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Leading and Facilitating within Practice Development in Healthcare

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ABSTRACT BOOK

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Keynote 1

Keynote 1
09:30 – 10:30 / Room: Singapore

Compassionate Leadership for High Quality, Compassionate Health Care

Professor Dr Michael West

How can we ensure our health care organisations are developing cultures of high quality, continually improving and compassionate care? This presentation gives the research evidence and practical guidance necessary to help leaders ensure compassion, high quality and innovation are at the heart of health care cultures in their organisations. It describes the key cultural elements associated with high performance in health care: vision and values; goals and performance; support and compassion; learning and innovation; and team work and collaboration within and across organisational boundaries. The masterclass describes how compassionate leadership is essential to create the conditions for practice development. Practical, open source tools that leaders can use to develop their leadership and their teams will be described. The presentation will show how leadership that creates cultures for high quality care for patients also can ensure the well-being and flourishing of all those who work within our health care organisations.

Parallel Session 1

Concurrent Session 1
11:00 – 12:30 / Room: Singapore

01.01.01 Quality clinical leadership for improving patient safety with patients, carers and staff centre stage.

Kim Manley

Safety in healthcare is an international concern with impact on quality of care (Hollnagel, et al, 2015). A Regional Patient Safety Collaborative, one of 15 nationally set up to place patients, carers and staff at the heart of quality improvements in patient safety, supported four large acute National Health Service hospital providers with a model to help facilitators use safety and quality improvement tools with frontline teams and to be mutually supported through action learning.
The evaluation used realist evaluation (Pawson & Tilley, 2004). Its aim was to understand what works for whom and why, when: working with frontline teams in large acute hospitals to embed a safety culture, and grow leadership and quality improvement capability. Specifically, to identify which strategies are effective in supporting front line teams to sustain bottom up change and quality improvement driven by the needs of patients and practitioners.
The study drew on ethnographic principles across study sites using descriptive case study design. Mixed methods of critical observation of frontline practice, stakeholder evaluation, emotional touch points, self-assessment; qualitative 360 degree feedback;

and the Teamwork Safety Climate Survey tool (Sexton et al 2006) were used to facilitate the development of a rich picture for each team and each context so as to answer the evaluation questions. In tandem, interrogation of the literature to distil relationships between context, mechanisms and outcomes generating hypotheses at individual, team and organisational level factors for safety culture.
Key findings identified an interdependence between quality clinical leadership within frontline teams, safety culture, safety behaviours and teamwork echoed in microcosm through safety huddles; the skills and attributes of facilitators; and the impact of organisations on microsystems. The interdependence between patient safety and person centeredness was also identified as was the need for organisational strategies for supporting clinical leaders and frontline teams.

01.01.02 "We have to be faster than the pressure ulcer– so let's go"

Christa Wernli-Fluri

Background Increasing pressure ulcer (PU) rates primarily affect patients and also affect nurses emotionally, lead to questions and calls for action. Interviews with advanced practice nurses (APN) and nurse leaders resulted in the hypothesis that while our nurses have the guidelines to prevent PU, they don't use them in their daily practice. A survey among 306 nurses confirmed this assumption. In terms of practice development, the conclusion is clear: technical knowledge alone is insufficient in practice improvement. More important is to understand our nurses in their world of practice and develop shared values.
Methods We used the established method combination for APN projects. To meet the heterogeneity of patient needs, to progress effectively and to enable several nurses, every ward delegated a nurse in a group as participant. Led by an APN as facilitator, this group developed a shared understanding of PU prevention, creating a visual of our guideline in a common clinical pathway. We used simple pictures, starting with creative associations like 'time means skin' and ended in generally accepted definitions for the symbols used. Along this 'PU pathway', each ward worked on its own gap, supported by the leading APN. Besides ward-tailored actions, the groups worked on procedures needed when patients leave or change wards.
Results Pressure ulcer rates were noticeably reduced, and the awareness, value and implementation of PU prevention was increased. Monitoring critical events by safety crosses shows PU-free days or, in case of incidents, leads to supportive analysis. Nevertheless, enhancing PU prevention is not over, and this will continue to occupy nurses for the foreseeable future.
Literature Frei, I.A., Massarotto, P., Helberg, D. & Barandun Schäfer, U. (2012). Praxisentwicklung im Trend der Zeit. Padua, 7(3), 110-115. Manley, K. & McCormack, B. (2003). Practice development: purpose, methodology, facilitation and evaluation. Nursing in Critical Care. 8(1), 22-29.

01.01.03 From refusal to enthusiasm – the implementation of the nursing process in a mental care hospital

Therese Hirsbrunner

Background Since 2010 the mental health services have been working with an electronic nursing documentation system that was developed primarily for acute care hospitals.
Problem The implementation of the documentation system revealed different views on the nursing process in mental health and acute care. After the implementation of the electronic system, several training sessions were held, some adaptations were made to the system and the nursing assessment, but still the implementation of the nursing process remained poor and nurses were dissatisfied.
Method and sample A practice development project based on the person-centred practice framework[1] was implemented from 2015-2017. All 14 wards of the mental health services were involved. Every ward was represented in one of the three project groups by three staff members, one of them the ward manager. The monthly meetings of the groups were facilitated by two clinical nurse specialists and a member of the nursing management. A range of methods were used in mini-projects to facilitate the participation and collaboration of all team members in the implementation and evaluation activities.
Results A shared vision of the nursing process in the mental health services was established. Patient-involvement and the communication of the nursing process in the interdisciplinary team were the primary focus. At every ward, the structures to facilitate primary nursing were discussed and improved in a more person-centred way. Analyses of the nursing documentation and observations at the wards reflected patient involvement in the care planning and the implementation of consistently formulated nursing plans to a high degree. All nursing teams found ways to communicate the nursing process in interdisciplinary meetings, with very encouraging experiences and feedback from physicians and therapists.

[1] McCormack, B., & McCance, T. (2017). Person-centred practice in nursing and health care theory and practice, West Sussex: John Wiley & Sons Ltd.

Concurrent Session 2
11:00 – 12:30 / Room: Rio

01.02.01 Commitment, Consistency, Creativity and Challenge

Catherine Schofield

Since 2006 Practice Development (PD) in Tasmania has flourished. The growth of PD has been from an initial vision and then an unwavering commitment from a small team of professionals. This commitment has enabled a consistent focus on the development of person centred cultures of care; on evidence based change; and safe quality patient care. This has had a significant influence in the way in which a growing number of professionals are approaching their work which is evident at all levels of nursing and midwifery in Tasmania.
There has been a creative approach taken to the hosting of PD Schools to support staff participation. Support is also provided for participants to apply new skills and try them out in practice. As a result models of care have been transformed that enables practice

to focus on patient centred care rather than tasks; and an ongoing commitment to effecting positive person centred workplace cultures. The implementation of PD has required commitment and investment from the leaders in nursing and midwifery at all levels: At the local level, nurse unit managers have recognised the importance for staff to have dedicated time to critically reflect on their practice and identify and implement change. At executive level promotion and role modelling has been evident but at times this has also been challenged due to the organisational changes that have occurred where a more transactional way of working has dominated to the detriment of morale.
At the state-wide strategic level the commitment from the chief nurse and midwife has grown to support the ongoing work to embed practice development ways of working further within our health service.
There are ongoing challenges as our circle of influence grows which our presentation will outline with some of highs and lows that we have encountered along the way.

01.02.02 Spiritual care: can student nurses learning contribute to leading person-centred practice?

Ann Price

Spiritual care is recognised as a neglected aspect of nurse education (Baldacchino 2011). I undertook a phenomenological study, using semi-structured interviews, to explore the experiences of student nurses learning about spiritual care. Ten student nurses agreed to take part.
I analysed the data using Van Manen's (2014) existential themes to examine the phenomena – exploring lived body, lived relations, space, time, lived things and technology. The students' individual context was diverse with some expressing Christian beliefs whilst others were agonist; however, all felt spiritual care was important within nursing practice. They gave examples where dealing with person centred approach to spiritual care was challenging and they reflected on their learning and contribution to holistic practice.

Six key areas of learning about spiritual care were identified:
• Connecting through recognition of spiritual individuality
• Embodiment of spiritual care
• Spaces of spiritual learning
• Time dimension as a spiritual factor
• Materiality as a challenge
• Technology as 'taken for granted' aspect of spiritual care

The students were fearful about saying the wrong thing but their comments showed that asking the patient and meeting their individual needs, was important to provide spiritual care. They also demonstrated their contribution to leading care by recognising spiritual distress and providing spiritual care; sometimes this involved challenging other staff or offering solutions to spiritual problems.
I wonder whether spiritual intelligence may be important process in learning about spiritual care to enable students to be aware of issues and to develop their leadership in this area. Spiritual intelligence is poorly defined (Esmaili et al 2014) but includes self-awareness, human presence dimension and personal meaning (Kaur et al 2015) aspects, which were reflected within

my findings. Therefore, I will explore whether developing student nurses spiritual intelligence within education may be one way they can learn to be leaders of person centred practice.

01.02.03 To move or not to move – this is the challenge for older inpatients!

Erika Wüthrich

Introduction Activity patterns of human beings have changed over time. In daily life there are many amenities to avoid movements. However, mobility is essential to stay independent in activities of daily living. Evidence shows low to moderate mobility levels of patients during hospitalisation which leads to reduced lower extremity strength and mobility. This is a risk factor for falls and deliriums in older inpatients leading to prolonged hospitalisations. Nurses are key players to motivate and support inpatients to move and keep or regain strength and mobility. To improve mobility levels in older multimorbid patients in internal medicine, a clinical development project will be initiated.
Aims Patients in hospital care are exercising according to their functional capacity and personal possibilities several times a day, integrated in daily care plans. Nurses know interventions to activate and move inpatients in different positions and foster them to move and exercise in daily care.
Methods Participatory action research with its three-phases and cyclic process is used for developing and evaluating activities with internal medicine teams in an university hospital in Switzerland from January to December 2018. To include the criteria "collaboration, integration, participation", several practice development methods will be used. Every nurse is asked about her actual practice of mobilising inpatients, about her priorities in the mobilisation and about her futures ideas of activating inpatients by a questionnaire. With creative approaches and collaboratively working with physiotherapists, we will develop a program with different options to mobilise inpatients. Sensibility and knowledge of activating inpatients will be deepened with nurses during workshops. A pilot test will be conducted in daily care practice, accompanied with several evaluation activities and a "good enough evaluation" approach. Evaluation data will be used for adapting further project activities.
Results/Conclusions First results and conclusions of the project will be presented in August 2018.

Creative Space 1
11:00 – 12:30 / Room: Nairobi

01.03.01 Move your Mind! Motor-Cognitive Dual-Tasking with Dalcroze Eurhythmics

Reto W. Kressig, Gabi Chrisman

The inability to simultaneously walk and talk has been shown a strong predictor for falls in older adults (Lundin-Olsson L et al. 1997). Indeed, safe gate while simultaneously performing cognitive tasks depends on highly automated motor-control. Due to functional losses and/or cognitive impairment among older adults, motor-cognitive dual task situations might exceed the available attentional resources and falls occur. Based on improvised piano music and changing movement patterns going with it, Dalcroze Eurhythmics builds up both motor and cognitive reserve. Not surprisingly, Dalcroze Eurhythmics performed once a week was not only able to improve Dual-Tasking in older community-dwellers but also decreased the fall rate by over 50% (Trombetti A et al. 2011). After a brief presentation of the theoretical bases linked to motor memory, multi-tasking, music and falls, workshop participants will engage into eurhythmics exercises themselves to experience the challenges of this technique but also to feel why this intervention is highly appreciated by its participants!

Creative Space 2
11:00 – 12:30 / Room: Mexico

01.04.01 The value of occupational therapy: exploring authentic practice and research that facilitates human flourishing

Niamh Kinsella

Over the past five decades there has been an increasing focus on "doing" in occupational therapy practice and research as a result of pressure to demonstrate effectiveness by service commissioners. There is an assumption embedded within this focus that engagement in doing (occupation) results in human flourishing. This assumption has resulted in evaluation with an emphasis on the quality and frequency of doing at the expense of practice guided by the fundamental philosophical value of occupational therapy- that attention to 'being' or authentic (value-based) existence guides "good" doing which facilitates human flourishing. Thus, research with a concern for being over doing may enable a return to person-centred practice in occupational therapy and research.
A recent research project explored the values that underpin occupational therapy practice and the contextual conditions that influence our potential to exist authentically as professionals and researchers, and in turn facilitate human flourishing for the people we work with. The research was underpinned by a critical creative case study methodology that used critical creative reflection on observations of practice to identify espoused and embodied values, processes and outcomes in practice with people living with dementia and in research.
The purpose of this creative space is to share and explore the findings of the research. The findings will be shared through the use of the visual metaphors that are derived from paintings and sculptures developed throughout the research analysis process. The exploration will focus on ways of being and contextual conditions that enable authentic existence and human flourishing that were identified during the research. This space will be an opportunity to engage creatively with the findings and collectively share understanding of authentic practice. The findings will inform a framework that aims to guide practice and research in occupational therapy that is concerned with authentic being first- person-centred practice.

*This search project was funded by Alzheimer Scotland

Creative Space 3
11:00 – 12:30 / Room: Hongkong

01.05.01 Exploring metaphor "self-as-instrument of care" in nursing leadership: Personal knowing as relational practice

Jasna Schwind, Louela Manankil-Rankin

Traditionally, nurses were viewed as simply 'users' of received knowledge. However, more recently, there is a recognition that nurses are also knowledge 'makers'. In this interactive presentation we explore with the audience how knowledge is created and co-created in practice, and how this process enhances the quality of nursing practice and nursing leadership, as well as the quality of patient healthcare experience. Our work is guided by constructivist philosophical perspectives, where knowledge development is viewed as something that is co-constructed in relationship with self and with the other. We are further guided by Dewey's (1938) philosophy of experience, Arts-Informed Narrative Inquiry, person-centred care, Carper's (1978) patterns of knowing, particularly personal and aesthetic ways of knowing, and finally Doane and Varcoe's (2015) relational practice.

In the creative space we begin by using the principle of 'starting with ourselves'. We invite the audience to engage in Narrative Reflective Process (NRP), using the metaphor of self-as-instrument of care, specifically focusing on nursing leadership. NRP in this context is used as a creative self-expression personal-knowing development tool, which includes storytelling, metaphors, drawing, letter-writing and reflective dialogue. This creative process serves to turn attention on the self: to develop self-awareness and personal knowing. Aesthetic knowing, builds on this step, exploring more deeply the meaning participants draw from the relationship of the professional self to their practice, specifically focusing on professional and therapeutic relationships, particularly compassionate leadership within practice. Through reflective dialogue, in small and large groups, we explore new ideas with participants by posing thought-provoking questions: How do we build relational capacities, such as commitment, curiosity, compassion, competence, and corresponding, in practice, particularly nursing leadership? How do we teach future practitioners these pillars of relational practice? How do we support the transformation-of-self of current nurses into relationally compassionate practitioners and leaders?

Concurrent Session 3
11:00 – 12:30 / Room: Guangzhou

01.06.01 Using research to develop at scale solutions to seeking and acting on patient feedback

Deborah Baldie

Using experiences of care to inform practice is a key practice development principle. It is however fraught with challenges including: capacity within complex and busy health care systems to regularly collect and share feedback; health care practitioner concerns over validity of feedback methods; availability of systems of feedback that support patients and families to give honest feedback without fear of reprisal; capacity to hear about the experiences of people who cannot engage with traditional methods

such as surveys or interviews; and the ability of teams to effectively engage and overcome local and organisational barriers to effectively act on feedback.

This presentation details the development of an infrastructure for inclusive, regular and facilitated patient feedback within health systems. This process has required strong practice development leadership: the creation a compelling need; working where opportunities lie; and innovative use of resources to develop novice research roles that focus on subjects of strategic importance.

We will share our evidence informed model for gathering and use of regular feedback; our research with volunteers and people with dementia or cognitive impairment that has supported the development and introduction of a bespoke toolkit to hear from those usually seldom heard in feedback systems. It will also detail the partnership we have developed with our local education providers to build capacity within undergraduate students and consequently, our health system to regularly collect and learn from people's experiences of care – a partnership that has provided rich learning experiences for all.

Lastly, we will share how we used critical creativity to combine our local evaluation data and international evidence relating to the use of patient feedback in practice to develop and commence implementation of whole system practice standards and associated support tools and learning opportunities for teams to enhance their patient experiences of care.

01.06.02 Quality and Safety Culture from bedside to boardroom: how person-centred approaches made it possible

Karen Tuqiri

The ability to support the development of a culture focussed on patient safety in today's complex and chaotic health environment is pivotal. One such approach is understanding how adopting person-centred approaches to connect leaders and clinicians in meaningful ways, benefit both patient experience and outcomes, staff experience and the workplace environment.

The results of a hospital wide interviews with all nursing and midwifery leaders focusing on exploring their understanding of the current practice program clearly indicated that a change in strategy was required to re-engage with leaders and clinicians. In addition workshops exploring courage and leadership, completion of role clarification process and discussions directed on the elements of a safety culture and how these would then inform more specific unit/ward based work were critical to refocus the leadership group. A quality and safety framework was developed that included how to capture data on clinical outcomes, patient experience, staff experience and environmental factors. This was provided to each unit manager and they were given the freedom to articulate what was important in their specific speciality and contexts. A baseline measure for this work included the Safety Attitudes Questionnaire alongside tools such as Emotional Touchpoints, quality boards, safety crosses and a safety huddle framework adopted to evaluate care and culture. Key to the success of this hospital wide initiative has been on supporting leaders to adopt person-centred approaches to engage clinicians in evaluating practice.

This presentation will highlight the journey of a newly appointed Director of Nursing and Midwifery and how the development of person-centred strategy can make a difference at the bedside. Specifically gaining the support of the senior leadership team, the use of person-centred approaches to engage staff and to make meaning of the practice context and the enhanced sense of ownership of change processes will be discussed.

01.06.03 Practice Development by "Mini-Audits" in Intensive Care Nursing at University Hospital Basel

Conrad Wesch

Background Since 2011, hospitals in Switzerland have been obliged to collect nursing-sensitive outcomes on a specific date every year. For the intensive care units (ICUs) at the University Hospital Basel, the prevalence yearly measured on a defined day is not very meaningful. Additionally, such controls do not conform to the idea of evaluation in Practice Development (PD), which strongly promotes the principles of collaboration, inclusion and participation. **Method** In 2015, the ICUs introduced "Mini-Audits": Nurses of the ICU-workgroup "Pressure Ulcer Prevention and Wound Management" (abbreviation: nurse experts) conduct a focused ward round six times a year. In this ward rounds, pairs of nurse experts examine the skin of each patient together with the bedside nurses, assess the risk for pressure ulcer, discuss measures to be taken and review the documentation. This process explicitly focuses on learning in practice. The nurse experts actively involve the bedside nurses with the aim to support them and to facilitate good nursing care. Subsequently, a survey form is completed together. So the

results can be compared and graphed. Finally, the teams receive feedback on the results and discuss possible conclusions. **Results** The Mini-Audits are highly accepted by the bedside nurses and they appreciate the opportunity for qualified discussions. The nurse experts regularly reflect their support role.
In our ICUs, the prevalence of pressure ulcers is currently 20.6%, which is comparable to results of the literature. Such results have become more meaningful to the health care team than the prevalence data because of the immediacy to improve quality care.
Conclusion The process of our Mini-Audits is in line with PD. Meanwhile, Mini-Audits on other topics (e.g. mechanical ventilation, delirium) have been developed. In this presentation, a nurse expert will present the steps of the Mini-Audit and a CNS will illustrate the relation to the PD principles.

Concurrent Session 4
11:00 – 12:30 / Room: Osaka

01.07.01 Building Research capacity In Clinical nurses; through Knowledge Sharing B.R.I.C.K.S

Val Wilson

The Nursing and Midwifery Research Unit of a large Local Health District in Australia is leading the operationalising of the Chief Executives Vision of an organisation that is respected and recognised for research and innovation to improve health care. This leader's vision has changed the research landscape of the organisation and its staff. However, this vision has required leadership at all levels (macro, meso and micro) and an approach that considers addressing the known barriers to building a research culture.
Knowing these barriers has enabled us to consider how we provide ongoing support and leadership for clinicians engaging in research. Key principles (building bricks) of the research unit are
1) Engage with staff at all levels in particular clinical experts
2) Work with the values of the organisation (Collaboration/Openness/Respect/Empowerment). Thus seeing our role as facilitators of learning and research inquiry rather than research consultants. Sharing our knowledge with individuals and groups of staff who share a common interest e.g. falls prevention. We work alongside clinicians through all stages of the research process enabling them to navigate the complexities of systems and processes required to undertake research
3) Person-centredness is embedded into the research design
4) Using action-orientated research approaches as this aligns to the Quality Cycles of PDSA, which clinicians are familiar with, it is more engaging and hopefully less daunting thereby enhancing clinician confidence in undertaking research.
The number of research projects being led by clinicians has increased significantly within the last 18 months. We believe that leadership is the key to this increase. Within this presentation we will share lesson learned; the ongoing barriers we have encountered and how we are working to overcome these; what has worked well and not so well and illustrate the successes of the research to-date by sharing examples of clinician led research.

01.07.02 Facilitation of person-centred care for families with a preterm or ill newborn

Klaeusler-Troxler Marianne

In neonatal intensive care unit the facilitation of person-centred and effective care for families after birth is essential to quality care. Family nursing interventions support families throughout their babies' stay in intensive care, and strengthen the family system's capacity to live with this new, unfamiliar and uncertain life situation. However, nurses often lack the expertise and skill to work with families during unexpected life events, such as the birth of a preterm or ill newborn.

