatory philosophy of the practice development framework.

• Participants explored the language that is used in the organization not only with older people but amongst themselves. Work is ongoing in this area to heighten awareness of a person-centred approach in the language used. Awareness is kept high by challenge and support exercises and collage work and posters.

• Staff have undertaken exercises to get to know their residents as people by finding out what they would most like staff to know about them and their likes and dislikes. The programme days involved staff reflecting on their own likes and dislikes and considering how this might feel for the people we are caring for. More recently life story work is being done to get a more in-depth knowledge of the resident as a person. This information is being linked into their care plan in order to make all staff aware of preferences.

• Observations of care have taken place on each unit and participants have been encouraged to repeat this exercise and to involve as many staff as possible in

conducting an observation of care. This exercise has been one of the most powerful tools in allowing staff to reflect on practice and how it might feel for the residents. We have given feedback on the observations of care to the team and any residents who wished to be present. This was a very useful exercise in trying to get everybody on board and to let them know more about person-centred care.

- Environmental walkabouts have been facilitated and participants encouraged to involve residents, families and visitors in reflecting on how person-centred the environment is for people living and working in the setting.

- Participants have been introduced to a reflective framework and encouraged to undertake reflective exercises about their practice and their facilitation work. It has been very difficult to get participants to do the reflective work and this is something that needs to be worked on by the Internal facilitator in future.

- Giving and receiving feedback has improved perceptions of the programme as a supportive and developmental endeavor to improve experiences for both staff and residents. This has helped to develop the facilitation skills of the team.

Specific Action plans Developed across Participating Sites

- Developing meaningful activity plans for the residents.

- Developing a person-centred culture to enhance teamwork and staff relationships in order to improve communication and well being for staff and residents.

- Enable residents to maintain their connections with family and the outside community. A meeting was held with the residents group and some family members in Trim and their issues were very much the same as the themes emerging from the overall evaluation of the programme (Chapter 4). Groups have been established at the other sites to address family and community connections.

- Giving residents a voice and choice.

- Working towards making changes and improvements in the environment to create a person-centred context and culture.

- Changes in mealtimes in order to make the experience more person-centred.

- Wall mural and sitting areas to encourage socialization and to make a place for visitors to meet residents.

- Traditional music for residents.

- Opportunity to have choice to see old movies or some of the programmes they enjoy.

- Offering more choice around bathing and grooming activities.

- Having the opportunity to get involved in cooking and baking that was a part of many lives before they came into residential care.

- Shopping trips to Dundalk. This was something that came out of the narrative work and conversations with residents that they would like to go shopping. It has been a great success.

- Pet therapy in the Dementia unit in St Joseph's Trim

- There is a resident dog in St Joseph's Ardee since the new extension was built. Many of the resident's enjoy spending time with this little dog and observing what she gets up to. Her name is Cara which is a Gaelic name that translates as friend in English.

Achievements at St Josephs
- Clarifying values and beliefs
- Vision Statement
- Ongoing work on language staying person-centred
- Dining room area where residents can socialize and meet relatives and friends
- The team are focused on providing meaningful activities for residents there is an activities co-ordinator in Trim who is a programme team participant.
- Menus available to residents for meals
- Had a traditional music session

- Had a garden party for residents and staff
- Dementia unit has a visiting pet and new décor has helped with creating a more pleasant environment.
- Continue observations of care to highlight challenges that need to be addressed

Achievements at St Mary's

- Clarifying values and beliefs
- Vision statement
- A diversional therapist has started employment to increase meaningful activities for residents.
- Complementary therapies such as hand massage are now arranged for the residents who wish to avail of them.
- Afternoon tea party including a music concert arranged every week.
- One programme participant arranged a cookery and bread making activity for residents and it is planned for this to become a regular activity.

Achievements at St Joseph's Ardee

- Clarifying values and beliefs
- Vision Statement
- Changes to meal and mealtimes to allow choice for residents including menus.
- Wall mural displayed on area leading to garden. The visiting artist involved the residents in this and also developed a small area in the annex with a mural and some comfortable seats where the residents could socialize.
- A further development led by the Teagleach model helped build an extension on the ground floor leading out to the garden. This area has a living and dining area and a purpose built kitchen that can be used by the residents and their visitors. It is possible for residents to cook and bake in this area which is something many of them missed doing. There is a dog in the unit as a resident pet. The new extension allows for a place to socialize and meet with family and visitors and both the residents and visitors can make refreshments in the purpose built kitchen. Whilst this project was led by the Teaghleach project it helped with the achievement of some of the action plans.
- Residents shopping trips.
- The making of local trips accompanied by staff.

Sustaining the programme of work

The plans for the future are that the team at each site will meet once a month. They will continue the activities from the programme. The internal facilitators will maintain contact with the national group. A resource pack for each site is being developed to continue to embed PD and PCN principles into practice. It was recognized that the buy in from the management of the service is crucial, so raising awareness in that area is a priority.

Summary

There was an expectation that the participants in the group would learn about and become facilitators of person-centred care. Participants worked very hard to try to change the culture and context of the participating sites. There was 'ebbing and flowing' of progress and things didn't always move and change and sometimes things slipped back. The group surprised themselves by engaging in creative practice development work and it exposed them to new ways of thinking and of doing things. This work encouraged participants to challenge the status quo and to see that reasonable risk taking can make enormous changes for everyone in the organization.

SOUTH AREA

Description of the Sites

Three hospitals participated in the Person-Centred Practice Program in the HSE South, Cork and Kerry region.

St Finbarr's Hospital is the largest centre of care for older people in the HSE South, and is also the largest unit in the country to participate in the program. The current site was first designated as a workhouse in 1838 and received its first 'inmates' in 1840. This former workhouse now forms the basis of the St Finbarr's Hospital site. It consists of nine long stay and two rehabilitation wards. Services for the older person include: rehabilitation (2x40 bed wards), respite facilities, day hospital and residential care (155 beds).

St Josephs' Unit is a 24 bedded residential care unit, situated on the second floor of Bantry General Hospital and is the smallest unit to participate in the program. Eighteen beds are designated for residential care, five for respite and one for palliative care.

St Columbanus Care Home operates under the Primary Community and Continuing Care Services. It was opened as the Killarney Union workhouse in 1845 and was designed to accommodate 800 inmates. It is now a 130 bedded residential care facility, providing continuing care primarily for older adults. St Columbanus provides residential and palliative care. These services are delivered through three nursing units namely, Hawthorn, Heather and Fuschia. Each nursing unit has a variety of 2 – 8 bedded wards, a single side ward, sitting room, dining room and social areas.

Program Groups

St Finbarr's program participants group consisted of ward managers, nurses, care attendants and ward kitchen staff. At the end of the first year a community nursing unit was opened up on site and 50% of the participants group were redeployed to this service. Approximately 4 weeks later a further 25% of participants were lost to the program team through staff relocation to other wards. This necessitated the recruitment of new participants to the team. This was challenging for the Internal Facilitator as program days had to be structured to accommodate these new participants and they also required extra support to develop their action plans. While

their initial involvement meant that all program processes had to be reviewed, this, while challenging at the time, proved beneficial to the group as a whole, as existing participants reported this review helped them to understand the principles of Person-Centred Care more thoroughly.

St Joseph's program group included nurses and care assistants. At the beginning of the second year, there was a change of both external and internal facilitators. Initially these changes led to disruption of the program, but they also led to fresh ideas and new personalities.

St Columbanus program group consisted of CNM2, CNM1, staff nurses, care assistants and an activities therapist.

Phase 1 data collection findings (January 2008)

Preparations for the program commenced in the Spring of 2007. Data were collected on three occasions during the period of the program delivery, namely January 2008, November 2008 and June 2009. The baseline findings from the first round of data collection in January 2008 informed the participants about the needs of residents and about some organisational issues that needed to be addressed. For example:

- Residents had limited access to outdoors or to spaces where they could share private time with their families.
- Residents had limited choice around mealtimes and activities, or if residents were unable to inform staff of their choice/need, how could staff address this?
- Staff felt there was not enough time available to spend with or chat to residents. They felt disempowered with little autonomy and that care delivery was task orientated, with the emphasis on the biomedical model of nursing.

Action Plans arising from phase 1 data collection

Team building exercises assisted the participants in progressing their action plans. They reminded each other daily about the language being used and becoming more person-centred. An agreed process for giving and receiving feedback was developed, and for managing high challenge/high support. Activities were developed in order for residents to have more choice. More meaningful conversations with residents were encouraged and residents' narratives were obtained.

Participants discussed action plans they wished to progress on their own wards. They worked with the action plan template and involved others at ward level. The key to implementing action plans is more engagement and involvement of other staff, residents and where possible, relatives, and friends. Participants made posters of their action plans which were displayed on their wards. Some action plans included:

- installing a fireplace
- hanging new pictures
- changing seating arrangements and appearance of the church altar
- organising for residents to attend Mass on Sundays
- encouraging friends to become more involved in visiting residents
- maintenance of grass and garden areas
- obtaining a CD player and relaxation CDs for the residents
- decorating a hallway and upgrading an entrance and patio area
- solving storage problems and addressing issues with an adjoining smoking shelter
- installing blinds
- developing a leaflet on end of life care for families.

A residents' forum was formed and regular meetings held. An information booklet for residents was developed and the social aspect of mealtimes improved. These action plans were worked upon throughout the program. Several achievements were reported by the implementation of the action plans. Participants' communication skills improved including interaction with other staff, residents and families. Vision statements, linked to the person-centred framework and person-centred practice, were prepared for each site. Participants' confidence grew in challenging non person-centred practices, such as use of language and encouraging a culture change towards delivering more person-centred care. Choice for residents increased. Mealtimes became more sociable and interactive. Participants began to undertake reflection on their own practice or practice observed.

Phase 2 data collection findings (November 2008)

From the initial pilot sites, it was reported that participants be forewarned that changes do not occur overnight and not to expect significant improvement in the short term. This was borne out by the findings from the data collected in phase two.

Evaluation of phase two data collection indicated that there was still room for improvement in a number of areas. Environmental walkabouts showed where communication between residents, relatives and staff could be further improved. A lack of appropriate activities for some of the more dependant residents was identified. There was very little storage space for equipment. Christmas celebrations were not as residents would wish and some residents were unhappy at being unable to attend Mass. On-site changes and rotation of staff lowered the motivation of some staff. From the residents narratives in particular, it was noted how some residents suffer from lack of or poor social contact, and expressed feelings of powerlessness and boredom.

Action plans arising from Phase 2 data collection

Person-centred Christmas celebrations were planned to ensure that all residents had the opportunity to enjoy the build up to Christmas as per their suggestions. For example, some residents expressed a wish that they would not receive a visit from Santa Claus, but instead they would prefer a greater emphasis be shown towards religious services. This highlighted for participants how assumptions about residents' preferences are not always correct.

In St Joseph's Unit, a roof garden was developed in which residents could enjoy the pleasure of being outdoors. In another site an overgrown garden was cleared and seating and walkways were installed in order to enhance the residents' experience.

"De-institutionalisation" and "establishing a home from home atmosphere" came about through the transformation of an entrance and lounge, in St Finbarr's, into areas where visitors and residents could sit and chat in comfort, and in another site where a dull lounge was transformed into a homely cosy sitting room where residents could relax and mingle. Improved mealtimes and the purchase of new bed linen served to improve the residents' comfort in St Columbanus. A particular project titled "A New Direction" focused on erecting visible signage to ensure that relatives and friends of residents would be able to find the unit/ward more easily.

Independence and choice for the residents were enhanced through the development of a mobile shop, a hairdressing comfort room, increased accessibility to Mass, and resident support groups/meetings. Improvements were made around end of life care issues, including the design and implementation of an information leaflet for relatives whose loved one had died.

"What's your story" led to the development of residents' life story books, in order to provide engagement, discussion and connection with residents and their families.

As a result of the actions outlined above, increased awareness of person-centred processes grew. Participants became more empowered, and became aware of the process of achieving change and utilising it. Residents' choice and voice were heard regarding ward processes. For example the establishment of residents' support groups was of great benefit to the residents in order to improve their overall quality of life and their environment. Increased interaction with residents and their families was developed through 'life stories'.

The social and aesthetic aspects of mealtimes were improved by including the use of table cloths, jugs, serviettes and glasses on tables; television is turned off during mealtimes; all clutter/equipment is removed from dining room areas; liquidised diets are presented in a more appetising manner; and as a result of residents' meetings in one site, fruit is now on offer in the afternoons.

Phase 3 (final) data collection findings (June 2009)

As a result of phase three data collection in June 2009, the final evaluation findings were as follows. Environmental issues continue to be a problem with most wards needing painting and decorating. Lack of privacy is very evident where some wards do not have doors at the entrances to their 6 bedded bays. A number of residents appeared to have no particular purpose to their day or a lack of appropriate activities for them was evident.

Although it is difficult to transform culture and break away from routine, sometimes little changes are as significant as major modifications. However the ongoing moratorium on staff recruitment within the HSE makes it more difficult to maintain the momentum of implementing change. It takes time and energy to eliminate comments like "this is the way things are done around here" and to sustain change. Nevertheless the biomedical model is less evident in favour of the person-centred model of care.

Achievements

Positive interaction and engagement is obvious between residents and staff and this two way communication helps to support the change process, which has been described as "a definite process of getting things done". Residents are encouraged to voice concerns and to take part in ward decisions. Correspondingly, staff are more aware of choice for residents and are more actively listening to them. Personal growth and development of staff involved in the programme has been of benefit not only to residents but to other staff on site as well. Participants feel more empowered to get things changed.

There has been a major shift towards using person-centred language. Signage has improved. Team work is more encouraged and enhanced. Meal times have become a social/interaction time and are more aesthetically pleasing. Environmental issues, while not perfect, are being noted and addressed in a person-centred manner. Involvement in the person-centred programme is assisting with fulfilling obligations under the HIQA Standards (2007) and the Health Act (2009).

A residents' forum was piloted on one ward and then extended to all wards on that site. Advocacy services are now available on all three sites. A relatives' support group has been established on one unit, which brings the residents, relatives and staff together to work on improving life and the environment for present and future residents of that unit. An information booklet for residents and relatives is designed and is available. Also, a 'Help to get to know you' booklet has been developed for residents and their carers to complete prior to admission.

Into the future, full day or half day program days will be delivered on person-centred care on a regular basis in order: to involve more staff by recruiting new members from all wards; to up-skill current participants to develop and deliver program days; and to continue to transform attitudes towards person-centred care. Residents will be encouraged to become more involved in the planning of their care. They will be asked about their preferences/issues rather than their wishes being assumed. Current action plans will continue and new action plans will be implemented to further progress person-centred care.

Progress evaluation will be ongoing with the continued use of WCCATs, Narratives and Context Assessment Index (CAI).

CHAPTER 3

FINDINGS PART 2: LEARNING AND DEVELOPMENT OUTCOMES ARISING FROM THE FACILITATION ACTIVITIES

INTRODUCTION

The National Practice Development Programme had a set of clear activities through its two year programme, one of which was the provision of formal programme days and interim sessions. Programme days were held once every 4-6 weeks with a shorter or interim 2 hour session held midway between each programme day. The interim sessions evolved into action planning or working groups in year 2.

The overall aim of the programme days was to enable staff to have the confidence to become facilitators of practice development in their own workplaces. This was a complex and slowly unfolding process. In the first instance staff who were attending the programme days needed to be able to self-facilitate in order to role model the new ways of being in their day-to-day work. Then they needed to find ways to influence their colleagues to adopt new ways of relating and being.

There were 12 programme days held over the two years of the National Practice Development Programme. These were day long events organised as workshops. Each workshop had a programme and facilitation guidance. For year one the external programme leads devised the workshop programme and produced the facilitation guidance. This had several benefits:

- It ensured educational quality in regard to the planning and organisation of learning for programme participants
- It ensured national consistency in terms of how the days were delivered and the coordination of workplace learning activities
- It enabled the NMPDU facilitators to focus on developing their skills in facilitating the workshops based on translating the pre prepared facilitation guidance
- The facilitators were able to share experiences within the team as they had been working on the same programmes and drawing on the same guidance.
- It provided detailed written guidance and structure for new internal facilitators to work from and a theoretical background to enhance their knowledge
- It contributed more readily towards evaluation of the programme
- It enabled more diverse the testing of the methodology of Active Learning and some of the specific work place learning activities

The planning of the programme days/workshops evolved in year two so that by the end of year two the NMPDU and internal facilitators were designing the programme day learning aims and some of the active learning activities.

EVALUATION QUESTIONS

In the second year, the team generated three evaluation questions to frame their evaluation of the programme days which were:

1. What has been the programme participant's experience of engaging in active learning?
2. What did programme participants learn?
3. How did programme participants make use of their learning in the workplace?

WHAT HAS BEEN THE PROGRAMME PARTICIPANTS' EXPERIENCE OF ENGAGING IN ACTIVE LEARNING?

This report uses data from days 1, 3, 6 and 11 across four of the regions to answer the questions above, as these regions had complete data sets to work with and thus provide an accurate reflection of development over time. They are however representative of the other sites.

Day One

Active learning in practice development work involves participants becoming involved in reflective practice, having a dialogue with self and others, engaging in learning activities which involve making use of the senses and multiple intelligences and involving colleagues in workplace activities (Dewing 2008). Thus, programme participants were introduced to a number of different active learning methods throughout the first programme day that acted to signal different learning methods would be offered on these days and at other programme events. As this was the first day of the programme, it was anticipated that the participants may be somewhat apprehensive; thus a carefully chosen opening activity was devised to help create a friendly and supportive atmosphere. Typically across the sites there was a mixed group with staff representing nursing, care attendants, catering, housekeeping and administrative areas. While the participants may have known each others names,

they may not have had, the opportunity to get to know each other in a meaningful way. Neither would they be used to learning together. The creative activity was designed to help address that. The focus was on them as a person and thus it was role modelling the importance of knowing the person and not making assumptions about other people. Whilst initially there seems to have been some trepidation amongst the groups, once the participants became involved and embraced the challenge, the evaluation from all sites was very positive. One participant commented that:

"Starting with the self portrait, put me at ease and promoted a relaxed learning environment".

Another one said:

"I knew right away this was going to be a very different way of learning, because of how we started…and I felt both nervous and excited by today"

Throughout the first day the participants were introduced to other ways of active learning. The terms of engagement (i.e. how the group was going to work together over the 2 years) were developed and agreed, again using creativity. This was done through the use of cards such as 'angel cards' or picture postcards. The focus on this activity was participation, inclusion and hearing everyone's voice in the room. This approach is in keeping with the principles of collaboration, inclusion & participation known as the CIP principles which are an integral part of practice development work (McCormack et al 2006; McCormack et al 2009). Other activities used throughout the day involved participants with individual reflection, working in small groups and working together as a whole group. Thus setting the scene for the style of learning on the programme.

For some of the participants working this way was very new to them. "Traditionally, the participants would have attended a "study day" where the focus would have been more didactic and directional with the focus been on the presenter/lecturer doing all the teaching mainly through them talking. Many of the participants, in their evaluation, commented that this way of learning was new to them; this is summed up by one participant who said:

"I really like this way of learning, it's more inclusive usually when I attend study days I just sit and don't get involved to much".

In summary, the existing culture in the sites was such that at the beginning of the programme sustained attention had to be given to enabling each person, regardless of their role, an opportunity to believe in their self-worth, find and use in positive ways their voice both in the programme days and in the workplace. Further, the morale of the groups tended to be very low and the self-belief also very low. Participants lived with a huge gap between what they wanted to do for residents and how they actually worked. Participants tended to express high levels of powerlessness and very low levels of engagement and empowerment.   There was a huge focus on concerns such as rules, perceptions about management and what wasn't allowed, obstacles and reasons why things couldn't be done. The most common themes were lack of staff and lack of time. There was a variety of evidence indicating that staff worked to a routinised even ritualistic culture that was in many ways harmful even brutal for them and for older people. Examples from the programme records from different participants at four sites:

"We won't be able to deliver on what we promise"
"It's too much work"
"I don't think other staff will take to this"
"What if the managers won't allow this to go ahead?"

