



ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

***'It's a nice place, a nice place to be'.* The story of a practice development programme to further develop person-centred cultures in palliative and end-of-life care**

Brendan McCormack*, Caroline Dickson, Tracy Smith, Hilary Ford, Steffi Ludwig, Rhona Moyes, Laura Lee, Elaine Adam, Tracy Paton, Brigid Lydon and Juliet Spiller

*Corresponding author: Queen Margaret University, Edinburgh, Scotland
Email: BMcCormack@qmu.ac.uk

Submitted for publication: 8th February 2018
Accepted for publication: 9th April 2018
Published: 16th May 2018
<https://doi.org/10.19043/ipdj81.002>

Abstract

Background: Palliative and end-of-life care services need to be person centred. However, it cannot be assumed that such services are 'naturally' person centred as, in reality, they face the same pressures and challenges as any other service. This is the case in the practice development research reported in this article. While the service had good patient and family feedback/satisfaction, the context of care provision for staff did not reflect these same levels of satisfaction. This contrast poses challenges for organisations in the context of staff wellbeing and the sustainability of person-centred care. The work undertaken in this programme aimed to address this issue.

Aim: To implement a programme of practice development to further the development of a culture of person-centred practice in the Marie Curie Edinburgh Hospice.

Methods: The programme was theoretically informed by the Person-centred Practice Framework of McCormack and McCance (2017) and operationalised through the methodology of transformational practice development. Thirteen multidisciplinary team members formed a 'core group' and participated in 10 three-hour workshops of learning and development, spread over a 12-month period. Practice development activities were planned in between the workshops to be undertaken by the group members. Evaluation data were collected at the beginning of the practice development programme and as a continuous process throughout the 12 months. Data collected included patient and staff stories, practice observations, creative expressions and routinely collected data. These data were analysed through a participatory approach with the group members and theorised through the lens of human flourishing.

Results: The findings are located within a framework exploring the conditions for human flourishing. They illustrate the tension between person-centred care and person-centred cultures. Key findings demonstrate the need for all persons to be 'known' in order for effective person-centred relationships to exist, the significance of shared values, the importance of addressing 'small' practice changes as well as the need to ensure the hearing of different voices. Findings from routine collected data further demonstrate the relationship between the development of a person-centred culture with patient and staff outcomes.

Conclusions and implications for practice: This programme is one of the first explicitly to use a framework for human flourishing to analyse the relationship between person-centred culture and care provision. The programme demonstrates the importance of person-centred cultures for sustainable person-centred care. Implications for practice include:

- Practice settings need to be clear about the difference between patient- and person-centredness
- The engagement of a multidisciplinary team in interdisciplinary systematic transformational practice development has the potential to transform the culture and context of care, and produce sustainable outcomes
- Human flourishing is an appropriate focus to adopt in exploring how practice settings embrace the principles of person-centredness for all persons

Keywords: Person-centredness, person-centred culture, human flourishing, end-of-life care, hospice, facilitation

Introduction

This article presents a report of the structure, processes and outcomes of a 12-month practice development programme at Marie Curie Hospice, Edinburgh, focusing on the development of a person-centred culture. The article describes the background to the programme, aims and objectives, theoretical perspectives that shaped the programme framework, evaluation methods and key findings. A shared experience of the programme among participants was the sense that it enabled them to flourish and so the programme's processes and outcomes are presented through the lens of 'flourishing' and its alignment with the development of person-centred cultures.

Background

Current evidence suggests person-centred ways of working are crucial in palliative and end-of-life care (Yalden et al., 2013; Independent Cancer Taskforce, 2015). Respecting persons' needs and wishes, shared decision making, family involvement and sensitive communication are highlighted in the literature (Leadership Alliance for the Caring of Dying People, 2014). Van der Eerden et al. (2014) reported a qualitative study exploring the experiences of patients and their carers of person-centred end-of-life care in five European countries. Participants reported feeling valued as a person rather than being an illness, discussing prognosis and treatment openly and honestly, and the formation of trusting, personal relationships as key considerations. 'Being there' and information sharing between professionals that reduced the need for repetition of their story were also identified as hallmarks of person-centred care.

Marie Curie has an overall strategic direction of the development of person-centred palliative and end-of-life care, reflecting this evidence. It also reflects the *Ambitions for Palliative and End-of-life Care: a national framework for local action 2015– 2020* (National Palliative and End-of-life Care Partnership, 2015). Embedded within Marie Curie's (2015) strategy and five-year plan are its espoused values:

'Always compassionate, making things happen, leading in our field and people at our heart.'

The People Strategy (Marie Curie, 2015) highlights the need for recruiting and retaining an appropriate skilled and diverse workforce who feel confident and capable to deliver care and experience wellbeing while embracing change and keeping quality improvement central. However, McCormack et al. (2017) posit person-centredness will only happen where there are cultures in place that will enable staff to experience person-centredness for themselves. The Marie Curie organisation therefore decided to use its Edinburgh hospice (hereafter referred to as 'the hospice') as a case study for developing and modelling a person-centred culture, as a means of exploring how the processes could be transferred across the organisation and of identifying outcomes that could be used to demonstrate effective workplace cultures in action.

The programme built on the learning from previous projects that have focused on the development of person-centred services (Boomer and McCormack, 2010; McCance et al., 2013; McCormack et al., 2015) and aimed to develop further the processes used and outcomes achieved. Experience and evidence from practice and research has shown that person-centred care is more likely to be

implemented where there is a culture that integrates person-centred thinking into everyday work (Yalden et al., 2013). This is particularly important for new or developing organisations. Task-orientated ways of working and hierarchical ways of thinking can easily become the norm in organisations that do not make explicit their commitment to a more person-centred approach. According to Manley et al. (2011) workplace cultures are those that impact at the point of care delivery. They suggest effective workplace cultures reflect the characteristics of a person-centred culture.

Emancipatory and transformational practice development are identified as methodologies for bringing about culture change that is consistent with the values underpinning person-centredness (McCormack and McCance, 2010). The aim of transformational practice development is to increase effectiveness in person-centred practice through enabling healthcare teams to transform the culture and context of practice and, in this case, to transform the experiences of care by staff and service users/families (McCormack and Titchen, 2006; Titchen and McCormack, 2008; Titchen et al., 2011). Transformational practice development focuses on creating the conditions for all persons to flourish, as a process (ways of working) and as an outcome (the person's experience). This is achieved through a series of phases aimed at helping all staff become empowered to act, using staff knowledge and expertise to identify the need to change, encouraging reflection on and in practice, and supporting staff to challenge themselves and each other and take ownership of addressing barriers. However, operationalising this methodology is not without its challenges (McCormack et al., 2013) and experience from similar programmes has shown that success is best achieved by including all grades of staff in the practice development programme (Boomer and McCormack, 2010; Manley et al., 2011; McCance et al., 2013; Yalden, 2013; McCormack et al., 2015) and that there is a direct link between the participation of leaders in the programme and outcomes achieved (McCormack et al., 2009a; Mekki et al., 2017).

Programme aim and objectives

The aim was to implement a programme of practice development to further the development of a culture of person-centred practice in the hospice.