Hence, a practice development project was initiated to increase health care teams' knowledge and skills in family care and to improve the quality of caring relationship between health professionals and families. The practice initiative was guided by an action research methodology using the three phases of looking – thinking – acting.

First, documentary and stakeholder analyses were conducted (looking phase) to discern current practices and policies related to family. While staff perceived that caring for families was important, there was little evidence of systematic involvement of families, which occurred most often only at admission and discharge. Stakeholders perceived family care as a welcome opportunity to improve quality of care, but were concerned that caring for the whole family would increase their workload. Second, based on these insights, a family care program was devised (thinking phase). Using the CFAM / CFIM, theoretical foundations were defined and practice instruments were adapted to the local context. Third, the family care program was introduced through interprofessional team education and reflective practice sessions and expert and peer coaching (action phase).

Using a collaborative and inclusive approach, the family care program seeks to shift the current care culture from an individual focus to a relational, family-centered one. Inclusive and visionary leadership facilitated health care team' attitudes towards families, and their ability to work with them.

01.07.03 Challenges and opportunities within the organisation, who's responsibility is it to develop practice?

Honor MacGregor

Shifting cultures and embedding person-centred ways of being in teams requires a transformational practice development approach. Culture transformation is more often realised when supported and taking place at the meso, macro and micro levels within an organisation. However, achieving this can often be hampered by organisations' requirements to meet targets; a reliance on technical approaches to quality improvement and assurance and a focus on quick fixes. This presentation will tell our story of how we have systematically worked with leadership teams, teams of in-patient ward managers, care teams and non-clinical teams across our organisation, facilitating their exploration and development of increased person centred cultures.

We will share how we have:
• built capacity for the use of practice development as a method-

ology to effect change at the micro level
• developed meso leadership capacity to embody person-centred ways of being and
• facilitated macro level leaders to shift their approach to monitoring and continuously improving quality of care and care experience to one that is more heavily focused on learning from practice data

This journey has not been one of tight project management. Instead, it has been one of a gradual building of a collective vision; exploring and working in the spaces and places where opportunities lie; systematically reflecting on ourselves and our personal and collective practice and being courageous to evaluate the impact of our micro work in order to build local evidence to influence and build relationships and partnerships at meso and macro levels.

Concurrent Session 5
11:00 – 12:30 / Room: Samarkand

01.08.01 Advanced practice nurse collaboration enables an integrated, patient-centered care process in liver transplantation across hospitals

Sonja Beckmann

Liver transplant (LTx) is an established treatment for end-stage liver diseases delivered in specialized centers. Based on the illness trajectory, patients often move between their close-by primary care hospital and the LTx center, leading to fragmented care delivery in a patient group with chronic conditions and complex needs. In 2014, the interprofessional teams at the University Hospital Zurich and the Cantonal Hospital St. Gallen were complemented with an advanced practice nurse (APN), responsible for self-management support in LTx and hepatology patients, respectively.

Using the principles of collaboration, inclusion, and participation, the APNs established a pathway for LTx patients across the two hospitals. The pathway encompasses an evidence-based, integrated, and patient-centered care process before and after LTx, embedded in an APN-led consultation service. The consultation service was developed based on a literature review and focus group interviews with patients, caregivers, and health professionals. Additionally, the LTx center developed two brochures, delivered to LTx patients in both settings to guide counseling and provide written self-management support and information. Regular exchanges between the APNs ensures the coordination of care activities, the transition of tasks and equal clinical information. This is essential when patients are transferred between settings and guarantees prompt action in a population with rapidly changing needs.

Forty patients received 167 consultations from both APNs. The comparison between the settings showed differences in structure and content of the consultations, highlighting patients' diverse and specific health needs subject to their illness trajectory. Patients and team members reported increased satisfaction due to the improved flow of information. Supported by nursing management and lead physicians, the APN-led consultation became an integral part of delivery service in both settings. Moreover, the unique APN-collaboration between the two hospitals provides high-quality care and ensures continuous care planning, self-management support and patient-centered care in the course of LTx.

01.08.03 The challenges of meeting older emergency department patients' specific care needs

Florian Grossmann, Deborah Allen

Older emergency department (ED) patients are a vulnerable and fast growing patient group with special care needs. However, most EDs are poorly prepared to meet these. In the ED of the University Hospital Basel several initiatives have been undertaken to improve care of older patients, two of which will be presented and reflected on in this presentation.

The "geriatric fast track" is a pathway which aims to enhance disposition of patients likely to be admitted. Patients are identified at triage and are treated in a dedicated and specifically equipped area within the ED. A team of nurses, led by a Clinical Nurse Specialist (CNS), takes an in depth patient history and performs a short geriatric assessment including e.g. delirium screening and falls risk assessment.

The "ED based community nursing" service aims to facilitate discharge of patients who otherwise would have to be admitted to inpatient beds. After one night in the ED's observation unit, a CNS assesses patients who meet inclusion criteria for eligibility. Eligible patients are accompanied back home. There, the CNS, together with the patient, elaborates a care plan for the coming days, and installs an emergency call system. The following day, the CNS evaluates the patient situation during a follow-up visit. Both initiatives were planned carefully, inspired by CIP principles (collaboration, inclusion, participation), and practice development methods. However, after one year, and three months, respectively, we established that far fewer patients than expected were included into both services. Reasons for this are currently being investigated. In our presentation we will describe how the services were developed, reflect on why we fell short of meeting our goals, and facilitate a discussion on how to more effectively transform ED care of older patients.

Concurrent Session 6
11:00 – 12:30 / Room: Miami

01.09.01 Big data and practice development: Lessons learnt from the Australian Nursing Outcomes Collaborative (AUSNOC)

Jenny Sim

The purpose of this presentation is to describe how the Australian Nursing Outcomes Collaborative (AUSNOC) has used data in combination with the principles of practice development to measure, monitor and improve the quality and safety of nursing care. AUSNOC is an Australian indicator set for measuring the quality and safety of nursing care which elucidates the unique contribution that nursing makes to patient outcomes. The indicator set is founded upon a conceptual framework that explores nursing care using the following constructs: Care and Caring; Communication; Coordination & Collaboration; and Safety. Data collected includes administrative data, adverse events, observational studies of the processes of nursing care, and the use of three periodic surveys that use validated tools (Nursing Work Index – Revised: Australian; Caring Assessment Tool; and one of a number of approved Patient Experience Surveys). Feasibility testing of the AUSNOC indicator

set was undertaken in three hospitals in NSW, Australia. This presentation will explore the tensions between using big data and data registries to achieve person-centred and evidence-based care that enables individuals at the micro-system level to enact change and improve patient outcomes. The concept of big data may be seen by some as the antithesis of practice development principles. Data registries, metrics and indicator sets are frequently seen as vehicles by which organisations can hold management and staff accountable. Arbitrary benchmarks are used to set key performance indicators and measurement for accountability rather than measurement for improvement then ensues (Solberg et al. 1997). AUSNOC has chosen to use work-based learning, skilled facilitation and evaluation approaches that are participatory, inclusive and collaborative to support micro-system changes in nursing processes to influence patient outcomes. Lessons learnt from the development and feasibility testing of AUSNOC as well as the development of AUSNOC as a collaborative research centre will be shared during this presentation.

01.09.02 Evidence building as a leadership concern in practice development (PD)

Greg Fairbrother

The case for building quantitative and mixed study designs into PD work ('evidence -based PD') has been made in recent years and received a favourable response from members of the PD community. Key to this response is a view that it's time that PD-generated change is studied at sufficiently high levels to be evidentiary and become a driver of cross-organisational change. Collaborative leadership is now needed to establish some of the core system requirements for an evidence-based PD to flourish.

To explore the contemporary evidence-related scenario among practice developers, the authors surveyed delegates to E P16 (Edinburgh). Findings of note were: i) most respondents reported feeling up to date with the evidence in their practice domain; ii) respondents varied widely as to what evidence sources they relied upon; iii) only about 25% of respondents reported having used quantitative approaches when evaluating PD work; iv) open-ended responses suggested that the low usage of quantitative methods found in the survey was not related to philosophical objections to positivism. Instead resource-, pragmatic- (e.g. sample size) and knowledge-related barriers were reported.

Sample size is key to effectiveness evidence generation. Well conducted multi-site work enhances the potential for generalisability. If within the PD movement, we were to establish a centralised PD Clearing House (PDCH), formal 'like-with-like' project merging may become achievable. This would require outcome measurement to merge, not localised context-specific actions. The diversity of local actions could be tracked via adherence-checking. So a PDCH could work with separate projects targeting aged care falls reduction, data-merge, and generate one international multi-site result.

Our presentation focuses on the survey findings and on related PDCH- and research capacity building-related strategies which would be realisable only if led collaboratively. Audience discussion around strategic intent, feasibility and pragmatic factors will be encouraged.

01.09.03 Developing Academic Nursing Leadership

Shaun Cardiff

Although nursing has been an academic discipline for decades, there is wide variation in how nursing science has developed within various countries. In The Netherlands the first nursing professor was only appointed in 1986 and there have been no studies investigating academic leadership by postdoctoral nurses. Whilst academic nurses are known to advance nursing science and positively influence healthcare (Hafsteinsdóttir et al, 2017), a need for leadership practice development among Dutch post-doctoral nurses has been identified (Brekelmans, 2017). To strengthen nursing research and improve the research productivity and career development of 12 postdoctoral nurses, a tw0-year Leadership Mentoring in Nursing Research (LMNR) program was ran between February 2016-18. The program was developed by a collaborative of dutch university nursing science departments and international partners. Participants followed intensive (personal and professional leadership development) workshops, worked with Kouzes & Posners (2007) leadership model, and met with leading international experts in health care research. Alongside a personal professional development plan, participants were also mentored by an academic nurse leader and research mentor of choice.
Longitudinal qualitative participant evaluation has been conducted to inform program development and gain insight into the influence the program has had on participant being and doing. Open interviews were conducted at the beginning, middel and after completion of the program.
Results show that the program has influenced participant identity and leadership (mindset and practice). It has also increased contextual awareness as participants continuously cross multiple boudaries between, and within, academia, education and clinical practice.
Having presented the findings of this evaluation study, a critical dialogue with the audience is desirable. The key questions for discussion is: Are (existent) leadership models adequate for post-doctoral nurses leading at macro-/meso-/micro-levels? And, how can more post-doctoral nurses be supported in developing their leadership competency in austere times?

Parallel Session 2

Creative Space ICOP
13:30 – 14:30 / Room: Singapore

02.01.01 Celebrating Person-centredness: International Collaborations through a Community of Practice

Professor Brendan McCormack

Focus: In this session the 'International Community of Practice for Person-centred Practice' (ICoP) will present an overview of the work of the ICoP and how we are advancing knowledge in the field of person-centredness. Approaches to person-centred theory and practice continue to grow and there is much scope in creatively developing global partnerships to advance knowledge. In addition, practices continue to evolve and it is important for us to engage in dialogue about such changes and identify new ways of supporting, researching and educating about these ways of working. The ICoP exists to advance such theory and practice through dialogue and partnership working. Over the lifetime of the ICoP we have focused on research into particular theoretical approaches, creative methods of evaluation, developing measurement tools and processes and developing evidence to support practice at individual, organisational and strategic levels. In this session we will present this work and engage in a critical dialogue about future directions for person-centredness.

Concurrent Session 7
13:30 – 14:30 / Room: Rio

02.02.01 A person-centred co-design approach to advancing facilitation:Outcomes of an advanced facilitation program.

Rebekkah Middleton

Skilled facilitation is key to the success of practice development. Using a person-centred approach to facilitation is an essential aspect of engaging stakeholders, "working with people" rather than "working on people" through the change process and in supporting systematic approaches to enhancing the practice context. Facilitation centres on co-producing knowledge using critical reflection and critical conversation and supporting learning in and about practice. Those who facilitate are enabling others to grow. But how do facilitators themselves further develop their skills, strengthen their theoretical knowledge, evaluate their own facilitation and advance the art and science of facilitation practice? The International Practice Development Collaborative (IPDC) provides foundational facilitation skills through its 5 day program. There was however nothing to challenge and support those seeking to enhance their facilitation skills beyond this foundational course. An IPDC working party was formed in 2017 to address this gap. The group worked together to develop a principle based program focusing on advancing facilitation skills within the context of person centred practice. The pilot of the program was delivered in Wollongong, Australia using a 2day-1day-1day model, with twelve participants commencing October 2017 and ending in February 2018. This presentation will explore how a person-centred co-design was used to develop, implement and evaluate the pilot program.

The experiences of those facilitating and those participating in the program will be explored through the key themes of building knowledge around theories of person-centredness, critical social theory and facilitation, understanding the role of critical reflection as an advanced facilitator, participating in the co-design of the program, being person-centred, achieving learning and development outcomes, and exploring 'new frontiers' of facilitation and how the participants themselves could shape and contribute to the evolving art and science of facilitation.

02.02.02 The Journey to Embodying Facilitation

Margaret Kelly

Facilitation is key to engaging people in transformational change and creating sustainable person-centred healthcare environments. However, a thorough understanding of the nature of skilled facilitation and how people gain expertise remains elusive.
This paper will present findings from a doctoral study that investigated the experiences of practice development facilitators, exploring their understanding of transformational facilitation and developing expertise.
In-depth interviews were held with 22 facilitators who were using practice development approaches to support transformation of workplace cultures. The facilitators were recruited from 6 countries and their experience ranged from novices to those who were considered highly skilled. Interviews were transcribed verbatim and thematically analysed using a 3-phase approach.

Seven overlapping and interacting themes were identified that arranged into 3 distinct clusters:
1. Internal to the Facilitator
• Inside your own head
• Walking a fine line
• Being me
2. External to the Facilitator
• A lens on facilitation
• Making sense of theory
3. Enacting transformational facilitation
• Being fluid
• Understanding people in context

There was evidence of a spectrum of development from early experiences as a facilitator through to being highly skilled. The spectrum reflected the way in which facilitators' thinking, processing and practice changed as they gained expertise.
This doctoral study provides a clearer understanding of skilled transformational facilitation and highlights the ongoing nature of development. The findings have implications for up-and-coming facilitators and experienced facilitators who enable and support them to develop. It highlights the importance of a range of strategies used to support the continuing development needs of all facilitators and the ways in which these are utilised.

Creative Space 4
13:30 – 14:30 / Room: Nairobi

02.03.01 From Root to Fruit – Flourishing in Change.

Caroline Dickson

This creative presentation will explore leading and leadership within practice development in end of life care. We will be exploring the use of transformational practice development (PD) as a PD team transitioned through both role and management changes. Recent research demonstrates that creating a workforce that feels engaged, empowered and inspired will help achieve strategic outcomes whilst also ensuring that patients receive high quality care and remain at the heart of everything (McCance et al. 2015; McCormack and McCance 2017).
During the transition into their new Practice Development Facilitator (PDF) role, Marie Curie partnered with Queen Margaret University to create a programme of development which would enable PDFs to be pivotal in embedding cultures of person-centred practice. The programme was intended to address some of the strategic challenges in a way that fit with the Marie-Curie vision. It would also contribute to wider work of developing a culture of person-centeredness across the organization.
During our interactive presentation, we will show process and end-point programme outcomes and give examples of how these were achieved. i We will outline our journey from the beginning where the team learned about PD principles and person-centred practice through the process of active learning (Dewing 2006). How they agreed shared values came to know themselves through being with others, knowing others and taking time "to be" rather than always being busy doing. We will share how critical reflection, and critical creativity were mediums which enabled growth of themselves as facilitators of person-centred practices.
During the creative presentation space, we will explore the challenges and successes of this continued work and share with other delegates how we would envisage further developments from person-centred moments to a culture of person centeredness where people who are at the end of their life are receiving care.

Creative Space 5
13:30 – 14:30 / Room: Mexico

02.04.01 Leading the process of co-production to ensure user involvement with a municipality – HOW?

Ragnhild Steinsland

Co-production of knowledge is a current form of user involvement to improve and develop health care services. Doing research with persons and not on persons, means that stakeholders will be involved in all stages of the research process. This is especially a demanding task for project leaders when involving so many different stakeholders. These stakeholders and participants are: users (older persons living with dementia and their relatives), staff in home care services, municipality leaders (political and home care leaders), user organizations and professional organizations.
This presentation is based on an ongoing co-production of knowledge project called MEDVIRK DEM. The MEDVIRK DEM project is a co-designed project involving different positioned

stakeholders in a small municipality in Norway to ensure user involvement and relevance. The aim of the research project is to gain knowledge on "what matters to older people living with dementia at home". Furthermore, the overall aim of the project is to innovate and develop the care services in line with the older persons and their relatives` preferences in co-operation with the municipality leaders.

In order to gain knowledge of "what matters to you" a combination of focus group interviews and individual interviews will be used. In addition, participant observation will be used to gain knowledge of the collaboration process involving the different stakeholders.

The aim of the presentation is to engage the audience in a creative session to explore how we can engage the leaders and different positioned stakeholders to ensure user involvement beyond tokenism.

Creative Space 6
13:30 – 14:30 / Room: Hongkong

02.05.01 Development of 3D complexity project model

Kristin Ådnøy Eriksen

Background In a show in tell display in the conference we present a dynamic 3 D model of the complexity of a Practice Development project. The model represents a map of a complex project. We have found it useful in planning projects, in untangling confusing processes and in deciding areas for evaluation and research. The model is dynamic, and can be adapted to different project. Experience has shown that it changes slightly depending on the context. Participants in a Practice Development conference in Norway developed the model. And in the Creative Space we would like to invite participants in the EP-conference to continue this development. **Activities in Creative Space** Step one will be to use a 3D-version and explain the model to the participants. Step to will be to give the participants a representation of the model on a sheet of paper, and ask them to adapt the model to their own project. Third step will be sharing and discussion in groups asking questions like: -is the model useful? -why or why not? –what is missing? Fourth step is to provide additional material and invite the participants to explore and elaborate the model (either in groups or together, depending on the number of participants). **Aim** In this way we hope to explore how the model can be utilized and refined. And at the same time that we and the participants can learn more about how to understand and handle the complexity of Practice Development processes. We believe it will be possible to understand more about how elements in projects may relate to each other, see examples of how people have planned evaluation and research, and gain insight in different contexts the participants represent.

Creative Space 7
13:30 – 14:30 / Room: Guangzhou

02.06.01 Using creative self-expression to develop cultural competency in hospice-care for the homeless population

Namarig Ahmed, Jasna Schwind

Three community care organizations in Toronto, Canada, partnered to build a hospice for those experiencing homelessness and a life-limiting diagnosis. A vital component of the project was to ensure that hospice leaders, caregivers, and volunteers would receive comprehensive and meaningful training in cultural competency when working with the homeless, who also require palliative care. We first engaged the caregivers and clients with lived experience in traditional focus-group interviews to elicit their input on the provision of person-centred care at the new hospice. We additionally wanted to develop hands-on training, which would be more impactful than the traditional task list, for future hospice leaders, caregivers, and volunteers. To access a more holistic understanding of what the new hospice care could look like, we adapted Schwind's Narrative Reflective Process (NRP), a creative self-expression tool, which includes storytelling, metaphors, drawing and letter-writing. Those with experience of living in homelessness, and those who work with this population, were invited to engage in the second set of focus-groups, where they shared stories of being cared-for, drew images of their care-metaphor, and they wrote letters (clients wrote to hospice caregivers, and caregivers wrote to new staff). The combined outcome of focus-group interviews, was more holistic and meaningful. From the traditional interviews we learned the expected, professional steps in hospice care. However, from the creative focus group interviews, we experienced a humanistic response, that was authentic and passionate, from both caregivers and clients. Following these activities, we analyzed their responses using Narrative Inquiry approach, and crafted a series of vignettes on caring, a composite story, and a poem, using participant voices, respectively. Using the outcomes of both traditional and creative focus-group interviews, we developed a creative and meaningful cultural competency interactive training for the new hospice leaders, caregivers, and volunteers, which was received with great commendation.

Concurrent Session 8
13:30 – 14:30 / Room: Osaka

02.07.01 Leading, Managing and Facilitating with a Divided Brain

Ross Clifton

This session will explore key aspects Iain McGilchrist's understanding of the divided brain as outlined in his seminal work "The Master and his Emissary". I will explore this framework from organisational and clinical perspectives, particularly the relationship between leadership, management and facilitation and the opportunities and threats related to person centredness.
McGilchrist introduced a story where a lady was informed of her brother having passed away in a mining accident. She saw her brother in the hospital morgue and bent down to kiss him. Feeling

that he felt still warm she also thought she could sense a weak pulse and immediately approached the nurse standing close by who replied "Don´t you worry about that my dear, it says quite clearly on this piece of paper that he's dead" and turned away. The sister then ran to find a doctor who administered intracardiac adrenaline and the brother still lives.

Here the formal, the virtual, the bureaucracy (the left brain) can matter more than what is more humanly experienced. What kind of clinical environments have been created where the opposite of person centredness (more right brain) is being espoused?

This divided brain framework will be used to explore a range of themes at individual, team, organisational and community levels to facilitate a practical understanding of metaphors associated with both sides of the organisational and individual brain such as: the dualities of impersonal and personal; the relationship of management and leadership (and facilitation); creative innovation and conformity; organic development and strict controls; quantitative (the what) and qualitative (the how) processes; and, virtual representations and the "mechanisation" of care versus "real" personalised experiences.