Day three

The participants, by this time, were generally easily re engaging in the learning ethos of the programme days and there was evidence of trust and team effectiveness emerging from the programme day evaluations.   The groups "Terms of Engagements" were starting to be effective as a means of creating and sustaining "group norms" and were being used to set an agreed level of behaviours which guided participants on how to interact with one another.   Some quotes from the participants about the "Terms of Engagements" included the following:

"Participants feel more confident having these"
"Permission to say things – I did not have this before"
"More together as a team"
"Opened up minds to new ideas to find ways to change" "Important to apply this to the whole team - outside and in the room"

This day saw the participants discussing quality of life and comparing their insights with the evidence they had previously collected in the workplace learning activity Cats Skirts and Lipstick with residents. This activity grounded in practice provided all of the participants with the opportunity to relate the lived experiences of residents and participants own knowledge some evidence from research and policy relating to quality of life indicators e.g. "Improving Quality of Life for Older People in Long–Stay Care Settings in Ireland (National Council on Ageing and Older People (2006), HIQA Standards (2007), and NCHRDF (UK) Review (2006). The PCN framework was again useful here in order to establish the complexities of cultural transformations and what would need to be addressed in order to make the quality of life indicators they identified for their residents/patients a reality. This activity revealed that knowing the older person is vital – however it was found to be tokenistic in day-to-day relationships.

The participants were introduced to the concept of knowing self as well and in particular High Challenge and High Support. Participants identified with the traditional methods when challenge was needed: either *pussyfooting,* being so nice that the issue is avoid or *clobbering* being so punitive that the response is aggressive and wounding (Heron 1999 cited in Brockbank and McGill 2006). A third option of skilled, supportive and enabling confrontation with the challenge being to get it right was the theme for day. In practice development challenge is recognised as essential for helping teams to move forward and become effective. In challenging custom and practice and the taken for granted it can sometimes be perceived as threatening, and may also be threatening in reality (Brockbank and McGill 2006). The participants were encouraged to start looking at how they were using HC/HS in their own areas and to practice the skill in order to become more confident in questioning practice issues.

"Challenge and support – I need to understand more about how to best implement it"

"Difficulties of High Challenge and High Support - a big risk but it can bring about change. I can see that"

Prior to this programme day participants were introduced to the learning activity Observation of Care. This was a pre planned activity where participants undertook a simplified observation activity, wrote it up and provided feedback in the group on their experience. These experiences were varied from "*this was an interesting experience which highlighted both good practices and areas for improvement*" while others experienced the *"resistance from other members of staff to being observed"*. The plan following this activity was for each participant to continue to participate in the Observation of Care activity within his or her own area and offer colleagues feedback. It was proposed that when the participants felt comfortable with the activity they would invite/encourage other staff members to have a go for themselves and be facilitated to identify what they had learned.

In summary, by day 3 the groups were informally collecting, analysing and learning from a range of evidence they were collecting from their own workplaces. They were beginning to develop some of the attributes needed to embed a learning culture in the workplace including learning in and from practice and setting up systems for giving and receiving feedback. They were also experiencing the need for role modelling and resilience as they discovered that their colleagues needed repeated challenging and support to adopt new ways of working and relating.

Day six

By this time in the programme (mid way), each site had its own local action plan based on the evaluation data from timeline 1 that had been collected and analysed.

Four themes emerged from day six across the sites:

(1) Working effectively as a group: support from the group was found to be encouraging when dealing with common obstacles. Participants said that they feel part of a "special group". Another group declared that:

"*We thought we knew but as a group we have to continue to learn so that we share the message".*

(2) The dual experience of positivity and challenge: *"Going forward is a challenge; bringing person-centred care forward is hard work"*. At the same time participants could see and feel *"we have seen how much we have achieved and we are getting stronger, we've achieved what others thought we could not"*. Participants were beginning to realise that transformations were focused on the implementation of numerous small changes that they had the power to lead and embed, e.g. trying to move away from task-orientated to resident choice; to be more observant; to ensure person-centred language is used.

(3) Getting action plans in motion: this required another burst of energy to get interest and involvement from other staff, residents, and where possible relatives and friends in order to progress the implementation using CIP principles.

(4) Critical reflection and reflective practice: in the programme to date, the groups were finding reflection to be central to understanding the way care affects the resident. A few groups were starting to find group reflection to be very effective as *"a way of debriefing after an incident on the unit before going home"*. However, apart from two sites, most groups and facilitators were still not systematically building in the reflection sessions that were included in the programme days thus there was minimal recording written reflections as part of the programme days. Sharing critical reflection in writing or in a group using a structured method was probably the biggest and longest challenge that participants and facilitators experienced. Throughout the two years this continued to be an issue. See discussion chapter where this is given further consideration.

Day eleven

Sixty participants in total attended the specific programme day (day 11) from the 11 sites. This figure is offered as it gives some indication of the continued commitment of participants and facilitators to the programme. The breakdown of nurses and non nurses who attended was approximately 67% registered nurses (ADON, CNMs and Staff Nurses) and 33% non nurses (healthcare attendants, catering staff, housekeeping staff).

Towards the end of the programme the local facilitators and participants were now devising the detail of the programme days themselves and sending them to the

programme leads for review. It was evident from the notes at this stage, that the workshop days were becoming more varied or contextualised in some respects. Although they had common themes such as evaluation and analysis, planning for sustainability, conducting observations of care, patient narratives work and action planning.

By this point in the programme, creative methods to learning were more accepted and the local facilitators were actively experimenting. Different activities were used by the participants as an opening activity to day 11. The use of artefacts was used in three of the sites. The participants in one of sites were asked to describe using their artefacts in relation to …. *What does PD and PCC mean you over the last two years?* One of the participants described "…*a spider's web as… catching flies, catching people and catching attitude".* Another participant used the analogy of a Laurel Leaf to describe PD and PCC as *"bright smooth and shiny, but can have different meaning… naive at the start of the programme – but, relationships are getting closer between staff and staff and staff/patients".* Creating pictures, collages and poetry were utilised by the facilitators and participants to explore the learning and understanding of PCC and PD and the transfer of the learning to working with residents in a different way.

The involvement of residents and their families was more evident in the data by programme day 11. Some of the sites had held joint learning sessions with residents to explore change and how to improve practice.

Observations of care and discussion of the findings within the group were taking place in several groups on an ongoing basis indicating some sustainability of this method. Participants were also involved in regular observational environmental walk abouts together as a group, and discussed the importance of involving residents and their families and wider community in the process. Overall the learning from this process of participating in and carrying observations of care was positive and powerful in relation to understanding and gathering evidence to change and improve practice. Through dialogue with other group members the participants described *"how this was a powerful way of looking differently at the way we do things and really makes you think and puts you in a different place for that period of time …".*

At some sites, participants on programme day 11 worked outside in the garden area in two of the sites specifically looking at HIQA Standards about outside space,

another site carried out an observations environmental walk around. Feedback was positive in relation to this from the participants, they liked being outside and ideas such as "… *involving older people in observing and inspecting, changing, …giving residents choice about their environment and involving residents in the walk around".*

One of the sites used the data collected to explore planning a garden area and putting up a Christmas tree. Through evaluation of the observations of care by the participants the change in many aspects of the practice area was identified, such as, "… *less non PCC language, staff are much more aware, noise levels much better since we started". "…atmosphere much more improved since we first started the programmes".* This finding is supported by formal data gathered through structured observations in the evaluation research (WCCAT). At this point, participants were able to recognise what they had and were still achieving.

The challenge of carrying out workplace learning activities was noted as been less challenging for participants and the wider healthcare team as time went on. One of the participants in her evaluation of the observations of care reported "*that staff were hostile at the beginning, no longer are …*". The importance of giving feedback in a constructive way and the involvement of other staff members was identified as both challenging and a necessary part of the process. Role play was often used in the workshops between the participants to learn and get feedback and support from within the group as the skill set developed. In day 11, HC/HS skills were discussed and role play was used to demonstrate the process on one of the sites. Giving and receiving feedback was considered to be challenging and a skill that required learning both for the facilitator in giving feedback and also receiving feedback. The PD group participated in this process through active learning and directed learning in relation to the used of the HS/HC grid as a framework.

WHAT DID PROGRAMME PARTICIPANTS LEARN?

From day one, five core themes were found across all the programme records. These are summarised now with some quotes from participants from different sites to illustrate what is being said.

(1)   Working as a group: most frequently recorded was how working together with a shared vision would enable so much more to be achieved.

"Importance of being part of a group with a shared vision and support from each other"

Another participant *said:*
  "The group work today has been great I really enjoy working this way"

(2) Principles of Practice Development and the Person-centred Framework: from discussing the framework and working through examples participants were able to see that developing person-centred care is as much about staff as it is residents.

"I like the person-centred model because it looks at staff as much as it looks at the residents. That's important because if the staff don't feel that they are valued and that their input matters it will be hard for them to see that involving the residents/patients in developing a person-centred culture matters"
"its going to require us all changing how we do things around here and its not just about what we do but they way we do things" Its going to be a challenge"

(3) Creative ways of learning:
  "Opening up my mind to new ways of learning"
  "Learning can be fun relaxed and fulfilling"

(4) Self-awareness: participants were beginning to become aware of their own practice and the impact they could have on changing the culture by role modelling person-centred ways of working. In particular, everyday language was something that participants identified with. The participants tended to comment that the activity on person-centred language made them realise that they first needed to look at their own practice before they could comment on others:

  " I had no idea I was using that language every day but I do now. I am going to change how I behave."

  "it is only when you stand back and reflect on what you are doing every day and how you might be behaving, that you really can see what you are actually doing, I had no idea"

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Another commented that she was quite shocked and she was going to look at "*my own practice first*". Thus the participants had started the process of self reflection and committing to action in their work through reflecting on their own practice around everyday language and how that could impact on care delivery. This is a necessary part of enlightenment and bringing closer the gap between how practitioners believe they act and how they actually do.

(5) Active Learning: active listening and how that links to creating a person-centred culture;

> "*I found the day very interesting and can't think of anything I didn't like which is unusual for a course day*"
> "I *learned how to learn in a very different interactive way*"

At one site, the three points of learning from the day that participants were going to share with other staff were:

- Importance of reflective practice
- Change starts with us
- Explored ways of making life better for everyone by using a model of person-centred care which looks at skills of staff, environment, care processes and outcomes for patients and staff.

The two facilitators at each site recorded intentionally working with a range of facilitation tools and processes including:

- Introduced to terms of engagement and ways of working together as a group
- Values clarification
- Creative engagement – role playing, art work
- Reflecting in and on practice
- Evaluation using claims, concerns and issues
- Collaborative and participatory action planning
- Collaboration, participation, inclusion
- Reflective questioning

This demonstrates the facilitators intentionally working with practice development methods and processes in a real workplace situation.

Day three

The data identified that adult learning and development was occurring on both a personal and professional level. In particular, in regards to knowing self, participants reported that their self awareness was growing:

"Becoming more self aware myself"

"Learning more - I'm changing.

"I find role play difficult and would shy away from doing it but felt comfortable in the group so that made it easier"

"Determination to do better and be more patient centred myself before helping to introduce change"

"I think of the impact my presence has on patients and what can be"

"Things are becoming clearer to me"

"Feeling more confident and 'on track' with the programme"

"Learned how to improve my practice without being confrontational (High Challenge and High Support)

"That we have already developed some facilitation skills"

"Role playing (observing) despite the fact that I hate role play"

"Good facilitation skills are developing-the challenge is for me to use them more"

"Learning more as I go along"

The learning experiences from the programme day provided the participants with the opportunity for interaction, camaraderie, inclusion and collaboration. These are significant experiences because they did not generally get this in their day-to-day workplaces. Changing patterns in the workplace is not just a matter of changing the ideas of individual practitioners alone, but also discovering the discursive, material, social and cultural, conditions under which practice occurs (McCormack 2008).

Five significant themes are identified here from this programme day:

(1) Justification of the programme: participants had to explain the programme to others and found this challenging as they felt they had to justify the time they spent on the programme during times when cut backs were being made in the health service. *"The more things are discussed, the better understanding of person-centred care".* The participants found it difficult when met with resistance but with the continued support of the program days, they were both developing resilience to this and staying focused to overcome this resistance. The participants reported that having a good knowledge base and being confident with the processes used on the program helped them with this. *"It is starting to make more sense, I feel more confident".* This highlights that cultural change needs time and spaces for discussion. Inherent in this, the discussion need to be championed by team members. The traditional way of simply handing down or informing staff at a meeting will not suffice.

(2) Reflective Practice: as already highlighted, initially it was difficult for participants to engage in structured written reflection as many had not written in a structured way previously. In particular they found it hard to write about emotional aspects of their work, which demonstrates the emotional disconnection with work experienced by many. On day six there was an intentional focus on reflection and structured reflection using a variety of models. Encouraging participants to reflect on things that were not practice-based *"helped to overcome the initial fear of writing"* and participants were able to transfer this new skill to practice. They became "*more in tune with their feelings*" and *"perceptions of what was happening". "Reflection is central to understanding the way care affects the resident and is a valuable tool in helping me learn".* As already noted, acquiring the discipline to systematically write reflection was an ongoing challenge. Some sites and facilitators took this challenge on board whilst others were less systematic about it. Those that engaged in a systematic and structured way tended to see more progress.

(3) Interview techniques with older people: initially, participants found it difficult to 'stop', sit down and ask residents personal questions about themselves or their lives. By this point, participants had learned how to approach the resident, how to frame questions and listen to what is being said or not being said.

Participants also reported that this skill could be used in their day–to-day work to facilitate more meaningful conversations with older people.

(4) High Challenge and High Support: participants found it particularly difficult to challenge their colleagues initially, especially if they were more senior to them:

"They [the RNs] won't take it from me"
"I'm fearful about staff saying I'm being too bossy and making things difficult for me"
"Change can take forever" but it is possible to change".

The significant learning for participants was (i) surprise at just how resistive some of their colleagues were and probably that they had not noticed this before (ii) how often the same message or challenge had to be repeated to the same people (iii) the negativity and hopelessness their colleagues expressed

(5) Evaluation data collection and what that means to practice:

(i) Environmental walkabouts: doing a walkabout while taking on the role of a prospective resident/patient, a visitor or a member of staff was enlightening for the participants as they felt they saw the wards/facilities in a new light which previously they had been too busy to see. Critical questions were identified for action planning: *"How do we accommodate more personal belonging?"* or *"Does the ward layout impact on peoples' perceptions of the ward?"* They were also able to identify areas where improvements could be made and this learning was added to the local action planning process: e.g. *"Can more choice be given regarding meals?"* or *"How do we create more space for the residents?"*

(ii) Observations of care: the majority of participants now found doing of the observations of care most helpful. They had not looked at the care environment in this light before and found it to be an eye-opener. They reported at being amazed at some of the things they observed such as "No stimulation of patients" or "piped music and television both on together", the glare of the lights, inappropriate music and clutter. Several sites committed to doing these on a monthly basis and introduced this activity (and the walk about as learning activities for students and new staff).

(iii) Analysis of WCCATs and narratives: participants reported that in reading the WCCATs and Narratives, they were able to gain a lot of information on

what it meant to be a resident. They found this helpful and thought-provoking. It also showed that *"using enlightening questions can get deeper meaningful information".* They learned to identify what needed to be addressed and how to develop action plans around these gaps.

In commencing their action plans, participants were adhering to the basic principles of CIP, as they needed to engage with other members of staff in order to progress the plan. They also had to engage with senior management which to date would not have been the norm. This promoted a better understanding from the participants' viewpoint of how to address issues through the proper channels, e.g. "I learned a better way to look for improvements to be done".

Day eleven

The focus was on achievements both personally and professionally in terms of care for residents. Data indicates that there were benefits for the organisation from the learning in relation to issues such as, communication, evidence gathering, analysis data, action planning and the development of new ways of 'doing things', the need to challenge new ways of doing things 'old 'habits, routines and attitudes'. Seven themes were identified:

(1) Team work: open and honest communication within the PD group and the wider team.

(2) Evidence based frameworks: policy divers such as HIQA standards and where it fits in the framework; for the service and for older people. The Person-centred framework: Practice Development framework and what it means. Again participants were surprised at how long and how much effort needs to be put into getting awareness about evidence based tools into day-to-day consciousness. Further, feeling comfortable with these resources and seeing them as positive and offering opportunities was a challenge as teams were generally suspicious and negative about such developments.

(3) Reflection and how to do it: the ability to reflect on practice and '*the way we do things'*, although the reflection was still experienced as been 'hard' and 'new learning,' one of the participants described the need to reflect on what we do every day as*…* '*vital to know how we are ourselves and how we react in*

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different situations'.   Many participants were becoming more comfortable with some level of reflection: "I *feel I am doing it every day, I can see it now and what it really means to think more about what I am doing and what it means both in the community hospital and in my life…'*

(4)   Personal transformations: self awareness by participants was identified as a learning curve and something that happened through taking steps to change; being more able to voice their opinion; enlightenment; care assistants having a voice and have a place in the decision making process.

(5)   Role clarity: more clarity of each other's role.

(6)   Care Context: the importance of an appropriate environment: the need for support from management to support the process and keep it going.

(7)   Active Learning: the value of active learning and the challenge that it can pose. Active learning activities were key to how participants did learn and acquire new skills.   Understanding the CIP principles and utilising them in practice and within the PD group was demonstrated.   The following comments from the participants demonstrated their learning over the two year period, "… *how far we have come …"; "the learning from gathering the evidence and changing the way we do things …"; "how much we have achieved"; "… involving our residents has been so important and something we must do"; "… the link to the HIQA standards …".*   Difficulties for the participants in relation to sustaining the programme were also identified though the use of colour, images, one of the participants referred to concept of a pea/seeds as a representation of the challenges of PD and PCC work "…*planted the seeds… needs water care and attention"*; another participant used the image of a windmill "… *Work good, colourful, stopped at times, needs energy to keep it going".*

The variety of different approaches that were used by the facilitators to evaluate programme day 11 included group process evaluation activities, liked least like most, significant learning.   The following quote is from one of the participants in relation to HC/HS and their significant learning that had occurred:

"*Challenge is difficult but if you are passionate about it, it's easy to do"*

HOW DID PROGRAMME PARTICIPANTS MAKE USE OF THEIR LEARNING IN THE WORKPLACE?

During day one participants learnt how to commence the first phase of the Values and Beliefs Clarification activity (Dewing and Titchen 2006; Manley and Warfield 1990) with the residents staff and families; to describe the PCN framework to 3 team members and to notice language and make notes on the types of language used in the workplace that they would consider to be more or less person-centred. In order to illustrate the workplace learning activities that were taking place and how the learning activities in the programme days were followed through to the programme days an example is offered here. Between day 2 and day 3 the programme groups were working on five workplace learning activities:

Draft vision statement: Sharing and consulting on the draft vision statement and vision in colour was largely a positive experience. However, the challenge posed by their colleagues and others was as to how it would be made a living document or a working statement.

"*Some good words in statement*"

"*Just a statement*"

"*Promoted what we expect but does it work?*"

"*Only works if we work as a team*"

"*What is team work?*"

"*Statement too long*"

All sites had by this point a draft of their vision statement and had sought feedback from staff residents/patients and families. A final draft was prepared for circulation to ensure consensus would it before it became the hospital or facility's "Vision Statement". The consultation with staff revealed a range of views about person-centredness, which are captured in these quotes below:

"Choice is fundamental to everything we do". I agree….. but whose choice-the patients or the nurses and carers? As we work (nurse and carer) in a long term setting we become institutionalised, patients get less due to the constraining effects of that institutionalisation.

"Overall this is good-however; I think that patients should come before staff"

"Have you ever heard an older person saying the word holistic? And if a person is recognised as a unique individual - is holistic not redundant?"
"All are treated with dignity and respect here. Surely this doesn't need to be written – is this not already here in ____hospital?"

Discussion took place on how their vision statement would be utilised and shared, suggestions included through their hospital booklet, by having a formal launch, displaying it at entrances and all wards and to continue discussing the statements in terms of peoples values and beliefs. Each site came up with their own action plan for which they secured support from the Director of Nursing.

Language Posters: All sites identified the inappropriate use of non-person-centred language as an issue of concern**.**

"I learned that language is not just words but that we have to be   careful about how we speak to older people in general i.e. ageism etc"

Participants found the posters they had made in day one or day two invaluable in promoting discussion on the use of person-centred language within their work environment. The participants were trying to find appropriate ways to challenge the use of inappropriate language and they were encouraged to continue to raise awareness among their colleagues. In one site the Speech and Language Therapist expressed an interest in being involved in the activity.

Cats Skirts and Lipstick Activity: This activity prompted a review of some existing care plans that did not facilitate the recording of this type of information.