Objectives:

- Enable participants/key facilitators and managers to recognise the attributes of person-centred cultures in hospice care
- Facilitate learning and development about transformational practice development to support person-centred practice in the hospice setting
- Promote quality of care and wellbeing for all persons in the care facility
- Develop skilled facilitators who will champion and lead a person-centred approach to practice, ensuring sustainability of the practice development programme in the organisation
- Use a participant-generated dataset to inform the development and outcomes of person-centred practice

Methodology

The programme was theoretically informed by the Person-centred Practice Framework (McCormack and McCance, 2017). This framework provides a way of thinking about a care environment as a person-centred culture and a place that embraces meaningful engagement with people as colleagues and as patients/families. To operationalise this theoretical perspective, the methodology of transformational practice development was employed. This approach focuses on developing cultures that enable all persons to flourish, through critical and creative engagement in facilitated learning. The focus of the learning is the work of the individual or team. Through creative and critical reflective activities, learners are enabled to bring about change in themselves and in the cultures and contexts in which they practice. The learning is set within a strategic context to ensure it is embedded in organisational cultures. The methodology of transformational practice development was operationalised through active learning (Dewing, 2010). This is a form of action-oriented learning concerned with work and work practices whereby the style of learning and consequent activities is underpinned by principles of

active engagement in observation of care and practice by self and others, critical reflection with self, critical dialogue with others and doing or action with others in the workplace. Participants are guided to increase the range of active learning methods they use in their day-to-day work, and learn to use these methods in their workplaces with team colleagues.

The setting

The hospice is one of nine run by Marie Curie across the UK. The services it offers work together to meet the palliative care needs of people with progressive, life-limiting illness. The aim is to provide specialist, research-based palliative care that enhances quality of life for people affected by cancer and other illnesses. The hospice's inpatient unit employs more than a hundred staff to provide care and support for up to 20 adults over the age of 16. In addition, day and community services operate from the hospice in Edinburgh and from the Macmillan Centre in Livingston, West Lothian, Scotland. A team of trained volunteer staff also supports the hospice in various activities, such as working on reception, offering drinks and snacks, and gardening.

Participants

The programme began with a core group of people from mixed disciplines (the co-authors of this article). The group consisted of, the hospice manager, practice development facilitator, two lead nurses, a charge nurse, a clinical nurse specialist, two registered nurses, two healthcare assistants, a secretary, a physiotherapist and a medical consultant. The group membership changed over time for a variety of reasons, including sick leave, retirement and leaving the organisation.

Programme structure

The programme was structured over 12 months and centred around 10 'programme days' of learning and development (Table 1). Each of these days incorporated three hours of facilitated active learning with the core group on the identified themes. While the programme appears linear in design, each session incorporated elements of previous learning and responded to the learning and development needs of the participants. The focus of each programme day and the activities engaged in were informed by the work of Dewing, McCormack and Titchen (2014).

Table 1: Programme days of learning and development

Day	Programme day theme	Programme day focus and active learning/practice development activities
1	Knowing and demonstrating values and beliefs about person-centred practice	<ul style="list-style-type: none"> • Reflection on own values and beliefs • Identifying the values and beliefs of all who work in and receive services from the hospice • Putting values and beliefs into practice
2	Developing a shared vision for person-centred practice	<ul style="list-style-type: none"> • Setting up a practice development coordination group • Creating and sharing personal and organisational visions • Development of an organisational vision statement
3	Developing teams and building an effective culture of person-centredness	<ul style="list-style-type: none"> • Observations of care and patient/staff stories • Identifying personal and group attributes • Recognising the context in which care is delivered
4	Introduction to evaluation	<ul style="list-style-type: none"> • Developing evaluation questions • Methods for gathering evidence in the care setting • Observations of care (Workplace Culture Critical Analysis Tool) • Patient and staff stories • Giving and receiving feedback
5	Working with stakeholders in co-designing a person-centred service	<ul style="list-style-type: none"> • Maintaining identity in the care setting • Compassion, dignity and choice • Drawing on multiple voices • Reflective learning • Evaluation
6	Action planning	<ul style="list-style-type: none"> • Linking the Person-centred Practice Framework, practice development model and action plans • Identifying indicators to prioritise action planning
7	Mini-projects	<ul style="list-style-type: none"> • Translating the action plans into action through 'mini-projects'
8	Learning in the workplace	<ul style="list-style-type: none"> • Creating a person-centred learning environment • Giving and receiving feedback • Active learning processes • Reflective practice – key processes
9	Sharing and celebrating	<ul style="list-style-type: none"> • Acknowledging achievement • Acknowledging and celebrating achievements in the working day • Sharing and celebrating with local communities
10	Follow-up evaluation three months post day 9	<ul style="list-style-type: none"> • Reengagement with practice development group • Workplace Culture Critical Analysis Tool (WCCAT)

Evaluation

The processes and outcomes were evaluated within a collaborative framework, drawing on reflective dialogue data between lead facilitators and programme participants, individual interviews with key stakeholders and observations of practice made using the Workplace-culture Critical Analysis Tool (WCCAT) (McCormack et al., 2009b). The aim was to gain insight into the deeper layers of culture and person-centred practices. We identified a 'starting point' to collect data at the beginning of the programme – this occurred after the group had developed a shared vision of person-centredness in the hospice. Data were collected during October 2016 by a research assistant who was neutral to the programme. Four observations of practice were undertaken in the day unit, one in the hospice reception area, one in the staff canteen, 21 in ward 1 and 24 in ward 2. Each period of observation lasted 30 minutes. A total of 28 individual interviews were conducted, each lasting between four and 24 minutes. Interview data were collected from 15 members of staff, including 11 nursing staff, a medical doctor, two catering staff and a member of the reception team, as well as seven patients, two family carers and four volunteers.

Following the 'starting point' period of data collection, the participants agreed to ongoing collection of data that would capture the embeddedness of the culture changes as the programme progressed. These included: practice illustrations and graffiti boards to capture examples of person-centred practices observed by anyone who wished to contribute; 'sit down' and 'walk around' observations using WCCAT; patient and staff stories that were recorded and transcribed; and use of existing data, such as compliments, complaints and surveys of patient and staff.

Data gathered using these multiple methods were analysed to identify required changes in the practice culture at the beginning of the programme, as a means of providing a starting point for comparing the findings of ongoing evaluations. Patient and staff stories were analysed by the Queen Margaret University research assistant. WCCAT data were analysed as a participatory process among the programme participants using creative hermeneutic data analysis (Simons and McCormack, 2007; Boomer and McCormack, 2010). Findings were compared with the starting point data to determine further action. All data were mapped onto a matrix we developed derived from the Person-centred Practice Framework (McCormack and McCance, 2017), so that two matrices were used to compare the data at the starting point and periodically as the programme progressed (an example of the mapping matrix from the starting point data is presented in Appendix 1). In addition, analysis of the development data was undertaken with the participants and the external facilitators. The participants identified the specific activities they had engaged in, reviewed/considered the data they had collected to inform these developments and together with the external facilitators reflected on how this impacted on the culture. Practice examples from the graffiti boards were also reflected on. A timeline of changes was created to help the participants plot the journey over time and what had been achieved. At the end of the programme, the participants engaged in a collaborative reflective workshop where they identified outcomes of the culture transformation, identifying how this reflected their shared vision and their shared understanding of the reasons for this transformation. A framework of human flourishing was used to shape this reflective workshop. To ensure trustworthiness of the processes and outcomes, the core group worked collaboratively on all of the development methods, data analysis, sharing of findings, planning of development activities with others and reporting on progress.