There will also be the opportunity to further explore the clinical impacts and opportunities in key areas such as power relationships, systems and processes, technology, values based leadership/ management, innovation, change, organisational culture, relationship management and effective communication.

02.07.02 Adapting to Local Context to Advance the Health of Populations: Implementing a People-centred BSCN Curriculum

Shelley Cobbett

A new, people-centred BSCN curriculum admitted the first students in September 2016, with the first cohort of students, advanced standing, graduating in October of 2018. The purpose of this presentation is three-fold: to share the philosophical underpinnings of the curriculum, including people-centredness, health and social care, and professional transformation; to illustrate application of practice development within the curriculum; and, to highlight the importance of a developmental evaluation framework to enable "changes on the fly" during implementation. The underpinnings of the curriculum are based upon educational theory (Fink, 2013; Gardner, 2008) and direct that learning be equally focused on the creative mind (Gardner, 2008), as well as the discipline, synthesizing, respectful and ethical minds (Gardner, 2008). Fostering growth in each of these five minds maximizes opportunities for creative potential to emerge in the learning environment, contributing to active, engaged significant learning. A reincarnation of the concept of "team teaching", which was common in nursing education in the 1970s and 1980s, enabled the school to share the expertise of faculty and adjunct appointees across the undergraduate program and provided more opportunities for faculty to role model respectful and healthy debate of ideas. The creation of a nursing practice foci certificate within a generalist BSCN degree will be outlined, with successes shared from a collaborative relationship with our service sector partners, as an exemplary example of adapting to local context, ultimately improving the health of the local population.

Concurrent Session 9
13:30 – 14:30 / Room: Samarkand

02.08.01 Critical Companionship and leadership – I couldn't have done it on my own

Catherine Schofield

Using Titchen's Critical Companion (CC) domains, Relationship, Rational Intuitive, Facilitation and Use of Self I will examine a particular CC relationship that has been developed and deepened over the last 10 years.

From our initial collaboration in opening the first forensic mental health unit in Tasmania we have maintained a close professional working relationship. This relationship has been one of overt critical companionship that has seen us both flourish and gain influence within the Tasmanian health system.

The relationship has been underpinned by an ongoing commitment to the pursuit of excellence, person centred practice, taking risks and opportunity and championing the involvement of our consumers while never taking ourselves too seriously.

This presentation will be a reflective piece on the key elements that have influenced the way in which we work together and the development of both our professional relationship and personal friendship. Authentic leadership must be an ability to examine ideas, motives, attachments, fears, risks and opportunities critically, creatively and supportively. Critical companionship provides an ideal model where this can and does occur.

02.08.02 Practice Development in Clinical Leadership Programmes - what works best for whom, when and why?

Helen Stanley

Clinical Leadership has a key role globally in both high quality patient care and quality improvement (Bender et al 2016, Mianda and Voce 2017). Strong and effective clinical leadership is one of the most influential factors in transforming organisational culture (West et al 2015). Clinical leadership development in the past has focused on enabling participants to develop their leadership skills through participating in leadership programmes and despite vast investment made in leadership development, there is little understanding or robust evidence of the impact or what learning or practice development strategies are effective in Clinical Leadership Programmes (ibid).

Method Realist Evaluation (Pawson and Tilley 2004) was used for Phase 1 of this PhD study to identify relationships between context, mechanisms and outcomes to identify what impact, and in what ways, specific learning and practice development strategies within a Clinical Leadership Programme have on workplace culture and person-centred practice. This approach underpins the UK NHS Leadership Development Evaluation Framework (Health Education England 2017).

Results A concept analysis (Rodgers 1989) clarified the defining attributes, enabling factors and consequences of Clinical Leadership across health professions, alongside a realist review of Clinical Leadership Programmes (Saul et al 2013), outlining the context of the programmes, highlighting the mechanisms of the learning and practice development strategies and defined the outcomes to

explore relationships between interventions used in the programmes of the impact on workplace culture, for individuals, teams, service and organisations. Together, this phase of the study generated an initial programme theory whereby successful programmes were embedded in the organisation delivered in the workplace, utilised interprofessional, reflective, experiential learning and creative practice development strategies.

The international implications for individuals, teams and the service/organisation in developing Clinical Leadership Programmes, workforce culture and person-centred practice will be critically explored to contribute to the theory of impact of practice development (Manley et al 2011).

Concurrent Session 10
13:30 – 14:30 / Room: Miami

02.09.01 How does collaboration between academia and practitioners contribute to the development of professional practice?

Katharina Tritten Schwarz

Background Since 2008, contractual agreements between universities of applied sciences and practice institutions have been in place for the provision of practice-based learning for undergraduate midwives. These agreements are based on the concept of "collective impact", which implies successful collaboration[1]. Continuous revision and optimisation contributes to such structured collaboration[2,3] which can also impact the quality of perinatal care.[2,4,5]

Research question Does structured collaboration between practice institutions and universities contribute to an optimal quality of education and training and, in so doing, improve clinical midwifery?

Method Both contractual parties regularly evaluated the educational and training standards, and mapped out development needs and common challenges of the programmes.

Results Collaborative partnerships for the academic and practice-based learning of undergraduate midwives attained a high standard of quality.[6]

Both students and clinical supervisors reported that implementing evidence-based knowledge was a practical challenge. The "theory-practice-theory" transfer was also described as demanding. Furthermore, due to the day-to-day challenges arising in clinical practice, new content which had been taught at the universities of applied sciences (eg "clinical assessment", was slow to be applied in everyday practice).

Conclusion Cyclical quality meetings between universities of applied sciences and practice institutions are important because on the one hand they facilitate working towards common goals to optimise the education and training of midwives and on the other hand they can have a positive impact on perinatal care. Universities and practice institutions should collaborate more closely in the future to strengthen specific profiles at the interface of academia and clinical practice and promote dual competencies profiles in junior staff.[7,8] There should also be a coordinated division of responsibilities to bridge differences in financial processes, objectives, cultures and priorities.[9]

Further research is needed to be able to determine the impact of optimal 'academia-practice partnerships' as well as parameters for practice developments.

02.09.02 What's the added value in developing facilitation and leadership capacity?

Christine Boomer

Aim To share one organisations review of a programme aimed at developing facilitation and leadership.

Background The practice development and professional literature emphasises the need for facilitators and leaders in the drive for person-centred cultures. Over the years there has been much debate on the best way to develop staff in this area. A practice-based facilitation and leadership module has been delivered aiming to enable staff to flourish as facilitators and leaders for development of practice and staff. The module introduces participants to key themes in facilitation, leadership, adult learning, knowing self, and how this links with practice development and enabling person-centred cultures. Within an outcome focused agenda it is important we can demonstrate the value and contribution activities have for our staff, our patients and services.

Method To ascertain the value in terms of impact from the module, evaluation data from all the modules completed to date (n=8) was reviewed using descriptive statistics and creative hermeneutic analysis (Boomer and McCormack 2010).

Findings This work remains on-going, to be completed March 2018. To date 75% (n= 64 out of 86 who commenced) have fully completed the module, with another 16 on this year's programme (to complete March 2018). While not an explicit intent of the module, it is encouraging that 24 participants (38%) have subsequently gained promotion or changed roles to one where leadership and facilitation are key aspects of the job. While many participants commence not seeing self as either leaders or facilitators they leave transformed, rising to new challenges. A key element within the programme is the development of self-awareness and this has enabled participants to view themselves through a different lens; to understand how their attitudes and behaviours can affect others and practice, the result being that many actively use this raised consciousness in leading practice development.

Keynote 2

16:00 – 17:00 / Room: Singapore

Dance and Leadership: How leaders and followers relate and influence each other

Professor Dr Brigitte Biehl-Missal

In complex environments in 21st-century organisations, leaders need to engage in new, innovative and people-centred ways of managing. Leadership has thus been considered an "art", not only a "science", and has also been compared to "dance": The interaction in leadership situations involves both leaders and followers, is "in motion" and constantly changing. Leaders and followers participate in the situation collectively and perceive the relationship not only through their rational mind, but with their whole body and its empathy. Leadership theory has long said that bodies do not matter until researchers have taken into account the lived world of leadership – which also is particularly important for people working in the healthcare sector. This keynote provides examples from the arts world, from ballroom dancing and from

DJs who use their bodies to make sense of situations. It also includes practical elements of movement exercises to make participants experience in new ways the dynamics of leadership and followership.

Keynote 3

THURSDAY, AUGUST 23RD

Keynote 3
09:00 – 10:00 / Room: Singapore

Swarm Intelligence in Honey Bees

Professor Dr Thomas D. Seeley

Swarm intelligence is the solving of a cognitive problem by two or more individuals who independently collect information and process it through social interactions. With the right organization, a group can overcome the cognitive limitations of its members and achieve a high collective IQ. To understand how to endow groups with swarm intelligence, it is useful to examine natural systems that have evolved this ability. An excellent example is a swarm of honey bees solving the life-or-death problem of finding a new home. A bee swarm accomplishes this through a process that was discovered at the Zoological Institute of the University of Munich in the 1940s, and that has been analyzed more deeply in recent years. It includes collective fact-finding, open sharing of information, vigorous debating, and fair voting by the hundreds of bees in a swarm that function as nest-site scouts. Thomas Seeley will show how these incredible insects have much to teach us when it comes to achieving collective wisdom and effective group decision making.

Parallel Session 3

Concurrent Session 11
10:30 – 12:00 / Room: Singapore

03.01.01 "It's a nice place to be": The story of development of a flourishing hospice.

Professor Brendan McCormack

According to van der Eerdener et al. (2016) where professionals are working collaboratively, engaging with patients in open and honest ways, the patients are more likely to feel valued as persons rather than an illness. Marie Curie, a UK-based charity has an overall strategic direction for the development of person-centred palliative and end of life care reflecting current best evidence (Yalden et al. 2013). A PD programme was implemented to develop a culture of person-centred practice within one UK Hospice. The programme drew on a number of theoretical frameworks including Person-centred Practice (McCormack and McCance 2017), transformational PD (Manley et al 2008) which was operationalized through active learning (Dewing 2006).
We will use creative methods in this presentation to engage the

audience with this work. The aim of this session is to reveal how a shift in focus from person-centred care to a person-centred culture occurred. We will outline the cyclical nature of the work undertaken and share how adopting a framework for human flourishing enabled 'the person' to be at the centre, whilst simultaneously developing practice and a healthful workplace culture. We will share how, by adopting the Ecology of Human Flourishing (McCormack and Titchen 2014) as a lens for analysis, we have been able to get inside the process and outcomes and the impact this has had for individual staff, teams, patients and families.

At the end of this session participants should be able to:
1. Have insight into the process and outcomes of the development programme at Marie Curie
2. Understand how the Ecology of Human Flourishing can be used as an evaluative framework
3. Have the opportunity to reflect on potential uses of this new framework of analysis.

03.01.02 German version of the Person-Centred Practice Inventory (PCPI-S)[1]

Christoph von Dach

Background The development of person-centred care is a modern-day requirement in Swiss hospitals. The structured analysis of the state of person-centred care and workplace culture is in turn a cornerstone for further development. The PCPI-S was developed to measure these aspects. For this reason, a German version of the PCPI-S has been developed and tested.
Problem Until today, there has been no adequate German-language instrument to measure person-centred care based on the Person-centred Practice Framework.[2]
Method and sample The translation into German followed good practice3. It included two forward translations, an analysis by an expert panel, and two back translations. Testing in actual practice follows at the end. The PCPI-S will be applied for measuring the current state of person-centeredness at Solothurner Spitäler AG in 2019 based on an intervention study. The session will include a presentation and a discussion of the PCPI-S (German) in measuring person centred practice in Swiss hospitals.
Results At the time of this writing, the translation was still in process. Testing is planned for autumn 2018.
Discussion The translation of the instrument into German fills a gap in measuring the person-centred workplace culture in the German-speaking world and meets a need in practice development in Switzerland.
Literature
[1] Slater, P. & McCormack, B. (2017). The development of the person-centred practice inventory-staff (PCPI-S). International journal for quality in health, 29(4), p. 541-547.
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[3] Wild, D., Grove, A., Martin, M., Eremenco, S., McElroy, S., Verjee-Lorenz, A., Erikson, P. (2005). Principles of good practice for the translation and cultural adaptation process for Patient-Reported Outcomes (PRO) measures: Report of the ISPOR Task Force for Translation and Cultural Adaptation. Value Health, 13(2), p. 94-104. doi: 10.1111/j.1524-4733.2005.04054.x.

03.02.01 Challenge the further development of PD-culture and Lean Hospital

Irena Anna Frei, Katharina Rüther-Wolf, Anja Ulrich

In this symposium we like to share experiences of bringing together PD culture and Lean Hospital and how to develop strategies for an inter-professional approach.
More than ten years ago a multi-disciplinary Practice Development (PD) programme to enhance emancipatory change leading to person-centred, evidence-based health care was introduced in an acute tertiary teaching hospital in Switzerland. In 2016, Lean Hospital Management was adopted by the Executive Board in order to address the strategic fields of processes & standards, quality, productivity and employees & culture. While both approaches have a lot in common there are also some differences. Nursing practice was facing challenges and addressed the following questions: Why implementing a new approach to improve quality nursing care when there is already a well-established way of doing it with PD? What is the contribution of Lean Hospital to a culture of effectiveness and specifically on a person-centred care?

PD-culture and the way forward with the new initiative of Lean Hospital
This presentation will report on a multi-disciplinary Practice Development (PD) programme to enhance emancipatory change leading to person-centred, evidence-based health care in an acute tertiary teaching hospital in Switzerland. An action orientated approach was used to support work practices and the environment to that of collaboration, inclusiveness and participation across multidisciplinary teams to improve care practices. It also elaborates on the principles of Lean Hospital management and how the two initiatives enrich and complement each other.
Three sub-programmes were launched in 2006 to continuously develop clinical nursing practice towards a patient-, evidence- and outcome-orientated care culture. The Clinical Leadership Programme was aiming to enable nurse leaders to develop a patient-, staff-, evidence- and outcome-oriented leadership style. The Advanced Nursing Practice Programme was set up in order to support the roles of nurse at Master's or PhD level, and to link up the various disease management programmes which were developed using an interdisciplinary approach. The programme Best Practice-Best Care aimed to develop, implement, and evaluate evidence-based programmes and guidelines of disciplinary and interdisciplinary relevance. Unit-based clinical nurse specialists (CNS) are responsible for continuous practice development activities. Within this realm they facilitate change and promote and support the transfer of new knowledge and guidelines into the daily routine of nursing practice. Many CNSs have become skilled facilitators, using a person-centred approach to facilitation, engaging stakeholder throughout the change process and supporting systematic approaches to enhancing the practice context. Facilitation centres on co-producing knowledge using critical reflection and critical conversation and supporting learning in and about practice.
Over the years, other initiatives to support clinical practice have

found their way into our culture. However Lean Hospital was one initiative that challenged nursing practice but also PD philosophy, which is focused in this symposium.

Lean Hospital Management and the way forward with PD culture
This presentation illustrates the approaches of Lean Hospital Management and the implementation on a ward. Lean Hospital (LH) is a comprehensive management system adopted by the Executive Board of acute tertiary teaching hospital in Switzerland in order to address the strategic fields of processes & standards, quality, productivity and employees & culture. The division Patient-Centered Management is supporting the Departments and Clinics with the implementation of LH.
LH places the patient and his well-being consequently at the center of attention and supports the professionals to reach their quality and productivity goals – so that there is more time for patients and employees may work more effectively. Thus, LH is the investment of time and brainpower of all employees with the ultimate goal of improving the performance of the hospital for the patients. There are numerous interfaces between LH and other initiatives such as Practice Development (PD). In comparison to PD, however, LH sets a special focus on interprofessional collaboration.
On Lean wards, workload is levelled and all services are being brought towards the patient. Tasks are assigned to employees in accordance with their qualifications (Skill-Grade-Mix). The following five principles constitute the pillars of a LH:
• Focus on the **patient benefit** and on **value-added activities.** Patient flow is increased through the reduction of waste and process optimization;
• Commitment to i**nterprofessional collaboration**, for example through a short, structured and proactive planning of the daily routine (Huddle);
• Continuous development of the **competences** according to the hospital's mission. LH supports the self-competence, social competence and leadership competence;
• **Continuous improvement of the performance** through the continuous improvement process (KVP) and visits of the place where value is created (Gemba);
• The use of **standards** as basis for quality and support for patients and employees through **visualization**, for example through the introduction of patient boards.

PD-culture and Lean Hospital management: the challenge in nursing practice
In this presentation, I as Head of Nursing Medical Department will address the challenge of bringing together Practice Development (PD) culture and Lean Hospital in an already well-established person-centred culture in every-day practice. Ten years ago a multi-disciplinary PD programme was introduced to an acute tertiary teaching hospital in Switzerland to enhance emancipatory change leading to person-centred, evidence-based health care.
In 2016 the top management decided to implement a Lean Hospital programme, which was understood in practice to optimize processes and working structures. We also understood that one of the essential Lean concepts is continuous improvement of work processes in a new form of flow efficiency to increase the focal point of care on needs and values defined by patients. For this initiative the executive board created the acronym PIC, meaning "patient in the centre", which clearly focuses quality care and not the economical output.
But why implementing a new methodology to improve quality

nursing care when there is already a well-established way of doing it with PD? What is the contribution of Lean Hospital to a culture of effectiveness and specifically on a person-centred care? Consequently, I initiated discussions and reflections with the Clinical Nurse Specialists and the Ward Managers to find the congruent essence of the two approaches for a shared commitment of a high-quality and efficient care with shared values and beliefs.

Creative Space 8
10:30 – 12:00 / Room: Mexico

03.04.01 The Creative Caring Project

Sally Hardy

The Creative Caring project is designed to test a range of creative arts based projects. These include use of visual arts, aesthetics and ways of seeing the wider aspects involved in their learning and clinical practice. Participants will be given a broad range of concepts and practical skills to apply in the workplace, encouraging therapeutic creative caring skills required for effective person centred care delivery.
The Dance of Caring Persons, the Heraldic Shield for Caring persons and the Patient Story Cube are creative learning tools that promote self-awareness to capture personal attributes, characteristics traits of a caring person. These skills and artistic expressions, will be used by nurses to take with them into clinical caring situations that may potentially be traumatic or emotionally disturbing, to 'shield' them from stress and burnout.
Health and social care staff work in complex workplaces, exposed and interacting with people bombarded with distress and disease. In order to defend themselves from responding to pain and hurt exposed, staff form rituals, customs and practices that have been shown to deaden their senses in order to distance themselves from engaging with their clients in a person centred and compassionate way. The Creative Caring project will provide practical and accessible learning packages that can be used across the clinical settings and within higher education.
The presentation will allow participants the chance of engaging with each of these creative learning workshops, and explore how they too can engage in creative arts as an approach to enhancing workplace cultures of effectiveness, where all can flourish. The end result will be to influence workforce attributes and therapeutic outcomes aiming to improve wellbeing outcomes for all. The outcomes will also impact on service users, as recipients of care, and prompt a spiraling of ideas across clinical teams. Other Creative Caring activities may also emerge, alongside feedback and evaluation from the workshop activities.

Creative Space 9
10:30 – 12:00 / Room: Hongkong

03.05.01 Exploring the strategies to enable transformative learning in practice through snakes and ladders

Maria Mackay

This creative space presentation aims to explore through critical conversations, the disorienting dilemmas that clinical supervisor learner and student learners face in clinical practice. This session will engage participants by having them participate in a creative online game of snakes and ladders.
The creative space will be focussed on fostering healthy workplace cultures. The theoretical framework that will be explored is part of a larger PhD study, which is considering the question "How do healthful relationships between clinical supervisor learners and student learners influence transformational learning?" Healthful relationships in this context includes shared decision-making, collaborative relationships, transformative leadership and innovative practice. The development of person-centred workplace cultures is an outcome of the development of healthful relationships (McCormack and McCance 2017, p.60).
Facilitation of learning is a principle within practice development which is recognised as being important for people in practice to grow and flourish. Clinical supervisor learner and student learners in the complexity of clinical practice face many disorienting dilemmas. These may arise throughout a placement period in the knowing, doing, being and becoming phases. The interactive game will represent the disorienting dilemmas as snakes for the people to consider and the ladders will be represented as potential strategies to effectively facilitate learning in clinical practice.
This session will challenge the participants to consider how strengths based transformative learning (Mezirow 2000) strategies in clinical practice can enable both the clinical supervisor learner and the student learner to balance doing and being in practice and transform to become and embody nursing practice whilst reaching their full potential. The interactive game will form the conduit to engage the participants and generate critical conversation that will provide a variety of perspectives on the facilitation of learning in clinical practice.

Concurrent Session 12
10:30 – 12:00 / Room: Guangzhou

03.06.01 Enhancing cultural competence in healthcare professions: A case study of a multicultural college in Israel

Lipaz Shamoa-Nir

Background Practical knowledge is needed in order to educate healthcare professionals with cultural competence, especially in a social context in which there is ethnic and religious diversity.
Summary of Work The purpose of this research is to examine how the multicultural reality in Israel is reflected in the curriculum and in the field training of departments of healthcare professions in a multicultural college. Both the academic goals and the training programs were analyzed in the light of the different nationalities,

ethnic groups and religions within the: students, academic staff, and in the training field. The study included an analysis of interviews with several senior staff members (administrative and academic), and an analysis of contents of the curricula of two academic departments (nursing and physiotherapy) and the syllabuses of different courses. In addition, several observations were conducted in classes, workshops and social events on campus.