They should have been asked when they were admitted "what is" and "what was important" to them, not after a few months or years"
"Chat could make life better for you here" (Resident)

Participants planned to share the learning by facilitating their colleagues to carry out the activity in the clinical area. Participants recognised that there were things they did not know about their residents and that they probably had not really considered

asking the older person what mattered to them. Further, many of the things that the older person would like were quite small and achievable.

Reflection: Participants engaged in reflective practice which afforded them the opportunity to expose, confront and understand the contradictions within practice, between what is practiced and what is desired. Some participants viewed reflective models as being prescriptive and reducing their experiences to just answering a set of questions. Facilitators took different approaches to reflection. Some persisted with using the agreed model of reflection whilst others were encouraged to use any model that they felt comfortable with or utilise any strategy such as poetry as an alternative approach to develop skills in reflection.

"Doing the reflections –makes you think more (differently)"

"The reflective cycle-I found it useful-it helped me understand how changes have occurred"

Overall, the programme day data shows that reflection as a learning activity was postponed or given minimal time. This was to become a recurring issue within the programme.

From analysing the programme records across the sites it was possible to see movement towards developing a person–centred care culture at all the sites, although there was some variation. A number of themes were identified which are set out and illustrated here:

(1)   Working collectively towards a person-centred care systems/workplace.

"The importance of involving all staff"

"We can do it"

"There is light at the end of the tunnel, and we are all working together towards a better future"

This theme also encompassed learning more about the culture of their organisation and questioning custom and practice issues: *"That change is*

possible when ideas are challenged" and *c*hallenging the taken-for granted and attitudes that are non person-centred: "*to keep trying when it comes to explaining the programme".* There was also the tension that PD and its outcomes and benefits may not always be recognised by some colleagues and managers.

"Still trying to get people who have doubts on board"
"That we all have a part to play in promoting p.c.p"
"How do we get people to come on board?-we invite them in!"

(2)   Being proud of 'our' vision statement that is representative of peoples' beliefs and values.

"Proud of our posters and vision statement"

(3)   Learning in and from practice.

"Connections between the person- centred care framework,
vision statement and practice becoming clearer"

This theme also incorporated using the evidence that they have gathered in and from practice including the patient's experiences to develop action plans.

Learning to work in new ways—using creative ways to communicate information, encourage dialogue and have fun.

"Need to laugh more at our mistakes and solve problems together"
"The programme has benefits for everyone and we need to help our
colleagues to have more courage"
"The interaction and views of others"
"If we want to do something, don't say we can't do it.
Say what we need to do to make this happen"

(4)   Development of greater team capacity within the hospital/facility

"Feeling part of the group, which is growing stronger each time we meet"
"People have such good ideas"

"Great teamwork makes the job a lot easier"
"Need to keep all staff informed and involved"
"Team development is about growing and sharing together"

(5) The need for resilience and support within the programme participants and facilitators

"I have support from this group -I am not alone"
"Need to support and listen to each other"
"More ways to 'skin a cat'-we are not helpless"
"We can do it"

Participants were demonstrating in more frequency and detail how they used their learning to both challenge and support colleagues in the workplace. They used the different types of evidence they had gathered from to develop action plans, e.g. duvets for beds, improved signage, movie day, Christmas celebrations more person-centred, and a buddy system to bring colleagues with resistive behaviours on board.

Day eleven

The themes that were identified from this day were:

Seeing the bigger picture: understanding the reason for involving residents and the wider healthcare group in their care journey; more involvement of residents, families and the wider community in their care; healthcare staff leading and chairing residents groups; involvement of the community.

More awareness of PC language and able to articulate the PD processes; a better understanding of the PC framework; raising awareness of HIQA and the legislative process.

Using reflection in daily work and being open to undertaking reflection, the challenge of reflection was articulated by this participant …difficulties around reflection.

PD processes: increasing knowledge in relation to facilitation skill development through reading, sharing, networking and role modelling; role modelling facilitation skills: the process of giving and receiving praise; analysis and evaluation methods through facilitated processes; establishing resident's groups using PD processes;

establishing working groups and extending PD to other members of staff and the residents in relation to action planning etc; utilising new learning for example, using creative activities in their daily work: increased use of person-centred language and facilitating workplace learning in the workplace; developing strategies to share their learning – PCC and PD; carrying out observations of care and environmental observations. By becoming an active part of the team, the participants identified that need to find ways to sustain the programme of work in the future may pose a challenge but were positive that their learning and work must be sustained.

SUMMARY

The programme days were the most visible and regular feature of activity. However, they were not simply study days, instead they acted as a collective rehearsal ground for transferring learning into the workplace and introducing or enhancing a learning culture. This is known to be necessary for developing a person-centred culture. Indeed the learning activities are in fact the building blocks for the new ways of person-centred working. By enabling participants to experiment with these in a learning capacity the participants and other staff are offered a safer way of exposing themselves and their work to critique. Getting these activities right – so that they help move the culture on but do not cause panic within individuals or for the team is vital.

This programme also experimented with delivering centrally developed programme days across all the sites at approximately the same time. There were several benefits to this and some drawbacks or limitations.

The Active Learning methods were for many 'new' but is viewed as an essential activity to develop and establishing new ways of working which are sustainable and evidence based. The concept of learning in this way is a journey for all members of the healthcare team and it is a journey for many that takes patience, makes individual take risks by moving away from comfort zones but ultimately provides a learning style which approaches the change process in a different way. This approach enabled different members of the team to learn and work together in a way that had not happened before.

The evaluation of this specific part of the programme identified a variety of active learning activities which were utilised. Many of the activities are now being replicated and refined in an Australian practice development program, again indicating their usefulness within practice development. The personal and professional growth for individuals across different roles and within the health care teams was evident in the analysis of the programme day notes, thus active learning activities were found to be acceptable to the participants and utilised throughout the programme day and in practice. Further, the acceptability and usability of Active Learning across all the sites and throughout all the days was high further indicating its usefulness.

This program also demonstrates that practice development programmes can be led from a distance and that a group of facilitators can be coached to locally lead and deliver complex practice development activity.

CHAPTER 4

FINDINGS PART 3:

QUANTITATIVE AND QUALITATIVE DATA

PERSON-CENTRED NURSING INDEX (PCNI) AND PERSON-CENTRED CARING INDEX (PCCI)

Response Rate

A detailed breakdown of the response rate for the PCNI and PCCI by each site is presented in Tables 4.1 and 4.2. The overall response rate decreased across the three time points. There was considerable variability in the response rate in each site. Examination of the data was restricted on two sites (site 7 and 17) due to a poor response rate or missing data collection points.

Site	Time 1	Time 2	Time 3
1	5 (0.8)	16 (3.2)	15 (3.4)
2	11 (1.8)	12 (2.4)	15 (3.4)
3	24 (3.9)	24 (4.8)	22 (5.0)
4	15 (2.4)	13 (2.6)	9 (2.1)
5	45 (7.3)	25 (5.0)	25 (5.7)
6	14 (2.3)	22 (4.4)	22 (5.0)
7	13 (2.1)	----	----
8	37 (6.0)	61 (12.2)	21 (4.8)
9	10 (1.6)	10 (2.0)	12 (2.7)
10	43 (7.0)	43 (8.6)	34 (7.7)
11	94 (15.3)	55 (11.0)	83 (18.9)
12	78 (12.7)	43 (8.6)	31 (7.1)
13	42 (6.8)	14 (2.8)	17 (3.9)
14	50 (8.1)	35 (7.0)	37 (8.4)
15	54 (8.8)	63 (12.7)	62 (14.1)
16	18 (2.9)	13 (2.6)	11 (2.5)
17	35 (5.7)	26 (5.2)	----
18	26 (4.2)	23 (4.6)	23 (5.2)
Total	614 (100%)	498 (100%)	439 (100%)

Table 4.1: PCNI response rate for each site for each time point

Site	Time 1	Time 2	Time 3
1	6 (1.0)	36 (7.1)	74 (15.4)
2	12 (1.9)	17 (3.4)	9 (1.9)
3	57 (9.2)	67 (13.3)	63 (13.1)
4	11 (1.8)	4 (0.8)	2 (0.4)
5	29 (4.7)	15 (3.0)	17 (3.5)
6	11 (1.8)	23 (4.6)	18 (3.8)
7	16 (2.6)	----	5 (1.0)
8	37 (6)	31 (6.2)	26 (5.4)
9	16 (2.6)	19 (3.8)	19 (4.0)
10	61 (9.8)	32 (6.3)	51 (10.6)
11	44 (7.1)	23 (4.6)	28 (5.8)
12	52 (8.4)	14 (2.8)	9 (1.9)
13	28 (4.5)	28 (5.6)	20 (4.2)
14	46 (7.4)	27 (5.4)	35 (7.3)
15	93 (15)	98 (19.4)	62 (12.9)
16	34 (5.5)	31 (6.2)	24 (5.0)
17	28 (4.5)	16 (3.2)	----
18	34 (5.5)	23 (4.6)	18 (3.8)
TOTAL	614	498	422

Table 4.2: PCCI response rate for each site

Nursing Context Index (NCI) and Caring Context Index (CCI)

The 'care environment' is a key consideration in the development of a person-centred culture (McCormack and McCance 2006). The NCI and CCI determine the impact of change on creating a person-centred care environment as that which achieves a decrease in nursing and care worker stress; an increase in nursing/care worker satisfaction and organizational commitment; and a decrease in intention to leave the job in the next year. Using these criteria of change, the practice environment was examined for each care setting.

Nine factors measure aspects related to nurse/care worker stress levels (see Table 4.3, factors 1-9). In the nurse sample, scoring ranged from 1-7 and a decrease in scoring indicates a decrease in stress levels. The overall stress levels were low among the sample of nurses' at all three time points. A heavy workload was deemed to be the main cause of stress among nurses on all three occasions and equally the scores decreased over the three time points but not at a statistically significant level. Conflict with other nurses was scored as causing the least amount of stress. Stress levels decreased at a statistical level on five of the nine constructs (inadequate preparation; lack of staff support; and uncertainty regarding treatment; lack of communication and support and career development). All statistically significant changes reflected a positive change in the practice environment.

Similar findings emerged among the care worker sample (Table 4.4). A heavy workload was deemed to be the main cause of stress among staff on all three occasions and the scores decreased over the three time points. Uncertainty regarding treatment was scored as causing the least amount of stress. Stress levels decreased at a statistical level on three of the five constructs (see Table 4.5). All changes were significant at a statistical level. The overall stress levels of care workers show it to be scored low among the sample at all three time points. All three time points were rated as causing little–some stress. The levels of stress decreased significantly at time 2 before return to a slightly higher level of stress at time 3.

Nurses' and care workers levels of satisfaction with their job was assessed using a 7-point scale that ranged from *'Very dissatisfied' to 'Very satisfied'*, with *'Neither Satisfied nor dissatisfied'* as the mid-point (a score of 4). Four constructs (18 statements) helped to measure specific areas of satisfaction (factors 10-13). Personal and professional satisfaction with the job was scored highest by the total sample. In the nurse sample, both constructs increased by a small but statistically significant amount by the third time point. A small sustained growth in satisfaction with pay and prospects among nurses was also reported, this was after an initial strong growth that receded but still registered a statistically significant change.

In the care worker sample, personal and professional satisfaction with the job was scored highest by the total sample. Both constructs increased by a small but significant amount at time 2 before decreasing again at time 3. The fluctuations in scoring were indicative of changes at a statistically significant level.

There were four key indicators of the practice environment – adequate staffing and support; empowerment; professional staff relationships; and, nurse management (factors 14-17). Scores above four or more indicate a positive growth in the practice environment.

In the nurse sample, all four factors indicated a movement towards a more positive environment. The largest increase was recorded on the construct that was most negatively scored (adequate staffing and support). Further, this increase was at a statistically significant level. The professional relationship between staff also increased and at a statistically significant level. Whilst the remaining two constructs also increased this was not at a statistically significant level. Among the care worker

sample, the largest increase was recorded on the construct that was most negatively scored (staffing and support). All increases were at a statistically significant level.

Two factors were directly related to turnover of staff; intention to leave and organizational commitment (factors 18 and 19). Slater et al (2009) reported the two factors to have an inverse relationship. A positive change in each is represented by an increase in organizational commitment and a corresponding decrease in intent to turnover. The findings for the total sample of nurses reported here shows similar findings and a positive change across all three time points. Organizational commitment increase and intention to leave the job decreased with the changes at a statistically significant level. A summary of the total mean scores for the nurse sample for each of the 19 constructs at each time point is presented in Table 4.3.

In the care worker sample similar findings were found with positive change across the three time points. Organizational commitment increased and intention to leave the job decreased with the changes at a statistically significant level. A summary of the total mean scores for the nurse sample for each of the 19 constructs at each time point is presented in Table 4.4.

	Data Collection points			
Factors	Time 1	Time 2	Time 3	Significant change
(1) Workload	4.37	4.27	4.24	NS
(2) Inadequate Preparation	3.03	2.91	2.86	0.01; Positive
(3) Lack of Staff Support	3.43	3.37	3.25	0.05; Positive
(4) Conflict with other Nurses	2.3	2.24	2.30	NS
(5) Uncertainty regarding treatment	2.48	2.34	2.44	0.03; Positive
(6) Work – Social Life balance	2.72	2.63	2.62	NS
(7) Working environment	2.63	2.61	2.57	NS
(8) Lack of communication and support	3.11	2.94	2.96	0.08; Positive
(9) Career Development	2.61	2.45	2.46	0.01; Positive
(10) Satisfaction with Pay and Prospects	4.25	4.68	4.37	0.00; Positive
(11) Satisfaction with Training	3.83	3.75	3.82	NS
(12) Personal Satisfaction	4.92	5.1	5.17	0.00; Positive
(13) Professional Satisfaction	4.91	5.04	5.06	0.02; Positive
(14) Adequate Staffing and Resources	3.02	3.3	3.45	0.00; Positive
(15) Doctor Nurse Relationship	4.45	4.58	4.69	0.02; Positive
(16) Nurse management	4.98	5.02	5.07	NS
(17) Empowerment	4.72	4.76	4.78	NS
(18) Organizational Commitment	4.7	4.94	4.92	0.00; Positive
(19) Intention to leave	3.34	2.96	2.91	0.00; Positive

Table 4.3:   Mean scores of each of the 19 constructs
* = statistical significance at p>0.05; ** = significance at p>0.01

Setting	Data Collection points			
Time	Time 1	Time 2	Time 3	Significant change
Workload	4.23	4.04	4.02	** Positive
Inadequate Preparation	3.24	3.05	3.13	** Negative
Lack of Staff Support	3.47	3.12	3.28	** Positive
Conflict with other staff	2.86	2.65	2.74	** Positive
Uncertainty regarding treatment	2.30	2.06	2.14	** Positive
Work – Social Life balance	2.69	2.61	2.72	NS
Working environment	2.97	2.78	3.06	** Negative
Lack of communication and support	3.38	3.02	3.08	** Positive
Career Development	2.70	2.45	2.49	** Unchanged
Satisfaction with Pay and Prospects	3.77	4.13	3.64	** Negative
Satisfaction with Training	4.22	4.30	4.24	NS
Personal Satisfaction	5.02	5.22	5.12	** Positive
Professional Satisfaction	5.00	5.16	5.14	** Positive
Adequate Staffing and Resources	3.08	3.3	3.60	** Positive
Professional Relationships with others	3.83	4.28	4.53	** Positive
Staff management	4.63	4.85	4.99	** Positive
Empowerment	4.04	4.32	4.43	** Positive
Organizational Commitment	4.72	4.99	4.97	** Positive
Intention to leave	3.24	2.74	2.90	** Positive

Table 4.4: Mean scores of each of the 19 constructs
* = statistical significance at p>0.05; ** = significance at p>0.01

In the nurse sample, statically significant changes were observed on twelve of the nineteen factors (see Table 4.5), all indicating the change to be in a positive direction. In the seven factors that changed but at a non-significant level, the modest change was in a positive direction with stress levels decreasing, job satisfaction levels increasing and the practice environment being stronger and a better environment to work in.   The care worker sample showed similar findings. Statistically significant changes were observed on seventeen of the nineteen factors, with twelve indicating the change to be in a positive direction. In particular, the programme had a very positive and significant impact on the organizational work environment. All 6 factors changed positively and all at a statistically significant level.

Overall, it can be concluded from both data sets that the programme had a significant effect in changing the practice setting, contributed to the development of more positive practice environments and facilitated better environments to work in.

Further data analysis sought to determine which constructs (factors) changed in the different participating sites. Whilst statistical analysis across the sites is limited to those sites where data were collected on all three time points, examination of the impact of the programme indicates variability in findings.

In the nurse sample, the number of significant changes in factors across each of the sites ranged from a maximum of 12 and a minimum of 1 (see Table 4.5). The average number of construct changes was 3. All sites reported at least one significant change. The largest impact was reported at Site 10 with 12 constructs being changed. Examination of the impact of the programme on factors shows that significant changes were reported on each of the factors but the biggest impact occurred on the factors 'satisfaction with pay and prospects', 'satisfaction with training' and 'intention to leave'.

In the care worker sample, the number of significant changes in factors across each of the sites ranged from 0 to 7 (see Table 4.6). Examination of the impact of the programme on factors show that significant changes were reported on each of the factors but the intervention had the biggest impact on changing the factors 'conflict with other staff 'and 'adequate staffing and resources'. Both these constructs are indicative of positive change towards more person-centred practice environments.

CONSTRUCTS	SITES															
	1	2	3	4	5	6	8	9	10	11	12	13	14	15	16	18
Workload	ns	ns	**	ns	ns	ns	ns	ns	**	ns	ns	ns	ns	ns	ns	ns
Inadequate Preparation	ns	ns	ns	ns	ns	ns	ns	ns	**	ns	ns	ns	ns	ns	ns	ns
Lack of Staff Support	ns	ns	ns	ns	ns	ns	ns	ns	**	ns	ns	ns	ns	ns	*	ns
Conflict with other Nurses	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Uncertainty regarding treatment	ns	ns	ns	ns	ns	ns	ns	ns	ns	*	ns	ns	ns	ns	ns	*
Work – Social Life balance	ns	*	ns	ns	ns	ns	ns	ns	*	*	ns	ns	ns	ns	ns	ns
Working environment	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Lack of communication and support	ns	ns	ns	ns	ns	*	ns	ns	**	ns	ns	ns	ns	*	ns	ns
Career Development	ns	ns	ns	ns	ns	ns	**	ns	**	ns	ns	ns	ns	ns	ns	ns
Satisfaction with Pay and Prospects	ns	ns	*	ns	**	*	**	ns		ns	ns	ns	ns	ns	*	ns
Satisfaction with Training	ns	ns	ns	**	ns	*	ns	ns	**	*	ns	ns	ns	ns	**	ns
Personal Satisfaction	*	ns	ns	ns	ns	ns	ns	ns	**	ns	ns	ns	ns	ns	**	ns
Professional Satisfaction	ns	ns	ns	ns	ns	ns	ns	ns	**	ns	ns	ns	ns	ns	*	ns
Adequate Staffing and Resources	ns	ns	ns	ns	ns	ns	**	ns	**	*	ns	ns	ns	ns	**	ns
Doctor Nurse Relationship	ns	ns	ns	ns	ns	*	*	ns	*	ns	ns	ns	ns	ns	ns	*
Nurse management	ns	ns	ns	*	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Empowerment	ns	ns	ns	ns	ns	ns	ns	*	ns	ns	ns	ns	ns	ns	ns	ns
Organizational Commitment	ns	ns	ns	ns	**	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Intention to leave	ns	**	ns	ns	**	ns	ns	ns	**	ns	*	ns	ns	ns	ns	**

Table 4.5: Statistically significant differences in factor scores in each of the sites (Sites 7 and 17 did not provide data at all three time points and are not included in the analysis)

CONSTRUCTS															
	1	3	4	5	6	7	8	10	11	12	13	15	16	17	18
Workload	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	**	ns	ns
Inadequate Preparation	ns	*	ns	*	*	ns	*	ns	ns	ns	ns	ns	ns	ns	ns
Lack of Staff Support	ns	**	ns		**	ns	ns	*	ns	ns	ns	ns	ns	ns	Ns
Conflict with other Nurses	*	*	ns	ns	ns	ns	*	ns	ns	ns	*	ns	ns	ns	ns
Uncertainty regarding treatment	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	Ns
Work – Social Life balance	ns	ns	*	ns	ns	*	ns	ns	ns	ns	ns	*	**	ns	*
Working environment	ns	*	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns
Lack of communication and support	ns	**	ns	ns	**	ns	ns	ns	ns	ns	ns	*	ns	ns	ns
Career Development	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	ns	*	*	ns	ns
Satisfaction with Pay and Prospects	ns	*	ns	ns	ns	ns	*	ns	ns	ns	ns	**	ns	**	ns
Satisfaction with Training	*	ns	ns	ns	ns	ns	ns	ns	ns	ns	*	ns	ns	ns	ns
Personal Satisfaction	ns	ns	ns	*	*	ns	ns	*	ns	ns	ns	ns	*	ns	ns
Professional Satisfaction	ns	ns	ns	ns	*	ns	ns	ns	ns	ns	ns	ns	**	ns	ns
Adequate Staffing and Resources	*	*	ns	ns	ns	*	ns	*	ns	ns	ns	ns	*	**	ns
Doctor Nurse Relationship	ns	ns	ns	ns	**	ns	*	*	ns	ns	ns	ns	ns	ns	ns
Nurse management	*	ns	ns	ns	ns	ns	ns	ns	*	ns	ns	ns	ns	**	ns
Empowerment	ns	ns	ns	ns	ns	ns	ns	ns	*	ns	**	ns	ns	*	ns
Organizational Commitment	ns	*	ns	ns	ns	ns	ns	ns	ns	*	ns	ns	ns	ns	ns
Intention to leave	ns	ns	ns	ns	**	ns	**	ns	ns	*	ns	ns	ns	ns	ns

Table 4.6: Statistically significant differences in factor scores in each of the sites (Sites 2, 9 and 14 did not provide data at all three time points and are not included in the analysis)

Perceptions of Caring

The Caring Dimensions Inventory (CDI) comprises 35 operationalised statements of nursing actions designed to elicit the degree to which participants perceive these actions as representative of caring. The items included in the instrument have been categorised as, 'technical' 'intimacy' 'supporting' 'inappropriate' and unnecessary activities. A description of each category is provided below.

