THE PERSON CENTRED PRACTICE INVENTORY – STAFF SCORE SHEET

The scoring of the constructs of the Person Centred Practice Index is a simple process. Additional materials required include a pen and a calculator.

Simply transfer the scores from the completed Person Centred Practice Index into the corresponding sections in the following tables (as prompted) and calculate a mean score of each of the constructs. To calculate the mean score simply add all the scores in the table together and divide the total by the number of items in the table.

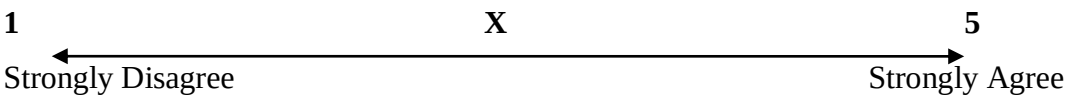
For example:

If the participant scores items Q1 = 1, Q2 = 5, Q3 = 2, Q4 = 4 then the total is 1+5+2+4 = 12 divided by the number of items = 4. The mean is 12/4 = 3

Professionally Competent

Question	Q1	Q2	Q3	Q4	Mean score
Item Score	1	5	2	4	3

Once each relevant section is completed transfer the mean score to the corresponding visual analogue scale, in this instance notified by an X at where the point 3 lies on the continuum. This will help provide a context for each score.



Complete all relevant sections of the Person Centred Practice Index accordingly. Once completed, calculate a mean score for each construct of the Person-Centred Practice Index.

The Prerequisites of the Person-centred Practice Framework

Professionally Competent: The knowledge, skills and attitudes of the practitioner to negotiate care options, and effectively provide holistic care.

Question	Q1	Q2	Q3	Mean score
Item Score				

1 **5**

Strongly Disagree ⟷ Strongly Agree

Developed Interpersonal Skills: The ability of the practitioner to communicate at a variety of levels with others, using effective verbal and non-verbal interactions that show personal concern for their situation and a commitment to finding mutual solutions.

Question	Q4	Q5	Q6	Q7	Mean score
Item Score					

1 **5**

Strongly Disagree ⟷ Strongly Agree

Being Committed to Job: Demonstrated commitment of individuals and team members to patients, families and communities through intentional engagement that focuses on providing holistic evidence-informed care.

Question	Q8	Q9	Q10	Q11	Q12	Mean score
Item Score						

1 **5**

Strongly Disagree ⟷ Strongly Agree

Knowing Self: The way an individual makes sense of his/her knowing, being and becoming as a person-centred practitioner through reflection, self-awareness, and engagement with others.

Question	Q13	Q14	Q15	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

Clarity of Beliefs and Values: Awareness of the impact of beliefs and values on care provided by practitioners/ received by service users and the commitment to reconciling beliefs and values in ways that facilitate person-centredness.

Question	Q16	Q17	Q18	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

The Care Environment of the Person-centred Practice Framework

Skill Mix: Skill mix is most often considered from a practice context and means the ratio of registered health professional and non-registered in a ward/unit practice team. In a multidisciplinary context it is means the range of staff with the requisite knowledge and skills needed to provide a quality service.

Question	Q19	Q20	Q21	Mean score
Item Score				

1 **5**

Strongly Disagree ⟷ Strongly Agree

Shared Decision-making Systems: Engagement that facilitates active participation in decision-making by all team members.

Question	Q22	Q23	Q24	Q25	Mean score
Item Score					

1 **5**

Strongly Disagree ⟷ Strongly Agree

Effective Staff Relationships: Interpersonal connections that are productive in the achievement of holistic person-centred care.

Question	Q26	Q27	Q28	Mean score
Item Score				

1 **5**

Strongly Disagree ⟷ Strongly Agree

Power Sharing: Non-dominant, non-hierarchical relationships that do not exploit individuals, but instead are concerned with achieving the best mutually agreed outcomes through agreed values, goals, wishes and desires.

Question	Q29	Q30	Q31	Q32	Mean score
Item Score					

1 **5**

Strongly Disagree Strongly Agree

Potential for Innovation and Risk Taking: The exercising of professional accountability in decision-making that reflects a balance between the best available evidence, professional judgement, local information, and patient/family preferences.

Question	Q33	Q34	Q35	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

The Physical Environment: Healthcare environments that balance aesthetics with function by paying attention to design, dignity, privacy, sanctuary, choice/control, safety, and universal access with the intention of improving patient, family and staff operational performance and outcomes (adapted from HfH 2008).