Ethical approval

Ethical approval to conduct the study was secured from QMU ethics committee and the Marie Curie research group.

Findings: unfolding a story of flourishing

Human flourishing occurs when we bound and frame naturally co-existing energies, when we embrace the known and yet to be known, when we embody contrasts and when we achieve stillness and harmony. When we flourish we give and receive loving kindness (McCormack and Titchen, 2014).

The term 'human flourishing' can be traced back to Aristotle, who suggested it occurs 'when a person is concurrently doing what he [sic] ought to do and doing what he wants to do'. Aristotle's moral perspective of human flourishing is at the heart of what it means to be a healthcare practitioner, with a moral requirement to do and want to do the right thing for others. McCormack and Titchen (2014) argue that to achieve this outcome requires an understanding of what is required of us as practitioners (the evidence that informs our practice) alongside an ability to want to do what is the right thing and to enjoy doing it. McCormack and Titchen built on this Aristotelian position and through a process of critical creative inquiry, identified eight conditions for persons to flourish:

1. Bounding and framing
2. Co-existence
3. Embracing the known and yet to be known
4. Being still
5. Living with conflicting energies
6. Embodying contrasts
7. Harmony
8. Loving kindness

We use these eight conditions for human flourishing to represent the processes and outcomes arising from the transformational practice development programme reported in this article.

1. Bounding and framing

McCormack and Titchen (2014) suggest developing a 'frame' of reference for both how we see the landscape (the culture) of the setting and the direction of travel we need to adopt to enable the subtleties of the landscape to be observed, engaged with and lived. A developed understanding of the need to pay attention to the existing culture of practice to enable person-centred services to evolve was required. Thus the journey began by the group getting to know each other, not by their job role, but as people. This is fundamental to person-centred practices and is a way of encouraging people to engage authentically with each other and to achieve connectivity, which Gaffney (2011) suggests is vital to human flourishing. Establishing a safe environment for open and personal sharing is critical to this activity, as persons will only share what they feel safe to share in a supported environment, and without this safety they will not flourish. Each member of the group was invited to create their own self-portrait, using creative materials. This proved to be enlightening and fun. At the time, the group felt too much time had been devoted to this activity but they came to know this was part of establishing the path on which they would journey, and they often referred to elements of 'knowing' each other they had developed through this activity. The portraits exercise also enabled the basis of a discussion about shared values to be developed.

Person-centred cultures are rooted in explicit values, which are reflected in a shared vision. This vision would become the evaluative statement, central to the work of the programme. Individuals in the group were encouraged to undertake a values clarification exercise (Warfield and Manley, 1990). The dialogue that followed this activity enabled the group to establish ways of working together in a person-centred manner. They also developed three different vision statements in small groups that reflected their espoused values. They recognised they would have to find ways of engaging with all stakeholders, including patients, carers, volunteers and staff, to ensure everyone's voice was heard and for the values to be truly shared. They were encouraged to repeat the process within their own areas of practice using creative methods as they saw fit. The group used graffiti boards, existing formal meetings, conversation and imagery and the same written values clarification exercise. The data collected were analysed using critical creative hermeneutic analysis by the group members and the facilitators. Key values were extracted and compared with the initial vision statements. The group then worked together to develop a shared vision statement that would serve as the anchor of the programme:

'Our vision for a person-centred culture is one that enables individuality, promotes autonomy and encourages aspirations in a secure and supportive environment.'

2. Co-existence

The core group used the vision statement as a marker of the existing culture. Data were collected and analysed to understand what needed to be done to realise the vision. Being attuned to the connections that exist in the care setting enabled the group to recognise when disconnections were happening and to rise to the associated challenges. Through dialogue, the data collection and analysis methods described earlier were agreed on. Through a process of critical creative hermeneutic analysis, the core group worked with the starting point data matrix and identified five overarching themes:

- Knowing the person
- Promoting individuality
- Balancing routines with informed choice
- Team effectiveness
- The physical environment

Knowing the person

The theme of 'knowing the person' reflected the extent to which staff in the hospice made efforts to know patients and families. Observations reported:

'A very good rapport exists between the patients and the staff. No one is talked down to. They are all treated as adults.'

Not only did these data demonstrate the determination of staff to maintain patient independence, they also highlighted the respect the staff had for maintaining patient dignity. Members of staff offered a personal touch to the care they provided:

'Every day I say to them, what's on the menu... I said no, not soup. She says wait a minute and I'll ask the chef what he's got; and she came back as she says omelette. I said stop before you get anywhere else... an omelette... it was one of the best foods, meals I've ever had. Brought out by the cook you see, now he obviously had the time to do it; but he brought it out and said, how did that do you?'

In an interview, a patient commented:

'One thing I have noticed, the nurses often don't get five minutes' peace, but when they do they don't go away and have a cup of tea, they come and chat with the patients just to see how their day is going and to give them a bit of company, the ones that don't get visitors.'

Promoting individuality

Enabling patients to express their individuality was generally a positive aspect of services at the hospice. In one interview, a member of staff stated:

'I think it's sometimes difficult for patients to realise that they're actually allowed to do that here (express individuality). Especially (comparing to acute care) for prolonged stays in more acute settings where you do have to fall into a bit of a routine. ...I think that a lot of patients... not exclusively but especially older patients have this thing that they can't cause too much trouble, and sometimes you have to encourage people and say... well actually it's for our benefit as well if you're as happy as you can be while you're here.'

The 'problem' of some patients not understanding that they were permitted to ask for things, and that it was part of the service that the hospice provided, was a challenge. Most members of staff agreed that they were providing individualised care but some believed that they could be doing more. One such comment stated:

'I think there are certain aspects that I would like to see changed to see people express their individuality more... so things like people using their own bed linen.'

However, some members of staff were cautious about increasing the individuality within the care setting and establishing where the line should be drawn. One gave the example of how to ensure a safe infection control environment so that the environment remains 'functional and safe', while offering a person-centred approach to their care:

'I think the ward team is respectful of people's individuality and are open to different cultures and beliefs, lifestyles. And we are flexible to a large degree about enabling people to continue their own lifestyles, even if that includes extremes such as drug taking... but then there has to be boundaries and sometimes those boundaries are quite broad.'

Staff were observed to endeavour to respect the beliefs and wishes of each patient:

'We try to give the patient what they want... their faith, their dietary... they will be accommodated... their dog in, family to be involved in their care... we try to accommodate but we also try to encourage.'

'There was a guy on the ward..., he liked his halal diet and he only liked it at half seven at night.'

However, some interview data suggested that there could be disagreement among family members regarding the care of their loved one. One such comment stated:

'The needs of families get lost in the mix of things. We do our best, sometimes they have different ideas of what they want. Some patients want to go home and the family can't cope. Sometimes we've got to manage that and it's a bit off sometimes.'

Overall, the staff at Marie Curie attempted to promote autonomy and individuality with patients, whenever it was safe and feasible to do so:

'So I said to the patient, you don't give yourself enough credit when you're able to do things... and to encourage them instead of underestimating what they are able to do. And they come back and say, yes you're right.'