1. Technical nursing – items that indicate technical and professional aspects of nursing (14 items).

2. Intimacy – getting to know a patient and becoming involved with them (10 items).

3. Supporting – items which indicate helping the patients with spiritual matters (2 items).

4. Unnecessary nursing – aspects of nursing which are not inappropriate or unprofessional but would not normally be expected of nurses (4 items).

5. Inappropriate aspects of nursing – nursing actions, which, in addition to being unnecessary, are certainly not, recommended aspects of nursing (5 items).

Table 4.7 shows the classification of each item according to the five headings.

Statement	Statement Classification
Being technically competent with a clinical procedure	Technical*
Observing the effects of a medication on a patient	Technical
Giving reassurance about a clinical procedure	Technical
Assisting a patient with an activity of daily living	Technical*
Making a nursing record about a patient	Technical*
Explaining a clinical procedure to a patient	Technical
Being neatly dressed when working with a patient	Technical*
Reporting a patient's condition to a senior nurse	Technical
Organising the work of others for a patient	Technical*
Consulting with the doctor about a patient	Technical
Instructing a patient about aspects of self-care	Technical
Keeping relatives informed about a patient	Technical
Measuring the vital signs of a patient	Technical
Putting the needs of a patient before her/his own	Technical*
Providing privacy for a patient	Intimacy
Involving a patient with his or her care	Intimacy
Being cheerful with a patient	Intimacy
Feeling sorry for a patient	Intimacy*
Getting to know the patient as a person	Intimacy
Sitting with a patient	Intimacy
Being with a patient during a clinical procedure	Intimacy
Being honest with a patient	Intimacy*
Exploring the patient's lifestyle	Intimacy*
Listening to a patient	Intimacy
Arranging for a patient to see his or her chaplain	Supporting
Attending to the spiritual needs of patients	Supporting
Praying for a patient	Unnecessary*
Staying at work after there shift has finished to complete a job	Unnecessary*
Keeping in contact with a patient after discharge	Unnecessary*
Appearing to be busy at all times	Unnecessary*
Coming to work if they are not feeling well	Inappropriate*
Assuring a terminally ill patient that he or she is not going to die	Inappropriate*
Dealing with everyone's problems at once	Inappropriate*
Making a patient do something, even if he or she does not want to	Inappropriate*
Sharing one's own personal problems with a patient	Inappropriate*

Table 4.7: Thirty-five items of the CDI and category classification (* = significant findings)

The analysis of the Caring Dimensions Inventory is completed using Mokken Scaling Procedure (Mokken 1997). This helps to identify a hierarchy of statements that have all been rated positively. The hierarchy of responses to items in the Mokken Scale indicates a cumulative scale whereby the level of endorsement of any particular item in the scales indicates the level of endorsement of all the other items in the scale. For example, an individual who endorses 'Consulting with a doctor about a patient' in the CDI at time 1 should also endorse all the other items in the scale which are more strongly endorsed such as 'Being with a patient during a clinical procedure' and 'Providing privacy for a patient'.

Findings from Nursing Sample

<u>Time 1</u> (Table 4.8)

The majority (8) of the 17 items are related to 'technical' aspects of nursing. 'Intimacy' aspects of care such as "listening to a patient" or "sitting with a patient" are included in the ranking and comprise the 3 highest ranked items. A total of 7 of a possible 10 items were identified as caring. Two spiritual items form the highest rank ordering indicating that 'supporting' aspects of nursing were considered caring but below that of the 'technical' and 'intimacy' aspects of nursing.

<u>Time 2</u> (Table 4.8)

Nineteen items were identified at time 2 with 16 items shared with the findings reported at time 1. Nine items were categorized as reflecting 'intimacy' in the nursing relationship; nine referred to the 'technical' aspects of nursing and one item was seen as being 'supporting'. Three new items emerged from the data as pertaining to nursing at time 2. Watson et al (1999) reported that this was not uncommon in a changing work environment when opinions and values fluctuate as new ideas of nursing emerge. This fluctuation in supported by the changes in rank ordering of items at time 2 from time 1.

<u>Time 3</u> (Table 4.8)

The participants identified 13 items of the CDI as caring at time 3. Four of the items were related to aspects that were concerned with 'intimacy' in the caring relationship; eight items address 'technical' aspects of nursing and one item was 'supporting'. The number of items identified was considerably lower than that of the previous two occasions indicating a much more focused perspective of the role of nursing and the four top ranked items were all related to providing 'intimacy'. There was considerable and constant change in the ranking of item 9 'Involving a patient in his/her care' that moved from a ranking of 9th to 2nd.

Rank	Statement	Mean	Mean Time II	Mean Time III	Statement Classification
1	Providing privacy for a patient	6.67	6.64 (2)	6.65 (1)	Intimacy
2	Listening to a patient	6.63	6.65 (1)	6.57 (2)	Intimacy
3	Being with a patient during a clinical procedure	6.55	6.56 (3)	6.42 (4)	Intimacy
4	Reporting a patient's condition to a doctor	6.55	6.47 (5)	6.39 (5)	Technical
5	Explaining a clinical procedure to a patient	6.54	6.34 (10)	6.30 (10)	Technical
6	Giving reassurance about clinical procedures	6.53	6.46 (6)	6.35 (6)	Technical
7	Observing the effects of medicine	6.50	6.42 (8)	6.33 (7)	Technical
8	Getting to know a patient as a person	6.50	6.37 (9)	----	Intimacy
9	Involving a patient with his/her care	6.46	6.48 (4)	6.55 (2)	Intimacy
10	Consulting with a doctor about a patient	6.45	6.43 (7)	6.33 (8)	Technical
11	Sitting with a patient	6.41	6.31 (12)	----	Intimacy
12	Instructing a patient about self-care	6.40	6.31 (11)	6.30 (10)	Technical
13	Being cheerful with a patient	6.35	6.23 (17)	-----	Intimacy
14	Measuring the vital signs of a patient	6.34	6.27 (15)	6.24 (12)	Technical
15	Arranging for a patient to see a chaplain	6.32	6.27 (14)	6.31 (9)	Supporting
16	Keeping relatives informed about a patient	6.31	----	6.23 (13)	Technical
17	Attending to the spiritual needs of a patient	6.29	6.18 (18)	-----	Supporting
18	Being neatly dressed	----	6.30 (13)	----	Technical
19	Being honest with a patient	----	6.26 (16)	----	Intimacy
20	Exploring the lifestyle of a patient	----	6.12 (19)	----	Intimacy

Table 4.8: The Ranking of the Caring Dimensions Index items at Time 1 and Time 2

Findings from Care Worker Sample

Time 1

The majority of items identified as caring (13) relate to technical and intimacy aspects of caring. The majority (8) of the 13 items are related to technical aspects of caring. A further 6 technical items failed to be considered as caring by the participants. These are marked with an * in Table 4.9.

Intimacy aspects of care such as "listening to a patient" or "sitting with a patient" are included in the ranking and comprise the 3 highest ranked items. A total of 5 of a possible 10 items were identified as caring with 5 items failing to be considered caring. These included 'being honest with a patient' and 'exploring the patient's lifestyle' (See * in Table 4.9).

Time 2 (Table 4.10)

At time 2 nine of the twelve items were related to intimacy issues, and the remaining three were all technically related. The highest ranking items related to intimacy. There was a movement towards the identification of more 'intimacy' related statements as being caring. This movement coincides with a reduction of the technical aspects as being caring.

Time 3 (Table 4.10)

The number of items identified as caring increased at time 3 to incorporate a combination of the nine intimacy items identified in time 2 and 8 technical items, 7 of which had been identified at time 1. As in time 1 and 2, the items relating to intimacy were rated highest.

Statement	Statement Classification
Being technically competent with a clinical procedure	Technical*
Observing the effects of a medication on a patient	Technical
Giving reassurance about a clinical procedure	Technical
Assisting a patient with an activity of daily living	Technical*
Making a nursing record about a patient	Technical*
Explaining a clinical procedure to a patient	Technical
Being neatly dressed when working with a patient	Technical*
Reporting a patient's condition to a senior nurse	Technical
Organising the work of others for a patient	Technical*
Consulting with the doctor about a patient	Technical
Instructing a patient about aspects of self-care	Technical
Keeping relatives informed about a patient	Technical
Measuring the vital signs of a patient	Technical
Putting the needs of a patient before her/his own	Technical*
Providing privacy for a patient	Intimacy
Involving a patient with his or her care	Intimacy
Being cheerful with a patient	Intimacy
Feeling sorry for a patient	Intimacy*
Getting to know the patient as a person	Intimacy
Sitting with a patient	Intimacy
Being with a patient during a clinical procedure	Intimacy
Being honest with a patient	Intimacy*
Exploring the patient's lifestyle	Intimacy*
Listening to a patient	Intimacy
Arranging for a patient to see his or her chaplain	Supporting
Attending to the spiritual needs of patients	Supporting
Praying for a patient	Unnecessary*
Staying at work after there shift has finished to complete a job	Unnecessary*
Keeping in contact with a patient after discharge	Unnecessary*
Appearing to be busy at all times	Unnecessary*
Coming to work if they are not feeling well	Inappropriate*
Assuring a terminally ill patient that he or she is not going to die	Inappropriate*
Dealing with everyone's problems at once	Inappropriate*
Making a patient do something, even if he or she does not want to	Inappropriate*
Sharing one's own personal problems with a patient	Inappropriate*

Table 4.9 Thirty-five items of the CDI and category classification

Rank	Statement	Mean	Mean Time 2	Mean Time 3	Statement Classification

140

1	Listening to a patient	6.55	6.57 (1)	6.44 (2)	Intimacy
2	Reporting a patient's condition to a nurse	6.42	6.35 (4)	6.37 (3)	Technical
3	Sitting with a patient	6.34	6.30 (5)	6.34 (4)	Intimacy
4	Consulting with a nurse about a patient	6.32	6.23 (7)	6.25 (8)	Technical
5	Involving a patient with his/her care	6.27	6.26 (6)	6.28 (7)	Intimacy
6	Being honest with a patient	6.18	6.18 (9)	6.14 (10)	Intimacy
7	Instructing a patient about self-care	6.10	6.00 (11)	6.08 (11)	Technical
8	Giving reassurance about clinical procedures	6.03		6.06 (12)	Technical
9	Being with a patient during a clinical procedure	5.91	5.88 (12)	5.98 (13)	Intimacy
10	Measuring the vital signs of a patient	5.90	----	5.82 (15)	Technical
11	Observing the effects of medicine	5.88	----	5.80 (17)	Technical
12	Explaining a clinical procedure to a patient	5.76	----	5.82 (15)	Technical
13	Keeping relatives informed	5.73	----	----	Technical
14	Providing privacy for a patient	----	6.55 (2)	6.55 (1)	Intimacy
15	Being cheerful with a patient	----	6.37 (3)	6.31 (5)	Intimacy
16	Getting to know a patient as a person	----	6.23 (7)	6.31 (5)	Intimacy
17	Exploring a patients lifestyle	----	6.06 (10)	5.97 (14)	Intimacy
18	Being neatly dressed with a patient	----	----	6.24 (9)	Technical

Table 4.10 The Ranking of the Caring Dimensions Index items

RESIDENT NARRATIVES AND OBSERVATIONS

In total across the 3 time points, one hundred and eighty (180) periods of observation and sixty (60) user narratives were collected. The process used for analysing these data sets is set out in Appendix 2. Four key categories were identified from across all data sets and each of these categories are operationalised through a number of themes. In the presentation of the data analysis, the key categories will be introduced and the themes will be discussed and illustrated with data extracts.