Question	Q36	Q37	Q38	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

Supportive Organisational Systems: Organisational systems that promote, initiative, creativity, freedom and safety of persons, underpinned by a governance framework that emphasises culture, relationships, values, communication, professional autonomy, and accountability.

Question	Q39	Q40	Q41	Q42	Q43	Mean score
Item Score						

1 **5**

Strongly Disagree Strongly Agree

The Care Processes of the Person-centred Practice Framework

Working with Patients Belief and Values: Having a clear picture of what the patient values about his/her life and how he/she makes sense of what is happening from their individual perspective, psychosocial context and social role.

Question	Q44	Q45	Q46	Q47	Mean score
Item Score					

1 **5**

Strongly Disagree Strongly Agree

Shared Decision-making: The facilitation of involvement in decision-making by patients and others significant to them by considering values, experiences, concerns and future aspirations.

Question	Q48	Q49	Q50	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

Engagement: The connectedness of the practitioner with a patient and others significant to them, determined by knowledge of the person, clarity of beliefs and values, knowledge of self and professional expertise.

Question	Q51	Q52	Q53	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

Having Sympathetic Presence: An engagement that recognises the uniqueness and value of the individual, by appropriately responding to cues that maximise coping resources through the recognition of important agendas in their life.

Question	Q54	Q55	Q56	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

Providing Holistic Care: The provision of treatment and care that pays attention to the whole person through the integration of physiological, psychological, sociocultural, developmental and spiritual dimensions of persons.

Question	Q57	Q58	Q59	Mean score
Item Score				

1 **5**

Strongly Disagree Strongly Agree

THEORETICAL FRAMEWORK FOR PERSON-CENTRED PRACTICE

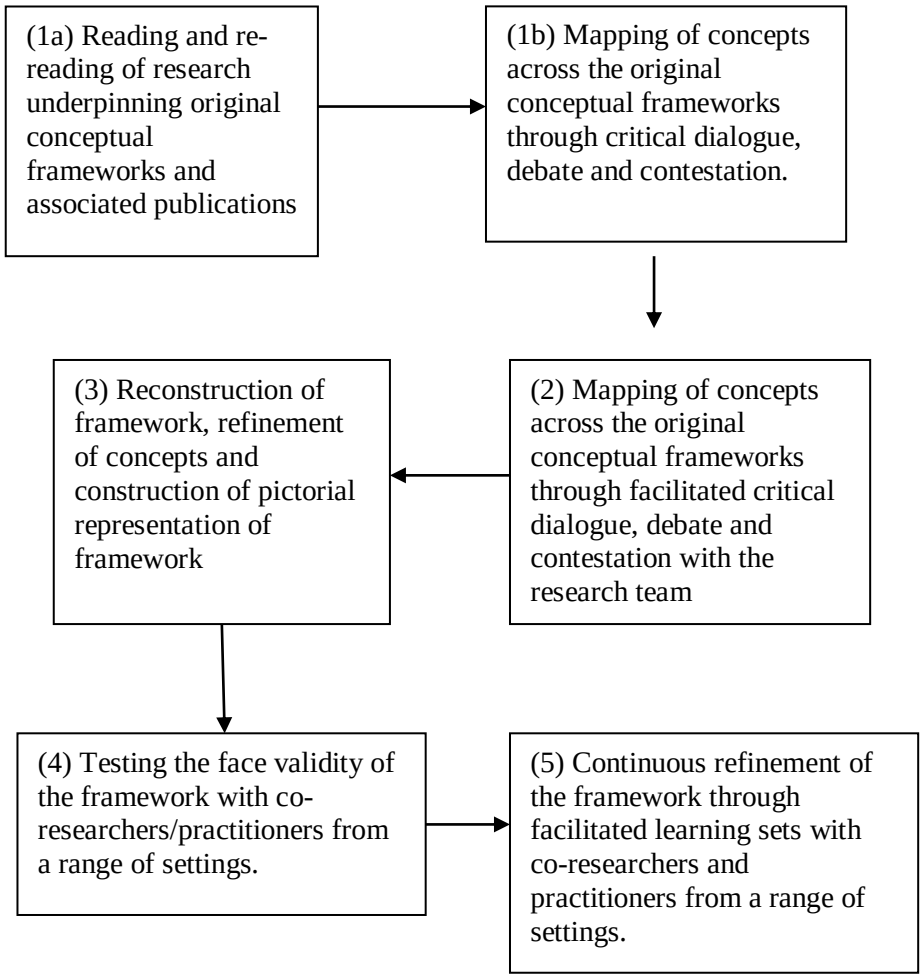
The Person-Centred Practice Framework (McCormack & McCance 2010, 2017) originates from the combination of two existing conceptual frameworks derived from empirical studies that have their foundations in nursing practice (McCormack, 2003; McCance, 2003). McCance developed a conceptual framework to describe caring in practice (as perceived by nurses and patients), whereas McCormack's conceptual framework focused on person-centred practice with older people derived from a study of autonomy. The principles underpinning these two conceptual frameworks are consistent with human science principles such as those articulated by Watson (1985), including the centrality of human freedom, choice and responsibility; holism (non-reducible persons interconnected with others and nature); different forms of knowing (empirics, aesthetics, ethics and intuition); the importance of time and space, and relationships. Collectively, they represented a synthesis of the then available literature on caring and person-centredness. The framework provides a unique perspective for health professionals that conceptually links caring and person-centredness.