Balancing routines with informed choice

One key message that came from the feedback was that staff took steps to enable them to spend more time with the patients, and ensured that the patients' dignity was preserved. One member of staff said:

'He (patient) was quite confused and agitated this morning, worrying about clothes and things. And I had that time to sit down and explain... you don't need to worry your wife. Here it is great, you can take that time to find out, especially if something is worrying someone.'

One relative offered their personal experience of this by commenting:

'The Marie Curie staff treat Mum with respect, I can't complain about anybody. The care she has had is excellent. Pretty fantastic really.'

It was subsequently observed that many members of staff took precautions to ensure that patients' dignity was maintained when talking to relatives, or to other members of staff about the patient. This is evident in the observations:

'A doctor is talking to relatives in the corridor. She is discreet and their voices do not travel.'

'A patient is receiving one-to-one care; I could not tell what kind of care it was. I could not hear the voices of the staff inside. Well done.'

'The voices of the receptionists don't travel, maintaining good levels of confidentiality.'

One key theme that was encouraging was the comments that elaborated on the staff members' attitude and approach to care. One commented:

'I've often seen the consultant on the ward round ask patients about drugs and other aspects of care...they'll be asked their permission... they don't just take the [care record] and say, we're going to give them this today... permission is always sought from the families as well.'

There were many responses identified that demonstrated that the staff in the hospice include patients in any decisions regarding their care:

'When do they want to wash, if they want papers in the morning, like a routine for us but also for the patients as well, if they want to stay in bed for breakfast? Do they want a wash today? You've just got to ask them what they like... If they want it in the afternoon that's fine... if they want it in the evening, that's fine.'

Another member of staff stated:

'I know you are here to promote person-centred care and I do think that for the patients. I always think the patient is the person that makes the decisions... they're in charge of themselves.'

From these two statements, it is evident that patient choice and independence were encouraged by the staff. Furthermore, the members of staff encouraged individuality and respected patients' beliefs. In an interview, a patient stated:

'Pastor came to visit when I first came as I am a Roman Catholic. I asked if I could have communion. He was very helpful to me. He came back on the Monday to see if all was as I had wanted.'

Team effectiveness

There were many positive examples of staff co-operation and multidisciplinary working observed, including:

'The other ward is short of staff and requests staff to help with jobs that require two nurses. The staff on this ward quickly find someone who is not too busy to send down.'

However, in other comments staff stated:

'Sometimes HCAs don't understand why SNs can't do washes'

'Members of the team not valuing other's roles, Domestic trying to do their job but no discussion with them during this with nursing team on the floor.'

This highlights that there was a lack of understanding of the roles of other health professionals on the wards. The perceived 'value' of the contributions offered by different members of staff was raised. One member of staff stated:

'If you treat your staff well and are flexible with them, then they will give back to you in return. If staff are constantly denied the opportunity of flexibility then they become resentful and eventually leave to work elsewhere. There needs to be a culture of trust and respect so that you know if you are flexible then people won't take advantage of it.'

There were some observations made of members of staff 'moaning' about new staff that had been appointed, and attempting to drag other members of staff into the conversation. Some staff expressed that they believed that the roles of the various multidisciplinary teams should be explained to the different staff on each ward. Another said that an understanding of how the hospice and day services interlink, and the services they provide, should be made clear.

Many members of staff reported that they were 'Generally very happy. I really enjoy my job and I love my team.' However, in the narrative interviews, different views were expressed about staff communication in the hospice:

'Some HCAs are excellent at communicating concerns with patients.'

'Some HCAs are poorer at communicating.'

'I feel that HCAs are undermined.'

One member of staff reported that:

'Communication is something that is continually discussed as an issue. Sometimes it's not clear when to communicate with the different departments and often small communication errors occur, for example, keeping reception informed about incoming patients, etc.'

Another member of staff stated that:

'Communication could be better about things happening for staff, to avoid problems. In certain areas some people have a sense of entitlement and don't appear willing to contribute or support other people.'

During a narrative interview, one relative complained that:

'My mum has dementia and some of the agency staff have treated her like a child – wash your hands now, smell them. Oh they smell lovely.'

In an interview a member of staff said they felt they were being undermined by the changes that were being made to the hospice, and that the management was not listening to their concerns. The staff held predominantly negative views of the ward staffing levels; several believed there were often not enough staff on the wards, and as a result *'some patients have to wait for things.'*

Overall, most members of staff made positive comments about working at Marie Curie:

'I enjoy working here as it is a very worthwhile job and I am made to feel my contribution counts in what is quite a unique environment.'

Some staff members were leaving the hospice, which was attributed to problems with team effectiveness. Staff commented on the 'emotional labour' of the job and the need for greater staff support:

'Worst thing: Stress of working with a caseload. Emotional aspects of the job – sadness/loss.'

The physical environment

Many people commented on the visual aesthetics of the wards. These included the size of the rooms, the patients' views of the gardens, the balcony and the bright colours on the walls. One person said: *'The front door area is fresh, clean and bright.'* There were some comments about how to improve the overall visual impact of the hospice, pointing out that the lighting in some rooms appeared very dim, that there were no pictures or decorations on some of the wards, that some rooms had no visual outlook and that there were dead/dying flowers left in a room.

Comments and observations were made regarding the sounds that were heard while on the wards. Such comments reported that the rooms were quiet, that the patients were heard chatting to one another in the side rooms, that the staff tried not to speak too loudly, and that the phones on the ward did not ring too loudly. It was observed, however, that there were a lot of noises coming from a machine just off the wards. The patient call-bells at times were too loud and *'pierced the silence'*. Furthermore, a member of staff reported that the wards were at times noisy and that the staff voices travelled easily. One observer reported hearing *'laughter and humour'* while on the ward.

There were many comments regarding the different odours present on the wards, including at times, the *'stale smell of faeces and urine'*. However, others commented on the smells of wood, lemons, sawdust, warm scones or the general aroma of dinner. Overall, members of staff and the observers found the wards to be *'calm and peaceful'* environments.

Summary

The different data collected largely demonstrate a positive experience for patients and families. The intent to provide individualised and person-centred care is obvious in the data, and the efforts staff go to to that effect are recognised by patients, families and co-workers. However, the theme of 'team effectiveness' revealed issues pertaining to teamworking, communication and consistency of approach, as well as some issues concerning the general hospice environment. This suggests a focus on person-centred care without paying attention to the need for a person-centred culture. Each of these issues became developmental themes for the core group to work on, in collaboration with other members of the hospice team.

