The translation of learning about person-centredness into practice from a community nursing preparation programme

Grant report

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Aim

The study aimed to explore the implementation of learning into practice about person-centredness of post-registration student and qualified community and public health nurses who had undertaken, a professional and educational qualification within a person-centred curriculum framework. Drawing from existing literature, we hypothesised there would be significant positive changes in the knowledge and practice of person centredness in qualified nurses as compared with students. We further hypothesised, these changes will be most prominent in the constructs/domains - clarity of beliefs and values, care processes and care outcomes of the Person-centred Practice Framework (PCPF) (McCormack and McCance 2017).

Sample

The research had ethical approval from Queen Margaret University Research Ethics Committee (REP 2020/4). Community and public health nurse graduates as well as current part-time and full-time students undertaking the current programme were invited to participate in the study. Purposive and convenience sampling recruited participants through existing networks (graduates) and through programme teams (students) during January and February 2022. There were 105 students on the programme at that time and approximately 279 graduates (from previous 5 years of the programmes). 67 respondents completed the survey

Potential student participants were invited to an introductory session giving an overview of the research purpose, aim and intended outcome. A written information sheet was then sent via email. Graduates were contacted through existing networks, professional lead nurses and social media with the written information. The study introduction included the following information – purpose of the study, voluntary participation requirements, consent forms, and a weblink to the online study. Upon clicking the link, participants were directed to the following information:

(i) Consent form –

(ii) Demographics form

(iii) Work environment –providing an open comment box for participants to include any other relevant information they wished to provide that they felt might not have been captured in previous sections. This includes information on current workplace, work environment, culture, and staff relationships.

(iv) Person-centred Practice Inventory (staff version (PCPI-S)

(v) Debrief page – This last page provided more information on the study and the contact details of the lead researcher should the participants wish to contact the researcher for more information on how their data would be used or for any other query they had regarding the study and their participation.

A summary of the sample size and demographics is provided in Table 1.

Table 1: Sample size and demographics

Qualification	Specialisation	Years since qualification (Avg)	Caseloads (Avg)	Sex (Number of Males)
Qualified (N = 22)				
	Registered Specialist Community Public Health Nurse - Health Visitor (N = 14)	3.14	1.86	0
	Qualified Specialist Practitioner District Nurse (N = 8)	1.62	1.25	2
Student (N = 35)				
	Student Specialist Community Public Health Nurse – Health Visitor (N = 13)	-	-	0
	Student Specialist Community Public Health Nurse – School Nurse (N = 9)	-	-	0
	Student Specialist Practitioner District Nurse (N = 13)	-	-	0
Incomplete (N = 10)	NA	NA	NA	NA

Setting

Postgraduate programmes within the Division of Nursing at our university in Scotland, UK are all philosophically and theoretically embedded in the mid-range theory of McCormack and McCance (2017) and specifically their Person-centred Practice Framework. It recognises and celebrates learners and facilitators' continued state of being and becoming, with the aim being promoting healthfulness, through the adoption of person-centred cultures and processes. We know from our programme evaluations (2015-2020) that community and public health nurses report the post-registration education programme prepares them for person-centred practice and to become leaders in developing person-centred cultures in their workplaces. Learners emphasise pre-requisites of the Person-centred Framework they have developed during the programme. They consistently convey a sense of increased self-awareness, including knowing their own values, that has arisen through embedding reflexivity within their practice. This has contributed to a sense of resilience and increasing confidence in their clinical judgement and decision-making and ability to be more autonomous in their practice. Their communication skills have developed, evidenced through the ability to communicate clearly with inter-disciplinary colleagues, having courageous conversations and advocacy. Person-centred processes which are now evident in their role are attitudinal and include being more present,

being helpful, empathetic, and knowing individuals within the team. Holistic practices have also been highlighted, as well as developing as a role model. Additionally, we have supporting anecdotal evidence from senior nurse leaders and service managers that the programme is effective. This study builds on the practice wisdom articulated in programme evaluation. Having empirical evidence to demonstrate the applicability and rigour of the Person-centred Framework (McCormack and McCance 2017) offers a contribution to the body of knowledge around person-centredness and person-centred practice.