The framework was developed through an iterative process and involved a series of systematic steps (Figure 1). Identifying the similarities and matched elements of each conceptual framework was an important first step and confirmed the strong relationship between caring and person-centred practice. For example, McCormack (2003) identified contextual factors that reflected many comparable elements captured by McCance (2003) under 'structures'. Similarly, the 'imperfect duties' described by McCormack (2003) incorporated elements of the process of caring described by McCance (2003). The second step involved the exploration of areas of difference using a critical dialogue with co-researchers (n=6) and with lead practitioners from a range of clinical settings (n=16) as a means of reaching agreement in relation to where these elements might fit within the new framework. The concepts underpinning both conceptual frameworks were then discussed. These conversations took the form of focused discussions using critical questioning techniques to unravel each concept. The original sources of literature and data were consulted in order to ensure shared clarity of meaning of key terms in each framework. These conversations were tape recorded and listened to after each discussion in order to identify key elements of each

framework that needed to be retained or amended in the combined framework. Key concepts from both conceptual frameworks were listed and a first draft of the Person-centred Practice Theoretical Framework was constructed.

A period of testing the framework was undertaken. Two focus groups were held – one with co-researchers (n = 6) and one with lead practitioners from a range of clinical settings (n=16). The draft framework was presented and their views on clarity, coherence and comprehensibility sought. Prior to the focus groups, the individual frameworks (McCance 2003 and McCormack 2003) were provided as background reading to enable discussion. The ease with which lead practitioners engaged with the framework and were able to contextualise elements within their clinical environments was clearly evident and was considered the most important indicator of its clarity, coherence and usability.