Summary of Results It was found that management support in multiculturalism and dialogue processes promoted diversity in healthcare teaching programs. The departments that were investigated addressed the diversity by adjusting education models to the needs of students and the community in which they integrate, and by doing so, enhanced the cultural competence of the students.

Discussion & Conclusion The research highlights the importance of engaging in difficult dialogues that are inherent in teaching about diversity. Moreover, teachers and field supervisors who represent the cultural diversity serve as role models for ways of working effectively in cross-cultural situations.

Take-home Message Cultural diversity should be addressed as challenge and be represented in the public sphere and among students and teachers in order to become a professional advantage.

03.06.02 Leading by timely, accurate, problem-solving communication: a challenge for senior physicians and head nurses

Margot Tanner, Micha Kämpfer

Objective Inpatient wards are a highly interdependent work environment: practitioners only realize their potential if structure, processes and culture are aligned. We propose and test that (a) a patient-centric design in structure and processes fundamentally enhances the performance of leaders and their teams and that (b) frequent, timely, accurate, and problem-solving communication drives effective coordination.

Methods Using the principles of lean management and the theory of relational coordination, we assessed by observation (3 medical teams) and surveys (158 participants) the current work processes and relational coordination in inpatient wards of 2 Swiss hospitals over a 12-months period. We introduced work process innovations and lean initiatives to improve team and leadership effectiveness. Pre- and post-intervention measures were conducted.

Results Based on the pre-intervention observation data, we found fragmented work flows, ad-hoc coordination and reduced joint accountability for shared care processes. The surveys evidenced lowest ratings for senior physicians in terms of their timely, accurate, and problem-solving communication. In addition, gaps existed between physicians' self- and external perceptions with regards to their effective communication and coordination patterns. Further-more, the data of the head nurses revealed moderate scores in timely, accurate, and problem-oriented communication despite frequent verbal exchange.

Conclusion The preliminary results of the pre-intervention data point to insufficient work processes and communication patterns that might hamper the leadership effectiveness of senior physicians and head nurses and negatively affect team performance. The pre-intervention measures proved critical to define lean initiatives specifically targeted to enhance the practice of a patient-centric design and to improve the performance of medical teams and their leaders.

Limitation The abstract focusses on the preliminary results of the pre-intervention measures, as post-intervention measures will be available earliest by May 2018. Exhaustive results will be presented at the talk.

03.06.03 The values conundrum: what happens when student values, Person-Centred Practice and workplace culture collide.

Carolyn Antoniou

Within healthcare, professional nursing values are a guiding principle, which articulate the beliefs and standards of the profession, unifying and identifying the individual to the group with the intention of providing high quality and safe care. Professional values are evident in healthcare policy and professional standards.

The nursing profession is comprised of individuals with personal values, influenced by multitudinous factors and widely varied, however the evidence suggest people are drawn to the profession when there is a sense of alignment of their values with the perception of the work nurses do.

Within nursing curricula, educational components transition the individual through the process of adopting and internalising professional nursing values. Then, through practice students actualise all they believe and have learnt, in an environment that is complex and does not always live up to the values it espouses. In situations where prescribed values are not always enacted, there is an intersect with students own values and the conflict becomes personal. Research has identified professional values at both ends of their degree and demonstrated a correlation with attainment of these to the student's sense of belonging to the profession. There is also clear evidence of the impact of negative experiences and the influence this has on the student's ability or even inclination to work within these values. It is imperative we consider the development of student nurses during these formative years.

In this presentation I will explore the values conundrum, the development of student's values and the fundamental relationship of this on person-centred care and effective workplace culture. Whilst we do not yet have a clear understanding of how professional values evolve during these years or the impact of this evolution of individuals to be participants in care that is person-centred; we do know it shapes the future of workplace culture.

Concurrent Session 13
10:30 – 12:00 / Room: Osaka

03.07.01 Improving care-givers experience – Enhancing end of life care for residents

Christine Boomer

Aim This presentation will share a collaborative programme between public and private sector organisations to enhance person-centred end of life care for residents.

Background As the ageing population grows nursing and residential homes are increasingly where people nearing end of life live and are cared for until their death. Many of these residents are living with chronic conditions and have complex care needs. Policy highlights the need for care providers to have up to date knowledge

and skills in providing symptom control and comfort to patients. However, evidence suggests knowledge gaps in care home staff (e.g. Brazil et al 2012). Traditional training approaches did not seem to have made a significant impact, compounded by high staff turnover associated with this sector.

Method A programme was developed and run collaboratively between one healthcare organisation and two care homes with the intent of developing participants' knowledge of palliative and end of life care, to enable them to develop and transform care practices in their homes. Sixteen staff participated, with registered nurses and care staff participating together in the six-month education programme and associated PD activities. Practice development (PD) methodology underpinned the programme; with PD tools, methods and approaches adopted throughout, for e.g. facilitation, reflection, exploring values and beliefs, collaborative working, encouraging ownership and spread, celebration of achievements alongside integrated evaluation.

Findings A mixed methods approach was adopted for evaluation. Results show that this PD programme has significantly improved the caregivers experience with an overarching theme of enhanced confidence as well as growth in knowledge and skills. This was evidenced by sustained change in culture and care practices within the homes, thereby fostering a healthier workplace culture. Subsequent anecdotal evidence, through home visits, shows sustained changes in practice with actions fully implemented and embedded despite an on-going turnover of staff.

03.07.02 The Inspire Improvement programme – Support for clinical leaders to create safe, effective and caring cultures

Joanne Odell

As a registered charity, the Foundation of Nursing Studies (FoNS) (www.fons.org) operates UK wide with nurses and nurse-led teams in health and social care for over thirty years, to lead innovation, improvement and culture change in practice. There is a great deal of evidence to suggest that the culture and context (Manley et al , 2013) within clinical settings and organisations play a vital part in influencing the way that care is experienced by patients and staff alike. However, there is less direct support for frontline clinical leaders to work to develop and improve their workplace cultures in real time. In 2017 FoNS launched the Inspire Improvement programme which is designed to fill this gap. https://www.fons.org/programmes/inspire-improvement. The programme will be underpinned by the Creating Caring Cultures model https://www.fons.org/learning-zone/culture-change-resources.

Twelve front line nurse leaders from a variety of clinical settings (UK wide) will take part in the programme in 2018, which will consist of six residential workshop days spread over a twelve month period to provide a safe learning space for the participants. With the focus on: themselves as facilitative leaders, understanding the components of culture change and then implementing some improvements in practice. Active learning (Dewing 2008) will be the main concept used within the workshops.

When back in the workplace the participants will have dedicated one to one time with a skilled Practice Development Facilitator (who acts as a critical companion), to work alongside them to implement new methods and approaches, gain confidence as a facilitative leader and to transfer their learning into practice.

This presentation will provide an overview of the programme and activities undertaken within the workshop days and the workplace visits. Evaluation data will be shared to demonstrate the impact of the programme for participants and their effectiveness in leading and developing their workplace cultures.

03.07.03 The "Integrative Model of Person Centred Care" - a framework for nursing practice in longterm care

Hanna Mayer

As part of a initiative of the federal state Lower Austria the development of a framework for all 48 Nursing Homes was commissioned. Two perspectives - that of science and practice - should ensure that both, the current scientific debate as well as regional practical knowledge and innovative ideas of the nurses, were considered. The aim was the development of a framework that meets regional conditions, cultural diversity and different forms of care and guarantees innovation, feasibility and long-term sustainability.

For development the process has been designed action-oriented (in alternating phases of developing, feedback, reflection) and participatory to actively incorporate the expertise and experience of the nurses. In addition to the continuous literature research, focus groups (4 /n = 47), 9 site visits in selected nursing homes, 2 expert rounds and 2 panel sessions were conducted. First results of the literature research structured the focus groups. They were analysed thematically and merged with the theoretical findings. Site visits and expert discussions were conducted to gain a closer look at specific practices. To develop a first concept, the structure of W.K. Kellog Stiftung (2004) was used. At the end of the process, 2 panel sessions took place, to validate the first construct. Since the core concept was person centredness, the concept was merged with the Person Centred Practice Framework (McCormac&McCance 2017). The result is the "Integrative Model of Person Centred Care (IMP-NÖ)" (image1) that describes person centredness at different levels and provides a basis for all care and support processes as well as for organizational, strategic and structural measures at the state level. It also provides the theoretical framework for evaluation. In an implementation process based on the principle of action-oriented learning, it was introduced in all state nursing homes. Additionally a 4-year research project for theory based evaluation has begun.

Concurrent Session 14
10:30 – 12:00 / Room: Samarkand

03.08.01 The influence of a 100% single-room environment on the experience of person-centred practice in acute-care.

Rosie Kelly

Aims and Objectives The aim is to explore the influence of a 100% single-room acute-care environment on the experience of per-

son-centred practice. The objectives are:

1. To explore, from the perspective of patients/families and staff, the experience of receiving/delivering care within a single-room, acute hospital environment.
2. To determine the factors that influence the delivery of person-centred practice in a single-room, acute hospital environment.

Background Much of the research on the single-room environment has focused on patient safety and the reduction in healthcare-associated infections. Recent research undertaken in the UK by Maben et al (2015) highlights the contrasting experiences for patients and staff relating to a new large, acute-care, single-room environment. The role of the physical environment in facilitating person-centredness remains unclear. While there is a significant body of work relating to person-centredness, the delivery of person-centred care and the impact of the environment on care delivery, there is no current evidence that links person-centred practice, staff and patient experience and the single room environment.

Design Ethical approval has been granted to undertake an exploratory ethnography to investigate the lived experience of patients and staff located in a single-room environment within a new inpatient ward block in a large district general hospital in Northern Ireland. The Person-centred Practice Framework (McCormack and McCance 2017) will be the theoretical framework underpinning this study, to better understand the connectivity between the environment and the delivery and experience of person-centred practice.

Methods The ethnographic research process will be guided and informed by the Workplace Culture Critical Analysis Tool (WCCAT) (ICOP 2017). Data will be thematically analysed to produce a thematic map.

Results Available preliminary results will be discussed within the context of the Person-centred Practice Framework.

03.08.02 Multiprofessional preoperative management for head and neck cancer patients with complex surgery

Roland Giger

Introduction Patients with advanced-stage head and neck cancer (HNC), which requires major ablative and reconstructive surgical procedures, are confronted with extensive functional, esthetical, psychological and social changes. Therefore, it is very important that the patient and his family are well informed about the treatment and its consequences. Feedback from patients treated in our HNC clinic and the involved professionals' shows that information provided during multiple visits was not supportive. To improve the comprehensive of care, the coordination of the involved professionals and the involvement of the patients' in the treatment and care decision, we implemented in 2015 a preoperative multiprofessional information day.

Objective To evaluate the practicability, benefit of the implemented preoperative information day for HNC patients undergoing complex surgery, regarding acceptance by the patients and professionals, effect on treatment decisions and patients' stress.

Methods In this longitudinal cohort study, all patients (n=94) scheduled for this day between February 2015 and January 2018 were included. The required data were extracted from the patient charts. The patient stress level was measured with the distress thermometer.

Results This information day was well accepted by most patients.

Only 12 (13%) of the 94 scheduled patients did not participate or complete the day. The majority of the patients felt well informed and had better understanding of the proposed surgery and upcoming care. They could also better accept the required treatment and related consequences, like the tracheostomy, feeding tube, etc.. The comparison of the stress values shows that 65.5% had at the end of the day a lower stress score, although the differences were not significant.

Totally, 16 patients (17%) did finally not undergo surgery. In 9 participating patients (11%), 7 refused the intervention, the tumor was estimated non-resectable by the senior physician in one patient, and another patient had important comorbidities. Seven of the 12 non-participating patients (58%) refused surgery definitively.

Although the pre- and post-consultation stress thermometer values were not significantly different, 65.5% had a lower score after the consultation.

Conclusions and relevance The results indicate that the implemented preoperative multiprofessional information day improves the patient's and family's understanding of the proposed care and it supports a shared treatment decision. It has also a positive effect on the stress level.

03.08.03 The Transformation Within: The Journey of a Strength Based Organisation

Grant Kinghorn, Semakaleng Hlapane

In 2015, Justice Health & Forensic Mental health Network (JH&FMHN) began investigating the application of a strengths based approach to support talent development and leadership capabilities throughout the Network. There was an intention to influence workplace culture using a person-centred focus to develop genuine collaboration within and across working environments and strengthen future success of the Network. Underpinning this approach was the use of strengths-based assessment which concentrated on the inherent strengths of individuals to encourage empowerment and transformation. Guided by adaptable facilitation and appreciative inquiry, the use of the assessment became a vehicle for initial person-centred conversations with staff regarding their influence on everyday practice and the impact they had on others, the Network and on the greater health care system.

Since its adoption, the strengths-based assessment has been undertaken by over 250 JH&FMHN staff members across both clinical and non-clinical sectors and has become an foundational framework for individual coaching and reflective supervision, team engagement and development as well as ongoing critical conversations surrounding Network engagement, organisation change, culture and values clarification. The assessment has also been embedded in individual and team based leadership and development programs that focus on fostering positive culture. While initial adoption was strongly associated to enlightenment and education for staff members, this has evolved to reflect a greater emancipatory focus with consideration of culture improvement at a systems level.

This presentation will explore the context and progression of the assessment within the evolving vision of JH&FMHN becoming a committed strengths-based organisation. It will also highlight

shared learning based on outcomes achieved and consider its application to other health care environments to support and sustain positive workplace culture.

Concurrent Session 15
10:30 – 12:00 / Room: Miami

03.09.01 Striving towards Person-Centred Midwifery Practice

Karen Tuqiri

In Australia midwifery practice is facing a number of practice challenges including such things as a severe shortage of midwives, lack of integrated services, inconsistencies in care delivery including medicalisation of maternity services, role clarity and growing staff dissatisfaction. These issues impact on the care that woman and their babies receive and directly influence access to services, preparation for birth and ultimately satisfaction with care. In this presentation we will discuss the urgent need to address these issues and outline why we think taking a person-centred approach in Midwifery Practice may be of benefit for woman and their families, staff and organisations providing maternity services. We will present one organisations approach to addressing these complex, interwoven issues through a person centred program of culture change work. Whilst over the last decade or so numerous attempts have been made to address these issues there has been little or no sustainable improvements in the prevailing culture. The current program includes a person-centred leadership curriculum, implementing new staffing models, developing recruitment strategies to attract new staff, providing person centred learning and development support for students, new graduates and staff and engaging staff in cultural change initiatives.
The implementation of this program has been far from easy, we will highlight what has worked well and not so well and how we have overcome the obstacles and barriers that have emerged as the work progresses. We will provide examples of the learning and development as well as the outcomes of the work to date, how these are influencing staff, the delivery of care and the experience of the woman and her family. We will finish by highlighting our journey towards achieving person centred midwifery practice and what the future holds.....

03.09.02 Different but same? Two nursing teams' journeys to a better understanding of person-centred-ness

Corinne Auer

Speaking of two nursing teams, let's call them team A and team B. Both of them are built up differently, and have different pre-existing issues. Nursing team A asked me for a list of nursing procedures which they are allowed to neglect when there is too much work to do. Nursing team B wished to create their own common understanding of nursing. I offered to accompany both teams on a practice developmental journey, with me acting as their facilitator. They accepted my invitation; team A being enthusiastic, team B feeling a little suspicious. Both teams prepared for the journey, took off,

went along, and finally arrived at the first destination.
Did team A still want their list at the first destination, or had something changed along their way? How did team B progress, and what had they created on their journey? Did the teams display shared values? Did they reach the first destination together? Have their initial feelings changed? Are they motivated to go on to the next destination? Are they taking their patients with them? Let me share their current journeys with you, and my experiences as a novice facilitator.

03.09.03 Strengthening Nurse Surveillance in General Wards: A Practice Development Approach

Jacqueline Peet

Prevention of patient deterioration is primarily a nursing responsibility in hospital. Registered nurses are educated to make judgements about emerging threats to patient safety and take action through a process of nursing surveillance: the purposeful and ongoing collection, interpretation and synthesis of patient data for clinical decision-making. In practice, nursing surveillance is often suboptimal on general wards, increasing the need for patient rescue at the end-point of clinical deterioration with poorer outcomes. Much is written about educating nurses to comply with protocols for patient safety, but very little research exists on transforming workplace cultures to support person-centred assessment.
The purpose of this research is to evaluate an emancipatory practice development methodology for strengthening nurse surveillance on a single medical-surgical ward in Brisbane, Australia. Thus far, exploration of the context and culture of patient assessment on the participating ward has been undertaken using nonparticipant observation and interviews.
We offer a metaphor of nursing surveillance as the threads that support the very fabric of hospital nursing work. These hidden threads enable nurses to weave the tapestry of care that keeps patients safe. Yet because they form a supportive structure that are hidden behind the visible outcomes of care, they are vulnerable to be weakened and distorted. A critical analysis of this data is presented which informs the beginning of a practice development journey with ward staff by generating core concepts to guide transformative action.
This workplace observation has deepened our appreciation for critical theory as a powerful analytical frame for PD research, here exposing the hegemonic structures operating in relation to nursing surveillance in the research setting. It has also challenged us to find ways to creatively engage with some of the underlying systems issues that so often remain hidden from view in the deteriorating patient literature.

Parallel Session 4

04.02.01 On Achieving Collective Intelligence

Professor Dr Thomas D. Seeley

We will build on the plenary address about collective decision-making by honey bees by discussing the challenges and solutions that we have experienced in the context of collective problem-solving by human beings.

04.03.01 Moving patients – moving professionals – getting patients out of bed!

Peter Suter

Movement is central to life and a vital activity of daily living. Movement promotes self-confidence, prevents complications and is an important component of early rehabilitation in the hospital setting. Preventing immobility in elderly hospitalized patients is one of the five interventions recommended by the Swiss Society of General Internal Medicine. According to the Diagnosis Related Group evaluation research, mobilising patients in acute care is most likely to be left out due to lack of time. Promotion of activity is an interprofessional and interdisciplinary task of health care professionals, physicians, nurses and physiotherapists. Therefore, the Board of Nursing Management at the University Hospital Basel has launched a PD-project to encourage and support mobility. An action orientated approach was used by the core group to include professionals across multidisciplinary teams to enhance emancipatory change leading to person-centred evidence-based practice.

In a first step about twenty nurses and physiotherapists were recruited and enabled to interview patients, nurses, physiotherapists and physicians asking the question: "What promotes and prevents mobilisation of inpatients?" The following areas were identified: motivation, knowledge, resources and patients' and staff's state of health. Patient motivation and staff commitment were considered to be promoting factors, whereas lack of knowledge regarding movement and consequences of immobility were seen as barriers. A wider range of physiotherapy, activity programs and walking aids appear to foster mobilisation. A structured interprofessional teamwork seems to be a key factor. The patient's reduced state of health and their fear of falling are important inhibiting factors.

In a second step these results were presented to the stakeholders. Feedback was encouraged, clustered and issues were prioritised to be addressed by different working groups.

In this creative space we invite participants to share their experience of patient mobilisation, concepts used in practice and to jointly develop new ideas on this topic.

04.04.01 Effective workplace cultures and good places to work – We are interested in your views!

Kim Manley

Through collaborative, creative approaches we would like to invite participants in the conference to contribute experience, expertise and interest in growing our knowledge and understanding about how to recognise and enable workplace cultures across health and social care that are effective[1] and also good[2]. Working within different settings and roles, our aim is to answer the question: "What works, for whom, and why, when developing and embedding such cultures?" our ultimate intention being to develop a greater understanding of what "makes" effective workplace cultures that in turn supports and enables collaborative practice change and transformation.

We plan to achieve this through a series of twitter chats, blogs and workshops, refining our insights systematically based on a wide range of peoples' experiences, expertise and evidence.

In this creative space we want to work with the ideas that are emerging to date around the following questions:

1. Why should we concern ourselves with workplace culture?
2. What if you came to work tomorrow and found yourself in a really good and effective workplace culture, what would it be like?
3. How would others (delivering and experiencing care) know that it is an effective culture and a good place to work?
4. How can we develop and sustain good and effective workplace cultures?

We also we would like to generate new insights and understanding based on your experience and expertise from different settings so as to refine our thinking together using a range of creative mediums.

The co-operative inquiry builds on previous work as an international practice development collaborative around the concept of an effective workplace culture.

[1] Effective means achieving the outcomes of person-centredness and evidence-based care (performance)

[2] A good workplace is one where healthcare staff want to work because they experience a sense of wellbeing and growth by working there.

04.05.01 Team Culture Development for Curriculum Transformation: Beyond the 'U' Bend

Jan Dewing

This symposium will offer an overview of a three year culture transformation project within a Scottish university. Scharmer's Theory U and the U bend has become the focus of much reflection and activity in our nursing team as part of developing our own culture with the intention of becoming part of the living person-centred curriculum. First, we will set the scene by presenting the context and prevailing culture as it was and also set out the

essential ideas within person-centredness and Theory U that give the theoretical framework for the project. The second presentation will demonstrate learning and evaluation from key time points within the three year timeline with a focus on the U bend or more importantly getting round and beyond the U bend and up the other side. Finally we will draw on significant learning and outcomes as well as the International ICoP curriculum statement to suggest what lies ahead. Overall, it is narrative full of hope!

