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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Knowing the person of the resident – a theoretical framework for Person-centred Practice in Long-term Care (PeoPLe)

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Abstract
Background: Demographic change and a shift of values in society bring new challenges for the long-term care of older people, suggesting the institutional model of care should give way to one that places the person at the centre of decision making.
Aim: To describe the development of a theoretical framework for person-centred practice with older people in long-term care.
Development process: The framework was developed by synthesising original empirical research, existing evidence and existing theory, using an iterative and integrated approach to theory development based on a dialogical understanding of knowledge construction. The project formed part of a five-year research and practice development programme on person-centred practice in long-term care in Austria.
Results: The Person-centred Practice Framework for Long-Term Care (PeoPLe) is a theoretical framework of person-centred practice, consisting of five constructs: prerequisites, practice environment, person-centred processes, fundamental principles of care, and outcome. It is dependent on the macro-context of healthcare delivery.
Conclusion: PeoPLe provides a comprehensive theoretical framework for the development of person-centred practice in long-term care. The framework can be used to guide empirical inquiry, education and practice development.
Implications for practice:
- The Person-centred Practice Framework for Long-term Care (PeoPLe) is a comprehensive theoretical framework that sets out principles for the operationalisation of person-centred practice with older people in long-term care
- The Fundamental Principles of Care component of the PeoPLe framework is reported to appeal to many practitioners and may serve also as a low-threshold starting point for practice development
- The Fundamental Principles of Care component may steer the development of person-centred processes and individual care plans with persons in care. It can, for example, be used to guide assessment, case conferences and documentation

Keywords: Theoretical framework, theory synthesis, person-centredness, person-centred care, person-centred practice, long-term care, older people

Introduction
This article reports the development of a theoretical framework for person-centred practice in long-term care, which resulted from synthesising original empirical research, existing evidence and existing theory. Its development was part of a research and practice development programme to develop and evaluate person-centredness in long-term care in Austria.

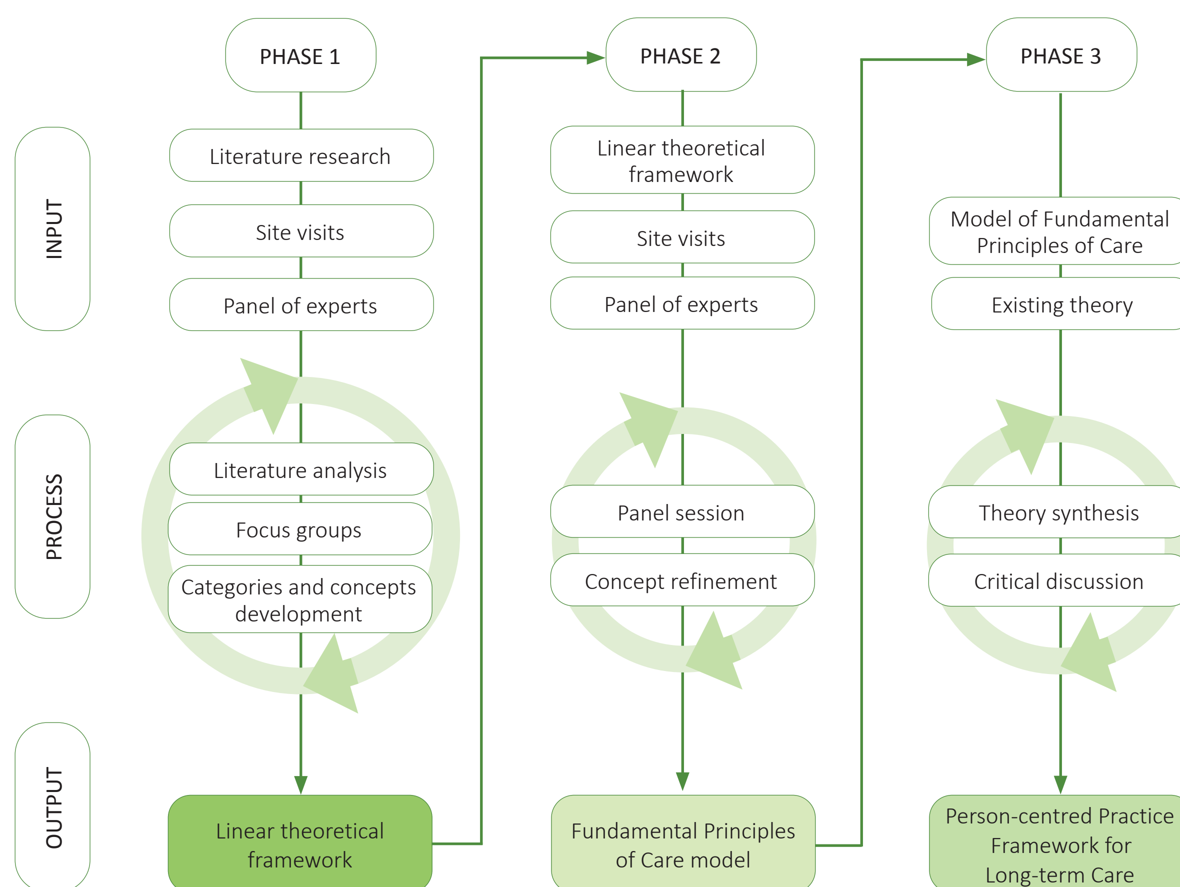
Background
The number and proportion of older people in the population is growing rapidly worldwide, due to increasing life expectancy and declining fertility rates (World Health Organization, 2015). The years in older age, however, are not always experienced in good health, resulting in a higher prevalence of care dependence and a growing need for long-term care (WHO, 2015). Moreover, a shift in societal values brings new challenges for the care of older people. This affects the expectations of ageing itself, but also the conception of care services. These expectations go beyond being provided with basic care and towards self-determination and autonomy (Kolland and Meyer Schweizer, 2012). In healthcare, these societal developments come with an increased focus on individual needs, the treatment and care preferences of persons in care, and the personhood of care recipients (McCormack et al., 2017). A shift in philosophy from an institutional model of care that meets care needs through organisational routines to one that places the person at the centre of decision making is also reflected in long-term care, which has been undergoing significant change internationally (McCormack et al., 2012). Consequently, a person-centred approach in long-term care would require outcomes such as feeling appreciated as a person, engaging in meaningful activities, being able to live according to one's preferences and choices, and maintaining important relationships. Such outcomes, however, rarely correspond with policy priorities (McGilton et al., 2012).