3. Embracing the known and yet to be known

The team was invited to engage with the data to raise consciousness of person-centred practices within the hospice. Interacting with the data was an important part of the process as, to flourish, they needed to understand elements of their own personhood. McCormack and Titchen (2014) suggest that, through a meaningful engagement with 'other', the hidden gems of our personhood can be revealed and made known to us. Following data collection and analysis of the initial data, the group felt they needed to pay attention to ongoing engagement of patients, staff and volunteers. They raised the issue of not knowing what Gaffney (2011) refers to as valued competencies, that is, they did not know about each other's talents. They used the hospice's summer fête to find out about each other, their strengths and willingness to contribute. The group recognised that it is these hidden aspects of persons that need to be surfaced to create a culture that enables all persons to flourish. This event was also used as an opportunity to model person-centredness by enabling all persons associated with the hospice to express those aspects of 'self' that shaped them as persons – their beliefs, values, needs, wants, desires, hopes and dreams. These were reflected in the consideration of the areas for development and how the different talents of staff could be maximised and used as assets to the ongoing development of the person-centred culture of the hospice. 'Mini-projects' were then established, each led by a member of the core group and working in collaboration with members of staff from across the hospice services. Some examples of these are found in Table 2.

process (Dewing, 2010). Working together creatively enabled the core group to come to understand the efficiency of creative ways of working and that they could use similar methods to engage patients, families, other staff and volunteers. By doing this from the beginning, the programme became a collective endeavour with all stakeholders and a platform for shared decision making. By module 3, members of the group reported feeling 'things were beginning to happen' a person-centred learning environment was emerging and, rather than waiting for concrete plans, they had begun examining their practice and seeking local solutions. While evaluating the session by writing a haiku, Participants wrote:

*Much less confused now
Positive about the future
Have the team working*

While another member wrote:

*Lots of work to do
Championing. Excited.
Yes I can do it!*

During an assessment of the workplace culture and context (Manley et al., 2011), there was recognition of using the shared vision as an evaluative statement and that they could work together to find out what the existing culture and context of care was like, and take ownership of developing person-centred practice. By analysing the data themselves, the group also recognised that themes relating to person-centred care emerged, but team relations were less visible. The facilitators helped the group to consider how they would collect further data by modelling person-centred practice and a holistic style of facilitation (Rycroft-Malone et al., 2016).

Conflicting energies emerged in a perceived dissonance with the organisational values and some concern about the inaccessibility of the language around person-centredness. Rather than seeking to explain, the facilitators opened dialogue where group members were encouraged to voice their concern and try, through dialogue, to question their thinking. They decided that it was important not to lose any of the voices that had contributed to the shared vision, otherwise this would impact on shared ownership. They also decided to update other stakeholders by identifying how their contributions were visible in the early work.

Being still

Making dedicated time for the programme was challenging because of the busy hospice environment. Despite the commitment of the team, attendance at the core group sessions was variable. Throughout the programme, the group met at additional times to take the work forward. Creating spaces for quiet reflection and stillness is a real challenge in busy healthcare environments, yet creating spaces for quiet reflection, critical engagement and meaningful connection with others are essential elements of an environment that enables all persons to flourish. One example of this is the work the team did to develop Schwartz rounds.

Schwartz rounds (tinyurl.com/PointofCare-Schwartz) were introduced to the hospice almost in parallel with the person-centred cultures programme, and the programme provided an effective platform for integrating the Schwartz rounds with the other person-centred developments. Their aim, as advocated by the Point of Care Foundation, was to provide a structured forum where all staff, clinical and non-clinical, came together regularly to discuss the emotional and social aspects of working in healthcare. Rounds were generally well attended by staff from clinical and non-clinical areas (20-30 people usually, although 90 when person-centredness was the topic). Feedback was sought from practitioners:

*'Thought provoking' 'Touching, relevant, poignant' 'Thoroughly enjoyed taking part'
'Fab discussion – lots to take away and think about' 'Good to share and learn together'
'Very good, made you stop and think about things, which I think is useful during a busy day'
'Really gave insight in to the value of the team' 'Nice to hear the human side of people'
'Good to hear different perspectives' 'Helps me better understand my work environment'
'Inspiring and bonding' 'I think we are getting better at sharing our thoughts and our fears'
'Very much enjoyed the stories from staff working in different areas/departments of the hospice.
Gave a most enjoyable and welcome insight into their roles and the impact this has on people's
lives, working in our unique setting of the hospice. Sharing is supportive and very worthwhile. Look
forward to the next Schwartz round'*

An example of how learning became a facilitated activity in the hospice, demonstrating a shift towards a person-centred culture, was the introduction of moments of stillness for healthcare assistants to reflect. The aim was to uncover patterns of practice – positive, person-centred, as well as ritualistic, task-focused practices. During the workshops, the healthcare assistants were also encouraged to think about their core values and agree new ways of working, together and in the wider team. Critical questions that arose from the sessions were captured for broader dissemination with the team and formed the basis of action plans.

Embodying contrasts

Feeling respected and showing respect are key ingredients of flourishing. Being respected as a person enables growth while simultaneously creating the conditions for the demonstration of respect for others. As well as identifying changes to practice and teamworking, members of the core group identified specific learning arising from the programme of work. A template with key questions was distributed to all group members to complete. Key learning from staff mainly focused on recognising that person-centredness is not just person-centred care, but is a way of being when engaging with all others. Following the programme one person identified:

'I understood better what person-centredness within the staff looked like and what it should feel like.'

Another reflected:

'I have learned how important it is to step out of the comfort zone in a focused way to really see what we are doing and how it might be different. I have also learned how important it is to use relevant examples to demonstrate how person-centred care has embedded in our hospice rather than trying to explain what it is!'

Participating in the programme also led to the use of more person-centred language:

'I use the words 'person centred' a lot more now! It has made me think more about other people's roles and how what I do impacts on them, and how their role impacts on my role.'

Others identified that they were surprised how much the focus was on the team and that is where the biggest changes seemed to have been made:

'I don't think it has changed my practice but I have seen very positive changes in a number of clinical and non-clinical colleagues in terms of engagement with, and feeling more part of, the hospice team.'

Perceived changes around language and the sense of team were expressed:

'I think most staff are aware of person-centredness now, even if they don't really realise it! People have definitely been talking about person-centred approaches to things when maybe they might not have before. I think staff are realising as well that it applies to them too, not just the patients.'

There is more understanding of different roles now as well, although this could be improved I reckon. The sense of being part of a team and being valued as part of that team has significantly changed for the better for some staff. There is a willingness to consider and understand other's roles and an awareness that this is an important part of working in the hospice. Notable outcomes have been the new induction model and a huge amount of teambuilding energy coming from the admin team!

Harmony

There is no beginning and no end to flourishing (McCormack and Titchen, 2014). Acknowledging this brings dynamism to practice that responds to the context and the persons who shape that context. It creates a dance between the specifics of practice and the vision for transformation. It is also reflected in indicators of success collected from multiple sources. In this programme, we used routinely collected data to demonstrate outcomes arising from the practice development work undertaken.

In May 2017, there was an unannounced inspection by regulator Health Improvement Scotland (HIS) (tinyurl.com/HIS-MC-Edinburgh). The 2016 HIS report for the hospice had made nine recommendations particularly around staff wellbeing and patient and family involvement in care planning. In the 2017 report, having invited comments from patients and families, HIS scored the hospice as excellent in four of the five categories, and 'very good' in the fifth. The report commended the hospice on a positive environment, noting culture, and effective teamworking where staff felt valued and respected. HIS noted evidence of a culture where feedback is sought and valued.

The transformation of the culture was also revealed in a review of complaints. There was a drop in the number of complaints from 30 in 2016 to 18 in 2017. What was remarkable in the 2017 review was a renewed approach to handling complaints that paid attention to reflecting and learning on the process of complaints, as well as responding to individual feedback. There was a sense of openness to change. Some examples included improvements to hospice procedures, environmental changes addressing safety issues and improved pathways of communication with patients and staff in community teams.