Category 1 = Choice

```
                        Themes

 •   Choice -           "Is it facilitated"
                        Meal and mealtimes

 •   Family -           Visiting
                        Roots

 •   Activity/Boredom - Lack of stimulation
                        and meaningful
                        activities
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The theme of choice was a significant theme across the data sets and indeed it is something that featured in the work of the programme groups across the participating sites. The data demonstrate that over the period of the programme, residents were provided with a greater range and number of choices. Specific activities (such as resident and family groups) were initiated and established in the majority of settings as methods of enabling more choice for residents. However, the data also reflects a range of challenges and ongoing issues in the development of person-centred care environments that facilitate choice for older people.

A key question that was in particular reflected from the analysis of the observation notes, was "is choice facilitated"?

"Some evidence of choice, however there is poor evidence in the notes to show that it is continuously reviewed" (observation note)

"Evidence of strong knowledge among staff of the individualised preferences of the resident, however, no evidence of formal structures of handover of this information" (observation note)

"Well it depends on my experience, it's a tough life being a patient … As regards my control, they'd say they are scared in case I'd go to the toilet on my own in case I'd have a fall and that way. Two years ago I had a fall and they are still referring to that

as if it was recent … I am able to get up and go to bed when I want. I have people
coming in and I suppose I can go out – I don't know if I want to … " (Resident story)

Whilst there was increasing evidence of choice being facilitated, for example, greater choice of mealtimes, more choice of recreational activities, individualised waking and retiring times, there continued to be a sense of this being inconsistent and individual nurse/care worker dependent:

"Does anyone take responsibility for monitoring radio and television usage?"
(observation note)

"It would be good if people could remember or know when films like the westerns are
on because all of the men like them. They were films you would have gone to see in
the picture houses – John Wayne is great. You can talk for hours about them. A keg
of Guinness would be good too – I do not like the cans. He [pointing to another
resident] has one when a friend or sister comes into visit" (Resident story)

The involvement of families in the life-world of the residential setting and of residents was a challenge and one that was considered to be critical to the ongoing development of practice in residential settings. At some stage in the majority of the stories, residents recounted family-oriented experiences – experiences that they valued, missed, still wanted or felt sad about. In all cases, these family-related experiences provided a significant source of reminiscence for residents:

"I became a widow 44 years ago. My husband was only 39. He had cancer and we
didn't know at the time and we were not expecting him to die. I got a phone call at 2
o'clock in the morning and was told he was dead., I was all alone when I got the
phone call. I worked in [shop name] in the boot section – we made loads of money. I
had no kids so I had a lonely life, but I had my sister's kids. I spoilt them really. I
was good to them and now they are good to me. I go to my sister's every Sunday for
dinner and my nephew/nieces call nearly every day to me. They ask do I want
anything and they'll always bring it to me" (Resident story)

"I'm alright, I don't like to be a patient anywhere but I don't have a choice about it. I'm
here till I go into a box. When I was a young fella I used to play around kicking ball
with the others from the area and go fishing with my friends. When I had to take
early retirement I used to walk every day for about 3-4 hours. I used to walk all over

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[name of town]. Some nights I used to meet my friends down in the local for a few drinks" (Resident's story)

The explicit encouragement of families to visit was one that was identified as necessary in all settings as it was felt that there was often a lack of visiting from families:

"My kids used to visit me a lot when I was in hospital first, but now I don't see them very often. I suppose they are busy with their own lives. My wife visits every day for an hour or so and takes me for a walk in my wheelchair. I used to go out once a week with the wheelchair people but they find me too heavy to manage so that outing has stopped" (Resident story)

In addition, the need for the environment to support family engagement with the care setting was also necessary and the observations of practice highlighted efforts that teams had made to make the environment more 'homely' for both residents and visitors, but the environment continues to be a challenge that needs ongoing attention:

"Large bright colourful lounge. Nice homelike furniture and fireplace …" (observation note)

"Feels relaxed today in the sitting room. Three men snoozing in chairs – look comfortable. There is a student nurse playing cards with two residents, laughter and positive interaction. Residents greeted me when I came into the sitting room and welcomed me … Chairs and space arranged in different settings throughout the room. Looks homely …" (observation note)

Colour of ward and curtains – not good
Clutter on locker
Paint work not good
Curtains don't seem to draw together
Board up on window
Tyres flat on wheelchair
Bed space between the beds limited for privacy (observation note)

Throughout all the data sets, the issue of meaningful activity and prevention of boredom was a recurring issue. The observation data in particular highlighted the lack of meaningful activity for residents, particularly those who had high levels of physical need or who had a dementia. Developing meaningful activities and alleviating boredom were key components of most action plans in all sites. The data reflects a significant shift in the range of activities available to residents and this was noted in the observation data in particular:

"I use a wheelchair, I can't walk. I don't go on outings because I don't want to. I go in a wheelchair to the drawing and I like that. The girls come once a week but I would like it to be more …" (Resident story)

I asked M [resident name] if she ever goes out of the unit or visits other areas and she stated 'no'. "I like my own space here, I never was one for socialising or mixing. I have been to their [family members] homes a couple of times but the children running around and the noise, I prefer them to come here … I don't do any of those activities like painting or bingo. I don't enjoy that kind of thing … I just like the peace and quiet and staying in my room. I have always been that type, just a quiet person" (Resident story)

"I like living here. The nurses are nice. The new hospital is nicer than the old one as there is more space for me to get around in my wheelchair. In the old hospital the beds were so narrow I used to get caught. Now I can go out into the front hall and the chapel as I like. I'm up at 6am every morning. I love to get up at 6. When I was at home I would go to bed at midnight and get up at 6am. I would hate it if someone told me I couldn't get up till 10am. I like my routine … (Resident story)

"… I would like to be able to go out in the sun" (Resident story)

"… The day is boring, but I wouldn't suggest anything to the doctor as it's he who has control you know. I don't know what could be done to make it less boring, but I'd like to go to [other ward] because of the easier way of it. It's more calm. I liked it there. I was there for a month before. Everything was different there. I was able to do my own thing there, and I won't say any more now …" (Resident story)

"TV dominates the space – nobody watching it …" (observation note)

"I can get to Mass at the end of the yard to a lovely little church … anytime I get the chance. It's a bit of a break in the monotony of it … If I could get to Mass more often t'would be handy. I wanted to go to Mass on [specific Holy Day] but there was nobody to take me" (Resident story)

Overall, the data demonstrates that a range of processes have been put in place to facilitate residents' choices including the use of biography and reminiscence – Image 4.1 is one such example and illustrates the kind of creative practices that have been implemented in order to develop individualised approaches to care. Further examples of these can be seen in the work described in Chapter 2 (individual site reports). There was a general sense from the data of staff trying hard to pay attention to choices and to respecting individual preferences. However, there is still much work to be done in the facilitation of choice as reflected in much of the data, in order to ensure that 'facilitating choice' is a central aspect of the way practice is organised and a focus of relationship building.
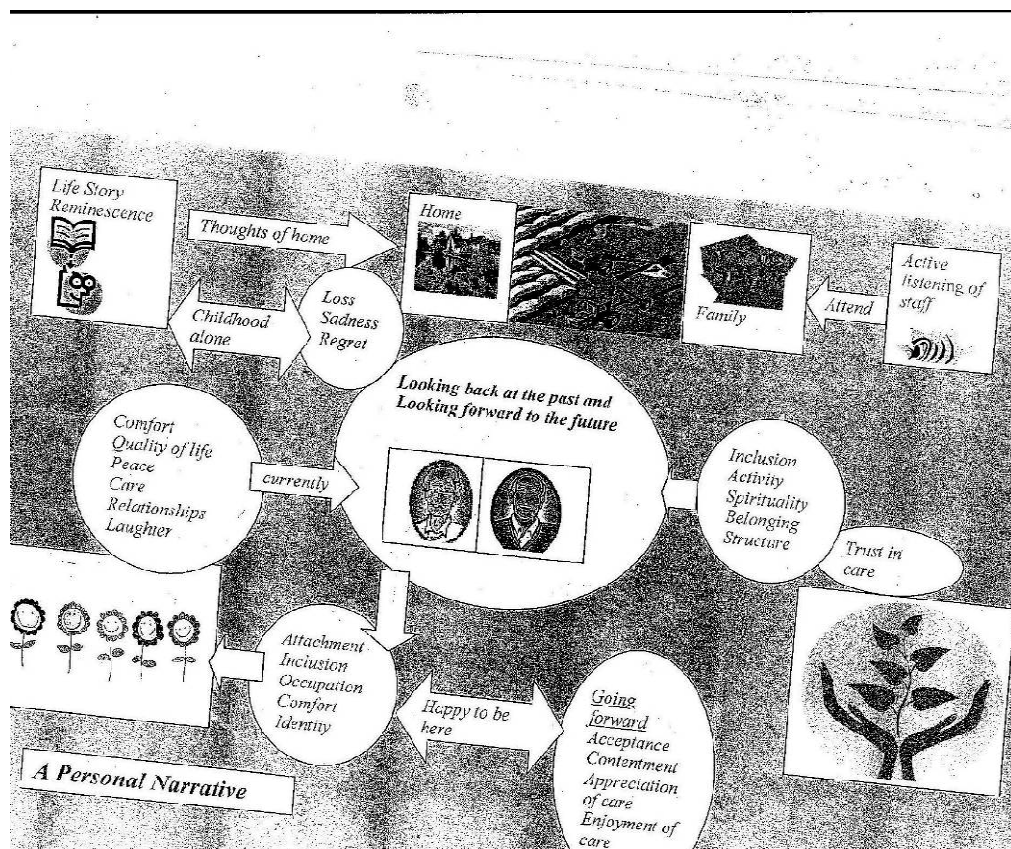

Image 4.1: Creative work using a resident's narrative

Category 2 = Belonging & Connectedness

•	Individual -	Knowing the person
		De-personalisation
		Dignity
•	Environment -	Noise Structure/space
		Contrasting environment
		Garden/nature
		Bright/Dull
		Space
		Design flaws/Depressing
		Lack/sense of home
		Comfort
		Safety
		Institutional – e.g. seating
•	Loneliness -	Boredom
		Isolation
		Monotonous
		Worry
•	Connectivity -	Connection to past family
		Connection to past life
		Connection to past role
		Connection to outside world
•	Inclusion	
•	Environment	
•	Isolation	
•	Family	
•	Celebration	
•	Loneliness	
•	Social outlet	
•	Belonging	
•	Change	

Belonging and connectedness reflects an observation of the data as reflecting the way in which the practice development programme enabled movement towards a greater sense of belonging and connectedness among residents and staff in the residential settings. The practice developments and culture changes initiated and implemented over the 2 year programme was seen to instil a greater sense of belonging and connectedness in most of the participating sites. At an individual level, the data reflected a greater sense of 'knowing the person'

"Yes, meaningful conversations and interactions with residents can be seen. Staff seem aware of residents'' likes and dislikes" (observation note).

This was demonstrated for example through improvements that were evident in care workers in terms of taking more account of residents' biographies

"J says that she enjoys getting her hair done. She was a brunette when she was young. He does not colour her hair as 'the grey ones are as easy to carry as the white'! She enjoys living in this house – there are 'special doors' (she looks down at her co-tag). J says that she likes the garden and the birds that come in to the feeder – 'I like to walk around the garden'. She says that she would like an open fire and someone to talk to when she is back in her room …" (Interview with resident)

This progress was evident in the range of activities planned in action plans and in the focus on knowing the person that featured in the observations. In addition, the narrative data demonstrated a sense of belonging by residents and more engaged relationships with care workers and teams

"Most of the people who entered the day room did not acknowledge the residents who were there. One nurse was an exception to this and she did interact with the residents. She placed her hands on residents' shoulders when she was asked a question and she looked into their eyes. The residents smiled and seemed comforted by this. The nurse asked if the sun-glare was disturbing them [the residents] and explained that she would close the blinds to prevent it being a problem. A resident asks the nurse what time it is. She takes the time to explain the time and that tea would be served shortly. Quiet calm respectful communication. Non-threatening and friendly" (observation note)

These activities were seen to contribute to a greater sense of reducing depersonalisation and preserving individual dignity

"I get good care here and the staff take a genuine interest in me. I love music and really enjoyed 'scriocht' [traditional Irish storytelling and poetry activity] last year. It reminded me of being at home with my friends and neighbours … I am very thankful to those who care for me and try to improve life for me in all their different ways"

Paying attention to the environment was an important part of this category. Whilst acknowledging that in most cases, the environment of the care settings in each of the participating units did not reflect contemporary evidence about residential care environments, an increased focus on developing the environment was seen to occur. In previous rounds of data collection, issues of noise, environmental constraints and a lack of 'homeliness' were noted. Whilst not completely eradicated (and it would be unrealistic to expect that!), the data reflects a greater emphasis on paying attention to environmental aspects and considering how these could be improved. Changes to the environment have included changes to the management of noise, better use of space, colour and light, and gardens, all with the impact of providing more comfortable spaces for living and reducing the institutional 'feel' of the care setting (e.g. seating arrangements).

The overall impression from the first observation carried out [4 months previous] was of a great improvement in the décor of the room. The room was bright, freshly painted and looked great. The tables and chairs and furniture in general in the room was very much improved. The small tables were much more conducive to a homely dining area. The tables were spaced out well with easy access for residents. In the

room there were some pictures on the walls and some memorabilia displayed on shelves (observation note)

Calm music in residents' lounge. Very soothing, resident friendly, not loud (observation note).

There are nice paintings and artwork on the walls … it is a warm day so the windows are open which leaves a pleasant breeze. There is toast being made for the residents, the smell is pleasant and fills the room. The residents seem happy to see each other and greet each other warmly as the two staff members do. There is a good 'banter' – a happy atmosphere. There are magazines on the coffee tables – some of them are out of date. There are bowls of fruit available. When each resident enters the room they are greeted warmly, often b other residents but the staff are friendly and cheerful too (observation note).

Chairs and space arranged in different settings throughout the room. Looks homely. Fish tank being cleaned, residents interacting with the man cleaning the tank. Photographs of the residents on the mantle. Decorations for St Patrick's Day up around the room … Nice radio (old style), pictures nice on the wall (observation note)

However, whilst it is evident that staff have become much more aware of the need to create an aesthetically pleasing environment as a part of being person-centred and have done much to address environmental issues, there is still much work to be done, as the following data extracts illustrate

The visitors room feels sparse, chairs not comfortable (observation note)

The tables were very sparsely dressed with condiments and napkins and some cutlery on the table. Sugar was on the table, stored in a plastic Tupperware container. Lovely serviettes were placed on the table except for one table where 3 men sat and who had none (not sure why?). There were mugs but no drinking glasses or drinks on the table for residents. No refreshment/choice was offered to the residents during the meal except for tea at the end of the meal (observation note)

Room very cluttered and dull, some effort made to make it Christmassy . Lots of chairs and equipment stored in room – wheelchairs, physio equipment. Parallel bars and physio screen impact hugely on the atmosphere. Clock up high on wall difficult

to read. Large date calendar on wall easy to read. Blue blinds on windows contrast with wall colour and make room appear cold. Random positioning of tables and chairs (observation note)

"Everybody is very well trained here and that's very important. People have been very encouraging. I like the free and easy attitude of staff; they do not try to control the patients … The dayroom is depressing, no proper storage, mismatched furniture, looks like an old peoples home. I would like to see a better dayroom and nice garden" (Resident story)

However, the issue of balancing a person-centred approach and meeting safety requirements is one that continues to complicate the extent to which a full person-centred approach can be maximised and there is indeed an issue of managing risk, meeting regulatory requirements/demands and meeting individual needs in a person-centred way, as illustrated by this reflection from one of the internal facilitators:

"During the observations there were a few issues with signage over resident's beds that privileged staff and not residents and were there as a risk management measure and were not very person-centred. While the signage was observed during the observations, it was in the feedback to the ward that it became apparent that this was for risk management. Another problem was that strip lighting was on and seemed very bright and harsh during an evening observation but it was only again during the feedback that staff stated that they wanted to have bedside lamps but in order to comply with HIQA hygiene standards and risk management of the hospital, they were unable to have them. The challenge of the relationship between risk and person-centredness became obvious when the action plans were being implemented, as participants had to address the risk in order to get approval for the action" (Internal Facilitator Reflection)

Alleviating loneliness due to boredom and isolation is a key theme in the data. The data reflects an increased focus on alleviating loneliness and reducing isolation

Took residents in St Josephs on a Christmas Shopping Trip to Dundalk, this was something that came out of the narrative work and conversations with residents that they would like to go Christmas shopping and it was a great success (North East Area Action Plan)

Across all three sites, programme facilitators at unit level worked with residents and staff on the development of individualised activity plans. These plans were based on activities/programmes the resident wanted to partake in. For some residents, trips to the local pub, local cinema, the resident's home place, local matches has now become the norm. Other activities have been introduced within the units based on the specific identified need of individual residents (Midlands Area Evaluation data)

A resident through her narrative shared a life long dream to travel to Lourdes but because of her medical condition never thought this could be possible. In collaboration with the family staff and members of the multidisciplinary team, this was organised. She fulfilled her life long dream accompanied by members of her family and staff members from the hospital (Midlands Area Evaluation data)

It was generally reflected by participants in the analysis of the data, that the care environments are largely 'monotonous' and that there is a need to pay more attention to activities that act as diversions from day-to-day worries that residents may have and that lead to a greater sense of belonging and engagement

"It's a shock being a geriatric when you were healthy up to this … it could be terminal here, problem of passing the time. I get the books and pass the time with them. I find it hard in the late evening. Spirits tend to go down in the evening. Playing cards helps a bit with this" (Resident story)

One way of alleviating loneliness is through the maintaining of connections with the older person's 'life-world'. Having social outlets is critical to this kind of engagement and there is evidence from the participating sites action plans and reports of achievements that a range of activities have been put in place to develop ways of engaging with communities and social activities.This example from the participating sites in the Midlands illustrates this work:

A similar theme that emerged from the narratives across the three areas, highlighted how the residents were lonely and missed the connection with the outside community. For some they found the day really long with little to do, in particular the evenings for some were very lonely and boring. Several actions arose from this across the sites. In St Vincent's Hospital an action plan was developed to address the establishment of a volunteer programme. This would involve the local community and link in with the national volunteer project. A series of communication strategies

were identified to invite local people of all ages to get involved in volunteering. This included a visit to the hospital from the former Taoiseach, Albert Reynolds to promote the programme. A volunteer programme is now established with all the required protocols in place from Garda vetting to education and training programmes for volunteers.

Music evenings for the residents are now facilitated by members of the active retirement group in St Vincent's. A kitchen has been developed for the diversional therapy department in St Vincent's this is now used by for cookery sessions where the residents are actively involved in cooking/baking, using their own recipes. This time provides a great opportunity to socialise and reminiscence about times past and has become very popular. Plans are under way to install a new computer into the diversional therapy unit where the residents will have access to the computer and have the opportunity to learn new skills. Gardening has also been included into weekly activities - this was highlighted by one of the residents in his narrative.

Paying attention to the life-world of the residents was increasingly recognised as important by participants, as illustrated by this poem, written with a resident at Bantry Hospital, Cork

Meanwhile in St Josephs Unit
In the unit of St Joseph's you won't hear too much noise
Some of us are silent an odd one sits and sighs
But look behind the faces and put away the chart
I'm sure my pulse is normal but try to read my heart.

In my years before St Josephs' I had some golden hours
and I walked with my true love among the leafy bowers
and if my eyes look vacant and sometimes I don't hear
I may be gone to shelter from the rain that fills my tears.

There was a time believe me when friends were near and dear
And I drank the cup of kindness and laughed without a fear So
when you think I'm hungry and I push away the food
I am struggling with my demons and don't mean to be rude.

And, staff, I do take notice when you greet me with a smile
And I really mean to thank you when you go the extra mile
But sometimes I am angry though I know it doesn't help
And when you lose your patience I can only blame myself

In the unit of St Joseph's there are some who dare to hope And
some whose hopes are fading feel like giving up the ghost But
life is very precious though the deal you got is raw
There's no room or self pity with your back against the wall.

So please listen to my story and try to make the time
You might just learn a lesson and be a bit more wise
I will try hard to respond and not be such a pain
With a little understanding we both can stand to gain.

In the unit of St Joseph's life may seem very bleak But
life is still worth living for the sad and for the weak And
one thing is for certain as you go about your chore The
day is so much brighter when you look into my soul

A significant finding in the baseline data was the lack of connection between the older person and various dimensions of their life. In the final data set, participants recognised a number of themes that reflected the attention to re-connecting and maintaining relationships – with family, past life, past role and to the outside (similar to social outlets theme) as illustrated through the following data extracts:

When I was seventeen I was told I was going on holiday and that is when I came to here where the nuns were, to the big grey building. I worked for the nuns looking after the flowers and the vegetables. I like my music, I like to listen to it and play the mouth organ. I am very happy here and everyone is very good to me. I go to Knock and to Lourdes (Religious Shrines) every third year. I have my own television and I watch lots of films. I watch it when everyone is in bed. I put the sound down low and watch the picture. I like all sorts of films … (he proudly showed off his collection). Every evening I listen to my music while having a cup of tea. Most days I don't think about my past experiences, however, some days it just comes in to you. But I am very happy here [Narrator's note: he also showed off his picture album which had photographs of all his birthdays since he came to (hospital name) and there was also

photographs of day trips out they have had. He could name everyone and told us those who had died and those still alive] (Resident story)

However, this is an area of practice that needs much more consideration and continuous planning based on an assessment of individual resident's needs, wants and desires with respect of their social connections – a key aspect of being person-centred. Engaging in these activities helps to maintain a sense of inclusion in the community and a greater sense of belonging that enables the older person to grow and change as well as experience change in their daily life.

Finally in this category, the theme of 'celebration' was identified. Throughout the life of this programme, participants identified the need to pay attention to celebration for residents and staff. Developments were put in place that celebrated staff achievements and also that celebrated older people and their lives. Examples of this included more individualised attention to residents' birthdays and the planning of events at Christmas that were focused on the desires of residents rather than on an 'established routine'. Initiatives were put in place that celebrated being more person-centred, such as the welcome cards designed by participants in the South East (see individual site report – Chapter 2)

In summary, it is clear that participants in the programme invested a lot of effort and energy into developing a greater sense of belonging in the settings and developed a range of creative approaches, building on the ongoing evaluation data that reflected the uniqueness of their individual context. Whilst it is recognised that in no way is this work 'finished' and it requires an ongoing commitment to further development, it also needs to be recognised that many of the environments are not conducive to contemporary practice in residential care for older people and the work that staff do to reduce the imagery and impacts of institutionalisation is to be applauded.

Category 3 = Hope and Hopelessness

Category 3 = Hope and Hopelessness	
• Hope	
• Loss –	Health
	Independence
	Identity
	Self Life
	Freedom
• Hopelessness –	Worry
	Ignored not included
	Loss
	Depression low spirits
	Sad
	No enjoyment
	Sense of hopelessness
• Acceptance -	Making the best
	Loss of independence
• Voiceless -	Fear of future
	Fear of Dying
	Staying quick
	Fitting in
	Ignored not included

The category of 'hope and hopelessness' reflected the contradiction that was evident in the data, i.e. a greater sense of hope being instilled into residential care settings, seeing them as a place of growth and development, whilst at the same time a prevailing sense of hopelessness existing.

The theme of 'hope' was reflected in the variety of activities that had been developed to enable older people in residential care settings to have a more meaningful life, irrespective of disability (physical and/or cognitive). However, overall there continued to be a prevailing sense of hopelessness, predominantly reflected in the themes of loss, hopelessness, acceptance and voicelessness.

The theme of 'loss' is not unsurprising as it is recognised that loss is a common experience for older people. The areas of loss identified in the data are also not surprising – loss of health, independence, identity, self, life, freedom

I like reading and doing crosswords. I tend to spend a lot of time in my room but I get involved in activities when they are available. I enjoy listening to classical music … in the afternoon I go for a nap just before tea time I don't sleep very much so I tend to read quite late into the night. My sleep is always broken waking during night to go to toilet. This is very tiring and I feel 'sick of it all'. I feel obsessed. I feel I am troublesome because of going to the toilet. The incontinence has become a phobia. I am absolutely shagged and my bones are like biscuits and I feel very apprehensive about the future … I feel inept in my life, I have been a perfectionist. Little things make me intolerant. I constantly compare how I would do it myself. I feel I need to relax more … I miss my old home and I am still unable to let go ..." (Resident's story)