In 2014, in an effort to address these societal developments, the federal state of Lower Austria launched an initiative to target a comprehensive change in the organisational structure and culture of its long-term care sector. This included stronger service-user orientation, new leadership and management structures, a fresh architectural concept and the development of a care framework for 48 state-run long-term care facilities in the state (Office of the Provincial Government of Lower Austria, 2015). The target population of these long-term care facilities are persons who are at least 60 years old and receive care allowance at level four under Austrian regulations, meaning they need more than 160 hours of care per month.

The department of nursing science at the University of Vienna was commissioned to develop the care framework. The framework was expected to provide guidance for practitioners in long-term care, with the potential to inform processes at the institutional level and individual actions of practitioners at the micro level. Another requirement was that it provide conceptual consistency across all long-term care facilities, outlining the main principles and concepts of care. The aim was to build this framework scientifically, taking into account the evidence of the needs of the persons in care, as well as the experiences, perspectives and expertise of practitioners from various professional backgrounds.

Development process
An iterative and integrated approach to theory development (Meleis, 2018) based on a dialogical understanding of knowledge construction (Finlay and Gough, 2003; Bohm, 2014; Jacobs et al., 2017) was employed to incorporate these elements in the development of the framework. At the foundational level, this is also in line with principles of practice development, such as the development of evidence from practice and its use in practice, active learning in the workplace, and inclusive, participatory and collaborative ways of doing research (Manley et al., 2008). The framework was developed alongside a five-year collaborative research and practice development programme (2014-19) between researchers from the department of nursing science at the University of Vienna and practitioners from selected long-term care facilities in the state. The development process was operationalised in three main phases (Figure 1).

Figure 1: Development process



Phase 1

The first phase sought a broad insight into current and innovative care concepts as well as principles of good care in the long-term care setting. As a basis for a framework, contemporary research evidence was connected with international best practice examples and initiatives in selected long-term care facilities in Lower Austria.

The process started with a literature search drawn from three databases (CINAHL, PubMed, Google Scholar). Additionally, a hand search of relevant journals and a free web search were conducted. The findings were used to thematically inform focus groups with practitioners using a semi-structured guide. Focus group participants were recruited from a range of professions, including: registered nurses; senior care workers; care assistants; physical therapists; occupational therapists; and physicians. The group sessions were recorded digitally and transcribed, thematically analysed and synthesised with theoretical findings. Simultaneously, site visits in long-term care facilities in Lower Austria and interviews with experienced staff were conducted to observe specific practices addressed in the focus groups. The experts were nurse managers and/or practitioners responsible for practice development and innovation in their long-term care facilities. All procedures were iteratively linked and repeated. Four focus groups with staff (n=48) from various long-term care facilities, nine site visits, and two rounds of expert interviews were conducted in addition to the literature search.

In order to develop a draft framework from the data collected, a logic model template (W.K. Kellogg Foundation, 2004) was used as an heuristic device. The programmatic premise regarding the object of research inherent in the logic model was taken into account with regard to healthcare and nursing as a profession. The actions of healthcare professionals, while not always planned and partly guided

by tacit knowledge (Mayer, 2019), follows a professional logic of action. It can thus be described as a complex model of action aiming to achieve desired goals on the basis of specified resources (Haubrich, 2009).

The logic model was adapted to fit the object of research: the 'activities' contained in the model template were replaced with 'principles of care', and 'outputs' were replaced with 'interventions'. This was justified by the fact that healthcare and nursing consist of numerous activities, interventions and interactions. These are difficult to list in their entirety, and doing so was considered neither feasible nor desirable. Rather, it was the underlying attitude that motivates such activities and thus the actions of healthcare professionals that appeared to be of interest. The adapted logic model reflected this by showing that action results from attitude (in the form of principles held by practitioners), so the action can be regarded as an output of the attitude. While the changes conceptually adapted the original logic model, it retained its linear and causal logic. It should be noted, however, that the relationship between action and attitude is an iterative one so a linear representation can hardly do justice to the realities of human behaviour and social practice.

The result of phase 1 was a draft linear framework, linking:

- Resources: staff; finances; institution; cooperation; and regional resources
- Eight principles of care: person-centredness; high-quality and individually adapted care; meaningful relationships; self-determination; identity and self-esteem; meaningful activities; social participation; and living in a home-like environment
- Examples of evidence-based and person-centred interventions
- Long-term outcomes: quality of care; quality of life; and quality of housing, including suggested measurement tools
- Long-term outcome or impact (wellbeing)

In the sense of the dialogical approach, this draft framework was discussed with practitioners and the terms used validated for general comprehensibility.