"We are the people we have been waiting for" (Laloux 2016)

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Creative Space 13
13:30 – 14:30 / Room: Guangzhou

04.06.01 About holding space in facilitation - Learning from Native American culture

Christoph von Dach

Background A crucial prerequisite to the successful facilitation of a group is the creation of a space that makes the group feel safe and allows creativity. On the other hand, the active participation and support of the group is necessary to create this creative space. In native cultures, such as the Lakota, a Native American nation, the importance of holding space for ceremonies is very well known. The medicine man creates the space and opens and closes it. Looking at the Native American tradition may provide a strong idea of what holding space in facilitation means, and how it may work in the context of facilitation in Practice Development.
Question and Problem The workshop will be led by the following questions: "What are the factors that help to create and hold safe spaces and what may Practice Development learn from Native American culture?"
Method Working on the question by using critical creative methods, group discussion and an exchange on Skype with a Native American medicine man.
Literature Mails, E.T. (2013). Fools crow. Lincoln: Bison Books
McCormack, B., & McCance, T. (2017). Person-centred practice in nursing and health care theory and practice, West Sussex: John Wiley & Sons Ltd.

Creative Space 14
13:30 – 14:30 / Room: Osaka

04.07.01 Are we person-centred? Leading person-centred cultures by understanding and "being"

Helen Pratt

How do you define person-centredness? Do you practice "being" person-centred? What person-centred qualities do leaders need to possess to support teams to flourish, and what do person-centred teams look like?
In my experience as a clinical educator, practice developer and academic facilitating numerous active learning spaces, dialogues and group discussions on person-centred care with clinicians, managers, and students I have seen little evidence of a shared understanding of person-centredness. This is recognised in the literature, and differences in understanding how person-centredness translates to actions and behaviours at macro, meso and micro levels impacts on healthcare cultures and the experiences of all who participate in healthcare. Leading person-centred workplaces and supporting teams to create person-centred cultures requires a deeper understanding of our "self" and our own values and beliefs as reflected in the McCormack & McCance (2017) Person-Centred Practice Framework. With no shared understanding of person-centredness, it is difficult to create a values-based culture where actions and behaviours lead to flourishing workplaces and good care experiences.

Do we need to "be" to "do"?

In a creative space I plan to engage with participants in an exploration of being person-centred and leading and working in person-centred ways.
Exploring the doing and being, feeling and knowing through a series of activities and critical dialogue this space will encourage and support those present to gain a greater understanding of their knowledge, values and beliefs around person-centredness, and aims to create a space to reflect on how this translates to authentic person-centred actions and behaviours in the workplace.

Concurrent Session 16
13:30 – 14:30 / Room: Samarkand

04.08.01 Exploring person centred care in the post anaesthetic care unit: Does it matter to me?

Erna Snelgrove-Clarke

Using the best evidence in clinical practice improves patient outcomes. Person-centred care (PCC) has demonstrated positive outcomes when employed in healthcare settings. However, the concept of PCC has yet to be studied in the environment of a Post Anesthetic Care Unit (PACU). When using the five processes that make up PCC, (1) Working with the patient's beliefs and values, (2) Engaging authentically, (3) Sharing decision making, (4) Being sympathetically present, and (5) Providing holistic care demonstrated outcomes related to a good care experience, to promote feelings of well-being for both client and provider, and to promote a healthful culture are evident. This implementation project will build upon the PC-

CFramework in a PACU and identify appropriate evidence-based interventions to change interdisciplinary provider behaviour in this setting. We will achieve this goal by seeking to understand the barriers and facilitators for PCC within the context of the IWK Health Centre Gynaecology PACU and aim to successfully implement evidence-informed PCC in this environment.

This mixed method implementation study, conducted in a regional tertiary care and university teaching hospital in Atlantic Canada, will influence the provision of health care in a variety of ways. Optimal and consistent evidence-informed practices for PACU are expected to support health care providers to improve care experiences and patient outcomes. In addition, using a PCC framework, we will take into consideration the well being of the provider to ensure that the culture of the unit is consistent and mindful of PCC. Evidence-informed strategies improve patient care, align with provider well being, and will be cost savings in terms of health outcomes and of emotional well-being.

At this presentation, we will explore care providers' barriers and facilitators to PCC and share our selected strategies for implementing PCC in a PACU.

04.08.02 Person-centred practice and "learned helplessness" ...Beauty and the Beast

Katherine Riley

Nursing professionals working in person-centred ways aim to ensure the nursing care they provide is authentic, compassionate and holistic. In doing so we understand the importance of embracing evidence informed practice changes that will ultimately enhance the person-centred cultures that we contribute to.

As a registered nurse, I have had moments within my career where my ability to adapt to change and embrace innovation have been thwarted with periods of 'learned helplessness'. There has been much written on the theory of learned helplessness and how we may come to mimic this characteristic in society from failed experiences. A past negative experience can emulate into a person feeling they cannot affect the outcome of a current situation. If we consider the healthcare environment where innovation and change occurs concurrently, blended with staff that have been immersed in a work place culture that does not embrace collaborative practice changes you then have a setting where learned helplessness can transpire.

As clinicians, learned helplessness can stifle our ability to be person-centred by suppressing our contribution to the care environment through shared decision making, effective staff relationships and innovation and risk taking. In this presentation I will outline how learned helplessness impacts on our ability to be person centred. Ill explore what our role is in safeguarding our experiences with innovation and change and provide examples of how we can tame the beast, ensuring we can all positively contribute to workplace learning.

Concurrent Session 17
13:30 – 14:30 / Room: Miami

04.09.01 Imagining a better future: the outcomes of the Wellness Wednesday self-care program for healthcare staff

Val Wilson

There is recognition that working in the aged care setting can be physically and psychologically demanding, stressful and can lead to staff burnout. These types of demands can result in reduced job satisfaction, disengaged staff and can be detrimental to care delivery. In order to address these issues in a 52 bed sub – acute geriatric hospital within Australia, a self-care program was initiated to support staff wellbeing. The staff (nursing, allied health, managers, security staff) themselves were engaged in co-designing the self-care program alongside the project team.

The Wellness Wednesday program runs for 45-60mins every Wednesday for eight weeks and includes a variety of self-care strategies e.g. yoga, reflexology, mindfulness and gratitude. There is wide recognition that strategies such as mindfulness can enable healthcare staff to work with compassion in stressful and demanding work environments, improving listening to others, being more present, less judgmental and more considerate of others perspectives. All staff within the hospital were invited to participate in the eight sessions. Each eight week program caters for 10–12 multidisciplinary team members. Throughout the study participants were supported to 'IMAGINE' how the care environment could be enhanced to support the well-being of all staff, suggestions for improvement were captured and submitted to the Imagine committee for consideration. In addition staff were encouraged to use the techniques they were learning with their colleagues and where appropriate with patients (e.g. providing simple hand massage).

In this presentation we will share the results of this mixed-methods intervention study including what worked well, how the strategies impacted on improved participant well-being and promoting a healthy workplace culture. Highlighting improvements in staff engagement, job satisfaction, workplace wellbeing and reduced intention to leave. We will also offer insights into how you could use the Imagining a better future process for staff in your workplace.

04.09.02 Using curriculum to foster healthy workplace cultures

Tracey Moroney

Embedding person centred practice and placing values at the heart of a nursing curriculum and learning environment are essential to developing graduates with transformatory abilities who can influence culture and the context of nursing.

A curriculum can be a powerful tool used to prepare individuals for roles that support professional excellence, personal and professional growth. It can equip individuals to think critically and challenge established processes in pursuit of compassionate and transformatory practice. These are key skills in supporting personcentred environments.

Effective curriculum development is a staged process that begins with the development of a conceptual framework; conceptual

frameworks provide a structure for how knowledge and practice should be defined, categorised and scaffolded throughout the degree. Using principles of person-centredness and the person-centred practice framework to facilitate the structure of the curriculum has provided the School of Nursing at UOW with a clear guide. These have influenced the design of subjects, learning outcomes, teaching and learning strategies and assessment. The aim of our curriculum is to develop graduates who are enabed to practice authentically within their identified values and beliefs. Working with students in person-centred ways will facilitate the development of effective and cohesive knowledge and practice essential for the development and flourishing of successful registered nurses who actively contribute to the creation of healthful cultures. This presentation will outline the steps taken in the preparation of the Bachelor of Nursing and will highlight the person-centred concepts that have been embedded throughout the curriculum.

Show & Tell

Show and tell display
14:30 – 16:00 / Room: Foyer

ST.10.01 Using the P.I.E.C.E.S. program to lead and sustain practice development

Lilian Hung

Knowledge translation can be a very slow process and often difficult to achieve to full potential. We have a dearth of knowledge translation research that explores "how" to effectively move best practice into daily applications and achieve sustainability in the field of gerontology. The Older Adult Tertiary Mental Health program in Vancouver General Hospital took on the task of bringing the P.I.E.C.E.S. program, a Canadian developed and evidence-based clinical assessment and care planning program into practice. The team had support from clinical leadership and the hospital research institute to complete their first knowledge translation study in 2015-16. A paper was published in 2016 to share the lessons learned. The first study examined what enabled the success of rapid adoption of the P.I.E.C.E.S. program. Qualitative methods were used, including focus groups with 20 staff and individual interviews with three leaders. We identified three key enabling factors: (a) fostering positive energy to make continuous improvement, (b) working with team members across disciplines at all levels, and (c) using knowledge translation tools to enable and sustain the new practice. To-date, we continue to apply P.I.E.C.E.S. in our practice. We hold weekly P.I.E.C.E.S. huddles with the whole team and families for care planning. We've seen the benefits and shared our tools with other teams who care for older adults in British Columbia, Canada. Our clinical nurse specialist is taking the next step, leading a second knowledge translation study to move the P.I.E.C.E.S. program into community care. In this presentation, we will describe the P.I.E.C.E.S. program and how it works. We will also share and discuss what factors support and hinder the spread of the P.I.E.C.E.S. program across settings.

ST.10.02 Applying gamification to develop practice in dementia care

Lilian Hung

The literature shows most hospital staff do not receive dementia education despite they care for patients with dementia in daily practice. Research tells us the key barriers to effective dementia education include a lack of staff engagement, experiential learning, and sustainability. Workshops have limited effectiveness as staff often find the classroom content boring, not relevant and difficult to retain. Many are unable to attend due to busy work schedules and staffing shortage. The goal of this project is to increase staff engagement, motivation, knowledge, and effectiveness of dementia education among hospital staff. This project involves a student in computer science program working with the clinical team and learning technology team in Vancouver General Hospital to develop online games for learning Effective Communication in Dementia Care – The ART & SCIENCE of Person-Centred Care. The three phases of the 10-week project include: (1) literature review and needs assessment with users (hospital staff), (2) co-design of the content with 70 interdisciplinary staff (e.g., nurses, physicians, occupational therapist, physiotherapist, unit clerk) in medical and mental health units, (3) testing the games by using multiple PDSA cycles. The online course resides in the Learning Hub, a platform where staff in all hospitals within the province can have access to use. Staff not only gain communication skills in caring for patients with dementia individually but also can have fun and healthy competition as a social experience to stimulate ongoing engagement and active learning. In this presentation, we will demonstrate what we have learned about the impact of applying Gamification in Dementia Training (GDT). Findings related to improvements in knowledge and engagement will be discussed. We will engage conference attendees in dialogues about the acceptability and challenges in sustainability.

ST.10.03 Imbalanced nutrition in hospitals – a matter of culture and lack of person-centred care?

Silvia Grob

Introduction The nutritional status significantly influences complication risks e.g. infections, delayed wound healing, falls, delirium and pressure ulcers. The nursing diagnosis 'Imbalanced Nutrition' in hospitalised patients is a serious, often unrecognised problem (prevalence 30-50%).
Background A literature review and clinical evaluations indicate lacks of interdisciplinary responsibility for patients' nutritional status - especially in nurses. Previous findings show that the process of patient nutrition is complex, involving several professional groups. There is a literature gap on studies addressing Imbalanced Nutrition as part of the Advanced Nursing Process. Research on interventions to enhance patients' nutritional status over eighty years is urgently needed.
Facilitating inter-generational person-centred cultures. Attitudes and team-cultures including information flow need to be changed to better focus on patients' care needs.
Aim. First, the inter-professional process of patient nutrition and status are explored. Second, selected interventions are piloted. The overall aim is to improve patient nutrition and person-centred care in an acute care setting.

Method Design. Mixed method design with a literature review, followed by concurrent qualitative (interviews, observations) and quantitative data collections. Quantitative routine data e.g. protein- and energy-intake and Body Mass Index are statistically analysed. The Advanced Nursing Process including Imbalanced Nutrition and advanced nursing interventions is evaluated with the Q-DIO Instrument.

Setting This inter-professional research project takes place in a Swiss public hospital. It includes surgical, medical and acute geriatric University departments.

Sampling Quantitative (N=660 protocols) and qualitative data (n=27 interviews) of patients aged ↗80 with a LOS of ↗4 days is collected by convenience sampling. Patients with parenteral nutrition are excluded.

Results Our pilot results show a patient nutrition process including 14 phases, six professional groups and several lacks in person-centred care. Only 23% of patients met their basal metabolic rate.

Conclusion The study is ongoing, we will present new/more results at the conference.

ST.10.04 Unravelling Facilitative Leadership - A personal journey

Rachel Whittal-Williams

The presentation tells a story of growth and development of a nurse new to the role of leadership as a Practice Development Facilitator. The author led on a project 'Let's talk about miscarriage' (Whittal-Williams and Jones, 2017), funded by Foundation of Nursing Studies (FoNS) and Burdett Trust. The project gathered ten patient stories of the lived experience of miscarriage. The main aim of the project was to communicate the stories back to health professionals involved in delivering miscarriage care.

The show and tell display will use a hand crafted blanket to describe how a stray thread within practice was picked up, miscarriage support, and pulled on. This analogy will outline the messages of facilitative leadership development as the messages will be attached to the thread throughout the blanket. The blanket symbolises a common vision when it is whole. Unravelling the blanket symbolises the unravelling of the workplace, staff and ultimately the author herself as a facilitative leader. The messages will be handed out to the audience to hold and embrace the message.

The show and tell will reveal a journey of self-belief, embracing individuality and recognising self-worth. This personal journey of facilitative leadership will aim to achieve audience learning outcomes of:

• Facilitative leadership brings together the different strengths of individuals
• Facilitative leadership makes things easier and gets things done
• Facilitative leadership engages everyone to set agreed actions, empowering motivation.

Working towards a shared common vision, working towards a continuous process of improvement, building person-centred care by reflecting perspectives of patients and most of all keeping it real, embracing the real emotions of facilitative leadership (Dewing, McCormack and Titchen, 2014). The presentation will show the connectivity we can have when we come together in a shared vision, as the audience is connected together by the thread of the unravelled blanket.

ST.10.05 Living without a larynx; in collaboration with patients, care experts develop a "different" educational film

Kerstin Maschke

Laryngectomy patients have a considerable need for training to acquire self-care skills in the everyday handling of a tracheostoma. To meet the needs of the patients, an extensive education programme is used in the practice. But how well are patients and their relatives prepared for life at home with a tracheostoma?

To look into this question, affected patients and their relatives were verbally questioned in the form of narrative interviews. The interviews were carried out independently of one another in three different hospitals.

Inspired by the results, three care experts from these three hospitals developed the idea of producing a patient information film on the subject of "Laryngectomy in everyday life". The first step involved writing a script with care specialists, patients and their relatives. The film was then realised together with an affected patient and his family on a "normal" day in his usual environment.

The low-budget film gives answers to questions such as how the voice sounds with a voice prosthesis, what it is like to sit and eat at a table with friends when you have a tracheostoma, being around people or needing to quickly clean the tracheostoma.

Together with the extensive education programme and documentation to support self-management, the film offers patients, their relatives and care specialists a basis for actively bringing the life situation into conversation after a hospital stay. It allows all those involved to get an impression of what living with a tracheostoma could be like.

The implementation of the film in the three hospitals has shown that the conscious discussion between care specialists, patients and their relatives about life with a tracheostoma is a significant part of person-centred admission and discharge management.

ST.10.06 Advanced directives: the awareness of relationship

Tania Balestra

INTRODUCTION On January 1st, 2013 in Switzerland a law entered into force about the protection of adults, the right of people and parentage. The Swiss citizens can express their advanced directives (AD) on end-of-life health care. For this reason, nurses and doctors have to think about the right of self - determination and respect this one towards the patients. As a consequence of that, everywhere, some training sessions were implemented to help doctors and nurses.

AIMS The aim is the evaluation at ORBV (Ospedale Regionale di Bellinzona e Valli) about:
• Knowledge of the AD
• The effectiveness of the training implemented in 2014
• The awareness of the AD after the training

METHODOLOGY At the end of 2013, after a pilot survey on 20 nurses, a specific training was implemented to:
• Promote knowledge of the AD
• Help nurses to manage their emotions

After two years and about 40 training sessions, a second survey,

which involved 394 collaborators, was conducted on the subject.
RESULTS The first questionnaire (20/20) had shown a limited knowledge of the law (9/20) and of the meaning of the AD (15/20). The collaborators did not know how to deal with AD issues (13/20). In the second questionnaire (135/394) it was found that: 78% of collaborators deepened the subject for themselves and were able to raise awareness of it in the people out of the hospital. 53% no longer have problems talking about it. 80% appreciated training methods.
CONCLUSIONS This training has allowed more awareness of the topic in the nursing staff. Results show that self-awareness and relationship are the basis for patient-centered care. The idea is to extend the training to other EOC (Ente Ospedaliero Cantonale) hospitals and to make it multidisciplinary.
KEY WORDS Advanced directives.

ST.10.07 Mentoring: a way to become interdependent in the clinical nursing practice?

Annette Biegger

Background The Ente Ospedaliero Cantonale is a hospital system with seven locations, evenly spread over the canton Ticino. In 2016, the department of nursing of this hospital system, created a professional development model for the nurses working in the clinical practice. This model defines different new roles and responsibilities with the purpose to develop and enhance the professional clinical practice. Nowadays the clinical practice has to be interdependent because of the numerous professionals who have to collaborate to assure the best possible care for the patient.
Methods The way to become interdependent in these new roles requires hard and constant work. These are not skills that can be learned only from reading literature. A professional and personalized assistance is the most important element in this stage and we chose the methodology of mentoring. Mentoring increases the awareness of the professional development. This process is very appropriate and useful to assist these professionals in the development on the "maturity continuum" of S. Covey (2015). Mentoring became part of our professional development model.
Results and discussion To assure the coordination of the enhancement of the clinical practice in our different locations, we need a clinical nurse specialist (CNS) who is responsible for each location. These CNS have to demonstrate a wide competence on interdependence because of their interactions with different professionals. To guide the CNS along the "continuum of maturity" assistance in form of mentoring is provided by the department of nursing development of the hospital. After one year of application of this methodology, the CNS evolved from the stage of dependence to independence and are now closer to the final goal, the interdependence.
Conclusions Adopting the methodology of mentoring allows the role development from dependence to interdependence through independence. Interdependence is the fundament for the clinical practice enhancement.
Dependence → Independence → Interdependence

ST.10.08 Bridging the mHealth gap to improve person-centred practice

Emma Radbron

The ubiquitous nature of mobile phones and other portable information technology (IT) devices has seen the rapid development and acceptance of mobile health (mhealth) application use in healthcare. Historically, data has been fundamental in informing change, and the use of mHealth applications to collect data plays a pivotal role in quality improvement and healthcare delivery. mHealth apps have been developed to collect and deliver health related information for both patients and clinicians for a variety of purposes and there are large amounts of evidence available relating to the development and implementation of such apps. However, despite the sizable number of apps available for both health care providers and patients, there is limited evidence available on how the data generated from these apps is used, particularly in relation to using that data to inform person-centred practice or quality improvement.
This show and tell display seeks to illustrate how mHealth apps like the IMPAKT Healthcare app, are bridging the identified gap between patient and clinician and are fostering healthy workplace cultures by utilising technology to assist in person-centred data collection and analysis. IMPAKT Healthcare is an mHealth app developed to enhance the collection of data related to eight person-centred key performance indicators. The data is obtained from patients and carers as a means of highlighting their hospital or service experience. The app manages data collection and analysis and prepares data reports that are then fed back to staff and used as a way of gauging how person-centred they are. The app is currently undergoing feasibility testing in sites both in Australia and Ireland.
Using the medium of art, this show and tell display seeks to engage participants in a conversation about how we can bridge the gap between technology (mHealth app), improving practice and fostering healthy workplace cultures.

ST.10.09 Insights and perspectives: Workshop report on the partnership exchange and current revision of quality assurance

Sabine Welti Zwyssig

Background Students in the Department of Health Professions at Bern University of Applied Sciences spend a third of their degree programmes doing practical training. It is therefore essential that the dialogue between protagonists, practical-training institutions (PTIs) and the department is regulated.[1] The canton of Bern has been assiduously pursuing its education and training strategy since 2012.[2, 3]
Question/Aim Which quality assurance networks are important from an operational and educational perspective to ensure successful work placements for students?4 How can quality assurance ensure that such placements are beneficial not only for students but also for patients?
Method The structural framework requires quality assurance discussions between actors. In addition to situation analyses, these cyclical discussions include the identification of reciprocal adaptation processes and, where necessary, the adoption of

measures. Feedback from students about their work placements plays an important role here and flows into the exchanges between all involved parties.

Results Those responsible for practical training in the Department of Health Professions and the practical trainers from the PTIs meet regularly to discuss quality issues. Using standardised questionnaires, students are able to provide feedback about the practical module both to the department and the practical-training institution.