Participants in the programme recognised the difficulties inherent in addressing these issues as they are often at the core of older persons' life experiences. However, activities that enabled greater participation in the daily life of wards/units, activities to enable social connection and activities that enabled connection with past lives (see Findings Chapter 1 for examples of these) were implemented and were successful in addressing issues of loss for many residents.

The implementation of these activities has an added benefit of dealing with issues of hopelessness. The first and 2nd round of observations of practice identified how 'hopeless' some residential care settings are, often reflected by a lack of meaningful activity, a lack of meaningful social engagement and a lack of attention to maximising the older person's ability to do things for themselves (no matter how small). A has been illustrated in category 1 and 2, much effort went into addressing these issues by programme participants.

However, hopelessness continued to be seen in resident's narratives through their worries, sadness and depression and a feeling of being ignored. Older people seemed to accept their lot and make the most of their loss of independence and were content with where they were at. The voicelessness was underpinned by fear – fear of the future, fear of dying, fear of function and fears of not being included or fitting in:

"Time is long, boredom sometimes. I'd love to get home but there would be no one there. Just to get out would be great – great to get away from it. I will go out in the weather when the weather is good. I go down in the lift but my husband used to come down four times a week before he died. He is a terrible loss. The girls are working and live off away from here. I'd like to get out while I'm able …No, I don't feel I have a say in how things are done here – No say, no, just get on with it …"
(Resident story)

"There is no pressure on you to do anything. I like that because I find it hard to decide and they are very kind, the nurses, and I am not just saying that, they are very caring and very kind. The only big choices I have to make is if I will get up or if I will stay in bed. Most of the time I get up but some of the time I prefer to stay in bed. Sometimes I choose my clothes, well they ask me what will I put on and would I like this or that on, and sure I don't care … I don't talk to the others much , don't know why that is, sometimes it is not easy because you are inclined to close up at least I am anyway and it isn't easy to talk to people" (Resident's story).

"… on getting older – you just have to get on with it. You can't turn the clock back. I have retired but I would still rather be working. I am happy here. I have been here almost a year now. I get plenty to eat and enough cigarettes. I would like to get outdoors more. The staff are alright. They have rules and you have to abide by them, but I get on ok with all of them. I spend a lot of time on my bed but I don't sleep well at night. I miss my family" (Resident story)

Paying attention to narratives and stories enabled the sense of older people being voiceless to be addressed. Some facilitators viewed the sense of hopelessness as a bleak view of residential care and despite the range of activities put in place to address these issues, recognised that instilling a sense of hope needs to be a key strategic issue for the ongoing development of residential services for older people. The following poem by a programme participant, illustrates the heightened awareness that occurred regarding the need to pay attention to people's lives and to continuously facilitate them having meaningful lives:

Person-Centred Care
(by Mary Kinnaird CNM1 St John's Hospital, Enniscorthy, Wexford)

How would it feel if you or me,
Were suddenly known as 'pet' or 'dearie'.
Are we aware of what we say, When
we do our work from day to day.
The language we use may sometimes offend,
The people we care for and attend.

How would it feel if you or me,
Were suddenly the stroke down in bed three,
Who wears a nappy and needs a feed, That
wears a bib, 'an important need'. Lying there
unable to say
I don't feel like porridge today.
Or, I don't eat fish and can't you see,
The tea is too hot it's burning me.

How would it feel if you or me, Were
dragged from bed to go potty,
In a great big metal frame that scares, With
half pulled curtains and lots of stares.
There's lots of chatting going on,
But no-one speaks to us. Not one.
Wishing to speak, just to say,
'Nurse, I feel so lonely today'.

How would it feel if you and me
Changed our attitudes to see, That
the lady in bed three is Mary. She's
had a stroke and cannot speak, But
her prognosis is far from bleak. She
needs assistance with her meal,
A choice would be nice she may well feel,
So don't just leave her a slice of bread,
She may want porridge, please ask her,
She will nod her head.
She is very nervous in the hoist,
Just reassure her in a gentle voice.
She likes music, and did you know
She was in a band some years ago.
She has a daughter and likes when you say,
If she will or won't be visiting today.

How would it feel if you or me,
Suddenly found ourselves to be,
Dragged and hoisted, fed hot tea.
Stripped of our identity,
Unable to shout 'it's me Mary' NOT,
The stroke over there in bed three.

Category 4 = Meaningful Relationship

Category 4 = Meaningful Relationship
• Communication – PCC Language
Active Listening
• Teamwork - Tasks or systems of work
Time
Staff attitudes and behaviour
Lack of Autonomy/decision making
• Routinised Care -   Authority and rules
• Intentionality -   Positive Practice
• Communication/language
• Staff Attitude
• Rituals
• Lack of Privacy and Dignity
• Communication
• Individuality
• Communication
• Patient Satisfaction

The final category 'meaningful relationships' links with and in many ways consolidates the previous three categories (choice, belonging & connectedness, and hope & hopelessness) as the focus of the category is that of the place of older people having the opportunity for meaningful relationships.   Key themes underpinning this category include – communication, teamwork, routinised care and intentionality.

In the practice development programme, a key focus of development activities was that of 'language'. The baseline observation data demonstrated the contradiction that existed between the person-centred values espoused and the language used in everyday 'talk'. The use of words such as 'feeding', 'nappies', 'the heavies' are all illustrative of a non-person-centred approach to practice. Throughout the programme this language was challenged and staff were facilitated using high challenge/high support strategies to change this language to more person-centred talk, such as 'helping residents to eat and drink', 'having a meal', 'incontinence aids/pads' etc. The data demonstrates that significant changes did occur in the way language was used by staff:

"The care worker is helping a resident out of bed. She is working in a calm way and giving the resident lots of encouragement. The language she is using is very person-centred and is focused on the resident's needs – very respectful" (observation note)

The use of more person-centred language was seen to enable active listening and engagement with residents on a more equal footing.

Staff chatting to residents as they wheel them in the wheelchairs. All seems very friendly. Nurses communicating well with each other and with support staff.

Handover appeared professional. Residents referred to by name, communication appeared very person-centred and respectful. Meaningful conversations, e.g. 'Mary would you like to attend the exercise class?' Staff called each other by their first names and were respectful (observation notes)

This shift in power was also demonstrated in the PCNI/PCCI data.

The person-centred practice framework used in the programme places equal emphasis on the development of meaningful relationships among team members as it does between team members and residents. Indeed it is argued that the development of person-centred relationships with residents is predicated on those same relationships existing among staff. The data demonstrates that the two-year programme resulted in more evidence of teamwork and this was also supported by the PCNI/PCCI data.

However, issues of a dominant focus on tasks with a routinised approach to care, challenges of planning time in a person-centred way, lack of autonomy over decision-making and staff attitudes and behaviours all impacted on the extent to which the positive benefits of teamwork were realised.

"9 am in the morning and the staff are very busy. There is one nurse and two carers working in the 4th cubicle. One carer takes out the 'morning trolley' and checks that the trolley is set up. Another attendant wheels a patient into the shower and the nurse pulls the curtain and then and then asks the attendant to aid her with the resident … there is a resident sitting on her bed and she is saying her prayers, I can see the rosary beads in her hand. The care attendant asks her if she is ready for a shower and she replies 'yes' but does not want her hair washed as she is going out in the afternoon and her family is taking her to her own hairdresser to get a colour in her hair. The resident is sitting on the shower chair, she is wearing her nightdress and has slippers on her feet, she is holding a towel, wash-bag and clean clothes. She is now wheeled out and another resident is at the hand basin cleaning her dentures …" (observation notes)

Three residents in lounge. Nurse doing documentation in lounge as well. Very noisy in lounge. Staff member on mobile phone and noise from staff tearoom making it difficult for residents to hear TV. No communication occurring between residents or with staff. Several staff members in and out without asking residents if they want

anything. Nurse at table writing notes did not interact with residents and did not ask
other staff member to keep the noise down or to take her call elsewhere"
(observation notes)

In some respects, managers and leaders were less concerned with 'authority and rules' than they were with the development of a service that focused on the needs of individuals

Some evidence that some staff find it difficult to work with other staff. But staff on
duty today are very happy and enjoying work. Some hierarchy but no overt
distinction. Staff seem to be clear about what they are doing, asking for help from
colleagues easily but discretely. The leadership evident today is transformational – it
feels like an organised team. Staff look relaxed and are interacting with residents at
a slow pace … good evidence of resident involvement in [named] assessments and
personal profiles (observation notes)

The extent to which practices existed that compromised residents privacy, dignity and personhood, was influenced by the active participation of managers and leaders in the programme and the reinforcement of agreed ways of working by senior staff.

The data further illustrates and emphasises the importance of a continuous developmental approach to team development and team effectiveness as well as commitment from managers and leaders for this work. As illustrated in some of the site reports (Chapter 2) the extent of managerial support for the programme varied significantly and in some cases the work was sabotaged by managers/leaders (either directly or through their lack of engagement or support for the internal facilitator). This is something that needs to be addressed as a strategic issue for the development of residential care services in Ireland.

Where there was intentional practice, i.e. intent to engage in a meaningful way with residents then positive practices existed and meaningful relationships were developed and maintained

Conversation taking place in CNM II's office – gentle voice and door is open. Can
hear resident calling out for someone to help with their napkin. Very prompt
response from two members of staff ... Tone of voice appropriate during interaction
… encouragement of staff with residents to eat meals. Interaction between support

staff and resident re dinner/dessert, 'what type of jelly is it?' Answered – diabetic jelly. Resident said they would prefer something else. Reply was – 'let me see what I have, maybe tart?' 'That would be lovely' … relationship with the relatives at mealtimes was good and they were included in the meal. Nice friendly banter between staff member and relative. Visitors appear to feel comfortable and at ease. The Chef visited the ward and spoke with the staff in a quiet voice. Nice to see care assistant and staff nurse engage with one another and check that everybody had their meals – good practice (observation notes).

In summary, when undertaking the analysis of the data sets, programme participants felt that there was significantly more evidence of positive relationships with residents, between staff members and with visitors/relatives than in previous data collections. The narrative data also suggests that most residents are content with the extent of the relationship they have with staff. However, there is still much work to do in this aspect of residential care. It remains the case that the extent of the existence of these positive interactions is largely dependent on individual staff member practices and further developments are needed to embed such practices in the system generally and realise it as 'standard practice'.

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CHAPTER 5

DISCUSSION OF FINDINGS AND RECOMMENDATIONS

INTRODUCTION

Given the complexity of person-centred practice, it is important that any evaluation of it takes account of each of its different attributes and the inter relationship between them. In this practice development programme, we worked with several models: practice development model (Garbett and McCormack 2004) and the person-centred practice theoretical framework of McCormack and McCance (2006). Additionally, emerging from this programme is a new model of learning in practice development: *Active Learning* (Dewing 2008 and 2009; McCormack et al 2009). In addition, we actively experimented with scale of the programme and the programme leads being outside the local delivery of the practice development interventions and data gathering.

The person-centred practice theoretical framework is predicated on the conceptual stance which suggests – that in order for a person-centred culture to exist a number of pre-requisites need to be in place/attended to in a systematic way. A care setting that focuses on these prerequisites will have the foundation attributes of a team in place who can pay attention to the care environment, its management, leadership and learning. The combination of prerequisites and the positive attributes of the care environment, then enable effective care processes to be realised and sustained in practice. The evaluation of this practice development programme, whilst not explicitly structured on the concepts that make up the theoretical framework, does go some way to articulate the attributes of person-centred practice in residential care settings for older people, from the perspectives of staff, residents and their families.

DEVELOPMENT OF THE CARE ENVIRONMENT/PRACTICE CULTURE

The Person-centred Nursing Index (PCNI) focuses on many of those attributes that comprise the 'care environment' construct within the person-centred practice framework. This goes far beyond the physical environment. The PCNI instrument helps to illuminate how these attributes affect organisational factors such as job satisfaction, job stress, and outcome variables like nurses' job commitment and intention to leave the job due to the absence of the factors that enable person-centred nursing to happen. In addition it provides some insights into the importance of the care environment in the development of person-centred cultures. In other

words, the work environment and the quality of working relationships have a lot to do with the ability to thrive and ultimately flourish at work.

A heavy workload was deemed to be the main cause of stress among nurses and care workers in all three evaluations, with the scores decreasing over the three time points. Dissatisfaction and stress associated with workload is consistently shown to be a key indicator of satisfaction among nurses (Sheward et al 2005; Stanley 2009; Abrahamson et al 2009; Wheeler 1997). Having enough time to spend with residents/patients and to engage in practice without a constant feeling of being 'rushed' is important to effective nurse-patient/family relationships (McGilton and Boscart 2007; Abrahamson et al 2009). Some of this feeling of being rushed is created and driven by a routinised and task oriented culture, that practitioners themselves have a large role in creating and sustaining. Engaging in activities such as structured reflection and observations of practice enabled teams in this programme to explore for themselves the effectiveness of teamwork, workload management, time management and staff relationships and make changes that enabled more effective management of workload. The engagement in such activities contributed to an altered perspective and a desire to act on this. With collective action, this contributed to a change in culture where there was a greater sense of 'helpfulness' in teamwork. Data collected in reflective journals maintained by participants and observation of practice records reinforced this finding, such as:

"We have been overly obsessed by tasks in my unit and I am developing a greater awareness of how this gets in the way of being person-centred. However, it is only when we all develop a similar awareness can we become truly person-centred in the way we work" (Participant's reflective note)

Team members started the day by reviewing how they would schedule the different activities that needed to be done with residents and identified who needed to be involved. The plan included those activities (such as showering) that could be undertaken in the afternoon as a more 'therapeutic activity' as opposed to a 'morning task' … it was good to see team members check with each other what help they needed with their work … (Time 2 observation note)

The overall stress levels of nurses show it to be scored low among the sample of nurses' at all three time points. Few studies have evaluated nursing stress

associated with residential care settings and it could be argued that the less 'acute' focus of nursing in these settings means that there is more opportunity to engage in person-centred relationships with residents and families and therefore it is this aspect of culture that enables or hinders this rather than workload stress. Murphy et al (2006) suggested that adequate staffing levels in residential settings for older people were strongly related to job stress, job satisfaction and intention to leave. Additionally Nolan, Davies and Brown (2006) and Brown et al (2008) suggest that exposure to what they term 'impoverished' environments of care in which poor standards of care and negative attitudes towards older people predominate, encourage negative predispositions towards older people. This leads to staff experiencing their work as hard and older people as 'difficult'. However, if 'enriched' environments are experienced this is likely to encourage positive attitudes towards older people and their nursing which leads to reduced perceptions of stress in the workplace. Thus it is important that programmes such as the one reported here focus on changing workplace culture in residential care environments and maximise the opportunities available for nurses and other care staff to engage in person-centred relationships with colleagues, residents/families and communities.

Personal and Professional Satisfaction with the job were scored highest by the total sample of nurses and care workers. Both constructs increased by a small but significant amount by the third time point. The largest increase was shown in perceptions of there being adequate staff to do the job. This increase was at a statistically significant level. The professional relationship between staff also increased and at a statistically significant level.

At the time of this programme (2007-2009), the Irish Health Service was undergoing significant change and reorganisation in a climate of major financial pressure and resource rationalisation. Throughout the time-period of this programme, an 'embargo' was in place that restricted access to all external education and no travel to external venues for learning and development purposes was allowed. The fact that dissatisfaction didn't rise suggests that the programme continued to enable learning to happen in the practice settings and indeed that participants continued to be satisfied. Additionally, staff expressed a greater intention to stay in the work setting. This finding reinforces that of the international literature that demonstrates the importance placed on access to education and learning and that this access combined with available opportunities for career advancement are more important than 'pay' in itself (Spreitzer et al 2010). These authors found that learning and

vitality contribute to thriving in the workplace. In addition, they argue thriving also promotes related constructs such as resilience, flourishing, and more positive self-evaluations. Willingness to think of new ideas, explore new possibilities and behave creatively may require a number of facilitated conditions including 'Active Learning' about day-to-day work within the workplace (Dewing 2009).

The developments in the workplace culture taking place in the care settings started to enable staff to make better use of the staff complement (no staff increases took place in this time and there was a freeze on recruitment due to the embargo) and to develop more effective ways of working together. This suggests a shift in the practice culture to one where staff supported each other better, made better use of their resources and engaged in more effective collaborative working. The observations of practice data at times 2 and 3 reinforced the occurrence of these changes and showed a more effective approach to planning and delivering care to residents as illustrated by this observation of practice:

The leadership evident today is transformational – it feels like an organised team. Staff look relaxed and are interacting with residents at a slow pace … good evidence of resident involvement in [named] assessments and personal profiles (observation notes)

The embargo however had a significant impact on the engagement of the managers (Directors of Nursing) with the programme facilitators as the facilitated days with managers were stopped due to the ban on travel. Thus this aspect of the programme did not fully evolve. This may have had consequences for what changes took place in some of the sites. What is also clear from the data is that in particular settings where less improvement was made in the way that staff supported each other and in the development of a person-centred culture, there was evidence of poor support from managers of the developments that were taking place as measured through the PCNI.

Table 4.5 shows the changes (at a statistically significant level) that occurred in each of the participating sites, with site 1 achieving only one change and site 10 achieving change in 10 of the 12 constructs we evaluated through the PCNI. Whilst these findings are interesting statistically, they are also of interest when they are explored from the perspectives of management and leadership support and engagement. Site 1 had recurring reported problems with management support for the programme and

indeed there was evidence to demonstrate that it was continuously undermined as illustrated by the following reflection from the NMPDU Facilitator:

"… The work was so unsupported and undermined that at times it was difficult to know how it could continue. The challenges she [internal facilitator] faced were so non-person-centred and critical that it fuelled the staff who were resistant to change. This meant that every little development was hugely challenging and was continually undermined …"

In contrast, site 10 (achieving change in 10 of the 12 constructs) had a highly supportive director of nursing who took an active interest in the programme and actively participated in the programme activities and the support of the internal facilitator as illustrated by this reflection from the internal facilitator from site 10:

"… My DON was very supportive, but as time went on I found that when I requested a day to type up or prepare notes (no clerical support for this), I was usually not covered on the ward. This meant that as a ward manager my work was left for me to catch up when I came back. I did become slightly resentful of this as when the DON originally asked me to facilitate the programme she had promised to support me in any way she could. However once I discussed this with her she told me to inform the CNM 2 responsible for off duty when I needed a day and it would be covered. She was also extremely accommodating with regard to programme days …"

These contrasting reflective accounts provide support to the statistical data that the achievement of change in the practice cultures was to a large extent dependent on the engagement of the directors of nursing/managers in the programme, their overt support for the practice development processes and the internal facilitator and their personal effective with core leadership skills. Data from the programme days also shows how different sites made progress with their workplace learning activities and the way in which they 'talked' about management support for the programme also supports findings in the PCNI.

In summary, adequate staffing levels, good inter-professional relationships and effective nurse management/leadership at a unit level, (requisites of person-centred practice) have causal links with higher levels of professional satisfaction and nurses/care workers ability to engage in person-centred practice with residents (Manojlivich and Laschinger 2007; Gunnarsdottir et al 2007).

DEVELOPMENTS IN PERCEPTIONS OF CARING

The data from this evaluation also demonstrated how nurses and care workers perceived their caring role. The person-centred practice framework has been in part derived from research into caring and from theories of caring. Indeed in their most recent publication, McCormack and McCance (2010) demonstrate the relationships between person-centredness and caring and the constructs that capture this relationship are described as the 'care processes' in the person-centred practice theoretical framework. Thus, the evaluation of perceptions of caring as an indicator of movement towards a more person-centred work orientation is a legitimate proxy measure of person-centredness. To do this we utilised the Caring Dimensions Inventory (CDI)

There was significant change in nurses and care workers 'perceptions of caring' as assessed using the CDI. The data analysis shows that staff had shifted their views from one of seeing 'technical' aspects of practice as caring (such as the 'doing of tasks'), to a view that the 'non-technical' aspects of caring were more important (such as spending time with a resident) and this shift was reinforced by the observation data. For example the move from standing over and assisting several people to eat at the same time to sitting down and assisting one person at a time and spending more time on providing meaningful activities and occupation for residents.

This is an important finding as it suggests a greater orientation towards person-centredness and a change in attitude towards how staff engaged with residents and their families. Participants in this programme were seen to shift their orientation of caring from one where technical tasks were given greater priority to one where relationships with patients and families were more highly valued. This finding supports other international research which suggests that there is a direct relationship between the attributes of an effective workplace culture and patient outcomes (for example Manojlivich and Laschinger 2007; Gunnarsdottir et al 2007).

The CDI has been used to ascertain perceptions on caring from the perspective of a range of groups, including registered nurses, nursing students and non nursing students (Watson et al 1999; Watson et al 2003a), between different clinical areas and specialities (Lea and Watson 1995 and 1999; Walsh and Dolan 1999), and from an international perspective (Watson et al 2003b). An evaluation of the use of the

CDI by McCance et al (2008) identified consistent scoring of 12 core statements over five time points, suggesting it provides a strong indicator of nurses and care workers' perceptions of caring. The findings also mapped onto the person-centred practice framework of McCormack and McCance (2006). Mapping the core statements onto the framework reaffirms the strong correlation between caring and person-centred practice as perceived by participants. In relation to person-centred processes, the statements that remained consistent over time spanned across the five components presented in the Person-centred Practice Framework, with none emerging stronger than any others. This reinforces the validity of the range of person-centred processes presented within the framework and the legitimacy of using these as foci for facilitated discussions about how to develop person-centred ways of engaging in everyday practices with residents.

CHANGING PRACTICE