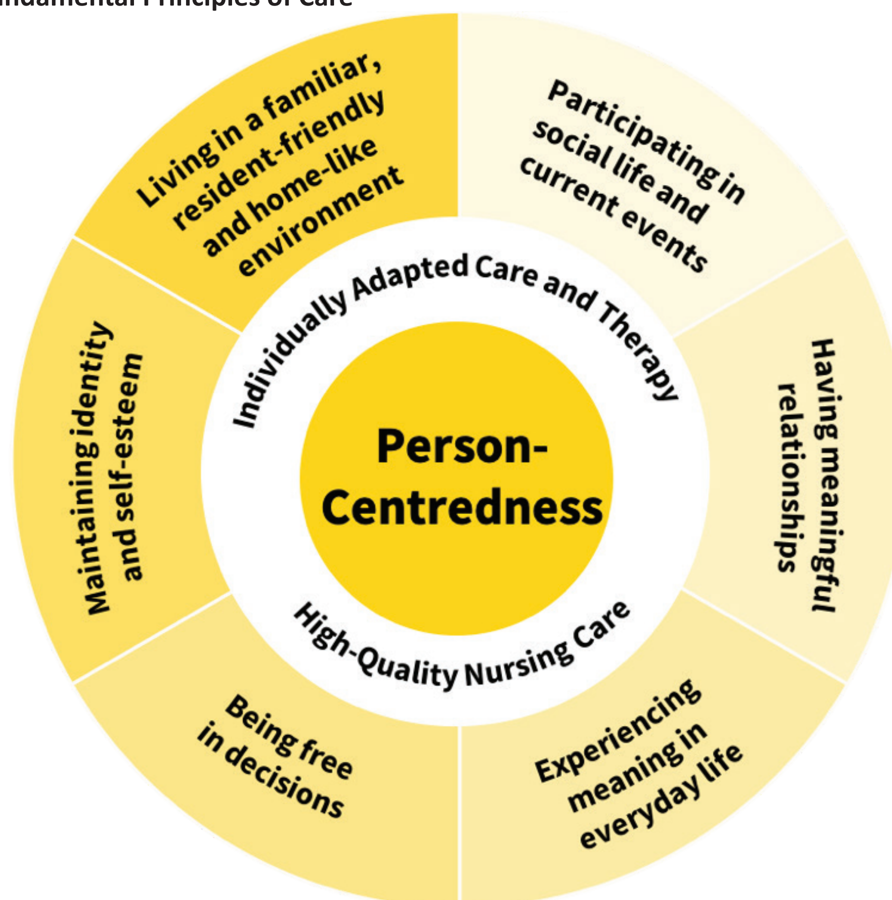
Phase 2

In this phase, the core content of the linear framework – the principles of care – were conceptually refined. On closer inspection, it became evident that two of the initial eight principles (person-centredness and quality of care) were conceptually different and on a different level of abstraction than the other six. Person-centredness was identified as an underlying core principle, pertaining to all caring action directed toward the persons in care; individually adapted and high-quality care pertained mostly to physical aspects of care. The remaining six principles were seen as reflecting social and psychosocial dimensions of health and care.

Next, the principles of care and underlying core concepts were detached from the linear structure and prepared as an independent model, represented by an illustration showing the principles of care arranged in a circle around an inner core (person-centredness) and an outer core (high-quality care and individually adapted care and therapy). This circular representation was chosen to depict the interconnectedness between the concepts.

The identified themes were discussed with a group of experienced staff, consisting of researchers and practitioners. This resulted in a model of Fundamental Principles of Care (FPC), representing the practitioners' understanding of what good care in the long-term care setting is and should be, that is, actual and desired aspects of care (Figure 2). Based on the premise that the person must be at the centre of caring processes and a commitment to high-quality and individually adapted care, the principles serve as a set of maxims to guide the decision making and actions of practitioners.

Figure 2. Fundamental Principles of Care



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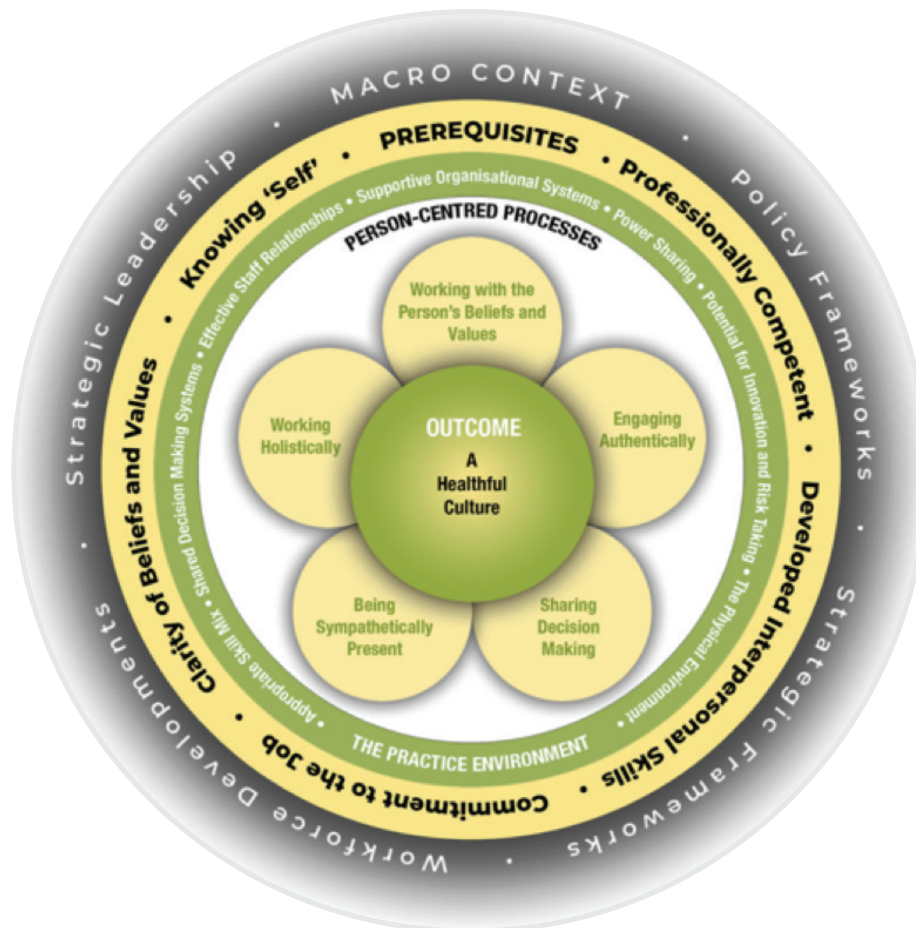
Phase 3

Person-centredness was identified as an underlying core principle of the FPC. This was evident from the focus group and interview data obtained in phase 1 in that practitioners clearly articulated person-centred values in their understanding of care, as demonstrated in the paraphrased quotes in Table 1. Practitioners also mentioned that the individual biographies and life stories of the persons in care were an important source of knowledge, informing their day-to-day practice to meet their needs. Noticeably, when reflecting on their understanding of care, participants mainly had the persons in care in mind, but also stressed the importance of institutional structures and cultures to enable staff to work in a person-centred way. Thus, the underlying understanding clearly went beyond simplified notions of person-centredness (Dewing and McCormack, 2017) such as individualised care. Following a focused literature search, critical discussion and careful review of the conceptual and philosophical underpinnings in the research team, the Person-centred Practice-Framework (McCormack and McCance, 2017) was chosen to elaborate the concept of person-centredness.

Table 1. Quotes articulating person-centred values inherent in the practitioners' understanding of care
'In everything we do, we keep the residents' perspective in mind and ask ourselves: what they can get from it?'
'We try to create a space where the resident can live their individuality.'
'We organise plenty of events and we offer several activities in order to be inclusive of all personality types and people from different cultures and backgrounds.'
'We try to offer all activities in a way so that the residents feel comfortable and at ease.'
'Structures should provide both safety/reassurance and flexibility, to be able to adequately address the needs of the residents individually and in different situations.'