Type of study: quantitative study with subset of qualitative data

Methodology

A quantitative survey-based research design was used to explore what learning has been implemented into practice, specifically regarding developing person-centred culture and practice. We also offered space for open comments from which invited in-depth responses. The survey was divided into two parts:

(i) Demographic information and open response:

Participants' age, sex, length of time since qualifying as a nurse, discipline, number of years since qualifying from the programme, and information related to caseloads they have managed were collected. Abbreviations are listed in Box 1. The open text-based sought more details on their current workplace, work environment, culture, and staff relationships. These cues were drawn from the domains of the PCP Framework.

Box 1: Study abbreviations

QDN: Qualified District Nurse QHV: Qualified Health Visitor sDN: student District Nurse sHV: Student Health Visitor sSN: Student School Nurse

(ii) PCPI-S:

An online version of the Person-centred Person Inventory – Staff (PCPI-S) was used (https://www.cpcpr.org/_files/ugd/26205d_a985e51cdaca4fa293aa3540631a7bb1.pdf). This inventory is the most comprehensive tool used to investigate person-centredness in different nursing contexts and has been standardised and translated into multiple languages for use in multiple cultures. It consists of 17 constructs with 59 items in total. Each item asks the participants to rate their

agreement on a Likert scale of 1 (strongly disagree) to 5 (strongly agree). Some of the domains included within the PCP framework are clarity of beliefs and values, effective staff relationships, knowing self and working with patient beliefs and values. PCPI – S is a reliable instrument with high validity and is suitable for electronic distribution and data collection (Slater et al. 2017).

Data analyses

Quantitative data was organised and analysed for completeness before statistical analyses. All the incomplete or missing data were case-wise deleted for maximum reliability. Average PCPI-S scores for all the constructs and domains were calculated using the rating scores as recommended in the PCPI-S scoring sheet. All the constructs of PCPI-S demonstrated skewness in the data suggesting a non-normal distribution. A Bayesian one-way analysis of variance was implemented to analyse the independence of samples across the specialisations. Although, the overall aim was to analyse the difference between qualified and post-registration students, we were also interested in the differences among individual disciplines. Jeffrey's (1961) suggestions were used to determine the statistical support for statistical differences – BF_{10}> 3 strong evidence, BF_{10}> 100 decisive etc. All the analyses were conducted using JASP (JASP team 2022).

Qualitative data from the open text question (Q60) was analysed using thematic analysis (Braun and Clarke (2006) (Box 2)

Box 2: Steps of thematic analysis (Braun and Clarke (2006)

familiarizing yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes Producing the report

Summary of results

Quantitative results

With specialisation being the independent variable, all the domains and constructs within the PCPI were individually entered as dependent variables. Bayes ANOVA model with *Pre-requisites* domain showed statistically supported differences (BF_M = 38.8). Other domains of the PCPI did not show any statistically supported differences (*Care environment* BF_M = 1.93; *Care processes* BF_M = 2.26). Post-hoc comparisons across specialisations for *Pre-requisites* revealed statistically supported differences

between QHV and sDN (uncorrected BF_{10} = 741, corrected posterior odds = 236.70) and QDN and sDN (uncorrected BF_{10} = 40.13, corrected posterior odds = 12.80).

Following this, individual constructs within the Pre-requisites domain were entered as dependent variables to tease out the nuances of these differences (*Professional competence, Developed interpersonal skills, Clarity of beliefs and values, Knowing self and Commitment to job*). Among these, *Developed interpersonal skills* (BF_M = 22.26), *Knowing self* (BF_M = 14.28) and *Clarity of beliefs and values* (BF_M = 23.11) showed statistically supported differences. Individual post-hoc comparisons are listed in Box 3:

Box 3: Individual post-hoc comparisons

(i) *Developed interpersonal skills* (BF_M = 22.26):
QHV and sDN (uncorrected BF_{10} = 60.50, corrected posterior odds = 19.33),
QDN and sDN (uncorrected BF_{10} = 7.92, corrected posterior odds = 2.53),
sHV and sDN (uncorrected BF_{10} = 4.48, corrected posterior odds = 1.43)
(ii) *Knowing self* (BF_M = 14.28):
QHV and sSN (uncorrected BF_{10} = 9.74, corrected posterior odds = 3.11),
QHV and sDN (uncorrected BF_{10} = 60.51, corrected posterior odds = 19.33),
QDN and sDN (uncorrected BF_{10} = 6.03, corrected posterior odds = 1.92)
(iii) *Clarity of beliefs and values*:
QHV and sDN (uncorrected BF_{10} = 14.36, corrected posterior odds = 13.85),
QDN and sDN (uncorrected BF_{10} = 46.57, corrected posterior odds = 14.88),
sHV and sDN (uncorrected BF_{10} = 13.28, corrected posterior odds = 4.24)