The data from the programme days, site specific reports, observations of practice and resident stories, affirm the reality of the shift in focus towards a more person-centred culture. The data from the programme days demonstrates that over the period of 11 facilitated programme days and related development activities in practice, the priorities for care changed among staff teams. Activities such as observations of practice, reflection on the language used among teams and with residents/families and 'cats, skirts, lipsticks and handbags' increased staff awareness about a more holistic approach to care that went beyond the doing of tasks:

"… For me person-centred care has been in the main about the staff. About developing them to deliver care to our patients that is of the best quality possible. It's about them learning about their own values and beliefs in order to be able to realise that the patients as people also have a set of values and beliefs that need to be met. My role of facilitator has been in facilitating the growth of the staff at the hospital and supporting them to provide person-centred care. I am very glad I had the opportunity to participate in this programme albeit that on occasion it broke my heart. All I have learned and the networking I have been able to avail of have been of tremendous benefit to me and will continue to be used to benefit the patients lives at this hospital …" (Internal facilitator reflection)

This reflection and the programme days evaluation clearly demonstrates that making these changes is not easy. This evidence is consistent with the international practice development evidence which demonstrates that changing cultures of practice from a routinised to a person-centred approach is challenging at individual, team and organisational levels (McCormack et al 2007). Because the essence of emancipatory and transformational development is that of changing 'self', i.e. adjusting my perspective(s) of situations, then to do this requires considerable commitment and dedication of staff to engage the analysis of 'self'. For the most part, we exist on a day-to-day basis within largely routinised ways of engaging and behaving – the 'crisis' (Fay 1987) that occurs when the comfort of such routines is challenged requires skilled facilitation. The crises that occur and the facilitation interventions necessary are not a one off event but reoccur to form a pattern until the individual can transcend it. The facilitation interventions to work with these crises are evident in this practice development programme. The evidence from the programme illustrates just how challenging it is for facilitators to engage staff who are feeling threatened by the approach being used, and to 'hold' staff as they make their own journeys in coming to terms with the realities of practice and maintaining momentum so that real changes can occur within a set time frame:

"When I began the programme 2 years ago I had totally underestimated the commitment required to be part of the programme. I've always welcomed new challenges and looked forward to this one. I found the weekend in Athlone to commence the programme was absolutely vital to give me a great foundation towards facilitation and practice development. Having a mentor in [NMPDU Facilitator] and [external facilitators] always available was crucial to my 'survival'. There were times when I felt like I was the only person in our unit that was interested in PCC. Without this sounding negative, if I knew at the start of the programme all the challenges I would meet, I'd have found it difficult to enlist …" (Internal facilitator reflection)

However, the data illustrates the extent of changes made to the practice cultures in the participating units and also to the lives of older people who are residents in these units. There are multiple examples of staff offering to make things happen that really mattered for the older person; such as going out for a meal or going shopping, going to see their old home and village, going to their old church. Other significant changes included clarification in roles including separating out housekeeping and care responsibilities, changes to the physical environments and considering evidence

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based design (especially for people with cognitive impairments), construction of a roof top garden and redesign of garden spaces, organising family events and the setting up of resident committees. The area reports offer a good insight into the range and depth of changes that have taken place.

CONTRIBUTION TO PRACTICE DEVELOPMENT KNOWLEDGE

McCormack et al (2006) identified nine key issues that need to be addressed in order for practice development to have a desired impact and these themes will now be used to shape a discussion about the contribution of the programme to the development of knowledge about practice development.

1. ***Decisions about practice development being uni or multidisciplinary 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.***

From the outset, there was an explicit multidisciplinary focus to this programme of work. The 'programme group' in each participating site was comprised of a representative group of staff from the roles within the hospital. It was particularly exciting to have had the involvement and important contributions of cooks, cleaners, administration, gardeners etc as the contribution they made were often seen as 'crisis moments' in the programme because they offered alternative views to those of dominant perspectives, i.e. registered nurses:

"[Name] identified on the first Programme Day the lack of Catering Dept involvement in patient care other than provision of food, and the fact that many in the catering department could not identify a resident by their face- this brought about the 'Face to the Plate' development where a photo of each resident was placed on their menu sheet - I spoke to ward staff about this and told them that the catering staff would be seen around the wards carrying out observations of practice, I asked them to introduce the catering staff to residents and tell them a little about each person. I further developed this new relationship by talking with the catering manager and the DON to suggest other ways to involve catering in patient care. Now we have them going on fortnightly outings with residents, sitting down with a cup of tea in the dining room at breakfast time to talk with residents. One of them went on a trip to Lourdes this year with 4 residents, they will be involved in selecting daily menu choices with

residents in the coming weeks, and some are on person-centred practice working groups." (Internal facilitator reflection)

Whilst the international evidence is unconvincing regarding the relevance of a multidisciplinary focus (or not) in practice development, the evidence from this programme would suggest that in a residential care context, the involvement of the 'whole team' is critical to success and thus, uni-disciplinary practice development would be highly inappropriate. Indeed, it could be argued that the methods of engagement employed in this programme offer a useful approach to the development of 'self-managed teams' as advocated in social models of residential care for older people.

2. The involvement of managers in practice development is crucial to the successful implementation of practice development processes and the sustainability of outcomes.

Previously in this discussion we have referred to the problems experienced in engaging managers/DoNs in the work of the programme. This was also a finding and reported in the pilot programme. Throughout the current programme, the support, interest and participation of the DoN was a continuous focus of conversation and dialogue among facilitators and participants. In the 'pilot programme', Dewing et al (2007) identified the significance the negative impact of the DoN can have in the participating sites. At the outset of this programme, agreed structures and processes of engagement with DoNs/managers were put in place and in the early days of the programme this appeared to be effective with evidence that this group were going to better appreciate practice development methods and processes. However, as the impact of the national HSE embargo became increasingly real, this level and type of engagement was unsustainable. As a result, many of the DoNs became increasingly 'passive' in their involvement and support of the programme, whether intentional or not. Whilst this is understandable given the demands placed on DoNs in the context of the HSE, more active engagement by the DoNs in the programme processes may have in real terms enabled them to achieve their goals also. In the absence of opportunities to engage with DoNs and have these discussions and provide new learning experiences, their disengagement to some degree was inevitable. Across a large group we therefore saw a range of engagement – disengagement as measured through the evaluation methods.

However, as has been highlighted in the findings, those units where the DoN provided active facilitative leadership, probably arising from their personal leadership styles, achieved a much greater degree of change to the practice culture and enabled a greater sense of achievement by the internal facilitator:

"Strong support and protected time was assured by our Director of Nursing … [and] was readily given and consistent. This was a crucial factor to enable us to try and fulfil our roles to the best of our abilities." (Internal Facilitator Reflection)

"Ongoing support from management was crucial to the success of the programme, facilitating the release of participants and supporting the ongoing action plans proved vital in the current cost containment environment. Management's acknowledgement of the need for the programme and seeing it as a vital link in maintaining standards also helped me work effectively." (Internal Facilitator's Reflection)

The role and contribution of other managers such as general managers and older people services managers was never clearly explored. This was another consequence of the embargo. We saw a varying but generally low level of interest and engagement from these managers over the two years of the programme which added to the general feeling that more senior service managers do not encourage and promote innovation that is practice led. It may be that these managers were unclear about their role in this respect, something that may need exploration in the future practice development work in Ireland.

In summary, the data clearly demonstrates the importance of the role of managers in practice development work especially those at the interface with practice. The methodology of practice development focuses on empowering staff to develop skills that enable them to make changes themselves, to do so in a critical and reflective way and to learn how to use those skills repeatedly in their practice. Without the support of managers, such growth, development and self-exposure falls on barren ground, is limited when the interface with management is encroached and the benefits are never fully realised:

"A wonderful programme for team building and getting all grades working together for the benefit of the clients - changing the culture and involving patients/clients in their daily care and giving choice to residents, thus empowering them and improving staff morale. The role of the Internal Facilitator has been critical. Strong leadership is

required to bring all staff on board with person centredness and reflective practice - a must to learn from actions. Continuous feedback to all stake holders is so important ...” (Reflection from DoN)

Whilst practice development is not dependent on effective management, as the evidence demonstrates how emancipatory change can exist 'in spite' of managers (and indeed this is evident in one site on this programme), managers play a crucial role in creating the 'necessary and sufficient' conditions for emancipatory change to flourish, as indicated in the reflection of the DoN above. They also can positively communicate the contribution of practice development approaches to corporate managers. This is a critical consideration for all future programmes.

3. There is universal acceptance of the need for patient/service user involvement (or engagement) in practice development work.

This programme focused on three key aspects of involvement with service users especially older people:

- Facilitating participants to learn from the experiences of older people and to regard the information they acquired as a reputable source of evidence that can be used to influence practice
- To provide structures whereby older people could have a voice in how their home operated and how services were provided
- Learning alongside older people within the programme

The programme day data and reflective accounts indicate that participants went through a process of learning how to learn from and with older people. To begin with many participants were sceptical about asking older people about their experiences. The more frail and cognitively impaired the older person the less staff felt or believed that the older person had anything to offer in terms of knowledge. A theme that is often seen the literature (McKeown et al 2010). Life experiences were regarded as stories that may or may not be truthful. Connected to this there was a high level of concern about whether what older people said was truthful or not. Through a range of programme activities and the narrative evaluation method, participants were able to come to value that truth is not fixed and not even the priority when it comes to life stories, narratives and reminiscences. At the beginning, staff were genuinely

surprised that older people experienced a reluctance to be open and honest about their views on care and the place they were living in.

> *I thought that we knew best what was good for the residents. Now I know that we don't and even if we do, it's not always what the older person wants. This programme has shown me that what I know is important but how I talk to and value what they [older people] want and do not want is more important*
> *(participants reflection year 2)*

Participants experienced and came to learn that their professional views about what mattered to older people was not necessarily what the older people said. Further, as has already been discussed in the previous chapter, at the beginning of the programme it was discovered that care plans generally did not represent the needs and priorities of older people. Whilst participants recognised that it was often the little things that mattered, they also learnt that the bigger things also matter. Birthdays, Christmas and dying/death (amongst other events) were all used as ways to promote learning and often as a way to promote unlearning of the rituals that had been set up and that generally did not include the choices and preferences of older people.

In many of the sites resident committees were set up to provide structures whereby older people could have a voice in how their home operated and how services were provided. It is well documented that these forums can take a long time to become effective and that they require skilled facilitation in order that the residents are genuinely voicing their views and that these views are representative of all residents. As a result of the committees that have been set up advocacy has become a higher concern and two areas undertook some work with an advocacy project. Across the sites residents committees have been consulted on a range of issues such as name badges, mealtimes and menu choices, special events (parties) décor and furnishings and pets. The Mental Health Service has been working on how to involve older people with dementia and learning from their experiences can be transferred to other services. This will of course become a growing need within older people services in the future.

The least successful aspect has been learning alongside older people within the programme within the programme days. A few sites were beginning to introduce this towards the end of year two so there is only a small amount of data relating to this. This is a new level of challenge for many staff to face for the future.

4. Practice developers in 'formal' practice development roles need to have skills in expert holistic facilitation.

The international practice development literature has consistently demonstrated the importance of facilitation in the achievement of emancipatory and transformational change (for example Shaw et al 2008; van de Zipj and Dewing 2009). The literature has highlighted the conflict that often exists between different facilitation roles and how these are operationalised, as well as the competing demands made on facilitators' time. In this programme these kinds of challenges were no different for facilitators in this programme. In addition, few of the facilitators on this programme came ready with advanced knowledge, skills and expertise in facilitation. Indeed for many this was a first-time experience – "… *We were both novices with a capital N and learnt from observation, practice and reflection very fast … We had supervision and strong support from our external facilitator …*"

However, what the majority of facilitators lacked in expertise they compensated for with their passion, commitment and enthusiasm for person-centred practice and practice development. Once the 'mystique' of working on a high profile practice development programme was eroded and initial confidence building established, it is clear that most facilitators engaged in a truly emancipatory way in the work. The programme structures and processes were new experiences to most facilitators but their reflections on the experience demonstrate how they valued this structured approach. Whilst at times it may have been frustrating for facilitators not to be able to 'do their own thing', having structure provided guidance, a sense of security, support and a platform for structured learning:

"… at first I found the structured programme days frustrating and limiting – why did we need this, couldn't we just get on with it? I felt irritated by it … with the support of the [external facilitators] and [NMPDU] facilitator I grew to appreciate the value of the structure and the way it helped me to keep track of the journey, challenge different perspectives, develop new skills, facilitate reflection and bring about the changes needed .." (Internal Facilitator Reflection)

"I have found the facilitation tools used in the programme very helpful. In particular I have found reflective practice helpful as a way of analysing both my practice and facilitation skills and a useful tool to look back on and see change. I have also found the process of developing and organising programme days both demanding and

rewarding as there is a lot to be learnt about planning and development and seeing a programme day through is very rewarding." (Internal Facilitator Reflection).

The importance of the role of the role of the NMPDU facilitators is a key consideration and learning from this programme. This is one of the first large-scale practice development programmes where the lead facilitators were not involved in the operationalisation of the methodology in practice, but instead, required local facilitation groups to do this. The NMPDU facilitators, working in partnership with the internal facilitators has been proven to be a highly effective model and one that should be replicated in other development programmes.   NMPDU facilitators were project managing complex packages of development work and discussed how 'emotional hard' this way of working was for them. It demanded a different values and skills set. Central to this was the nature of the relationship they built with internal facilitators and if the degree to which they were experienced as credible. Those facilitators that were able to do this effectively achieved more rapid progress.   Thus this way of working was exposing for NMPDU staff. Overall, this practice development programme has demonstrated the contribution that the NMPDU as an external facilitation resource can make to service development and enable deeper engagement and more direct benefits to be achieved. It has also shown that changing to this way of working can produce more visible changes and outcomes in practice and service delivery. This can only strengthen the NMPDUs case for their role in the HSE for the future, should they decide to nurture an emancipatory practice development approach. It does also raise the question that the NMPDU may wish and even need to review how it organises, sets up and delivers other practice development initiatives that are of a more short term and teaching/study day approach (Dewing 2009).

The programme utilised a cooperative inquiry methodology. Whilst the full potential of this methodology was not realised due to the learning and development needs of the facilitation team and the embargo, the quality of the data collection and its collaborative analysis by the facilitation team demonstrates the potential of enabling groups of staff, with facilitation to be actively involved in collecting and analysing evidence/data and developing their own action plans. Should this experience be replicated in other programmes then it could be argued that this would not just result in a changed appreciation of knowledge transfer, a culture change in individual practice settings, but also a change in the 'relationship-culture' between operational staff and managers. This is currently being further tested in a large scale practice

development program in New South Wales (*Aspire to Inspire*; Uniting Aged Care South Eastern region and the University of Wollongong).

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.

There continues to be debate in the academic nursing press (for example Walker 2009; Watson et al 2008; Dewing et al 2009) about the relevance of practice development to academic communities and HEIs in particular. Academics engaging in practice development have been accused of 'endangering' professional academic inquiry - *"[PD] …endangers the professoriate and academic enquiry into nursing by pandering to the insatiable appetite of the National Health Service (NHS) for 'pairs of hands'; and second, that PD is a diversion from, and an alternative to, academic activity"* (Thompson et al 2008) and further that "*… we have serious concerns that it is being seen as an easy substitute for scholarship and academic enquiry. It certainly has appeal to practitioners, but is PD any business of universities?"* (Thompson et al 2008)*.*

Whilst clearly, HEIs have to ensure that they are clear about the role of academics in facilitating learning, research and scholarship, supporting the facilitation and researching of practice development has a legitimate place in these endeavours and indeed can help HEIs achieve many of the education and research targets that currently dominate HEI performance measurement. Systematic engagement in practice development demonstrates how meaningful connections between practice, learning, evidence use and development and knowledge transfer can be achieved and further how research processes can be 'demystified' for clinicians.

The relationship between the HE in this programme and the participating sites was highly valued by participants and facilitators alike. Being part of a programme that was endorsed by a university was seen as important by participants, whilst facilitators valued the systematic approach and ongoing support that HE facilitators brought to the programme. What has been disappointing has been the low level of active interest and involvement from local HEIs in Ireland.

However, critical to the success of this relationship has been the methodology adopted and that needs to be considered carefully. The methodology was

underpinned by the practice development principles of 'collaboration, inclusion and participation' [CIP] (McCormack et al 2006) and set within a cooperative inquiry framework. Whilst we have earlier acknowledged some of the limitations posed on the extent to which we could realize a full cooperative approach, adhering to its underpinning principles and those of CIP ensured that the potential 'power relationship' that can exist between academia and practice was actively managed and worked with. The issue of managing this power relationship is critical to the success of any practice development programme and ensuring that academic staff are seen as equal players rather than as 'directors' of a programme.

Ultimately, HEIs and practice settings have different ideas in terms of what outcomes are desired – HEIs focus on the contribution of a programme to knowledge and scholarship (which go towards criteria for success in research in particular) whilst practice settings rightly focus on the impact of a programme on practice and service delivery. These agendas do not need to conflict and indeed it is essential that they don't. Ensuring that a rigorous collaborative, inclusive and participative methodology underpins a practice programme also ensures that the agendas of all stakeholders can be achieved. The opportunities that practice development affords academic staff to demonstrate a commitment to practice, a commitment to knowledge translation and a commitment to learning in and from practice are enormous, and it is imperative that methodologies such as that utilized in this programme are used to enable these outcomes to be achieved. The recent launch of the Republic of Ireland's 'Practice Development Strategy' (Department of Health and Children 2010) will go some way towards pursuing this agenda.

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.*

The literature indicates that this is and remains a perennial challenge for practice development and health care provider organisations. This is in part because organisations are heavily invested in more traditional learning programmes. Often provider organisations internally invest in a 'training model' and externally they may have little choice about what HEIs offer and are in essence a captive market. It is also because practice developers have focused on the 'micro' aspect of practice (in clinical/care settings) and not worked enough at the macro level (the strategic and

corporate level). Currently, as other programmes show, successful practice development work seems to present a challenge to organisations to carry on with the approaches and processes that have been introduced. In regard to this programme some of that challenge will now sit with the NMPDU Directors and how they demonstrate their leadership in taking forward practice development in their areas. As Bevan (2010) argues bringing in or buying in external project leads and consultants does not 'hard wire' or embed change into practice. Instead 'inside out' change creates the capability and builds up sustainable improvements in quality and costs.   In the current economic climate, HEIs and NMPDUs will need to work more and more on this principle.

7. *Effective practice development requires the adoption of three key methodological principles – collaboration, inclusion and participation.*

This principle has already been discussed in other parts of this section. In part it is achieved by making use of the methods set out in earlier principles These processes are in many ways a cumulative and simplified statement of the process of engagement which is in turn central to enlightenment, empowerment and emancipation. Enlightenment requires inclusion. Individuals need to be emotionally connected with others and the environment around them to perceive and experience things differently. Empowerment requires inclusion and participation rather than acting on self-interest. This enables the generation of latent or untapped energy and the establishment of different types of relationships which will fuel changes in work practices. Finally emancipation requires collaboration as this is the pinnacle of social and collective action.

This programme has helped clarify the ways in which different stakeholders can adopt these principles. However further research is needed to know more about which interventions in each attribute are essential.

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.*

These are:
• Agreeing ethical processes
• Analysing stakeholder roles and ways of engaging stakeholders
• Person-centredness

- Clarifying the development focus
- Clarifying values
- Clarifying workplace culture
- Collaborative working relationships
- Continuous reflective learning
- Developing a shared vision
- Developing critical intent
- Developing participatory engagement
- Developing shared ownership
- Developing a reward system
- Evaluation
- Facilitating transitions
- Generating new knowledge
- Giving space for ideas to flourish
- Good communication strategies
- Implementing processes for sharing and disseminating
- High challenge and high support
- Knowing 'self' and participants
- Use of existing knowledge

What the programme did with varying degrees of success was to contextualise these methods across the sites. Effective practice developers maintain a critical dialogue between method and context (and available facilitator expertise). Thus assessment and evaluation of context and culture in practice development is essential. Hence this programme introduced the CAI and WCCAT tools. The organisation now needs to establish how to carry on working with these or similar tools.