Conclusion Structured collaboration between all actors has a positive effect on learning culture. This leads to a culture of appreciative cooperation. The current revised documents facilitate these goals. Last but not least, patients can be cared for in a beneficial and person-centred way.

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ST.10.10 Handing the lantern over to the next generation - keeping the light burning

Sandra Walden

We often joke that we trained with Florence Nightingale yet sadly looking back over our nursing careers we are in the biggest staffing crisis yet. We have cherished the nursing values of caring for others throughout our careers and over the last decade as Practice Development Nurses we have focussed this on the nursing workforce rather than our patients with the belief that if they feel valued and supported they will be able to provide high quality safe care for our patients.

Being among the third of the nursing workforce reported to be retiring by year 2027 we want to pass on the lantern and leave a legacy of a highly valued profession. We recognise that the organisational culture is multifaceted and forever evolving, and our future leaders need to manage a workforce that is diverse in age, ethnicity, religion, sexuality, disabilities, education, workplace culture, values and so forth. To support and engage staff therefore needs to spread across a number of work streams and have wide accessibility.

When current budgets are being stretched beyond belief logistically all that can be offered to retain staff is development and feeling safe and valued yet the budget for CPD is also being cut year on year. We have therefore looked creatively at a variety of in-house professional and personal development courses.

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ST.10.11 Promoting a family-centered care culture in acute care: The story so far

Heidi Berlepsch-Schreiner

Evidence clearly indicates the need to engage families in acute care to increase their care experience, strengthen their capacities, and alleviate their suffering. For a major, university-affiliated hospital with 40'000 inpatients per year cared for by 2500 nurses, promoting family-centered care (fcc) practices across its diverse clinical in- and outpatient settings denotes a major challenge.

Initiating – creating a vision: More than five years ago, a small group of nurses with a shared vision around fcc initiated an organization-wide effort to put fcc approaches on the agenda. To do so, they conducted narrative interviews with nurse representatives across clinical areas to learn about attitudes towards, and ideas about fcc.

Developing –establishing a common frame: Based on these insights, a family-centered care group was established to develop fcc based on the principles of collaboration, inclusion, and participation. Over three years, the group worked on supporting its member in their efforts to promote family-centered initiatives within their clinical area. The group also sought to expand membership to include nurses and midwives from across the hospital while also struggling to keep fcc on the agenda. With the introduction of a professional practice model that defined person- and family-centeredness as central to the organizations' nursing care, momentum occurred for hospital-wide, concentrated efforts.

Implementing –nourishing practice initiatives: Subsequently, in consultation with nurses from across the care spectrum, the group created a two-year action plan. Its aim is to promote practice development projects around fcc, to enable nurses and midwives to work with families, and to create resources around developing, implementing, and evaluating family-centered care initiatives. Despite the many challenges and struggles, the family-centered care group succeeded in putting and keeping fcc on the practice development agenda, due to a shared vision, senior leadership support, and strategies that support local initiatives, connect people, and promote practice resources.

ST.10.12 Using an APP to facilitate inter-generational person-centred cultures

Brighide Lynch

This session provides participants with the opportunity to work with an APP that has been designed and developed to measure person-centredness. The iMPAKT study (Implementing and Measuring Person-centredness using an APP for Knowledge Transfer) is a collaborate venture between Ulster University and the University of Wollongong Sydney, and builds on previous research that focused on developing and testing Person-Centred Nursing Key Performance

Indicators to measure and improve the patients' experience of care. The 8 person-centred KPIs and tools for measurement have been robustly tested on an international stage in a diverse range of clinical settings that involved patients across the lifespan

The 8 KPIs are:

KPI 1: Consistent delivery of nursing/midwifery care against identified nee

KPI 2: Patient's confidence in the knowledge and skills of the nurse/midwife

KPI 3: Patient's sense of safety whilst under the care of the nurse/midwife

KPI 4: Patient involvement in decisions made about his/her nursing/midwifery care

KPI 5: Time spent by nurses/midwives with the patient

KPI 6: Respect from the nurse/midwife for patient's preference and choice

KPI 7: Nurse's/midwife's support for patients to care for themselves where appropriate

KPI 8: Nurse's/midwife's understanding of what is important to the patient and their family

The KPIs are measured using the following tools:

i. A patient/carer survey

ii. Patient/family stories

iii. Observing practice

iv. Reviewing the patient record and asking staff

Conference attendees will be able to work with the APP exploring how it is used to collect, manage and analyse information about the 8 person-centred KPIs and generate reports. As Person-centred KPIs are important across all areas of nursing and midwifery practice, participants will be encouraged to think about how the APP might be used to support nurses in their organisation to undertake inter-generational person-centred culture change and improve the care experience for patients and their families.

ST.10.13 Encountering patients with COPD as experts – moving from patient education towards sharing knowledge with patients

Gabriela Schmid-Mohler

Inadequate adherence to inhaled medication is associated with poor outcomes in patients with COPD. Incorrect inhalation, in addition to timing and dosing is a crucial and prevalent form of non-adherence. Patients who have not received any training have a 2.2 higher risk of inhaling incorrectly compared to patients given training. To improve inhalation techniques, a pulmonology nursing team set a goal to offer all hospitalised patients an individually tailored training programme. The vision was to provide the nursing team, which included a significant number of novices, with the skills to engage in higher quality of pulmonology-specific patient education. Claims, concerns and issues were discussed in detail with the nursing team. A patient education concept was then developed in a multi-professional team, which laid out the education process. The patient's daily routine, knowledge and adherence as regards inhalation are assessed and then, following an algorithm, the education is tailored to the patient situation.

The nursing team acquired basic knowledge regarding patient education and communication by completing two e-learning sessions and a subsequent communication training session. In a hands-on-training session, nurses tried out various inhalation

devices. Thus far, six nurses have received one-on-one training by the facilitator.

Between October and December 2017, 35 patients were hospitalised on the ward. An initial evaluation revealed that only four patients had received training. In discussion of their concerns, the nursing team reported that the majority of patients were experienced with inhalation. The team lacked the necessary confidence to engage with the experienced patient as a partner and expert. This required a shift in attitude from training the patient to sharing knowledge with the patient. Based on these results, the facilitator created opportunities for critical reflection within the team. An additional idea was to foster a culture of common learning by establishing critical companionship between nurses.

ST.10.15 MAMMA MIA - effective guideline implementation – from burden to strength

Eva Horvath, Mieke Koletsos

As clinical nurse specialists and responsible staff nurses, we are frequently challenged with guideline implementation. Sometimes it can be tedious particularly when guidelines are difficult to understand or of no relevance for patients in our wards.

We addressed the issue in our nursing forum. We reflected on how we could assure that nurses act according to the guidelines and provide safe care for patients. We further analyzed how we introduced our latest guideline concerning tracheostomy.

What was successful?

Important was, that the tracheostomy guideline was relevant for the patients in our wards, which awoke staff nurses' interest. Reading the guideline in advance was helpful. Sharing previous knowledge, asking open questions, summarizing important information and handling the material in a round table, contributed to a successful implementation. Essential was repeating the round table when patients with tracheostomy were on the ward.

What should we do better for an effective guideline implementation? What did we learn from this process?

We should focus on the relevance of the topic and facilitate that nurses at least read the important information in short.

We learnt, that systematically analyzing the relevance of the guideline in advance for every specific ward using Rolfe's reflection model is helpful. Asking questions such as "What? So what? Now what?" was an important step preparing the implementation. This process, in combination with our experience and successful methods of collaborating with the staff nurses, facilitated the actual handling of the guideline. We are ready now for our next implementation – a guideline about medication safety.

In the annual nursing conference, we presented our guideline reflection singing MAMMA MIA from ABBA in an adapted version, choreographed by a staff nurse who is a professional singer. This successful experience strengthens our power in guideline implementation.

ST.10.16 Implementing information support systems for personnel in the Department NKO at the University Hospital Zurich

Maisa Gerlach

At University Hospital Zurich, the turnover of nursing personnel in the Departments of Neurology, Neurosurgery and Head & Neck Cancer (NKO) is very high. The resultant steady drain of skills and expertise is a huge challenge for the organisation, perpetuating a low level of knowledge within the work force regarding delivery of care to this population as well as associated organizational processes. Consequently, patient safety, quality of care and work satisfaction among personnel are greatly concerning. To support the nursing personnel we developed information support systems for patient admissions, transfers from the Intensive Care Unit and post-surgical nutrition. The project describes the implementation process and provides an evaluation of the information support systems.

Two goals were pursued in implementing the information systems. The first was aimed at enabling new nursing personnel to master their daily work and the second at supporting their incorporation of new knowledge and skills.

Method We applied the participatory action research method by Stringer & Genat (2004) in carrying out this practice development project. We held a group interview with three nurses and administered a questionnaire with a 3-point Likert scale to all new nursing personnel in order to assess the usefulness of the information system. We applied knowledge mapping to analyse the interviews and descriptive statistics for analysis of the questionnaires

Results The knowledge mapping of the group interview revealed four themes regarding the usefulness of the information systems: "clear orientation", "necessity of ward specific information", "barriers to using the information systems" and "implementation into the job orientation process". The descriptive statistic of the questionnaire highlighted the usefulness of the information system for nurses.

The results showed that the implementation of the information systems, using the participatory action research method, effectively supported the new nurse orientation process for new nurses. The nursing personnel felt that the information system supported them in accessing information and in their ability to work independently.

ST.10.17 Learning from each other - factors, which influence the implementation of palliative care training

Silke Walter[1], Susanne Karner[1], Dr. Irena Anna Frei[1], Katharina Seibel[2], Prof. Gerhild Becker[2]

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Background The ELNEC – Palliative Care Course Germany (ELNEC = End-of-Life Nursing Education Consortium) is a training program based on the train-the-trainer principle. Participants are acquiring knowledge to teach their palliative care knowledge to colleagues at their work. A similar concept is the Resource Nursing Concept (RNC) at the University Hospital Basel (USB). Resource nurses are nurses with in-depth expertise on vital nursing issues and are responsible for enhancing nursing 3practice. They increase their knowledge for example in pain-management and make it available for patients and the nursing team. Resource nurses with the same professional focus meet regularly in groups led by Advanced Practice Nurses. Resource groups at the USB focus for example on palliative care, pressure ulcers or nutrition. The aim of the RNC is to improve patient care, to enhance nursing teams' competences and to facilitate interdisciplinary cooperation.

Methods A qualitative evaluation of the ELNEC – Palliative Care Course Germany examined which factors promote or inhibit the implementation of the role as multiplicator.

17 ELNEC-participants attended in semi-structured interviews about their experiences with implementation.

The results of the qualitative content analysis show that supporting factors are the interest of colleagues, a tangible assignment from nursing management, the motivation of colleagues to participate in training courses and time resources. Impeding factors are prerequisites at the workplace such as the transfer climate, lack of support from managers and working conditions (high workload, staff shortage). Some participants required networking to learn from each other.

Conclusions Managers play an important role for the implementation of a training concept and exchanging experiences are also important. The RNC enables a structured discussion of experiences. It regulates the role, tasks, responsibilities and cooperation between all professionals involved. This, in turn, supports the nurses with in-depth expertise to be effective in their role.

ST.10.18 "I felt safe at once!"

Christine Jaiteh

Background According to international studies, hospitalisation for addicted people with multiple substance use (dependency syndrome) spells particularly high psychological stress. There are reports about discrimination experienced and incomplete knowledge of professionals as well as about concerns pertaining to the continuation of the vitally important substitution maintenance treatment (SMT). A qualitative study analysed the experiences and needs of patients at the University Hospital Basel and reached similar results. The same served as a needs assessment in developing the role of an advanced practice nurse (APN) for addictive disorders.

Issue and method An APN attended to and accompanied a patient with dependency syndrome during his hospitalisation for several weeks. The discharge interview was arranged in a narrative way and its content was used for a "mini-evaluation" of the APN function from the affected person's perspective.

Result It is of particular urgency that hospitalised addicted persons feel safe: The concerns about continuing SMT are "very stressful", the fear of the "usual problems" is great. Having an APN as a permanent contact person with expert knowledge, who works in a network and "knows what it's all about", both promotes trust and relieves pressure. "The usual problems" do not occur or are discussed promptly, which significantly reduces psychological stress.

Conclusion A multidisciplinary team must involve the addicted patients in the decision-making process. Their personal values

and beliefs are to be considered as well as their particular life situation. The APN works comprehensively and according to the principles of patient-centred care (PCC): representing and strengthening the needs and knowledge of the affected patient during the hospitalisation and promoting inter-professional communication. Both this and continuity in care contributes to a person with dependency syndrome feeling safe and taken seriously, being able to develop adherence and receiving adequate treatment and care.

ST.10.19 Creative mediums to help strengthen and deepen reflection skills for international post-graduate nursing students

Siobhán Wragg

International and culturally and linguistically diverse (CALD) higher education students are increasingly commonplace across the globe. This trend challenges higher education institutions to embrace person-centred curricula design and facilitate innovative and inclusive teaching and learning practices that meet student needs.

A project was undertaken to transform a post-graduate Reflection-for-Practice subject, with an aim to facilitate person-centred teaching and learning practices and address issues associated with models of reflection that are based within western cultures. Re-imagining curricula and transforming teaching practice requires us to reflect, consider different perspectives and open our minds to new possibilities. A thematic literature review illuminating the student voice and focusing on student expectations, needs and experiences revealed that the current generation of diverse students need support with such things as developing speaking and listening skills, adapting to 'western' teaching, learning and assessment methods and consideration of different learning styles and customary teaching practices. In addition, empowering, collaborative, respectful, and mutually beneficial person-centred approaches were essential to foster human flourishing and practice transformation.

In this presentation, I will showcase how we adopted a variety of person-centred strategies to help meet the needs of students. A suite of blended teaching and learning strategies has been created including creative and playful approaches to facilitate enriched understanding of subject content and prepare students for assessments. Participants will be able to practice visual thinking skills, use learning circles and creative imagery, and learn about an eastern reflective practice model.

International and CALD students are a catalyst for positive change in nursing education. Academics and teachers can now embrace the shifting landscape and harness this new energy to transform how we use teaching mediums. The process of transformation is challenging but rewarding for the teaching team and students.

ST.10.20 A dynamic 3 D model of the complexity of a Practice Development project.

Hellen Dahl

Background: When planning, facilitating and evaluating PD-projects it is a big challenge to understand and handle the complexity. One part of a project is always a piece of a bigger picture: the outcome of the project, the roles of stakeholders, how elements in the project relate to each other, how the project can be evaluated, and how research question can be developed.

Aim: To present a model that can grasp the complexity of a PD project and be adapted to other projects.

How we developed the model: During a workshop, a group of facilitators and researchers co-created a model embracing the different facets of one particular PD project. In a group session, each person presented a PD-project she was involved in, and brought up questions needing attention in that project. Then the group chose one of the projects, and used creative methods to address these questions.

Result: We created a 3 D model of Lego, notes, yarn and available items from the room (see attachment 1) to help answer the questions. The goal is in the middle of the circle. Around the goal, the stakeholders stand as blocks of different coloured Lego. The colour of each stakeholder continue in a wider circle. At each step out from the centre, there are questions, pros and cons. The steps in the circle focus on WHAT and HOW for each stakeholder and for the evaluation of the project. What is the issue for each stakeholder? How can we collect data and how do we document? Through the circle there are pieces of yarn for documentation of the outcome.

After presenting the model it has been adapted and tailored to other projects.

Attachment 1: Picture of the 3D model

ST.10.21 Empowering Nurses to instigate Change and improve Person-centred Care in a Medical Outpatient's Department

Mary Louise Daly

Introduction Good leadership involves fostering a healthy workplace culture amongst staff members which in turn is necessary to ensure a person-centred approach to the care being offered to patients. The nursing management within the medical outpatient's department of the University Hospital Basel, Switzerland is empowering nurses to examine aspects of their workplace environment and encouraging them to implement change where possible.

Method The nurses were divided into 3 groups, each group was asked to consider one aspect of the question: What is needed to have a good experience in the outpatients' department, from the perspective of the individual, the nursing team or the patient? The issues identified within the groups were clinic waiting times, signposting within the department, time management, skill mix, acknowledging existing nursing expertise within the team, communication and conflict management. Patients and other team members including doctors and administrators were interviewed and the findings acted upon when possible.

Results The results to date include
- Improvement in signage within the department
- Reorganising certain therapies to areas where the nursing expertise is present
- Increased person-centred consciousness around booking appointments
- Increased awareness of supporting and motivating each other

- Acknowledging expertise from within the nursing team
- Proactively identifying tasks in advance e.g. restocking clinical areas, sending blood, keeping the workspace tidy

Conclusions This project is an on-going mission within the department and the results to date reflect only a small number of the topics raised within the teams. Some of the problems raised were beyond the scope of the immediate team to resolve. Being involved in such a project has assisted in empowering nurses to examine their work environment and implement change within their scope, as oppose to waiting for change to happen, thereby improving the situation for themselves, promoting collaboration with colleagues and offering more person-centred approach to care.

ST.10.22 Knowing me, knowing you: using creative methods to unearth identity and context in action research

Catherine Buckley

The process of reflecting is one that is said to help both researchers and practitioners define and explore issues that arise in their work. It can be used to critically examine things that are going badly, or to look at things that are going well and to see how that happened and what can be done to continue the trend.

This presentation is a critical reflection of my experience of using reflection during my doctoral studies. It focuses on reflection using creative methods, for highlighting challenges and discovering identity and context. It will focus on the use of a reflective journal, EVOKE cards and narrative poetry as critically creative methods to enable learning about self and others and to identify challenges that can occur when undertaking an action research study.

Using creative methods of reflection can open up (unlock) new ways of knowing, encourage a more in-depth exploration of experiences and promote dialog. The presentation will engage participants in the use of these methods while highlighting their utility.

ST.10.23 Speechless – speaking valve supports tracheotomized patients

Nina Clobes

Increasingly more people temporarily or permanently need a tracheostomy tube due to serious illness or accident. Use of a speaking valve is a central aspect of patient rehabilitation and increases quality of life by improving impaired physiological functions such as speaking, swallowing and coughing. During and after the phase of acute care, various disciplines and professions are involved in treatment and therapy. In this patient population, the speech pathologist provides a continuous care interface throughout the hospitalisation at the University Hospital of Basel (USB).

For the two intensive care units at the USB, a manual for handling speaking valves was developed and successfully implemented by speech pathology und nursing in 2012. No written instructions were available on the general wards, which led to uncertainty in dealing with the speaking valve. This posed a risk to patient safety

and resulted in an inconsistent use of speaking valves and stagnation of the rehabilitation success achieved so far. The lack of information and educational material for independent patients, their relatives and external health care providers are another source of interruption in patient-centered, continuous care.

An interdisciplinary and interprofessional group of nursing experts and speech pathologists was formed with the aim of developing evidence-based care guidelines for the general wards and for the external health care providers. A short version of the guidelines for relatives and independent patients should complement the documents.

To assess the needs and experiences, semi-structured interviews were carried out. The new guidelines were evaluated by an interdisciplinary and interprofessional, internal expert group. The evaluation of the developed short guidelines by patients, relatives and the Patient Advisory Board at the USB, is expected to be completed in June 2018. The care guidelines were implemented in September 2017 in the USB and are available to external health-care providers on request.

ST.10.24 Active Learning and Virtual Reality

Teatske van der Zijpp

At Fontys University of Applied sciences, graduate nursing students are facing many challenges when they prepare for their professional roles in practice. Students often describe their feelings of being overwhelmed by their experiences in practices e.g. when patients ´ability to communicate is impaired, or when confronted by aggressive behaviour. The formation and fostering of healthful relationships in these cases not only require commitment to the job and care competence but also ´knowing self´, clarity of beliefs and values and, last but not least, interpersonal skills (McCormack& McCance, 2010). Education that focuses too much on theory leads to a lack of self-confidence for newly graduated nurses and offers not enough opportunities for care processes which are characterised by having sympathetic presence, engagement and working with the beliefs and values of clients and those significant to them. Active Learning methods such as critical reflection, dialogue with self and others and engaging in learning activities in the workplace that make use of all our senses, multiple intelligences and doing things, offers opportunities to enhance person centred practices (Dewing, 2008). In this creative space a Virtual Learning Environment is utilised as an active learning method to trigger awareness and sympathetic presence in caregivers for care recipients perspectives.

Dewing, J. (2008) Becoming and being active learners and creating active learning workplaces: the value of active learning in practice development. Chp 14 in Manley, K., McCormack, B. and Wilson, V. (Eds) International Practice Development in Nursing and Healthcare. Oxford: Blackwell Publishing. pp 273-294.

McCormack, B., & McCance, T. (2010). Person-centred Nursing; Theory and Practice. Oxford: Wiley-Blackwell Publishing.

ST.10.25 New system of emergency consultations: increased competence and safety in nurse-led environment

Melanie Galatti-Bösiger

The emergency unit of the University Women's Hospital of Basel provides professional healthcare services for women with a variety of gynecological problems during and outside of pregnancy by a team of physicians, nurses and midwives.

The initial assessment of a patient's physical and emotional condition and urgency for treatment was previously performed by a qualified nurse or, in the case of pregnancy problems, by a midwife working in the emergency unit. The assessment of the situation was unsystematic and heavily reliant on the level of knowledge and professional experience of the caretakers.