Qualitative results:

Five QDNs/QHVs and 8 sHV/sSN/sHV made comments in the open text question which aimed to understand the context of their current practice. Data was themed highlighting: *Experiences of the practice environment; Perceived challenges in being person-centred and: Perceived agency in being person-centred.* Emerging from the Covid-19 pandemic, the practice environment was described as a high stress environment featuring time constraints, understaffing, absenteeism, lack resources. Psychological distress, perception of not being heard, lack of respect and recognition were highlighted. Responses were split into participants who perceived they had agency in being person-centred and those who did not. In the main, qualified nurses described respecting individuality, adaptability, and supportiveness. Other respondents (mainly students) perceived the practice context was not conducive to being person-centred augmenting the differences in the Pre-requisite domain in the qualitative data. They emphasised the need to care for themselves, reflecting the construct of *Knowing self*:

'I also feel there should be more care and attention for the staff to have team building events to help t allow the staff working in very intense environments to de-stress and feel safe amongst their colleagues' sHV

'I often feel self-care within teams is an issue. Staffing and burn out, stress levels all contributing to lack of respect for team members. I think we are person centred towards our patients and families but lack the same values within teams' sDN

Conclusions

We found statistically supported differences between QDNs/QHVs/QSNs as compared to sDNs and sHVs within the Pre-requisite domain of the Person-centred Practice Framework, but not the domains of Care processes and Care outcomes. This provided support for our first hypothesis. However, we identified further nuances within our second hypothesis. Among the five constructs that are contained within the Pre-requisite domain, three of them were statistically supported and supported by qualitative data. These are *developed inter-personal skills*, *clarity of beliefs and values*, and *knowing self*. Qualified DNs/QHVs scored higher on these constructs. Specifically, QHV/QDN scored significantly higher than sDNs in all the three constructs. Qualitative data added further insight into the practice environment that influenced translating learning about person-centredness into practice. QDNs/QHVs appear to perceive they have more agency in being person-centre. Developed inter-personal skills evident in advocacy and supportiveness. One QDN described striving '*to encourage it [person-centredness] at management level,' a*nother QDN sought feedback from her team, 't*he team felt supported and treated as individuals.* Respecting individuality or personhood, central to person-centredness in working with people's beliefs and values and for one QDN it is '*rewarding and essential.' At a team level, this construct was* described by a QHV who said having a shared vision of person-centredness meant they *'worked together to ensure we are all supported as a team.'* Students however appeared to have less agency, one sHV reported that, it can be *'Difficult to deliver the care and attention to the child or young person that you would like to due to the lack of staff and resources available.'* sHV described her commitment to person-centred practice despite the challenging context:

'...my focus for the best person-centred care my team can provide remains resolute as does making sure my team remain as individuals and recognise their needs and remembering to take care of myself also' sHV

This quote also highlights the construct of Knowing self. Recognising the need for self-care to be person-centred within the current context of practice was particularly highlighted by students. One sHV said more attention needs to be given to self-care to *'allow the staff working in very intense environments to de-stress and feel safe amongst their colleagues' A sDN said:*

'Staffing and burn out, stress levels all contributing to lack of respect for team members. I think we are person centred towards our patients and families but lack the same values within teams'

Implications

This is one of the first studies to provide empirical evidence that adds to existing knowledge gained through programme evaluation. We have previously known that the programme prepares community and public health nurses to be person-centred practitioners and leaders in developing person-centred cultures. We have also known they develop an increased sense of self-awareness, This study adds empirical evidence around the development of *Knowing self, Clarity of Values and Beliefs* on the programme and further evidences that students gain *Developed Interpersonal skills.* Educators therefore need to continue to emphasise knowing self, clarity of beliefs and values and to develop interpersonal skills in programme content. They should also strengthen content around the care process and outcomes. However, practice educators and leaders need to provide more supportive environments where students and qualified community and public health nurses feel able to be person-centred and promote person-centred ways of working. More research is needed in this area with a larger sample of post registration students and recent graduates from programmes in the Person-centred Practice Framework and similar programmes.

References

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