The Person-Centred Practice-Framework (PCP-Framework) is internationally recognised for healthcare practice and research (Slater et al., 2017). It consists of four interrelated constructs that address key aspects of person-centred practice, embedded in the macro context of the healthcare setting: prerequisites; practice environment; person-centred processes; and person-centred outcomes (Figure 3). Following the logic of the framework, the prerequisites, representing attributes of staff, must first be considered in order to develop an effective practice environment. The person-centred processes focus on interventions to achieve the person-centred outcomes expected from effective person-centred practice (McCormack and McCance, 2017).

Figure 3. The Person-centred Practice Framework



Compared with other theoretical conceptions of person-centredness (Kitwood, 1997; Edvardsson et al., 2008; Suhonen et al., 2018), the PCP-Framework stands out in that it puts an emphasis on the practice culture as an important enabling factor. Furthermore, the framework employs an understanding of 'person' that goes beyond others by explicitly including everyone involved in the caring processes, aiming to develop and foster healthful relationships between all persons (McCormack and McCance, 2017). This was also an essential finding from the empirical data in this study, resulting in the principle 'having meaningful relationships'. Person-centredness in this theory is defined as:

> *'An approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development'* (McCormack and McCance, 2017, p 3).

The process of integrating the FPC model and the PCP-Framework followed the strategy of theory synthesis, as outlined by Walker and Avant (2013), paying careful attention to the theoretical relationships and context of each of the models. Person-centredness served as a focal concept in theory synthesis and was used to identify relationships between the two frameworks, which were then illustrated in an integrated representation (Figure 4). The PCP-Framework was particularly useful in that it articulates requisite factors, processes and outcomes of effective person-centred practice, while the FPC helped to specify experiences and outcomes for persons in long-term care. Together, they consolidated related information and semantically equivalent concepts and terms into an organised and integrated format (Walker and Avant, 2013).

The PCP-Framework and FPC share a multidisciplinary and interprofessional focus of practice and a focus on recognising the contribution of all persons to the care of older people. The FPC's concept of high-quality and individually adapted care was consistent with the concept of 'working holistically' in the PCP-Framework and the latter term was chosen for the combined model. This dimension of the PCP-Framework includes paying attention to physiological, psychological, sociocultural, developmental and spiritual dimensions of persons (McCormack and McCance, 2017). The long-term outcome/impact of the initial linear framework – wellbeing – was consistent with the PCP-Framework, in which a healthful culture, including a good care experience, a feeling of wellbeing and involvement in care are considered important outcomes of effective person-centred practice. Another parallel was between the grammar of the FPC and that of the person-centred processes of the PCP-Framework, with gerunds used to denote activity (Dixon et al., 2018) – albeit from different perspectives: persons in care and staff, respectively.

Through this theory synthesis, the FPC model, representing the persons in care level, was combined with aspects that define person-centredness at the level of the organisation (practice environment) and staff (prerequisites and person-centred processes), resulting in what we have called the Person-centred Practice Framework for Long-term Care (PeoPLe).

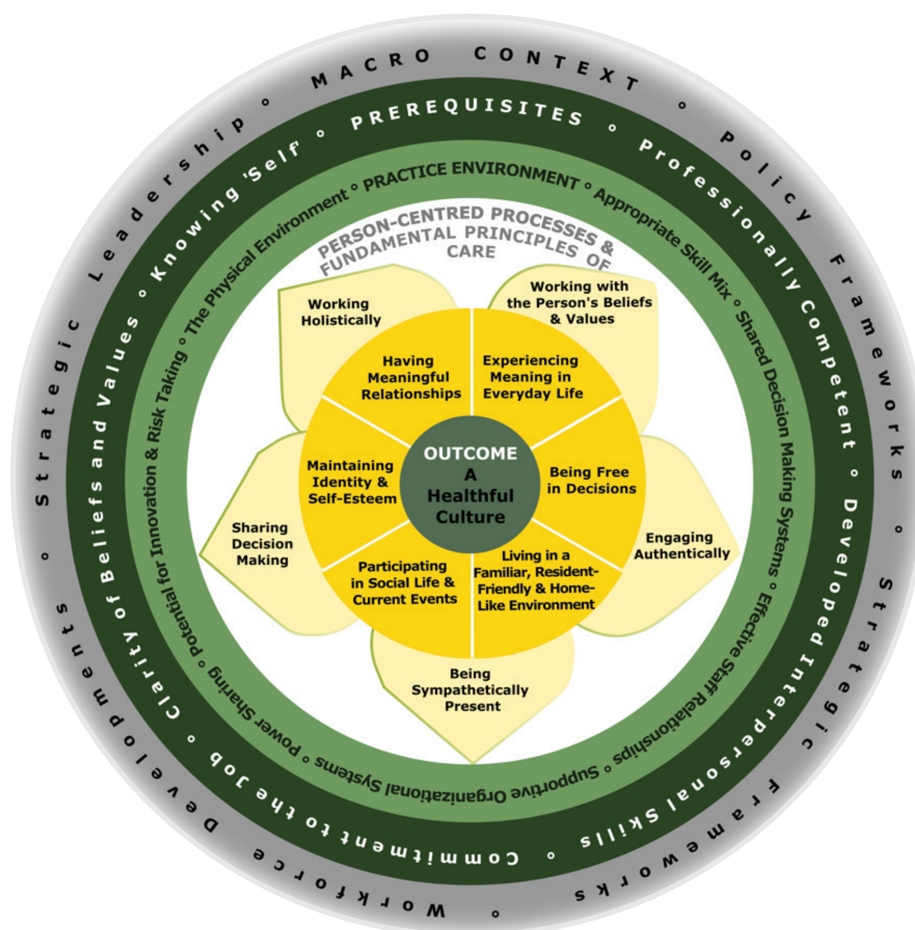
All procedures of the development process that included primary data collection were subject to informed consent procedures and were analysed in an anonymised manner. Because of research ethics regulations in Austria, approval from an ethical board is not necessary for non-interventional studies.

The development process was designed to be in line with principles of person-centred research to assure co-construction and co-ownership. Guiding principles included connectivity, attentiveness and dialogue, empowerment and participation, as well as critical reflexivity (Jacobs et al., 2017).