A new emergency concept was implemented in 2015 with the goal of unified and safe decision-making and care. In addition to the introduction of a triage instrument, new and innovative roles for the caregivers were introduced and the previous focus of the medical assistance was replaced in favor of independent and responsible activities. These include the determination of treatment priority, independent nursing activities according to defined standards, independent implementation of defined interventions and the control of the patient flow according to urgency. To implement the concept, the team of nurses and midwives was trained by the nursing expert of the department and accompanied by close-knit role coaching.

It was challenging for the team to adapt to the new roles and tasks, as they were associated with unfamiliar responsibilities. From a workshop, a so-called "echo group" was formed; this made adjustments to the concept and acted as a multiplier within the team.

After the new concept had been put into practice for a year, it was reviewed for its efficacy. The safety and satisfaction of the patients were increased, long waiting times were reduced and the professional and independent roles of the nurses were promoted. In summary, the implementation of the emergency concept can be considered a successful measure.

ST.10.26 Facilitating effective workplace cultures in a Norwegian context

Marianne Wennersberg

Background: FOUSAM is dedicated to contribute to effective and fruitful collaboration in inter-professional teams consisting of different health professionals, user representatives and academics. In order to achieve this, we use the processes of collaboration, inclusion and participation (CIP) and particular focus on person-centredness.

Facilitation is a new word in the Norwegian vocabulary. Facilitate stems from the Latin word facilis meaning "make easy" which for FOUSAM and our work with teams, gives meaning. Make it easy in the sense of enabling and guiding teams to find a shared purpose and common values.

In FOUSAM, facilitation has enabled us to see more clearly how we can make collaboration happen. Purposely using the term facilitate, and explaining what that entails in PD methodolgy gives us the opportunity to be more active in supporting teams in their processes.

Aim To describe how we understand our role as facilitators in a Norwegian context and in particular within FOUSAM.
Method: Focus groups with members of the FOUSAM-team were carried out in November 2015 and February 2017. In the first group we discussed how we could use PD methodology in FOUSAM's work. The group in 2017 had particular focus on how we understand our role as facilitators. A content analysis of transcribed data from the two groups will be done. This will be compared to existing theory about facilitation within the practice development methodology.

Results To be presented in a poster in the show and tell display in the conference.

Discussion/conclusion We suggest that this may add to and even expand the understanding of what facilitation is about, and thus be a contribution to the international PD-movement.

ST.10.27 Medication Errors (ME) in a Swiss University Hospital and the Effect of an electronically assisted Medication Process on ME

Kaspar Küng

Background Medication Errors (ME) and Adverse Drug Events (ADE) have affected patient safety for decades and remain a great challenge for safe hospital care. Studies from various healthcare settings report ME rates between 2% and 75% [1].

Research Gap Prospective studies from Swiss university hospitals, focusing on the frequency of medication preparation and medication administration errors and exploring the effect of a closed loop medication process on medication errors are missing. To close this gap, we have conducted the first scientific evaluation of an electronically assisted medication process in a Swiss university hospital.

Aims The aim of this study are 1) to investigate the frequency of medication preparation and medication administration errors in two mixed medical/surgical units of a Swiss university hospital before and after the implementation of an electronically assisted medication process and 2) to explore the effect of the new system on medication errors.

Method To fulfil the study aims we used direct observation of medical staff during the medication process, the gold standard to detect medication errors. Furthermore, we measured the time that medical staff used in order to prepare and administer medications.

Results In a first study, a total of n = 14 571 medication doses could be observed. Errors in the medication preparation stage occurred between 1 % and 7.6 % depending on unit and type of error. Medication administration errors ranged between 21 % and 27 %. The most frequent administration errors were due to wrong administration time (84.1 %).

Conclusions This is the first study conducted in a Swiss university hospital using direct observation to detect medication preparation and medication administration errors. Our study offers important basic data to evaluate the effect of an electronically assisted medication preparation and administration process on medication errors.

Keynote 4

16:00 – 17:00 / Room: Singapore

Work place culture in health care institutions

Barbara Gysi

The shortage of professionals in the health care system is becoming an increasing problem for Switzerland and other countries. This is the more surprising as there is a high demand for education placement options and that for specific professions there are too few training positions available within the Swiss health care system. A complicating factor is that, many health care workers leave the profession too soon after becoming graduated, on average after 12-20 years. Workplace conditions and culture are frequently mentioned as the driving factors behind the decision to leave. This presentation highlights the importance of a positive workplace culture. It will also review current studies looking at the needs of health care workers and the shortage of professional nursing staff. It takes the perspective of a personal leadership experience within a community and its long-term care institutions; trying to meet the demands of politics as well as unions. The speaker presents her practical and political experience on how to build a positive workplace culture within the context of healthcare recommendations.

Keynote 5

Keynote 5
08:45 – 10:00 / Room: Singapore

Learning to improve: challenging context and culture

Dr Donna Brown

Aim: This presentation will explore the way in which the many cultures found in any context, impact on the healthcare teams ability to deliver effective Person-Centred practice.
Background: Internationally the challenge and complexity of changing healthcare practices for enhanced patient care is the focus of much attention. Contemporary literature suggests that practice is greatly influenced by the environment or setting in which it takes place (context). Context has been identified as a multi-layered construct that brings together issues of culture, leadership, behaviours, and relationships.
Design: Drawing on the Promoting Action on Research Implementation in Health Services (PARIHS) framework, with its three key elements of evidence, context and facilitation, this presentation will explore ways to identify issues in practice and consider what is required to assist practitioners to make sustainable changes in practice.
Outcome: Holistic facilitative leadership and the creation of psychologically safe spaces are required to cultivate a climate in which individuals and groups feel safe to engage with the challenge of exploring their practice. Consistent, strong, facilitative leadership and authentic collaborative working are imperative if healthcare teams are to more effectively use evidence-based practice and undertake appropriate actions to enhance person-centred practices.

Parallel Session 5

Concurrent Session 18
10:30 – 11:30 / Room: Singapore

05.01.01 Shared decision-making in everyday nursing care

Shaun Cardiff

Within the Knowledge Centre at Fontys University of Applied Science (nursing faculty) we approach person-centred practice from a critical and relational paradigm. When looking at person-centred care relationships we work with McCormack & McCance's framework. Within this framework shared decision-making is defined as "the facilitation of involvement in decision-making by patients and others significant to them by considering values, experiences, concerns and future aspirations" (McCormack & McCance, 2017:54). Several models exist within healthcare literature to aid professionals in the shared decision-making process.
To explore shared decision-making within professional practice, and supporting (future) healthcare staff in engaging in this core process, we set up a community of practice (CoP) consisting of

university lecturers, final years nursing students and local nurses/ managers. Critiquing existent models of shared decision-making (Charles et al, 1997; Elwyn et al, 2012; Whitney et al, 2008) we concluded that most focused on (medical) treatment decisions during consultations and none were developed by or for nurses working at the bedside. This led to an exploration of shared decision-making during daily nursing care, from a person-centred perspective. The exploration entailed both critical dialogues during the CoP meetings as well as bachelor student dissertation studies.

In this session we would like to present the findings of the CoP. A definition of shared decision-making during everyday care was formulated, and a practice framework. Several tools and interventions were tried out by community members and/or studied in bachelor dissertation projects. We would also like to engage in a critical dialogue with you to further explore our understanding, findings and developmental plans for studying and developing shared decision-making outside the consultation room i.e. during everyday care practice.

05.01.02 Developing and introducing a professional practice model in nursing through a collaborative and participatory process

Rahel Naef

To establish a common frame and to create a shared vision for nursing within a university hospital, a professional practice model (PPM) was developed through a collaborative, inclusive, and participatory process. In 2016, a PPM was drafted that operationalizes the organizations' strategic plan, and integrates relevant nursing frameworks and evidence around person- and family-centeredness. Staff nurses from across the organization, including nurses with roles in management, education, and practice, were consulted about the PPM's content, usability, acceptance and potential benefit for their day-to-day practice. Subsequently, the model was refined and further reviewed before senior nursing leadership endorsed it in 2017. The PPM was then introduced through a variety of ways, including flyers, intranet postings, newsletter briefs, information sessions, and workshops, to the 2500 nurses working in the organization.

The PPM provides a frame for nursing care in that it defines person and family outcomes (i.e. well-being, participation, safety), values, beliefs, and caring activities (knowing, being present, supporting, enabling / strengthening), nurse characteristics (i.e. knowledge about self, interpersonal skills) and environmental factors (i.e. supportive leadership, interprofessional collabora- tion). It emphasizes the need to engage in relational practices with patients and families, and stresses the importance of a continu- ous, collaborative process of learning and reflecting with others to improve care and ensure a healthy work environment. The ongoing dialogue with nurses reveals the importance of the PPM, which supports nurses across the full spectrum of care to engage in person- and family-centered care practices while also making visible the forces that support or hinder them in their efforts to do so. Nurses report that the PPM affirms their current practices, invites them to deepen their commitment to relational practices, and both inspires and challenges them to improve the care they offer.

05.03.01 Person-centred nursing: What about person-centred teaching?

Famke van Lieshout

Contemporary health and social care policy, strategy and nursing practice is more and more underpinned by person-centred principles and concepts (McCormack, 2017). It represents a global shift from managerialism and system efficiency to a system that is more norm- and principle driven.

Education programmes in health and social care need to build up to and support the development of this tendency. As an important part of nursing education building up towards person-centredness, is person-centred (PC) teaching. The teacher should be equipped to practise this way of teaching in a sound manner. But how?

Within our institute a research project has been set up around the question:

How can we further develop person-centred teaching within Ba and Ma curricula?

The researchers adhered a qualitative and participatory/ responsive design to the research/ teacher professionalisation trajectory. This trajectory consisted of three workshops in which teachers practiced with different methods to develop their PC teaching. This trajectory ended with a collaborative creative reflection on what thoughts, feelings and images they had and now held towards person-centred teaching and what influenced the cultivation of person-centred teaching. All meetings were tape recorded and transcribed.

Data were provisionally analysed through thematic analyses to reach a first concept definition of PC teaching. Within a workshop at EAPRIL 2017 additional data was gathered through a creative concept analysis on the attributes of PC teaching, its consequences and the enabling factors needed.

Through thematic analysis, the researchers analysed the whole dataset and scrutinized their findings in a third meeting within the professoriate in which the procedure and findings were critically examined.

In this presentation findings on how person-centredness can be (further) cultivated within individuals and teams, will be shared for wider critique.

References McCormack, B., & McCance, T. (2017). Person-centred Practice in Nursing and Health Care. Theory and Practice. Oxford: Wiley Blackwell.

05.03.01 Critical ethnography: A method for grasping and changing workplace cultures?

Christine Øye

Change in health care cultures is difficult to achieve, as successful change not only rests on individual professionals` knowledge, routines and attitudes. It also rests on collective workplace cultures and staffs` ability to work towards a common vision. Critical ethnography is a useful method to study culture change doing practice development. Ethnographers immerse themselves in the culture they study, trying to understand the cultural life and interactions between the different stakeholders as well as the process of "back-stage" social life where implicit values and beliefs

are played out. Critical ethnography has been used as a methodology to discover and unravel power structures on different levels by looking into the cognitions, behaviors and practices of stakeholders within historical, cultural (symbolic), and social frameworks. Accordingly, critical ethnography seeks to acknowledge biases that may result from implicit values in order to provide new avenues for reflexive inquiry and dialogue on societal transformation via a bottom-up approach.[1]

Our presentation will be based on experiences from two different health care settings in Norway and Australia. In Norway the ethnographer worked closely with two facilitators to "use" person-centred approaches to reduce use of restraint in a nursing home towards persons living with dementia. In Australia, the practice development leaders observed the quality and depth of clinical and interpersonal communication in inpatient aged care settings – between nurses particularly at shift handover and also between nurses, patients and carers throughout the shift.

In both cases ethnographers have been working closely with facilitators to achieve change in a more person-centred manner as part of something more: persons, places, activities, materiality and so forth. We will invite the audience to discuss how ethnographic researchers together with facilitators can grasp and change workplace cultures in order to explain and facilitate change?

[1] Madison, D.S (2012). Critical ethnography: Methods, ethics and performance: Los Angeles. Sage publications

Creative Space 16
10:30 – 11:30 / Room: Mexico

05.04.01 CREATIVE ARTS AND WELLBEING: INTRODUCING AN ARTIST IN RESIDENCE PROGRAMME INTO HEALTH AND SOCIAL CARE

Xavier White

An aesthetic approach to professional praxis development will be explored through active collaborative participation in workshops and exhibitions, as a process of "mutual recovery". Crawford et al (2013) explored the value of creative practices as a 'mutual recovery' suggesting it offers new opportunities to build "resilient communities of mutual hope, compassion and solidarity". Within this context, the artist in residence becomes a facilitator of transformative change and creative learning processes to explore and expose the potentially hidden spaces of moving between individual person centredness, and broader group/relationship centred processes, recognising the influence of individuals on the group dynamic as a whole, and as a microcosm of wider social community wellbeing. Coproduction with people who have lived experience of health and social care, will create opportunities for capturing impact data on learners sharing and how this process offers a raised awareness. Exhibitions throughout the residency are presented, to further challenge public perception of transformational changes towards improved compassion and resilience in health and social care staff – as they continue moving towards a process of mutual recovery, and associated benefits for all (e.g. human flourishing). The residency year explores and exposes evidence and impact of human interaction as a mutual recovery; to recognise and expose internal transformative movements as they take place through education. Artistic expression of what students experience as they learn and

how molecules of compassion begin to challenge their assumptions towards improved understanding (ie praxis), through experiencing collaboration with experts by experience, working from the "I" to the "we", as a coproduction with broader social requirements. Without this transformative values based approach to learning there is risk and tendency to move towards ego centric modes of care delivery that exclude and objectify difference as problematic and resultant in negative outcomes for all (Francis, 2010; Kirkup, 2014).

Concurrent Session 20
10:30 – 11:30 / Room: Hongkong

05.05.01 Enhancing nursing core assessment in acute hospitals: The ENCORE pilot study

Clint Douglas

Introduction Over the past two decades researchers have documented the close relationship between organisational context of care and patient outcomes, connecting hospital nurse staffing to patient mortality. In these models, greater nurse surveillance capacity accounts for the association between better skill mix, work environment and the prevention of serious adverse events and failure-to-rescue. Yet our prior work indicates nursing assessment practices in general wards are narrow, focused on vital signs and concentrated at the pointy end of actual patient deterioration: a point at which effective and preventative nursing intervention is not relevant and medical rescue is the model of care.

Aims To evaluate the feasibility and acceptability of critical elements of a systems level practice change to strengthen nurse surveillance in a single general surgical ward.

Methods Over six months staff were engaged to redesign practice routines for enhanced nursing core assessment at the beginning of every shift, communicated by the primary RN during ward rounds. Evaluation methods included staff focus groups and individual interviews, staff surveys and patient audit data.

Outcomes: Nurses saw clinical value in adopting a systematic approach to clinical assessment that supported staff to go beyond intuitive judgement that "something is not right" when noticing early changes in patient status. Staff reported that quality of patient care was improved through greater team engagement and proactive recognition of early deterioration. Pre-post staff surveys showed improved perceptions of safety climate and teamwork, while perceived barriers to physical assessment significantly reduced.

Conclusion A radical shift in fundamental processes of care is necessary to comprehensively address the problem of unrecognised patient deterioration in general wards. This pilot underscores the importance of staff engagement and participation in developing context-specific solutions for practice change.

05.05.02 Listening to nurses and their issues raised regarding nursing process and documentation

Antoinette Conca

We used focus groups with ward manager and nurses to gain practice relevant knowledge how to plan and change toward a person-centered nursing process and documentation. To get to a common understanding, identify barriers and facilitators we started with the project group doing a value clarification scheme on the nursing process and the use of nursing diagnoses. Going to the different development steps we involved different stakeholders in management and nursing expertise in order to get a broader view and brainstorm ideas to streamline our electronic documentation system. We integrated the perspectives to find essentials in assessment, care planning, evaluation and participation of patients. Important was to focus on the benefit patients and the nursing team would have with the new form and continuously discuss the ideas in the context of the whole process. Engaging practice nurses, ward managers in the process was a key factor of success to gain commitment for change and development.

Concurrent Session 21
10:30 – 11:30 / Room: Guangzhou

05.06.01 Using an APP to measure person-centredness across the age spectrum

Tanya McCance

This session presents findings from a collaborative international research study that tests the feasibility of an APP to measure person-centredness. The iMPAKT study (Implementing and Measuring Person-centredness using an APP for Knowledge Transfer) is a collaborate venture between Ulster University and the University of Wollongong Sydney, and builds on previous research that focused on developing and testing Person-Centred Nursing Key Performance Indicators to measure and improve the patients' experience of care. The core set of 8 person-centred KPIs and the tools for measurement have been robustly tested on an international stage in a diverse range of clinical settings that involved patients across the lifespan. The iMPAKT APP has been developed by technicians in the Computer Science Research Institute, Ulster University and is designed to enhance knowledge transfer of the person-centred nursing KPIs and the measurement framework so that the information can be used to improve the patient experience and support nurses in undertaking inter-generational person-centred culture change.
The main aims of the iMPAKT research study:
1. to test the feasibility of nurses and midwives using the APP across a range of healthcare settings to collect, manage and analyse data about the patient experience
2. to assess the quality of the outputs from using the APP (data reports)
3. to explore nurses' experience of using the App to translate feedback obtained from patients/families (reports) to inform practice change.
This session will present the evidence from ongoing evaluation of the implementation of the person-centred nursing KPIs through the use of the APP. The findings indicate the significant value and

meaning that data from the patient/carer/family perspective holds for staff and how this in turn motivates staff and drives them to undertake improvements in their practice and bring about an inter-generational person-centred culture.

05.06.02 Person-Centred Practice and technology

Teatske van der Zijpp

During the last decade there has been a lot of investment in ICT guided solutions and tools within health care practices. Expectations are high in the sense that ICT could increase healthcare efficiency and effectiveness. Also, it could be argued that ICT solutions fit well with the current attention towards self-management by service-users. Information technology is expected to offer possibilities that promote service-user independence, choice and therefore empowerment. The expanding potential of new technological approaches in supporting care and independence trigger new and interesting research and educational questions from a personÐcentred perspective (Jacobs, Van der Zijpp, Lieshout, Van Dulmen, 2017). Fontys University of Applied Sciences aims to contribute to educational practices and research that create awareness of consequences of technology in healthcare practice . We would like to challenge students and care professionals to go beyond effectiveness or efficiency criteria when considering the use of such technologies in care practice. We believe that it is important to engage different stakeholders, both in education and care organisations to focus on the ethics of using technology, explicating the different values at play among the various stakeholders, and include all these differing views when deciding on the implementation/use of technology in healthcare. Also, we believe that it is important to take into account the implications of new technologies on healthcare relationships, i.e. we value working from a person-centred perspective. This presentation focuses on how nurses can be prepared to address the question how technology can contribute to person centred practice.
Jacobs, G., Van der Zijpp, T., Lieshout, F. & Dulmen, S. (2017). Research into person-centred healthcare technology: a plea for considering humanization dimensions. In: McCormack, B., Eide, T., Skovdahl, K., Eide, H., Kapstad, H., van Dulmen, S. Person-Centred Healthcare Research. Oxford: Wiley-Blackwell.

Concurrent Session 22
10:30 – 11:30 / Room: Miami

05.09.01 Exploring Conditions that Enable Human Flourishing: a convergence of mind, body, heart and spirit

Lorna Peelo-Kilroe

Human flourishing is an elusive, yet often longed for, outcome to how we live, work and function in everyday life. Although not a new concept human flourishing is beginning to hold greater significance in healthcare following in the footsteps of philosophers, positive psychologists, educationalists and theologians. The ancient philosopher Aristotle in his book Nicomanchean Ethics believed that the means and end for all human beings is to flourish

and feel fulfilled. In modern health care systems maximum output is often expected with minimum resource input leaving little room for considerations of flourishing and fulfilment. The notion of working in a way that promotes personal accomplishment within meaningful relationships becomes both exciting and some might say essential to our needs as human beings.

As part of a PhD study into exploring conditions that enable human flourishing, this presentation will attempt to demonstrate how a group of people flourished as they worked together over a period of eighteen months. The presenter will attempt to show how the group worked and grew through mind, body, heart and soul. A briefly outline of the guiding philosophy and methodology along with the guiding framework used will provide food for thought and discussion. Preliminary findings will demonstrate the growing changes that took place within all persons involved in the study as it evolved and the themes that became more significant as the work progressed. Suggestions will be made on how this study may have implications for practice.

05.09.02 Learning from falls – empowering teams, improving safety cultures with the Learning from Defects Tool (LFD-Tool)

Dorothea Helberg

Introduction Falls are a frequent adverse event in hospitals with potentially devastating consequences for patients and demoralizing effects on care teams. From a practice development perspective the participation and empowerment of nursing staff are essential in order to sustainably implement fall prevention efforts as well as to support learning from practice situations.

As part of a fall-prevention programme, we introduced a systematic approach analysing and learning from falls based on the LFD-Tool. The purpose of this session is to share and discuss our experiences, also encouraging others to use this approach.

Method An adapted version of the LFD-Tool is used by ward based Clinical Nurse Specialists and their teams after a fall incident with serious injuries. The LFD-Tool (Pronovost et al. 2006) consists of specific questions which guide the analysis and reflection of the incident.

Results Teams were able to identify interventions to minimise fall risks in future. Several interventions were related to factors on a systemic level, such as loss of information during handover. Analysing falls in their complexity empowered teams. The possibility to reflect and identify suitable actions is particularly important in fall prevention, where teams may feel overwhelmed by numerous factors contributing to risk of falls, which they cannot or can only influence over time.