A huge success has been the Active Learning method. This has enabled development of the methodology and a contribution to practice development knowledge. However, this needs to be balanced with the challenges participants associated with reflection on practice and how much energy and resilience was needed by participants to influence colleagues. Only a minority of sites made significant progress in producing evidence of incorporating structured reflection into their programme days. Other active learning methods did help develop other forms of reflection skills. It may be clearer from this programme that attending to and promoting reflection, even critical reflection as the main source of learning in PD is

high risk. Reflectivity underpins several of the methods set out above, therefore more exploration needs to take place about how this is done in ways that awakens curiosity and can engage practitioners. This programme has also demonstrated that much more needs to be done within HEIs and internal training and staff development to promote spaces and skills in critical reflection.

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.***

Of particular significance is the size and approach of the evaluation research carried out through this programme especially the qualitative aspect of the research. This programme has demonstrated that groups of staff with facilitation can be actively involved in collecting and analysing evidence/data and developing their own action plans and at the same time they can be actively learning. Practice development methods built on CIP principles mean that this 'work' can be experienced as a meaningful learning opportunity. This brings an added value to practice development work and also stresses the need for an evaluation rather than or alongside the traditional audit approach and for staff to be included in data collection.

Retention and recruitment

Within the facilitation team three members left during the course of the programme. Two members within year one and the third member in year two. Two sites withdrew at the beginning of the programme. In one case, the director of nursing made the decision themselves. One site was withdrawn in year two and one site took a break at the end of year one and then returned in year two. Some sites recruited new internal facilitators and programme members during the two years. Changes in Director of Nursing and other key stakeholder roles also took place in several regions. Towards the end of year two the structural reorganisation of the NMPDUs also saw changes in these Directors roles. This movement alone was challenging enough.

The main issue influencing the programme here was the national embargo. This began in year one and continued throughout the whole of year two. As a direct consequence of this several programme activities were either stopped or had to be renegotiated and provided in an alternative format. The teams development and

planning days were reduced. This had an impact on supervision. As an alternative method, telephone supervision was introduced with each team member being offered six sessions over year two. Uptake by the programme team was variable.

The Director of Nursing stakeholder group that was established had potential to engage managers in practice development in a meaningful way. However as this was stopped in year one there has been no formal evaluation of this group carried out. The programme National Reference Group also stopped.

The impact of the embargo although not significantly impacting on the delivery of the programme within the regions and at the sites, we believe will have a negative national impact in the longer term. Key stakeholders who could be influencing the embedding of practice development in service delivery and design and at national policy level have not been able to fully engage in the programme. The challenge of responding to this, in our view, now sits with the NMPDU Directors.

REVISITING THE PROGRAMME OBJECTIVES

Each of the programme objectives are set out here with a summary statement:

Coordinate a programme of work that can replicate effective Practice Development processes in care of older people's settings

This objective has been achieved. A programme was developed, coordinated and delivered. Once the programme began interest was shown by other sites who wished to become involved. HIQA inspections are prompting other sites to explore practice development activities to achieve their action plans.

Enable participants/local facilitators and their Directors and 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)

Staff and managers became familiar with the PCN and PD frameworks, and learnt a set of core practice development methods and processes. The ground work for embedding practice development within the organisation has taken place. It is now up to others to sustain and nurture this. Given the changes across the NMPDUs it is unclear how successful this will be.

Develop person-centred cultures in participating practice settings.

Significant progress was made in achieving numerous attributes of a person-centred culture. There is no end point to person-centred cultures, thus further development is still needed. If this is not systematically planned and nurtured then the new cultures will begin to fall apart.

Systematically measure or evaluate outcomes on practice and for older people

An evaluation framework has been introduced that could be continued at a local regional or national level. We believe this framework can support HIQA and other quality initiatives nationally across older people's services

Further test a model of person-centred practice in long term care/rehabilitation settings and develop it as a multi-professional model.

The model has been tested and will be reported elsewhere in more detail. The testing in this programme demonstrated the need for the physical care environment to be included.

Utilise a participant generated data-set to inform the development and outcomes of person-centred practice. (Already designed and tested tools will be used to produce data set)

The programme has enabled local NMPDU facilitators to work with shared principles, models, methods and processes in practice development work across older people services in Ireland. A range of learning and evaluation tools have been introduced through this programme that can be continued. The data set informed the development of local action plans the programme and has been used to demonstrate outcomes in person-centred practice across the sites over three time periods.

RECOMMENDATIONS

For future practice development programmes; for the development of residential care for older people in Ireland a number of issues need to be addressed and these are set out below under 6 themes.

Theme 1: Role of NMPDU and NMPDU facilitators

• Establish leadership role of NMPDUs in taking forward emancipatory/ transformational approaches to practice development work.

• Review of the effectiveness and value for money in staff input into training and short term training and practice development initiatives.

• Review/map the skills sets of NMPDU staff working in practice development.

• Plan for the ongoing development of facilitators who can enable emancipatory practice development processes to be realised in practice in line with the National practice development strategic framework.

Theme 2: Practice/Workplace Based Learning

• Address low levels of reflection and underdeveloped skills in critical reflection.

• Consider further Active Learning or other similar experiential based approaches to learning in and from practice.

• Generate opportunities for observations and feedback activities to become a regular feature in the workplace.

• Consider provision of more mixed groups for learning.

• Create learning spaces rather than teaching places.

• More work is needed on learning alongside older people and families.

• Review investment in classroom-based training and explore creative means of resourcing work-based learning.

Theme 3: Leadership and Facilitation Skills

• Develop more learning opportunities for the development of facilitation skills.

• There is a need for continued support for those who have already developed facilitation and practice development skills through this programme.

• A new national network for facilitators has been created by NMPDU and internal facilitators of this programme – there is a need for ongoing support for this new national network.

- There is a need to maximise opportunities to enhance the leadership capability of all staff.

Theme 4: Directors of Nursing and Managers

- Managers need to be formally introduced to PD processes prior to the commencement of a programme.
- Develop a 'contract' between managers, funders, facilitators and evaluators that makes explicit roles and responsibilities and support requirements.

Theme 5: Audit and Evaluation of Practice

- Practitioners to be actively engaged in designing and collecting data/evidence at local levels.
- Observation of care should be an ongoing peer review process in all sites.
- All sites should measure and evaluate their workplace culture and benchmarking across sites should be encouraged.
- All sites should have formalised action plans based on insider led practice development priorities.

Theme 6: Older People and Families

- Older people and their families should be considered to be active participants in all practice development programmes in residential care settings.
- Methods of developing practice should be mainstreamed and integrated into everyday care processes, and reflective and development processes.
- Ways of informing older people and their families about ongoing advancements in practice need to be established and evaluation data made public to them alongside other data sources such as HIQA review findings.

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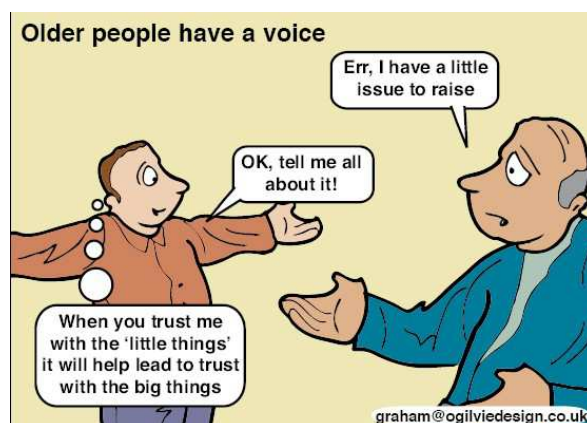# APPENDICES

Nursing & Midwifery

Planning &

Development Unit

The Development of Person-Centred Practice

In Nursing

across

Two Continuing Care/Rehabilitation Settings

for Older People

EXECUTIVE SUMMARY OF THE FINAL PROGRAMME REPORT

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Summary

This two year PD programme at Birr Community Nursing Unit and St Marys' Care Centre Mullingar *was successful in facilitating teams at both sites to establish a shared vision for nursing practice in services for older people. Achieving this required staff to examine and own both concerns and issues as well as positive aspects of the existing practice. Through a variety of activities, many of which included older persons, participants and other staff developed a deeper understanding of how their care impacted on older persons and their families. Through introduction to the generic values and principles underpinning person-centred practice and by collaborating with the wider team on a programme of practice development, a significant change in the culture of care has taken place at ward or unit level. However, even after two years, these are only the foundations for achieving more sustainable cultural changes that still need to take place more broader in the facilities. The local HSE will need to carry on investing in the type of learning that supports person-centred care and service delivery.*

In this initiative, a tailor made programme was combined with skilled facilitation, active learning and programme co-ordination to enable the processes and outcomes in this programme to happen. Facilitation also included offering a range of PD processes and tools for participants to use in their own workplaces to become leaders of PD.

This programme was particularly successful at enabling traditional and stereotypical values and beliefs about older persons to be challenged. It enabled the older people to influence life in their 'homes' including care delivery in several ways.   The programme was less successful at transforming the context surrounding practice and more work is needed in this area if a person-centred and practice development culture is to be expanded and sustained.

"I realise now there is much more work to be done but that we have come along way……I am now positive about facilitation and I feel I am more involved with decision making in my workplace. We have a shared vision for the future.

Key Learning for the Programme

Preparation of all staff at a programme site is necessary. This includes Directors of Nursing and all Assistant Directors.

Participating in emancipatory practice development can be a transformational experience for participants, which may have several welcome or unwelcome consequences for individuals.

The local and internal facilitator roles are essential to ensure PD is embedded in the workplace.

New facilitators to PD need to take time to become comfortable and confident with emancipatory PD methods and processes. Internal facilitators can benefit from protected time for PD within their usual responsibilities.

Working in a team with diversity of skills can be personally uncomfortable at times. Facilitating outside of ones usual workplace or in a different culture can be highly challenging.

Directors of Nursing can experience a range of personal feelings about PD and may need facilitation or other forms of support, to enable them to fully support and maximize workplace and corporate culture transformations.

An approach called 'Active Learning' can bring additional benefits to workplace/work-based learning. Ownership of the need for practice development is increased with active learning methods. Active learning can enable PD processes to be translated into the workplace with other staff and team members.

PD Advisory Groups need to be redesigned in a workshop or 'round table' format to enable maximum participation.

It is possible to introduce the core principles of person-centred care without reliance on any one model. However, use of a specific person-centred model may have enabled greater management support.

Programme design at the start of the programme can be simple and evolve as the programme progresses.

The needs of some stakeholder groups to see things happening in practice must not result in shortcutting PD processes and learning of PD skills at the start of PD. The early stages of PD work do not produce immediate or highly visible changes in practice, but instead are focused on clarifying values and beliefs, developing a shared vision and developing PD skills in the participants. Stakeholders may need support to value these processes.

Older People must be active participants in PD work about their care and services and ways need to be found to enable participants to gain skills in working with service users as also being evaluators of the service.

Many care attendants openly expressed an interest in learning more about PD and becoming facilitators of PD.

Emancipatory PD can bring benefits for workplace and care for older people, yet at the same time may highlight differences in priorities and processes between practice and management.

In summary, as a result of this programme, learning has taken place around:

1. **decision-making** - a movement from hierarchically controlled decision-making to participatory expert-driven decision-making is needed to evolve person-centred cultures. Practitioners can develop joint decision making with older persons and management.

2. **relationships**- changing relationships from those rooted in roles and responsibilities (that are often draining on both personal and team energy) to those that are based in mutual engagement generates energy for new ideas, growth and development

3. **resolving conflictual ways of working** – rather than engaging in negative and destructive ways of working, a range of forums and other opportunities such as PD working groups, generating new ideas and learning from practice can be nurtured. To achieve this, practitioners need skills that may use of critical reflection, problem solving, solution focused dialoging and working collaboratively with a range of stakeholders.

4. **application or use of power** - a power shift from the traditional 'power over others' approach to power as a resource to enable others to learn, grow and develop can help PD.

5. **processes for learning** - encouraging eagerness to learn and translating this into action and enable similar learning in others can help widen the impact of PD in the workplace

Recommendations

1. There is a need to secure formal on-going commitment for practice development as core day-to-day work among programme participants/internal facilitators and to have agreed systematic processes in place for increasing 'buy in' and active participation among all clinical staff.

2. Person-centred PD and management need to be more joined up.

3. Older People must be active participants in PD work around their care and services and ways need to be found to enable participants to gain skills in working with service users as also being evaluators of the service.

4. Where uni-disciplinary practice development takes place attention needs to be given to promoting awareness and longer term involvement with other disciplines,

5. Preparation of Directors of Nursing needs more attention in PD work. Directors and indeed Assistant Directors cannot always fully appreciate the implications of PD if they have not experienced it before.

6. Directors and other key stakeholders need to appreciate looking for 'quick fix solutions' that are not embedded into practice is not part of PD because the processes used are not led by or owned by practitioners and will therefore not be sustained.

7. Further work needs to be undertaken with Directors and Assistant Directors of Nursing in order to increase their understanding of emancipatory PD processes, so that they can 'lead' changes, role model and 'embed' them in everyday service delivery.

8. Future PD advisory groups need to be redesigned.

9. Internal facilitator role needs clarification and protected time

10. Some external facilitators require the same or similar preparation as internal facilitators especially if they are new to working outside of their own organisation.

11. There is a need to further develop, streamline and expand the role of skilled local facilitators within NMPDUs who can systematically both work with key staff acting as internal facilitators for practice development work (specifically using emancipatory approaches) and facilitate staff teams who seem stuck in outmoded forms of practice or 'unable to vision' new ways of working, to enable them to find ways of addressing organisational and practice 'blocks' necessary for sustained developments in practice and wider organisational cultural change to be effective on a large scale.

12. Active learning methods can be used more systematically in PD work.

13. Local action planning, including a commitment to staff development, will need to take over to secure longer term sustainability now that the programme has ended.

14. Several areas of project action planning are still ongoing e.g. Continuity of care, Nutrition. This needs evaluation at the appropriate time.

15. The work from this programme needs to be written up for publication. Theoretical development on 'Active Learning' in PD needs to be undertaken.

16. This programme is widely shared across Ireland and in particular with the forthcoming PD programme sites

Future Plans 2007-2010

Following this successful project, the first of its kind in the Republic of Ireland, partial funding has been awarded to support a national PD programme involving 20 sites across Ireland. This programme, probably the first of its kind internationally, is about to get underway. The existing funding will enable a skeleton programme to be delivered. The project team are looking for further funding to secure opportunities to carry out a more detailed evaluation of the national work (for which an evaluation plan has been established) and to be able to share the outcomes and learning widely, provide learning opportunities for older people about how they can influence what goes on in their care homes, more coaching to local staff to ensure long term sustainability and to ensure that PD resources and knowledge are made more widely available to practitioners working in care of older persons across Ireland.

Appendix 2

Creative Hermeneutic Data Analysis

Boomer C and McCormack B (2008) Creating the Conditions for Growth: report on the Royal Hospitals and Belfast City Hospitals Collaborative Practice Development Programme
http://www.science.ulster.ac.uk/inr/pdf/BCH_RGH_programme_report_final.pdf

Process used for Analysis of Narrative and Observation Data

Thirty two (22) internal facilitators participated in a workshop to analyse the observation and narrative data collected in round 3 of the evaluation. IN addition, the NMPDU and Lead Facilitators undertook data analysis of the same data at a separate workshop. This approach was adopted for two reasons – 1) the facilitators were free to facilitate participants in the data analysis workshop process, and 2) it prevented the facilitators from imposing themes and thus ensured that the themes were derived from the experiences of the internal facilitators. A structured approach to the analysis of the data using a framework developed by Boomer and McCormack (2008) was utilised. The framework progresses through nine (9) stages and was operationalised as follows in the workshop:

1. Copies of all (anonymised) narrative and observation data were distributed randomly among group members. Individuals had copies of both narrative and observation data from across all participating sites. The participants were asked to read the data and form general impressions, observations, thoughts and feelings.   They were encouraged to make notes on these if it helped as aide memoir to check later if they needed to. Participants had 30 minutes to read the data.

2. When they had finished reading the data, participants were asked to create an image of their impressions, feelings, etc as a means of capturing the <u>essences</u> of the data. Participants were allocated 15 minutes for this activity.

3. In this stage each participant was asked to join with another and take turns in "telling the story" of their creative work. While each person told their story, their colleague was asked to write the story verbatim.

4. Using the creative image as the centre piece and the story (written) and other notes they may have made at step 1, each person was asked to theme their image:

    1. as many themes as they liked
    2. write 1 theme on each post it and stick on the creative image.

5. Each pair (step 3) joined other pairs to form small groups. Four (4) small groups were formed. The themes identified by individuals were

discussed and "shared themes" [Categories] were devised. The importance of having whole-group agreement on the categories formed was emphasised.

6. When agreement was reached, each group matched their agreed categories with 'raw data from the narratives and observations.

7. The NMPDU and Lead Facilitators then undertook steps 1-6 above.

8. The NMPDU and Lead Facilitators then matched their themes with those of the internal facilitators and a final set of themes and categories were agreed by matching themes from this step with those of the internal facilitators and agreeing 'category labels'.

9. The final sets of categories were checked for authenticity and representativeness with a randomly selected sample of internal facilitators (5).

THEMES IDENTIFIED FROM STEP FOUR (4)

"Is it facilitated"
Meal and mealtimes
Visiting
Roots
Lack of Stimulation and meaningful activities
Knowing the person
De-personalisation
Dignity
Individual Noise
Structure/space
Contrasting environment
Garden/nature
Bright/Dull
Space
Design flaws/Depressing
Lack/sense of home
Comfort
Safety
Contrasting environment
Institutional – e.g. seating
Environment
Boredom
Isolation
Monotonous
Worry
Connection to past family
Connection to past life
Connection to past role

Connection to outside world
Inclusion
Environment
Isolation
Family
Celebration
Loneliness
Social outlet
Belonging
Change
Health
Independence
Identity
Self Life
Freedom
Loss
Worry
Ignored not included
Loss
Depression low spirits
Sad
No enjoyment
Sense of hopelessness
Hopelessness
Making the best
Loss of independence
Acceptance
Fear of future
Fear of Dying
Voiceless
Staying quick
Fitting in
Ignored not included
Bleakness
Resignation
Hopelessness
Acceptance of plight
Loss
Contentment and Acceptance
Hopelessness
Chaos
Loss of Independence and voice
PCC Language
Active Listening
Communication
Tasks or
Systems of work
Time
Staff attitudes and behaviour

Lack of Autonomy/decision making
Authority and rules
Routinised Care
Positive Practice
Intentionality
Communication/language
Staff Attitude
Choice (Lack of)
Rituals
Lack of Privacy and Dignity
Communication
Individuality
Communication
Patient Satisfaction
Meaningful Relationships
Rights
Dignity
Night versus day
More to do
Activity
Choice
Respect
Longing
Nostalgia
Fear

THEMES IDENTIFIED FROM STEP FIVE (5)

- Choice -   "Is it facilitated"
                  Meal and mealtimes

- Activity -   Lack of stimulation and meaningful activities

- Individual -   Knowing the person
                  De-personalisation
                  Dignity

- Voiceless -   Fear of future
                  Fear of Dying
                  Staying quick
                  Fitting in
                  Ignored not included

- Boredom

- Celebration

- Choice

- Loneliness   -   Boredom
                  Isolation
                  Monotonous
                  Worry

- Choice

- Inclusion

- Loss –   Health
                  Independence
                  Identity
                  Self Life
                  Freedom

- Environment

- Isolation

- Choice (Lack of)

- Rituals

- Loneliness

- Social outlet

- Belonging

- Change

- Hopelessness – Worry
  Ignored not included
  Loss
  Depression low spirits
  Sad
  No enjoyment
  Sense of hopelessness

- Family

- Teamwork -   Tasks or
  Systems of work
  Time
  Staff attitudes and behaviour
  Lack of Autonomy/decision making

- Environment -   Noise Structure/space
  Contrasting environment
  Garden/nature
  Bright/Dull
  Space
  Design flaws/Depressing
  Lack/sense of home
  Comfort
  Safety
  Contrasting environment
  Institutional – e.g. seating

- Hope and Hopelessness

- Connectivity -   Connection to past family
  Connection to past life
  Connection to past role
  Connection to outside world

- Acceptance -   Making the best
  Loss of independence

- Bleakness

- Resignation

- Acceptance of plight

- Loss

- Contentment and Acceptance

- Hopelessness

- Chaos

- Loss of Independence and voice

- Family -   Visiting
                       Roots

- Communication – PCC Language
                    Active Listening

- Hope

- Routinised Care -   Authority and rules

- Intentionality -   Positive Practice

- Communication/language

- Staff Attitude

- Hopelessness

- Lack of Privacy and Dignity

- Communication

- Individuality

- Communication

- Patient Satisfaction

- Meaningful Relationships

CATEGORIES IDENTIFIED FROM STEP NINE (9)

Category 1 = Choice

- Choice -   "Is it facilitated"
                    Meal and mealtimes

- Family -   Visiting
                    Roots

- Activity/Boredom -   Lack of stimulation and meaningful activities

Category 2 = Belonging & Connectedness

- Individual -   Knowing the person
                    De-personalisation
                    Dignity

- Environment -   Noise Structure/space
                    Contrasting environment
                    Garden/nature
                    Bright/Dull
                    Space
                    Design flaws/Depressing
                    Lack/sense of home
                    Comfort
                    Safety
                    Institutional – e.g. seating

- Loneliness   -   Boredom
                    Isolation
                    Monotonous
                    Worry

- Connectivity -   Connection to past family
                    Connection to past life
                    Connection to past role
                    Connection to outside world

- Inclusion

- Environment

- Isolation

- Family

- Celebration

- Loneliness

- Social outlet

- Belonging

- Change

Category 3 = Hope and Hopelessness

- Hope

- Loss –   Health
                  Independence
                  Identity
                  Self Life
                  Freedom
                  f
- Hopelessness – Worry
                  Ignored not included
                  Loss
                  Depression low spirits
                  Sad
                  No enjoyment
                  Sense of hopelessness

- Acceptance -   Making the best
                  Loss of independence

- Voiceless -   Fear of future
                  Fear of Dying
                  Staying quick
                  Fitting in
                  Ignored not included

- Bleakness

- Resignation

- Acceptance of plight

- Loss

- Contentment and Acceptance

- Chaos

- Loss of Independence and voice

Category 4 = Meaningful Relationship

- Communication – PCC Language
  Active Listening

- Teamwork -   Tasks or systems of work
  Time
  Staff attitudes and behaviour
  Lack of Autonomy/decision making

- Routinised Care -   Authority and rules

- Intentionality -   Positive Practice

- Communication/language

- Staff Attitude

- Rituals

- Lack of Privacy and Dignity

- Communication

- Individuality

- Communication

- Patient Satisfaction