Result: The Person-Centred Practice Framework for Long-Term Care

The Person-Centred Practice Framework for Long-Term Care (PeoPLe) comprises five constructs: prerequisites; practice environment; person-centred processes; fundamental principles of care; and outcome. Each consists of several elements (Figure 4). The abbreviated name of the framework, 'PeoPLe', is an acronym, with the capitalised letters referring to the phenomenon in the specific setting, that is Person-centred Practice in Long-term care. PeoPLe also connotes the aspect of healthful relationships between persons that is a constituent of person-centredness (McCormack and McCance, 2017), while also implying that all people involved in the caring process – staff, persons in care and families – matter when developing person-centred practice. This consistent with the core elements of the framework.

Figure 4. The Person-centred Practice Framework for Long-term Care – PeoPLe



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As in the PCP-Framework, the relationships between the constructs are depicted pictorially, showing that to reach the centre of the framework and thus the ultimate outcome, the attributes of staff must first be considered, as a prerequisite to managing the practice environment, in order to provide effective care through the person-centred processes. Design of the person-centred processes can be guided by the FPC, which reflects determinants of a good life in long-term care facilities at the level of persons in care. The entire model is embedded in the macro context, which has a significant impact on the implementation of person-centred practice through practical, organisational, and policy-related factors (McCormack and McCance, 2017). Below is a description of the elements of the PeoPLe framework, and Table 2 provides an overview.

Prerequisites

The characteristics needed by staff to be able to develop a person-centred attitude and be a person-centred practitioner, including: commitment to the job; knowing 'self'; clarity of beliefs and values; developed interpersonal skills; professionally competent (McCormack and McCance, 2017).

Practice environment

Unless the practice environment is supportive of person-centred ways of working, the potential of teams cannot be realised. Characteristics of the practice environment include: appropriate skill mix; shared decision-making systems; effective staff relationships; power sharing; supportive organisational systems; potential for innovation and risk taking; and the physical environment (McCormack and McCance, 2017).

Person-centred processes

Person-centred processes focus on the person in care. They operationalise person-centred practice through a range of activities and are synergistic and interwoven in practice. Person-centred processes

include: shared decision making; being sympathetically present; working holistically; engaging authentically; and working with the person's beliefs and values (McCormack and McCance, 2017).

Fundamental Principles of Care

These principles represent person-centredness at the level of persons in care, through the lens of practitioners in terms of desirable conditions and experiences for persons in care in long-term care. They are principles for shaping the social life and the environment in long-term care and guide person-centred processes on an individual level. A person-centred attitude and a supportive practice environment, as well as the person-centred processes, are necessary to meet the individual needs of persons in care, and to provide individualised care and support. The principles include: having meaningful relationships; living in a familiar, persons-in-care-friendly and home-like environment; maintaining identity and self-esteem; experiencing meaning in everyday life; being free in decisions; and participating in social life and current events.

Outcome

A healthful culture is the outcome that can be expected from effective person-centred practice. It is characterised by shared decision making, collaborative staff relationships, transformational leadership and supported innovative practices (McCormack and McCance, 2017).

Table 2. Definitions of the constructs of The Person-centred Practice Framework for Long-Term Care (PeoPLe)

Prerequisites	
Commitment to the job	Demonstrated commitment of individuals and team members to persons in care, families and communities through intentional engagement that focuses on providing holistic evidence-informed care
Knowing 'self'	The way an individual makes sense of his/her knowing, being and becoming as a person-centred practitioner through reflection, self-awareness, and engagement with others
Clarity of beliefs and values	Awareness of the impact of beliefs and values on care provided by practitioners/received by service users and the commitment to reconciling beliefs and values in ways that facilitate person-centredness
Developed interpersonal skills	The ability of the practitioner to communicate at a variety of levels with others, using effective verbal and non-verbal interactions that show personal concern for their situation and a commitment to finding mutual solutions
Professionally competent	The knowledge, skills and attitudes of the practitioner to negotiate care options, and effectively provide holistic care
Practice environment	
Appropriate skill mix	In a multidisciplinary context, skill mix means the range of staff with the requisite knowledge and skills to provide a quality service
Shared decision-making systems	Organisational commitment to collaborative, inclusive and participatory ways of engaging within and between teams
Effective staff relationships	Interpersonal connections that are productive in the achievement of holistic person-centred care
Power sharing	Non-dominant, non-hierarchical relationships that do not exploit individuals, but instead are concerned with achieving the best mutually agreed outcomes through agreed values, goals, wishes and desires
Supportive organisational systems	Organisational systems that promote initiative, creativity, freedom and safety of persons, underpinned by a governance framework that emphasises culture, relationships, values, communication, professional autonomy and accountability
Potential for innovation and risk taking	The exercising of professional accountability in decision making that reflects a balance between the best available evidence, professional judgement, local information and person in care/family preferences
The physical environment	Healthcare environments that balance aesthetics with function by paying attention to design, dignity, privacy, sanctuary, choice/control, safety and universal access, with the intention of improving outcomes for persons in care and families, and staff operational performance

Table 2 (*continued*): Definitions of the constructs of The Person-centred Practice Framework for Long-Term Care (PeoPLe)	
Person-centred processes	
Shared decision making	The facilitation of involvement in decision making by persons in care and others significant to them by considering values, experiences, concerns and future aspirations
Being sympathetically present	An engagement that recognises the uniqueness and value of the individual, by appropriately responding to cues that maximise coping resources through the recognition of important agendas in their life
Working holistically	The provision of treatment and care that pays attention to the whole person through the integration of physiological, psychological, sociocultural, developmental and spiritual dimensions of persons
Engaging authentically	The connectedness of the practitioner with a person in care and others significant to them, determined by knowledge of the person, clarity of beliefs and values, knowledge of self and professional expertise
Working with the persons' beliefs and values	Having a clear picture of what the person in care values about his/her life and how he/she makes sense of what is happening from their individual perspective, psychosocial context and social role
Fundamental Principles of Care	
Having meaningful relationships	Relationships that are important for the persons in care (for example, with family, friends, staff) are promoted and social commitment is supported (in the community, through generational projects, for example)
Living in a familiar, person-in-care-friendly and home-like environment	A safe, small-scale, familiar, cosy and homely living atmosphere should be promoted to support the wellbeing of persons in care. Living both in privacy (private room) and in community is made possible (for example, in housing groups, public facilities, meeting areas)
Maintaining identity and self-esteem	The identity of the persons in care, with their personal values, attitudes and life stories, as well as living/performing social roles is supported to help maintain their self-esteem (promoting life habits, creating opportunities for retreat, giving a feeling of being needed, meaningfulness, assistance in everyday activities)
Experiencing meaning in everyday life	Mentally and physically stimulating activities such as spiritual, social, nature- and animal-related services as well as opportunities for culture, humour and creativity and familiar daily routines are designed to promote the wellbeing of the persons in care
Being free in decisions	An autonomous, self-determined lifestyle, self-determination and co-determination as well as accompaniment in the individual daytime organisation are created for the persons in care. Independence and self-organisation are promoted
Participating in social life and current events	Creating opportunities for the persons in care to participate in the community, region and society through partnerships with schools, voluntary work, associations, visits, readings, exhibitions, events, and to gain insight into current events, for example by providing access to media or a daily newspaper
Person-centred outcome	
A healthful culture	A healthful culture is the outcome that can be expected from effective person-centred practice. It is characterised by shared decision making, collaborative staff relationships, transformational leadership and supported innovative practices