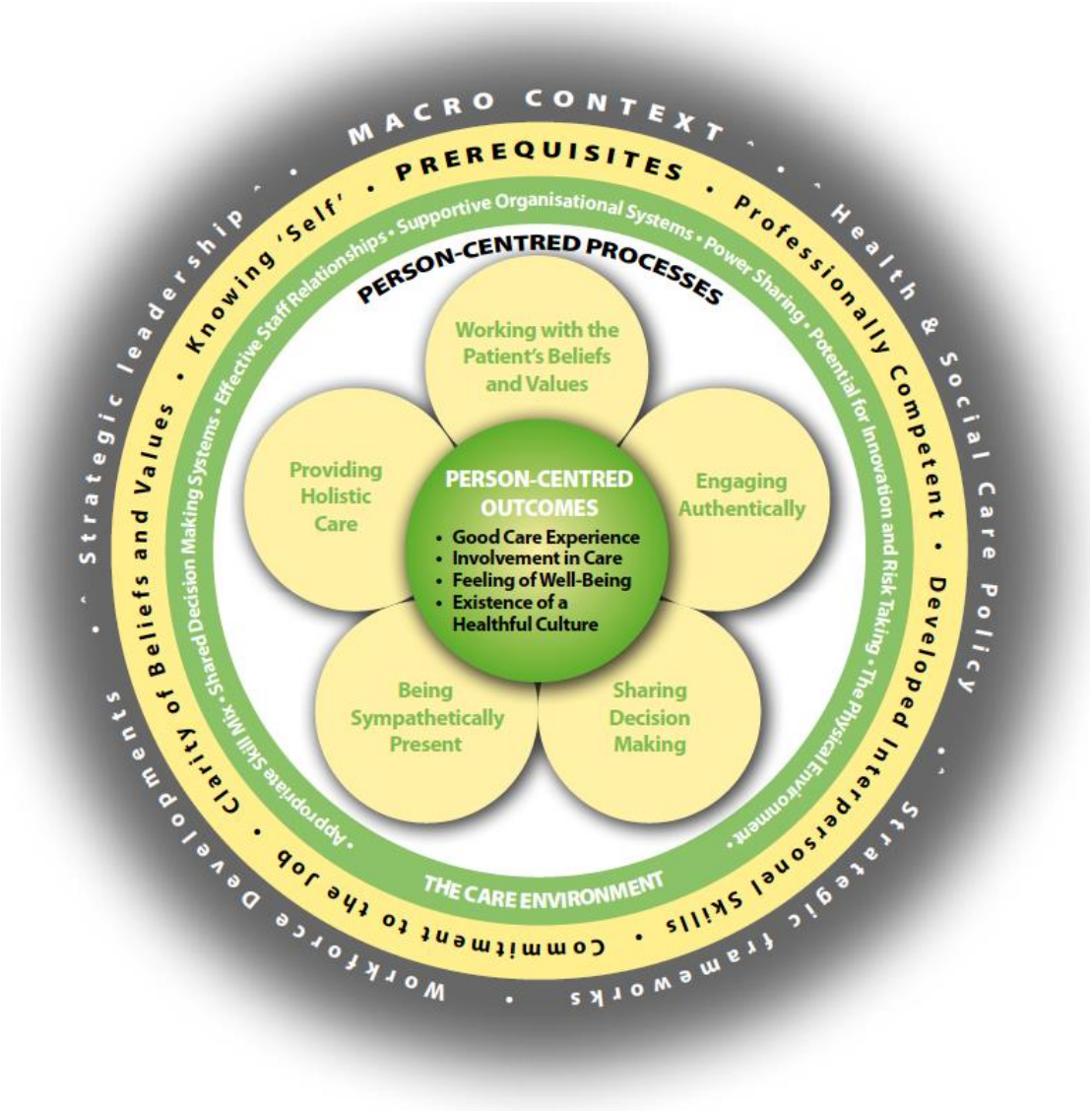
Figure 1: Processes used to develop the Person-centred Practice Framework



The Person-Centred Practice Theoretical Framework is presented in Figure 2 and comprises five constructs:

- *Macro context* which focuses on policy and procedures affecting care;
- *prerequisites* which focus on the attributes of the health professional;
- *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;
- *Person-centred outcomes* which are the results of effective person-centred practice.

Figure 2: Person-Centred Pracice Framework (McCormack & McCance, 2010, 2017)



The relationship between the constructs of the framework is indicated by this pictorial representation i.e. to reach the centre of the framework, the prerequisites must first be considered, then the care environment, which is necessary in providing effective care through the care processes. This ordering, ultimately leads to the achievement of the outcomes – the central component of the framework. It is also acknowledged that there are relationships within, and across constructs.

Prerequisites

The prerequisites focus on the attributes of the health professional and include being professionally competent, having developed interpersonal skills, and being committed to the job, being able to demonstrate clarity of beliefs and values, and knowing self.

The care environment

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

Person-centred processes

Person-centred processes focus on delivering care through a range of activities that operationalise person-centred practice and include: working with patient's beliefs and values; engagement; having sympathetic presence; sharing decision making; and providing for physical needs. This is the component of the framework that specifically focuses on the patient, describing person-centred practice in the context of care delivery.

Outcomes

Outcomes are the results expected from effective person-centred practice and include: satisfaction with care; involvement in care; feeling of well-being; and creating a therapeutic environment described as one in which decision-making is shared, staff relationships are collaborative, leadership is transformational and innovative practices are supported.

The Framework was used in several ways throughout the intervention phase. For example, it was used by facilitation teams to analyse underpinning barriers to change (arising for example from differences in beliefs and values), focus particular developments (for example the sharing of 'power' with patients) or evaluate developments as they progressed through the intervention (for example changes made to the care environment). The framework has been refined with co-researchers and project participants throughout the intervention period of the study and will continue to be tested though further practice development work.