In response to a high staff turnover and some instability in the hospice inpatient unit, during 2015 and early 2016, a six-month pilot was implemented, creating two supernumerary practice development and research nurse (PDRN) posts. The aim of these roles was to improve retention rates and staff wellbeing through mentorship and support, particularly for newer and less experienced nurses. Retention rates were scrutinised during and following the PDRN pilot: the number of nurses leaving the hospice fell by 40%. This followed a period of stability in the inpatient unit.

Towards the end of the programme in July 2017, all staff were invited to complete a short survey about the workplace culture of the hospice. A total of 28 (24% of staff) responded, almost two-thirds of whom (60%) said that they felt the culture had become more person centred. While many cited 'patient-centred' caring, there were reports of person-centred culture among the responses:

'There is an increased willingness to discuss and give feedback in an open and honest environment without fear of being judged or ignored.'

A new member of the team reported:

'From my time of working here, I can see the person-centre culture being at the forefront of Marie Curie. One example is when we helped organise [a celebration] for a patient's relative's birthday... the family were very appreciative and [now have] fond memories of the hospice.'

Some survey responses revealed examples of 'task-focused' rather than 'person-centred' approaches to care continuing in the wards:

'Still a lot of staff feeling every patient needs to be washed in the mornings when it's a 24-hour service. Can be done when time is right for patient. Also, breakfast tray going out early in the morning. Feel trays should be put out when receiving breakfast, not at 6am in the morning.'

Some staff highlighted that new ways of working including the newsletter, staff events, activities and graffiti boards had contributed to a sense of connectedness. A member of the kitchen staff said:

'Staff seem to be a bit more aware of their job roles and what impact they might have on them. Staff seem more friendly, especially some ward staff.'

There were examples in the data of cross-team working, for example, fundraising, increased participation in hospice meetings and improved inspection results. In the survey, respondents were asked if they had noticed any changes within themselves; they revealed they were more aware of other people's needs, but also of their aspirations:

'I have a greater general awareness of other staff and their experiences/what motivates them/challenges them. Broader perspective in general.'

'I try to think more out of the box when it comes to solutions. I try to be more mindful of how I might impact on others.'

Knowing each other better emerged from several quotes. One nurse commented:

'Among the staff at the hospice, I think there is more awareness of, and attention paid to, each other – names, experiences, life stories and aspirations. Time is taken to listen, talk and empathise. The whiteboards provide an opportunity to share information and learn more about each other.'

Individuals in the core group captured changes in their perspectives and key learning. This is captured in the messages shown in the photographs on the next page.



Next steps

Harmony is reflected in the embeddedness of the person-centred culture. The core group has ongoing plans to continue to develop practice. Mini-projects are becoming part of everyday practices. There is a commitment to sustaining ways of working and to development of the core group to include more members across the hospice. When asked what they would like to see happen next, two participants responded:

'I'd like to see more things being done to bring staff together (if they want to obviously!) and more staff taking a lead in this, not just the same people. I'd like to see development of respect, recognition and understanding of roles, especially towards non-clinical staff' (BL).

'I would like to see a specific piece of work with the healthcare assistants that involves all of them. I would like the group to have a clear idea by December of how we maintain the momentum and how we establish the benefit for patient and families' (JS).

Celebrating success is occurring in several ways, including sharing with other hospices and community services within Marie Curie, as well as presenting to the executive team and stencilling the shared vision in the reception area. The summer fête in July 2017 was used as an opportunity to celebrate success and another celebration event was planned for spring 2018.

Loving kindness

The person-centred development at the hospice illustrates how a systematic, collaborative and inclusive approach to culture change can have wide-ranging effects on the lived experience. Using human flourishing as a framework has helped to get 'inside and underneath' the processes and outcomes, and demonstrate a holistic approach to the development of person-centred cultures that

keeps the person at the centre while dealing with improving areas of engagement and quality. This is consistent with the methodology of transformational practice development (McCormack and Titchen, 2014). In this methodology, the purpose is to transform cultures towards those where all persons flourish. Transformational practice development is person-centred in its philosophy and uses methods that respect persons' diverse natures, ways of being and processes of engagement. It is not a linear process, but instead aims to 'be with' participants in ways that respect each unique learning journey. Transformation is sustained through active learning (Dewing, 2008).

However, while this philosophy and methodology have laudable, holistic aims, a mechanistic and technical approach to creating change can override the core intent of transformation through learning. Indeed, this contradiction was evident at the beginning of this programme, when the group had a desire to see tangible changes in practice at the expense of transformation of ways of being through learning. As facilitators, this was challenging and 'holding the space' was important to enable perspective transformation and ongoing commitment to the agreed ways of working and the methodological approach. The framework of human flourishing provided a useful means of doing this, so that all activities could be understood through the concept of flourishing and how this happens and is sustained. For example, while many practice development programmes can have the intent of culture change and transformation, the focus can easily shift to completing individual (mini) projects and evaluating their impact – thus losing the wider picture of culture transformation. Indeed, a focus on mini-projects is advocated by practice developers as tangible evidence of the translation of new learning into practice (Dewing et al., 2014). In this programme, mini-projects were developed (see Table 2), but they were understood in the context of 'embracing the known and yet to be known' and so were platforms for reflection, analysis and increasing engagement rather than 'ends' in themselves. These mini-projects provided a wide range of opportunities to demonstrate a holistic approach to person-centredness and a shift from providing person-centred care to the development of a person-centred culture that can sustain such caring practices (McCormack et al., 2010).

The relationship between person-centred care and person-centred cultures was particularly interesting in this programme. At the time when this work commenced, the results of a national patient survey by Marie Curie Care suggested high levels of patient satisfaction with care provided in the Edinburgh hospice. This was in part reinforced by the patient story data emerging from this programme. More significantly, however, our data revealed the lack of person-centredness experienced/felt by staff in the hospice and related services. This was a challenge at the beginning of the programme; some participants couldn't see the point of it, given the high levels of patient satisfaction. McCormack and McCance (2010, 2017) have consistently argued the need for a person-centred culture to sustain person-centred care, and this argument was pertinent to the culture of this care setting. The organisation's data demonstrated high levels of satisfaction among patients but not among staff. Evidence of this existed in the narrative data of this programme and this data reflected informal communications in the setting up of the programme and staff satisfaction and retention data maintained by the hospice itself. This lack of staff satisfaction drove the need for this programme and the desire to address the culture of the care setting. As a result, programme evaluations demonstrated little effect on person-centred care but significant improvement in staff satisfaction and the overall care culture of the service, as illustrated through the staff survey and the HIS quality monitoring report.

The existence of person-centred care in the absence of a person-centred culture is quite a conundrum. Buetow (2016) has argued that it raises moral questions that organisations need to address: can staff be sacrificed to achieve the outcome of person-centred care? The hospice leadership and management team were not comfortable with this – the continuous loss of staff from the organisation while patients and families remain satisfied with their care. This dilemma in organisations is not always addressed explicitly in the way that this team chose to, resulting in organisations espousing a person-centred philosophy, while in reality focusing on patient-centredness (Buetow, 2016). It was a revelation to most of the participants in this programme that person-centredness was about more than patients

and that staff had a right to consider these values for themselves. Other studies, particularly those operationalising the values of 'Magnet Hospitals' (Aiken et al., 2008), Planetree (Gilpin et al., 1991) and Culture Change (Scalzi et al., 2006) recognise the need for staff to be treated with respect and dignity as a means of improving the quality of care experience for patients. However, this approach privileges one person over another and uses one as a means to the other's end (Paton, 1971). The results of this programme demonstrate an equalising of perspectives and respect for the personhood of all those engaging with the service, irrespective of role, and the creation of a person-centred culture that can be sustained over time.