Note: Prerequisites, Practice Environment, Person-centred Processes, and Person-centred Outcome adapted from McCormack and McCance (2017).

Discussion

The Person-centred Practice Framework for Long-term Care (PeoPLe) is a theoretical framework of person-centred practice, with a particular focus on long-term care. It was developed by synthesising original empirical research, existing evidence and existing theory, using an iterative and integrated approach to theory development based on a dialogical understanding of knowledge construction. PeoPLe consists of five constructs relating to different aspects of person-centred practice and serves as the theoretical framework to guide empirical inquiry, education and practice development in long-term care.

PeoPLe was developed using an integrated approach to theory development, in that several of the major strategies described by Meleis (2018) were applied iteratively, combining both inductive and deductive procedures. While in reality, various methods were applied in a parallel manner, the

starting point was an inductive practice-theory approach, which was largely driven by clinical practice situations. The framework is the result of a hybrid form of theory building (Meleis, 2018), since both practical knowledge and research evidence were used. Methodologically, the process of theory development was guided by the strategy of theory synthesis as outlined by Walker and Avant (2013), and the two conceptions of person-centredness of the model of Fundamental Principles of Care and the Person-centred Practice-Framework served as focal concepts to identify relationships among the concepts of the frameworks. The PeoPLe framework consists of a limited number of concepts at a relatively concrete level of abstraction and can thus be classified as a middle-range theory (Fawcett, 1995), which is consistent with other theories of person-centredness (Dewing, 2004; McCormack and McCance, 2017).

The PeoPLe framework offers an original perspective on person-centred practice in long-term care. From the point of view of the PCP-Framework (McCormack and McCance, 2017), it can be regarded as an extension of an existing theory (Meleis, 2018). By adding the concept of Fundamental Principles of Care, the PCP-Framework is extended to include a new structural element for the specific setting of long-term care, with the potential to be adapted to other healthcare settings and contexts. These principles were integrated into the model as an additional level, situated between person-centred processes and the outcome. Although they are conceptually independent, the principles are congruent with the PCP-Framework. PeoPLe receives its heuristic value as an integrative theoretical model (Döring and Bortz, 2016) through connections resulting from conceptually linking PCP and FPC.

As one of the main challenges associated with person-centred care is its translation into practice, the PCP-Framework (McCormack and McCance, 2017) was developed to bridge the gap between concept and reality (McCance et al., 2011). The PCP-Framework provides an optimal basis for the development of person-centred practice, and it is argued that 'person-centredness is best operationalised at the level of "principle"' (McCormack and McCance, 2017, p 24), since the implementation is highly dependent on the context.

The concept of Fundamental Principles of Care in the PeoPLe model serves as a set of maxims to guide decision making and actions of practitioners. The principles describe outcomes in the sense of desirable states and experiences for persons in care and thus represent person-centredness at this level. They are not outcomes in themselves, but comprise outcomes semantically in the sense of envisioning their possibility. Thus, from the point of view of practitioners, the principles can be regarded as lenses through which the view is directed at the resident as a person, in order to get to know them and learn what is important to them. The abstract categories that emerged initially from the data in the development phase of the FPC (for example, autonomy and social participation) were later rephrased in the course of a member check with participants from the focus groups and thus gained their extended meaning. Rephrasing the FPC reflects the practitioners' desire for a more practice- and action-oriented language.

On the one hand, the Fundamental Principles of Care represent a professional understanding of the actual and ideal care of persons in care, from whose perspective the principles reflect not only fundamental needs but also higher-level needs (Trukeschitz, 2011). However, the claim to a positive care experience is also relevant to practitioners and families, which establishes another link to the PCP-Framework. The FPC reflect a social, rather than biomedical, model of health by explicitly focusing on the social dimensions of care.

As part of the development process of the FPC, the understanding of care of staff working in long-term care settings was reconstructed using qualitative methods, and then brought together with scientific evidence and examples of best practice. In their current form, the principles combine both actual and desirable aspects of care practice; in doing so they can be seen to evolve from two major sources of nursing theory: extant nursing practice and the conception of an ideal nursing practice (Meleis, 2018). This offers an opportunity to reflect on one's own practice, based on an ideal, yet attainable, practice.

Situated between person-centred processes and outcomes in the PeoPLe model, the fundamental principles have both process and outcome elements. This inherent dualism is also reflected in the model's wording: states or conditions are described that can be regarded as outcomes of processes, with the processes and thus actions of healthcare professionals not predefined, but left up to the practitioners who can adapt them to the person in care and the situation. In this way, the practitioners are urged to consider the perspective of the person and orient their professional actions towards the person's desired state or experience. Dualism in this case does not mean that one element takes precedence over the other or that the two compete; instead it underlines the mutual and inseparable connection between process and outcome in the context of social interactions, understood as subjectively meaningful behaviour between social agents (Weber, 1985).

Following the logic of the PeoPLe model, the first steps are to work on the prerequisites, the practice environment and the person-centred processes. Then, working in a person-centred way from the practitioner's point of view to achieve the desired outcomes means the point of view of the person in care becomes visible as the fulfilment of needs.

The fundamental principles show themselves in the attitude and consequently in the actions of practitioners. Prerequisites for this attitude are situated in the correspondingly named dimension of the PeoPLe framework, which articulates the characteristics of the person-centred practitioner. This original dimension of the PCP-Framework does not explicitly explain or address the FPC, but shows which aspects constitute a person-centred attitude, as it is inherent in the FPC. These constituent qualities can only effectively be brought to bear if the practice environment is supportive; if it is, person-centred ways of working and the desired outcomes will result (McCormack and McCance, 2017). The FPC model therefore implicitly touches on all dimensions of the PCP-Framework.