This systematic approach helped to promote communication in an open atmosphere in teams, since questions could be asked and blame was avoided. Thus, the LFD-Tool can be valued as a successful method for learning from practice, also enhancing workplace and safety cultures.

Conclusions Using the LFD-Tool supports teams to analyse and reflect adverse events. Thereby risks are identified, actions for their reduction undertaken, and a learning and safety culture is established.

Parallel Session 6

Creative Space 15
13:30 – 14:30 / Room: Rio

05.02.01 Age does matter. The power of intergenerational person-centredness in research.

Emma Radbron

It is often said that age doesn't matter, but in the delivery of person-centred care, age is important! In a culture where age is often used as a label highlighting difference between individuals, it is essential that health care clinicians recognise age as an indicator of rich knowledge and lived experience and an asset for collaborative endeavours. Such endeavours foster dynamic intergenerational person-centred cultures with patients, clinicians and research teams. This concurrent session seeks to facilitate a critical discussion on the value of intergenerational person centredness , inspired by the perspective of a PhD candidate working with a team of research and practice development experts.

In the critical discussion I will be exploring questions such as:
• What does someone of generation Y (PhD candidate) have to offer those from generations more senior to them?
• How do members of an intergenerational team combat generation-related gaps in knowledge and experience?
• What advantages and challenges are there in fostering intergenerational cultures within research teams?

There will also be an opportunity for a question and answer panel with a team of researchers aged between 30-60 years of age from Australia and Northern Ireland who are currently involved in an international intervention study, testing the feasibility of a healthcare app across 12 sites.

In addition, this session will create a space for reflection on individual practice enabling participants to identify potential intergenerational collaborations in their areas of interest. The combination of critical dialogue, reflection and creativity employed in this session will leave delegates inspired to foster intergenerational person-centred cultures within their workplaces.

Symposia 3
13:30 – 14:30 / Room: Singapore

06.01.01 Person-centred Discharge: Analysing and exploring the concept and exploring care home discharge decision-making

Gemma Logan

Analysing the concept of person-centred dischargeBackground
Person-centred practice has become an accepted part of the care landscape over the last two decades. Planning for discharge from hospital takes place on an individual basis organised around care needs, resources and family situation. However, it is unclear to what extent discharge from hospital is a person-centred process.

Aim To analyse the concept of person-centred discharge in inpatient general and rehabilitation hospital settings.
Methods Morse's (1996) criteria for concept evaluation was used to analyse this concept.

A literature search was conducted, with included publications set in an inpatient general or rehabilitation hospital focusing on hospital discharge and exploring, evaluating or defining person-c entred or patient-centred discharge. Included publications were interrogated to assess the structural features as detailed below.

Summary of Results 23 publications were used to inform this concept analysis.

Definition: One study provided a clear definition.

Characteristics: Four characteristics identified: promoting patient involvement, assessment of need and provision of support, provision of information, and effective communication and behaviour.

Preconditions: Grouped into staff factors and organisational factors.

Outcomes: Included system-based measures, standardised measures, and individualised or values based.

Boundaries: Not clearly identified. Person-centred discharge was challenging to differentiate from the wider narrative of person-centred practice.

Discussion Discharge from acute hospital is a critical step in the patient journey and an area with significant scope for improvement. While the principles of person-centeredness have the potential to achieve this, the specific components of person-centred discharge have not yet been identified.

Our findings suggest that the discharge process could be more supported, necessitating skills in frontline practitioners in communication, sharing decision-making and supporting individuals to manage their care after discharge. This has implications for practitioners at all stages of their professional development, and suggests that person-centred discharge incorporates approaches adopted by individuals, teams, leaders and the organisation in order to be achieved.

One chance to get it right: exploring care home discharge decision-making

Background Moving into a care home is a significant life event for any person and their family. Health policy documents recommend that discharge from acute hospital to care home be avoided. Despite this being a common occurrence in Scottish hospitals, the experiences of patients, those who are significant to them and staff who have experience of care home discharge decision-making in hospital are not well-understood.

Aim To explore how decisions are made to discharge patients directly from hospital to care home.

Methods The study took place in the Medicine of the Elderly and Stroke wards of two hospitals in south east Scotland. The study involved adult patients admitted from a non-institutional setting and awaiting discharge to care home, their family/those significant to them and members of the multidisciplinary team (MDT). A case study research design was adopted, with data collected through health records review and semi-structured interviews. Data analysis is taking place in two phases: firstly, the data sets are undergoing inductive thematic analysis ensuring that the dynamics of decision-making for each individual are captured; and secondly, analysis will be undertaken across the data sets using framework analysis with an analytic frame, which will include the key pillars of the Person-Centred Framework (McCormack and McCance, 2010).

Discussion and Presentation Overview Developing a clearer understanding of the enablers and barriers to effective care home discharge decision-making has the potential to offer significant benefit to patients and their families. By defining 'best practice' in transitions from hospital into a care home from the perspective of those who have experienced it, we have the potential to engage in informed quality improvement work. Explicitly person-centred analysis offers potential in developing the conceptualisation of person-centred discharge and understand its effectiveness in care home discharge decision-making.

Person-centred Discharge: Exploring the Concept

Overview of Topic There is a growing body research both in the United Kingdom (UK) and internationally that has focused on the development and exploration of person-centred practice among varying healthcare settings, patient groups and disease types. The discharge of older adults from hospital can be a complex process taking into account the physical, psychological and social needs of the individual and facilitating their involvement in the decision-making process. Whilst this process is often individualised, it is unclear to what extent discharge from hospital is person-centred.

Aim of Symposium The aim of this symposium is to explore person-centred practice in the context of discharge from hospital. The symposium will incorporate work that has been carried out using contrasting methodological approaches to develop understanding of the components, and effectiveness of person-centred discharge. The findings will be linked with the person-centred practice framework, inducing a facilitated discussion focusing on exploration of how person-centred approaches and values are utilised in discharge planning along with the significance and implications for practice.

Presentation One This presentation will provide an overview of a concept analysis exploring person-centred discharge. The findings will be discussed, demonstrating that whilst the specific components of person-centred discharge have not yet been identified, a number of consistent characteristics are evident highlighting that this is a rich area for research and practice development to improve care and the education of healthcare professionals.

Presentation Two This presentation will provide an overview of a research study that explored how decisions are made to discharge patients from acute hospital to care home, in which analysis incorporated the person-centred framework to explicitly explore the role of person-centred approaches in this process. The implications associated with person-centred approaches to discharge decision-making and planning will be made explicit.

Creative Space 18
13:30 – 14:30 / Room: Nairobi

06.03.01 **A taste of person-centeredness within the nursing process**

Famke van Lieshout

Practitioners in health and social care are currently preparing themselves for changes in society and its impact on their organisations and practices. There are multiple foci e.g. use of technology, evidenced based practice, self-management and person-centred practice. The knowledge centre at Fontys University of Applied Sciences defines person-centred practice as: the continous co-creation of relationships and structures within care-, learning- and work environments in such a way that self-determination and dignity can be realised by all.

At a local hospital in southern Holland several workshops were organised for two nursing teams (n=60) to offer them 'a taste' of

how person-centredness could influence the way they interpreted and worked with the nursing process. The enlightenment aim was achieved through role play and critical dialogue on what and how the person-centred practice framework (McCormack & McCance, 2017) would look like in the phases of the nursing process (from history taking to evaluation). We encouraged practitioners to critically reflect on the way they currently act and relate this to the underlying humanistic values of person-centredness and McCormack en McCance's (2017) framework.

In this creative space we would like to invite participants to explore how person-centred practice can manifest in the nursing process; history, diagnosis, intervention-planning, action and evaluation. Several creative methods and critical dialogue will be used to support this process. Insights will be compared to reflections and evaluations collected during the workshops carried out at the local general hospital.

References McCormack, B., & McCance, T. (2017). Person-centred Practice in Nursing and Health Care. Theory and Practice. Oxford: Wiley Blackwell.

Concurrent Session 23
13:30 – 14:30 / Room: Mexico

06.04.01 When "I" changed to "We" it led to "PC": Clinical Supervision a mechanism supporting person-centredness?

Denise Edgar

Both, Clinical Supervision (CS) and the delivery of person-centred care, have been incorporated into our Nursing and Midwifery Workforce Plan. CS in its simplest form is the regular protected time for facilitated, in-depth reflection on clinical practice. Personal insight and professional growth are said to be amongst the CS benefits, yet the outcomes of this growth to patient care are rarely reported or discussed.

As a CS facilitator I have noticed strong links to person-centred outcomes when staff share what they have implemented, including changes in practice and relationships. The sharing of these person-centred outcomes led me to consider why I was not capturing these more formally. Here is a recent example from one midwife "….with the help of the group and the facilitator I was able to come up with a plan for future interactions with the most significant being a change in my approach to communication (with the other team) using words from the organisations values and shifting my language from "how can I make this happen for this patient" to "how can WE make this happen". Using this strategy at the next delivery, the birthing mum, the midwife and a team member from another unit, all experienced a positive outcome. Another midwife shared that she had been encountering similar culture issues and used the same strategy, with the same positive result. Within this exemplar the facilitator and supervisees worked together to embrace the organisations values, collaboration, openness, respect and empowerment. The outcome was the delivery of person-centred care for subsequent patients and a shift in staff relationships between departments, all because "I" shifted to "we". The opportunity to use clinical supervision to support the enhancement of person-centred care is yet to be fully realised. This presentation will explore these links and the potential CS holds for person-centred practice.

06.04.02 Promoting family-centeredness in intensive care: A multifaceted practice initiative

Paola Massarotto

Critical illness profoundly affects families, and families are important for the recovery and well-being of their critically ill close other. Families in intensive care units (ICU) face a high burden and are in particular need for support. Despite regular, nurse-initiated, daily phone contacts with a designated family member, relational nurse engagement with families remains highly heterogeneous and unstructured among ICU nurses and units. Supported by a recently endorsed professional practice model that defines person- and family-centeredness as central to the organizations' nursing mandate, a collaboration between nurse specialists and practitioners sharing a commitment to family nursing was established. We embarked on a multifaceted practice initiative, guided by the principles of collaboration, inclusion, and participation, to improve families' ICU care experience, build up family nursing capacity, and to strengthen nurses' skills in working with families in ICU.

The initiative uses a participatory action research methodology and involves a before and after evaluation with families and staff. It will introduce a new family support pathway, delivered by a family nurse specialist, and a family nursing training programme. To create a shared vision around how families should be cared for in ICU and to ensure that the family support pathway will be meaningfully integrated into existing care processes, the interprofessional ICU team will be involved through collaborative working and consultations during development and implementation. To devise a family nursing training programme, consultations will be held with nursing teams to learn from them what they need and how they can be best enabled in their day-to-day working with families.

Insights gained from consultations with nurses across ICU units during the first look phase of the initiative will be presented. The manner in which these perspectives and needs are integrated into the endorsement of family-centeredness through a family pathway and nurse training programme will be discussed.

Concurrent Session 24
13:30 – 14:30 / Room: Hongkong

06.05.01 In My Shoes: Using an age – suit to improve empathy towards the older person

Alera Riley-Henderson

Healthcare professionals who have not experienced the aging process themselves lack empathy towards older patients. Their capacity to provide empathy can also be influenced by external factors such as the safety culture of their ward environment. Empathy is a critical component of person–centred care and positive patient outcomes. When patients experience empathy their satisfaction increases and they are more compliant with their treatment. Age–suits are a relatively new simulation concept, they literally enable the wearer to "walk in some else's shoes" and experience the impairments of the older person e.g. mobility restrictions, hearing and sight impairments. This presentation will discuss a pilot study that explored the effectiveness of an age–suit simulation

initiative on the enhancements of participant empathy levels and influence on safety culture awareness.

The mixed method pre-post-test study is set within a 52 bed subacute geriatric Hospital in Australia. Staff have varying skill levels, experience and are at different phases of their lifespan. All permanent employees were invited to complete pre-post surveys (1 empathy 2 safety attitudes). Staff on one ward were then recruited to participate in a simulation session wearing the age–suit whilst undertaking typical tasks that the older patient would face. Additional data was collected during a debrief and a follow up focus group held 6–8 weeks later, exploring the impact of the suit on their practice.

In this presentation we will share practice implications and explore enhanced empathy levels of staff who participated in the study, increased perceptions of compassionate care, and the influence of this on positive patient outcomes, greater safety awareness and increased patient and staff satisfaction.

Components of the age – suit will be used to assist the presenter in demonstrating key aspects of the study.

06.05.02 How to overcome obstacles in a PD project – What can we learn from it?

Christian Emsden

The PD project „Pain management on the two Intensive Care Units at University Hospital Basel" was carried out from 2013-2015. The aim was to improve pain management and reduce pain in the patients treated at the surgical and medical ICUs. The project followed different princinciples of PD first of all integrating and enabling the use of evidence in practice and the development of evidence from within practice and consisted of the following steps :

1. Consensus of the interprofessional management of both ICUs
2. Nursing staff sensibilisation and pre data collection
3. Defining an evidence-based set for non-pharmacologic interventions against pain
4. Pilot testing of non-pharmacologic interventions and implementation of four of these
5. Choosing an eligible pain assessment tool for patients unable to communicate based on literature research and pilot testing of three instruments
6. Translation and implementation of the Critical-Care Pain Observation Tool in multiple steps
7. Creating a table of the most used analgetics on both ICUs with important information for clinical practice
8. Different activities to assure sustainability of project outputs including coaching in daily practice
9. Evaluation of project outcomes with qualitative and quantitative data collection

The project had to deal with various exceptional obstacles.

All project group members were invloved in seven of nine project steps. Step six was carried out with a multidisciplinary team. Step seven was carried out by the project leaders: two Clinical Nurse Specialists of the ICUs.

With repeated determined efforts and by means of a strong leadership of practice development the project was successfully completed.

Discussion on project management and leadership aspects of PD within this is welcome in this session.

Concurrent Session 25
13:30 – 14:30 / Room: Guangzhou

06.06.01 Developing a new strategy for person-centred care at a hospital group in Switzerland

Christoph von Dach

Background Solothurner Spitäler AG is a Swiss hospital group that includes four hospitals. The group employs around 1,500 nurses and runs 650 beds for inpatients. The Board of Directors has stated its support for the development of person-centred care. To implement this strategy among the nursing staff, a strategy based on the principles of practice development1 and involving the conceptual model of caring2 was chosen.

Question and problem The strategy is based on the question of how to develop a person-centred culture in a large hospital group in Switzerland. The issue is made more complex by the fact that each hospital has its own history and culture.

Method and sample The strategy includes cooperation with Queen Margaret University (UK), an official statement from the Management Board, as well as a workshop with the ward manager and the management board about person-centred practice and caring based on the Person-Centred Practice Framework1. A survey by the Person-Centred Practice Inventory - Staff (PCPI-S, German version)3 will also be conducted. The presentation will be focused on the strategy of stakeholders involvement in a complex environment.

Discussion and conclusion Person-centred practice is a demand of modern society. Developing a person-centred culture by involving a large part of the nursing staff is the cornerstone of development. The PCPI-S, German version WCCAT, may be a useful tool to measure person-centred practice in nursing as a base for further development.

Literature
[1] McCormack, B., & McCance, T. (2017). Person-centred practice in nursing and health care theory and practice, West Sussex: John Wiley & Sons Ltd.
[2] Benner, P. (1984). From novice to expert: Promoting excellence and power in clinical nursing practice. Menlo Park: Addison-Wesley.
[3] Slater, P. & McCormack, B. (2017). The development of the person-centred practice inventory-staff (PCPI-S). International journal for quality in health, 29(4), p. 541-547.

06.06.02 Transformational theories for continuous professional development: the workplace as a resource for learning and improving

Kim Manley

Definitions for Continuous Professional Development (CPD) tend to focus on individual objectives, yet the goals of CPD activity are mutually interdependent on individual and system aspects (Billet, 2002)

Learning and development strategies are pivotal to ensuring that health and social care services remain person-centred, safe and effective. With limited budgets and a moral commitment to using public resources wisely it is essential that learning and development provision is fit for purpose and contributes optimally to health and social care practice.

Based on a study commissioned to develop and test an interpro-

fessional Impact tool for continuous professional development across health and social care, this paper presents the theoretical findings underpinning the resulting CPD Impact tool, namely, four interrelated transformation theories that describe and explain how to elicit good outcomes in the workplace through a series of learning and development strategies drawing on the workplace as the main resource for learning and development (Jackson et al, 2015) . Three of these theories identify the role of culture and leadership explicitly in contributing to CPD outcomes, whereas in the fourth, culture and leadership are implicit through the concept of team effectiveness.

Realistic synthesis, the methodology used in the primary study enabled a practical understanding of the relationships between context, mechanisms (strategies) and outcomes to be both developed and tested with multiple stakeholders and through documentary analysis. The four transformation theories contextualise the purpose of CPD and the strategies pivotal to achieving learning and development outcomes 'in and for' the workplace, linked to contemporary drivers and relevant philosophical influences.

These theoretical insights will enable commissioners, providers and facilitators of learning and development to be both explicit and intentional in emphasising the learning and development strategies needed to develop and sustain person-centred, safe, and effective care and services.

Concurrent Session 26
13:30 – 14:30 / Room: Miami

06.09.01 When the Trishaw came to stay – Development of a cycling without age programme

Catherine Buckley

Cycling Without Age is an initiative established in Belgium in 2012. In esseance it's about getting older people out and about on a Trishaw, reminising about their days on bikes and feeling 'the wind in their hair' once again. At St Luke's Home we are proud owners of one of only four Trishaws in Ireland!   This presentation will outline our story of how family, local enterprise and staff collaboration led to the delivery of our Trishaw in Sept. 2017. It will further outline the ongoing practice development initative in identifying and developing "pilots" for the trishaw and discuss the ongoing difference this has made to the residents in St Lukes Home. This presentation will share the stories of residents, their experiences of using the trishaw, what it means to them and their families and the benefits they have felt partaking in the programme. It will also focus on the stories of staff and family/volunteer "pilots" and their experiences of cycling without age.

06.09.02 Mind the gap – utilising guided discovery to enhance professional curiosity across generations

Andy Mantell

Background Professional curiosity (PC) has recently gained prominence in the UK in relation to safeguarding children, as a critical approach to uncovering areas of concern. Yet its knowledge base is unclear and practitioners struggle with how to question service users' narratives without seeming too intrusive. Guided discovery (GD), a cognitive behavioural therapy (CBT) technique for collaboratively exploring service users' narratives, has potential to address this issue.

Aims This research sought to:
- Identify the knowledge base for PC from nursing and social work.
- Identify the knowledge base for GD, from CBT./li→
- To consider if GD could provide a suitable approach to therapeutic professional curiosity.

Methodology A scoping review (Arksey O'Malley 2005) was conducted of the social work and nursing literature on PC and GD. Thematic analysis was then employed to identify key themes.

Findings There has been a limited knowledge base produced in both professions on PC, with the term not being clearly distinguished from curiosity by professionals. Curiosity impacts upon education, the individual and employing organisations. However, the knowledge base primarily relates to the importance of stimulating curiosity in education.

Curiosity can enhance the individual development and produce safer, more creative, better informed practice within organisations. Thematic analysis of the data identified that PC can be used therapeutically to explore a service user's experiences. Guided discovery provides a structured framework for practitioners to enhance a therapeutic rather than inquisitorial relationship with service users.

Discussion and Conclusion PC is an essential aspect of the caring professions. Its absence can lead to disengaged practitioners and poor and ineffectual practice. The responsibility for nurturing curiosity resides jointly with educators, employers and individuals. GD is a structured approach, which organisations could adopt to enable practitioners to use PC, in a therapeutic rather than bureaucratic manner.

References Arksey H, O'Malley L (2005) Scoping studies: towards a methodological framework. International Journal of Social Research Methodology: Theory & Practice, 8, 19-32
Hartley LP (1953) The Go-between. London: Macmillan.

Keynote 6

15:00 – 16:15 / Room: Singapore

PRACTICE DEVELOPMENT: Flowing between the known and the yet to be known

Professor Brendan McCormack

Practice development has a long and well-established history in nursing and healthcare. Emancipatory and transformational practice development methodologies have helped to inform significant changes to the practice cultures in healthcare settings globally. The International Practice Development Community (IPDC) has been at the heart of these developments and indeed IPDC collaborators have significantly designed and shaped these methodologies. Since the inception of practice development methodology in the 1980s, the healthcare landscape has changed enormously and so have the methodologies that guide practice change. Most significantly, quality improvement (QI) has become

the 'methodology of choice' (or indeed the only methodology!) in many healthcare organisations for bringing about changes in practice. Whilst having an impact on patient safety and practice consistency, QI methodology has had a limited impact on the development of person-centred cultures of effectiveness – the core goal of emancipatory and transformational practice development. The recognition of the need for both methodologies continues to be a challenge in healthcare organisations where the emphasis is on targets, key-performance indicators, compliance and surveillance.

So, what is the future for practice development and how do we flow into a yet to be known reality? This conference presents an opportunity for exponents of practice development to come together to reflect on the present reality (the known) to inform a future (the yet to be known). This keynote will challenge some existing thinking about practice development, QI and organisational cultures of surveillance. Drawing on the essences from shared conversations among 'home groups' at the conference, we will engage in a shared reflective engagement to identify key pillars of activity that can help shape a future for practice development that is 'yet to be known'.

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