McCormack and Titchen (2014) suggest that this kind of culture represents the eighth condition for human flourishing – loving kindness:

'Loving kindness lies at the heart of flourishing; loving kindness towards oneself and others in the contexts and situations we find ourselves in our work. Speaking loving kindness is like feeling breeze on our faces, hearing the rustle and brushing of grasses and leaves as the wind gusts and lulls. It is something that is sensed more than actually spoken although it can be heard in the tone of voice, in the softness of the eyes and in compassionate acts. Loving kindness warms our hearts as the sun warms the earth and all living things.'

Conclusions

In this article, we have provided a detailed account of the processes and outcomes of a programme specifically designed to develop a person-centred culture in a palliative and end-of-life care service. The programme used a transformational practice development approach for the development of a person-centred culture and a framework for human flourishing as a means of analysing processes and outcomes. The programme demonstrated the importance of person-centred cultures for sustainable person-centred care; the creation of such cultures is imperative if sustainable person-centred care is to be made a reality. Human flourishing is a desirable moral goal in organisations, recognising the need for the personhood of all persons to be respected. If we are to move beyond the rhetoric of person-centredness and truly embrace its values, then the continuous articulation of 'patient-centredness disguised as person-centredness' needs to end. We believe that the transformational engagement processes used in this programme offer a means of achieving this goal.

References

- Aiken, L., Clarke, S., Sloane, D., Lake, E. and Cheney, T. (2008) Effects of hospital care environment on patient mortality and nurse outcomes. *Journal of Nursing Administration*. Vol. 38. No. 5. pp 223-229. <https://doi.org/10.1097/01.NNA.0000312773.42352.d7>.
- Boomer, C. and McCormack, B. (2010) Creating the conditions for growth: a collaborative practice development programme for clinical nurse leaders. *Journal of Nursing Management*. Vol. 18. No. 6. pp 633-644. <https://doi.org/10.1111/j.1365-2834.2010.01143.x>.
- Buetow, S. (2016) *Person-centred Health Care: Balancing the Welfare of Clinicians and Patients*. Oxford: Routledge.
- Dewing, J. (2010) Moments of movement: active learning and practice development. *Nurse Education in Practice*. Vol. 10. No. 1. pp 22-26. <https://doi.org/10.1016/j.nepr.2009.02.010>.
- Dewing, J., McCormack, B. and Titchen, A. (2014) *Practice Development Workbook for Nursing, Health and Social Care Teams*. Oxford: Wiley-Blackwell.
- Fay, B. (1987) *Critical Social Science: Liberation and its Limits*. New York: Cornell University Press.
- Feinberg, J. (2014) Wordle. Retrieved from: wordle.net
- Gaffney, M. (2011) *Flourishing*. Dublin: Penguin.
- Gilpin, L., Nelson, K. and Schweitzer, M. (1991) A healing environment: the Planetree hospital project at San Jose Medical Center. *Journal of Healthcare Interior Design*. Vol. 3. pp 139-148.
- Independent Cancer Taskforce (2015) *Achieving World Class Cancer Outcomes: A Strategy for England – 2015-2020*. Retrieved from: tinyurl.com/ICTstrategy-2015-2020 (Last Accessed 23rd March 2018).

- Leadership Alliance for the Caring of Dying People (2014) *One Chance to Get It Right: Improving Peoples' Experience of Care in the Last Few Days and Hours of Life*. Retrieved from: tinyurl.com/one-chance-LACDP (Last accessed 23rd March 2018).
- Manley, K., Sanders, K., Cardiff, S. and Webster, J. (2011) Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Practice Development Journal*. Vol. 1. No. 2. Article 1. pp 1-29. Retrieved from: fons.org/library/journal/volume1-issue2/article1 (Last accessed 23rd March 2018).
- Marie Curie (2015) *The Clinical Workforce Strategy, Learn and Develop Strategy and People Strategy*. London: Marie Curie. Retrieved from: tinyurl.com/mariecurie-2014-19 (Last accessed 12th January 2018).
- Mekki, T., Øye, C., Kristensen, B., Dahl, H., Haaland, A., Aas Nordin, K., Strandos, M., Terum, T., Ydstebø, A. and McCormack, B. (2017) The interplay between facilitation and context in the Promoting Action on Research Implementation in Health Services framework: a qualitative exploratory implementation study embedded in a cluster randomised controlled trial to reduce restraint in nursing homes. *Journal of Advanced Nursing*. Vol. 73. No. 11. pp 2622-2632. <https://doi.org/10.1111/jan.13340>.
- McCormack, B. and Titchen, A. (2006) Creativity: melding, exploding, blending. *Educational Action Research*. Vol. 14. No. 2. pp 239-266. <https://doi.org/10.1080/09650790600718118>.
- McCormack, B., Dewing, J., Breslin, L., Coyne-Nevin, A., Kennedy, K., Manning, M., Peelo-Kilroe, L. and Tobin, C. (2009a) Practice development: realising active learning for sustainable change. *Contemporary Nurse*. Vol. 32. Nos. 1-2. pp 92-104. <https://doi.org/10.5172/conu.32.1-2.92>.
- McCormack, B., Henderson, E., Wilson, V. and Wright, J. (2009b) The Workplace Culture Critical Analysis Tool. *Practice Development in Healthcare*. Vol. 8. No. 1. pp 28-43. <https://doi.org/10.1002/pdh.273>.
- McCormack, B. and McCance, T. (2010) *Person-centred Nursing: Theory, Models and Methods*. Oxford: Blackwell.
- McCormack, B., Dewing, J., Breslin, E., Coyne-Nevin, A., Kennedy, K., Manning, M., Tobin, C. and Slater, P. (2010) Developing person-centred practice: nursing outcomes arising from changes to the care environment in residential settings for older people. *International Journal of Older People Nursing*. Vol. 5. No. 2. pp 93-107. <https://doi.org/10.1111/j.1748-3743.2010.00216.x>.
- McCance, T., Gribben, B., McCormack, B. and Laird, E. (2013) Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme. *International Practice Development Journal*. Vol. 3. No. 1. Article 2. pp 1-17. Retrieved from: fons.org/library/journal/volume3-issue1/article2 (Last accessed 10th April 2018).
- McCormack, B., Titchen, A. and Manley, K. (2013) The contextual web of practice development. Chp 14 in McCormack, B., Manley, K. and Titchen, A. (Eds.) (2013) *Practice Development in Nursing*. (2nd edition). Oxford: Wiley-Blackwell. pp 275-295.
- McCormack, B. and Titchen, A. (2014) No beginning, no end: an ecology of human flourishing. *International Practice Development Journal*. Vol 4. No. 2. Article 2. pp 1-15. Retrieved from: fons.org/library/journal/volume4-issue2/article2 (Last accessed 10th April 2018).
- McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T., Porock, D., van Lieshout, F. and Wilson, V. (2015) Person-centredness – the 'state' of the art. *International Practice Development Journal*. Vol. 5. Suppl. Article 1. pp 1-15. Retrieved from: fons.org/library/journal/volume5-person-centredness-suppl/article1 (Last accessed 10th April 2018).
- McCormack, B. and McCance, T. (2017) *Person-centred Nursing and Health Care: Theory and Practice*. Oxford: Wiley.
- McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Titchen, A., van Lieshout, F. and Wilson, V. (2017) A kaleidoscope of hope: exploring experiences of hope among service users, families and practitioners in various health care contexts. *Holistic Nursing*. Vol. 35. No. 3. pp 247-258.
- National Palliative and End-of-life Care Partnership (2015) *Ambitions for Palliative and End-of-life Care: A national framework for local action 2015-2020*. Retrieved from: tinyurl.com/EOL-ambitions (Last accessed 23rd March 2018).
- Paton, H. (1971) *The Categorical Imperative: a Study in Kant's Moral Philosophy*. Philadelphia: University of Pennsylvania Press.