The core concept of person-centredness, personhood, is inherent in the FPC, in that the person in care is placed at the centre of all efforts, so the focus of action is primarily on what matters to them as a person, supporting a neutral understanding of personhood with different manifestations of 'self' (McCormack and McCance, 2017). Person-centredness requires paying attention to our being as persons (McCormack and McCance, 2017). The fundamental principles reflect the four modes of being at the core of person-centredness, as proposed by McCormack (2004): being in relation (having meaningful relationships), being in a social world (participating in social life and current events), being in place (living in a familiar, person-in-care-friendly and home-like environment), and being with self (maintaining identity and self-esteem, being free in decisions, and experiencing meaning in everyday life).

In common with any theoretical framework of person-centredness, the PeoPLe framework will have to demonstrate its utility in gerontological practice (Dewing, 2004). Anecdotally, the framework, and particularly the FPC, met widespread acceptance from practitioners (that is not to say that working with them was considered 'easy'). This acceptance arises from what we assume is a sense of ownership created through participatory development and co-construction, leading to a more thorough grasp of person-centred practice. In practice, the FPC and the PeoPLe model have been used to inform assessments, case conferences, care planning, and staff development interviews based on an adapted version of a person-centred observational tool (Wilson et al., 2020). However, while the fundamental principles touch on all proposed dimensions of person-centredness, caution is advised so that the understanding of personhood is not oversimplified (Dewing and McCormack, 2017) through a set of appealing principles (Dewing, 2004) that favour practical utility at the cost of conceptual clarity and comprehensiveness.

Persons in care were not involved in the process of identifying and verifying the FPC since this was not specified in this commissioned work. The participating practitioners, however, demonstrated a strong sense of advocacy for the persons in care, which ultimately also led to rephrasing the FPC to reflect

the view of the persons in care, yet through the lens of practitioners. Moreover, evidence from existing literature, which was incorporated into the principles, does reflect the perspective of the persons in care. Future research might involve their participation to verify or validate the FPC.

Conclusion and outlook

PeoPLe provides a comprehensive theoretical framework for the development of person-centred practice in long-term care. The model builds on strong scientific and theoretical foundations and is underpinned by practice knowledge derived from original empirical research. The framework has a reasonable degree of abstraction, which allows context-specific implementation and adaptation to different long-term-care services, but is sufficiently specific to provide direction in terms of developing a person-centred culture at different levels. While the domains derived from the PCP-Framework of McCormack and McCance provide a focus to further develop practice at the organisational and staff levels, the fundamental principles guide the development of person-centred processes as well as individual care plans with the persons in care.

Working with the FPC means a paradigm shift in long-term care: from a biomedical, disease- and deficit-oriented perspective on persons in care towards a perspective on residents as persons with their own personality, history and individuality. The principles reflect the values and attitudes of practitioners and together with the person-centred processes they represent what constitutes good care in a long-term care facility. Therefore, the PeoPLe framework is appealing to practitioners, which is an important prerequisite for implementation into practice. Furthermore, the principles provide the theoretical basis for the development of specific tools for practice, such as case conferences and assessments of persons in care or families.

In terms of research, PeoPLe may provide the basis for programme development and theory-based evaluation. Existing evaluation tools based on the PCP-Framework, such as the Person-Centred Practice Inventory (Slater et al., 2017) or the Workplace Culture Critical Analysis Tool (Wilson et al., 2020), may be extended to include social aspects of long-term care as addressed in the FPC, thus offering a more comprehensive evaluation and setting-specific quality monitoring.
On a theoretical level, the FPC can be seen as an additional level of the PCP-Framework. Transferring it to other settings might require conceptual adaptation, since the implementation of person-centred practice is highly dependent on the context (McCormack and McCance, 2017). An iterative development process is recommended, based on a dialogical understanding of knowledge construction and with strong involvement of stakeholders, including collaborative, inclusive and participatory ways of working (McCormack et al, 2007).

In terms of theory development and testing, future research should focus on the empirical exploration of the relationships and correlations between the constructs as well as within the dimensions of each construct.

From the perspective of the federal government of Lower Austria, which initiated and funded this work, the project is seen as a best practice example of the intensive cooperation between science and practice. This project was established to develop practical and sustainable outcomes by challenging existing frameworks with the knowledge and experience of practitioners. The Fundamental Principles of Care and the Person-centred Practice Framework for Long-term Care (PeoPLe) provide a holistic foundation for the development of person-centred cultures.

To assure the sustainability of the PeoPLe framework, the federal government of Lower Austria has commissioned a further project to develop a mentorship programme for practitioners.

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References
Bohm, D. (2014) *On Dialogue*. Oxford: Routledge.

Dewing, J. (2004) Concerns relating to the application of frameworks to promote person-centredness in nursing with older people. *Journal of Clinical Nursing*. Vol. 13. No. S1. pp 39-44. https://doi.org/10.1111/j.1365-2702.2004.00925.x.

Dewing, J. and McCormack, B. (2017) Editorial: tell me, how do you define person-centredness? *Journal of Clinical Nursing*. Vol. 26. Nos. 17-18. pp 2509-2510. https://doi.org/10.1111/jocn.13681.

Dixon, J., Singleton, R. and Straits, B. (2018) *The Process of Social Research*. New York and Oxford: Oxford University Press.

Döring, N. and Bortz, J. (2016) Verbindung mehrerer Theorien zu einem integrativen Theoriemodell [Combination of several theories into an integrative theoretical model]. Chp 6.3.4 *in* Döring, N. and Bortz, J. (Eds.) (2016) *Forschungsmethoden und Evaluation in den Sozial- und Humanwissenschaften [Research methods and evaluation in the social and human sciences]*. Berlin/Heidelberg: Springer. p 170.

Edvardsson, D., Sandman, P.-O. and Rasmussen, B. (2008) Swedish language Person-centred Climate Questionnaire – patient version: construction and psychometric evaluation. *Journal of Advanced Nursing*. Vol. 63. No. 3. pp 302-309. https://doi.org/10.1111/j.1365-2648.2008.04709.x.

Fawcett, J. (1995) *Analysis and Evaluation of Conceptual Models of Nursing*. Philadelphia: F.A. Davis.