- Rycroft-Malone, J., Burton, C., Wilkinson, J., Harvey, G., McCormack, B., Baker, R., Dopson, S., Graham, I., Staniszewska, S., Thompson, C., Ariss, S., Melville-Richards, L. and Williams, L. (2016) Collective action for implementation: a realist evaluation of organisational collaboration in healthcare. *Implementation Science*. Vol. 11. Article 17. <https://doi.org/10.1186/s13012-016-0380-z>.
- Scalzi, C., Evans, L., Barstow, A. and Hostvedt, K. (2006) Barriers and enablers to changing organisational culture in nursing homes. *Nursing Administration Quarterly*. Vol. 30. No. 4. pp 368-372.
- Simons, H. and McCormack, B. (2007) Integrating arts-based inquiry in evaluation methodology: opportunities and challenges. *Qualitative Inquiry*. Vol. 13. No. 2. pp 292-311.
- Titchen, A., McCormack, B., Wilson, V. and Solman, A. (2011) Human flourishing through body, creative imagination and reflection. *International Practice Development Journal*. Vol. 1. No. 1. Article 1. pp 1-18. Retrieved from: fons.org/library/journal/volume1-issue1/article1 (Last accessed 10th April 2018).
- Titchen, A. and McCormack, B. (2008) A methodological walk in the forest: critical creativity and human flourishing. Chp 4 in Manley, K., McCormack, B. and Wilson, V. (Eds.) (2008) *International Practice Development in Nursing and Healthcare*. Oxford: Blackwell. pp 59-83.
- van der Eerden, M., Csikos, A., Busa, C., Hughes, S., Radbruch, L., Menten, J., Hasselaar, J. and Groot, M. (2014) Experiences of patients, family and professional caregivers with Integrated Palliative Care in Europe: protocol for an international multicenter, prospective, mixed method study. *BMC Palliative Care*. Vol. 13. Article 52. <https://doi.org/10.1186/1472-684X-13-52>.
- Warfield, C. and Manley, K. (1990) Developing a new philosophy in the NDU. *Nursing Standard*. Vol. 4. No. 41. pp 27-30.
- Yalden, J., McCormack, B., O'Connor, M. and Hardy, S. (2013) Transforming end-of-life care using practice development: an arts-informed approach in residential aged care. *International Practice Development Journal*. Vol. 3. No. 2. Article 2. pp 1-18. Retrieved from: fons.org/library/journal/volume3-issue2/article2 (Last accessed 11th November 2017).

Brendan McCormack (DPhil Oxon, PGCEA, BSc Hons, RMN, RGN, FRCN FEANS, FRCSI), Head of the Division of Nursing, Head of the Graduate School, Associate Director, Centre for Person-centred Practice Research, Queen Margaret University, Edinburgh, Scotland; Professor II, University College of South East Norway, Drammen, Norway; Extraordinary Professor, Department of Nursing, University of Pretoria, South Africa; Professor of Nursing, Maribor University, Slovenia; Visiting Professor, Ulster University.

Caroline Dickson (D HSSc, MSc, PG Cert Prof & Higher Ed, Dip DN, RN), Senior Lecturer, Division of Nursing, Queen Margaret University, Edinburgh, Scotland.

Tracy Smith (MSc Palliative Care, PG Cert Teaching and Learning in Higher Education, BSC Nursing), Practice Development Facilitator, Marie Curie Care, Edinburgh, Scotland.

Hilary Ford (OU Certificate in Management, PCGE in Adult Education, BSc Hons in European Studies with German), Hospice Manager, Marie Curie Care, Edinburgh, Scotland.

Steffi Ludwig (BSc Hons Physiotherapy), Physiotherapist, Marie Curie Care, Edinburgh, Scotland.

Rhona Moyes (BSc Palliative Care, RN), Clinical Nurse Specialist, Marie Curie Care, Edinburgh, Scotland.

Laura Lee (Diploma Nursing, RN), Registered Nurse, Marie Curie Care, Edinburgh, Scotland.

Elaine Adam (M Des and BA Hons Art), Health Care Assistant, Marie Curie Care, Edinburgh, Scotland.

Tracy Paton (BSc Nursing, RN), Charge Nurse, Marie Curie Care, Edinburgh, Scotland.

Brigid Lydon, Secretary, Marie Curie, Edinburgh, Scotland.

Juliet Spiller (MBChB, BSc(MedSci), MRCP), Medical Consultant, Marie Curie Care, Edinburgh, Scotland.

Appendix 1: Example from the data mapping matrix

Positive practice	
Professionally competent	<p>Staff story He (the patient) was quite confused and agitated this morning, worrying about clothes and things. And I had that time to sit down and explain... you don't need to worry your wife. Here it is great, you can take that time to find out, especially if something is worrying someone</p> <p>Observation There is a ward round going on. Their voices are quiet when out in the corridor and when around the person's bed. There is no intrusion of privacy to the patient or other patients around them. Their voices are quiet and don't carry</p>
Developed interpersonal skills	<p>Staff story I've often seen the consultant on the ward round ask patients about drugs and other aspects of care... they'll be asked their permission... they don't just take the kardex and say we're going to give them this today... permission is always sought from the families as well</p> <p>Staff story I think that by being approachable, flexible, relaxed attitude, yeah, and generally all the people that work here are good communicators and are good at putting people at their ease</p> <p>Patient story The staff are comfortable, very much so, couldn't be better</p>
Commitment to the job	
Clarity of beliefs and values	<p>Staff story If they request their own minister or other religious leader then the ward will welcome that person in</p> <p>Staff story The demeanour of the medical and nursing staff is that we're always approachable, and that we would always encourage people to voice their concerns and opinions if they felt strongly... And we do try to empower people to know the pros and cons of any treatment that we're initiating, and to make them feel that they are leading the care</p> <p><i>(Comment: do we make people feel they are leading but actually the professionals are?)</i></p>
Neutral practice	
Professionally competent	
Developed interpersonal skills	
Commitment to the job	
Clarity of beliefs and values	
Negative practice	
Professionally competent	
Developed interpersonal skills	<p>Staff story One of the things we could probably do better would be to try something like a screening tool for when they come in ... What matters to you?... I've started to ask each person I see now on admission, what's the most important thing we should know about you or what would you like us to know about you... I think that makes people feel listened to</p>
Commitment to the job	
Clarity of beliefs and values	<p>Observation A side room light is turned on because the room is dark. The patient was consulted but the healthcare assistant was determined that the light should go on. It is the patient's choice but I felt the patient was coerced to have the light on</p>