Finlay, L. and Gough, B. (2003) *Reflexivity. A Practical Guide for Researchers in Health and Social Sciences*. Malden, US: Blackwell Science.

Haubrich, K. (2009) *Sozialpolitische Innovation Ermöglichen: Die Entwicklung der Rekonstruktiven Programmtheorie-Evaluation am Beispiel der Modellförderung in der Kinder- und Jugendhilfe [Enabling Social Policy Innovation: The Development of Reconstructive Programme Theory Evaluation Using the Example of Model Funding in Child and Youth Welfare]*. Münster, Germany: Waxmann Verlag.

Jacobs, G., van Lieshout, F., Borg, M. and Ness, O. (2017) Being a person-centred researcher: principles and methods for doing research in a person-centred way. Chp 4 *in* McCormack, B., van Dulmen, S., Eide, H., Skovdahl, K. and Eide, T. (Eds.) (2017) *Person-centred Healthcare Research*. Chichester, UK: Wiley Blackwell. pp 51-60.

Kitwood, T.M. (1997) *Dementia Reconsidered: The Person Comes First*. Buckingham and Philadelphia: Open University Press.

Kolland, F. and Meyer Schweizer, R.A. (2012) *Altern und Wertewandel [Ageing and Changing Values]. Zeitschrift für Gerontologie und Geriatrie [Journal for Gerontology and Geriatrics]*. Vol. 45. No. 7. pp 587-592. https://doi.org/10.1007/s00391-012-0392-5.

Manley, K., McCormack, B. and Wilson, V. (2008) Introduction. Chp 1 *in* Manley, K., McCormack, B. and Wilson, V. (Eds.) (2008) *International Practice Development in Nursing and Healthcare*. Oxford: Wiley Blackwell. pp 1-16.

Mayer, H. (2019) *Pflegeforschung anwenden. Elemente und Basiswissen für das Studium [Applying Nursing Research. Elements and Basic Knowledge for Higher education]*. Wien: Facultas.

McCance, T., McCormack, B. and Dewing, J. (2011) An exploration of person-centredness in practice. *Online Journal of Issues in Nursing*. Vol. 16. No. 2. Article 1. https://doi.org/10.3912/OJIN.Vol16No02Man01.

McCormack, B. (2004) Person-centredness in gerontological nursing: an overview of the literature. *Journal of Clinical Nursing*. Vol. 13. No. S1. pp 31-38. https://doi.org/10.1111/j.1365-2702.2004.00924.x.

McCormack, B. and McCance, T. (2017) *Person-centred Practice in Nursing and Health Care: Theory and Practice*. Chichester, UK: Wiley Blackwell.

McCormack, B., Roberts, T., Meyer, J., Morgan, D. and Boscart, V. (2012) Appreciating the 'person' in long-term care. *International Journal of Older People Nursing*. Vol. 7. No. 4. pp 284-94. https://doi.org/10.1111/j.1748-3743.2012.00342.x.

McCormack, B., van Dulmen, S., Eide, H., Skovdahl, K. and Eide, T. (2017) Person-centredness in healthcare policy, practice and research. Chp 1 *in* McCormack, B., van Dulmen, S., Eide, H., Skovdahl, K. and Eide, T. (Eds.) (2017) *Person-centred Healthcare Research*. Chichester, UK: Wiley Blackwell. pp 3-18.

McCormack, B., Wright, J., Dewar, B., Harvey, G. and Ballantine, K. (2007) A realist synthesis of evidence relating to practice development: findings from telephone interviews and synthesis of the data. *Practice Development in Health Care*. Vol. 6. No. 1. pp 56-75. https://doi.org/10.1002/pdh.212.

McGilton, K., Heath, H., Chu, C., Bostrom, A., Mueller, C., Boscart, V., McKenzie-Green, B., Moghabghab, R. and Bowers, B. (2012) Moving the agenda forward: a person-centred framework in long-term care. *International Journal of Older People Nursing*. Vol. 7. No. 4. pp 303-9. https://doi.org/10.1111/opn.12010.

Meleis, A. (2018) *Theoretical Nursing: Development and Progress*. Philadelphia: Wolters Kluwer.

Office of the Provincial Government of Lower Austria (2015) *Leben Entfalten - Zukunft Gestalten. Innovative Lebensräume in NÖ Landespflegeheimen. Projektbericht zum Innovationsprozess in den NÖ Landespflegeheimen [Unfolding Life – Shaping the Future. Innovative Living Spaces in Lower Austria State Nursing Homes. Project Report on the Innovation Process in the Lower Austrian State Nursing Homes] (2013-2015)*. St. Pölten: Office of the Provincial Government of Lower Austria.

Slater, P., McCance, T. and McCormack, B. (2017) The development and testing of the Person-centred Practice Inventory - Staff (PCPI-S). *International Journal for Quality in Health Care*. Vol. 29. No. 4. pp 541-547. https://doi.org/10.1093/intqhc/mzx066.

Suhonen, R., Stolt, M. and Papastavrou, E. (2018) *Individualized Care: Theory, Measurement, Research and Practice*. Cham, Switzerland: Springer International.

Trukeschitz, B. (2011) Worauf es letztlich ankommt. Ergebnisqualität in der Langzeitpflege und -betreuung [What ultimately matters. Outcomes in Long-term Care]. *Kurswechsel*. Vol. 4. pp 22-35.

W.K. Kellogg Foundation (2004) *Logic Model Development Guide*. Battle Creek, US: W.K. Kellogg Foundation.

Walker, L. and Avant, K. (2013) *Strategies for Theory Construction in Nursing*. *Pearson New International Edition*. (5th Edition). Harlow, UK: Pearson Education.

Weber, M. (1985) *Wirtschaft und Gesellschaft: Grundriss der Verstehenden Soziologie [Economy and Society: An Outline of Interpretive Sociology]*. Tübingen, Germany: Mohr.

Wilson, V., Dewing, J., Cardiff, S., Mekki, T.E., Øye, C. and McCance, T. (2020) A person-centred observational tool: devising the Workplace Culture Critical Analysis Tool®. *International Practice Development Journal*. Vol. 10. No. 1. pp 1-15. Article 3. https://doi.org/10.19043/ipdj.101.003.

World Health Organization (2015) *World Report on Ageing and Health*. Geneva: WHO. Retrieved from: tinyurl.com/WHO-ageing2015. (Last accessed 21st October 2020).

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