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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

A person-centred observational tool: devising the Workplace Culture Critical Analysis Tool®

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Abstract

The Workplace Cultural Critical Assessment Tool (WCCAT) is a participant observational tool developed a decade ago to capture evidence about workplace culture that can then be used to support practice development initiatives. The WCCAT has been applied extensively across the world in a range of healthcare settings. Since its inception, practice development has progressed and it is now explicitly linked to advancing person-centred cultures.

With this in mind, it seemed timely to revise the WCCAT to reflect the progress made within practice development, and strategically link the tool to person-centred practice and achieving person-centred outcomes. This revision (WCCAT®) has been undertaken by members of the International Community of Practice (the authors of this article), whose focus is person-centred practice research. This article outlines the process undertaken for the revision and for the alignment of the revised tool with the Person-centred Practice Framework. Guidance is provided on when, why and how to use the tool to capture participant observational data that highlights evidence of person-centred practice. Detailed information and cues to support the observer in collecting and analysing data are provided, along with suggestions for facilitating feedback of data and subsequent action planning to support changes in practice. The benefits and limitations of using the WCCAT® are outlined.

Keywords: Person-centred practice, practice development, participant observational tool, research-derived actionable tool, workplace culture

Introduction

In 2009, an article was published outlining an observational tool developed to capture data in the workplace that would provide evidence about practice culture (McCormack et al., 2009a). In the 10 years since the tool was published, it has been used in a wide range of initiatives across different countries. Examples include work undertaken in Scotland (Smith et al., 2010), South Africa (Filmlalter et al., 2015) and Australia (Hennessey and Fry, 2016), in contexts such as endoscopy (Ferris and Henderson, 2014), perioperative care (Hamlin et al., 2010) and leadership development (Akhtar et al., 2016). The tool itself has been valued by those using it and has subsequently been adapted to fit programmes at a micro level, such as evaluation of a learning programme (Dewing et al., 2011), meso level, such as developing practice across 11 intensive care units (Filmlalter et al., 2015) and at

macro level, such as the statewide practice development programme ‘Essentials of Care’, which took place in more than 600 wards across New South Wales (NSW Department of Health, 2019). Practice development itself has progressed since that time and is now directly connected to the development of person-centred cultures (McCormack and McCance, 2017). With this in mind, there was a desire to update the tool to reflect progress and lessons learned since it was originally conceived, and to align it strategically with person-centred practice. Revision of the Workplace Culture Critical Assessment Tool (WCCAT®) has been undertaken by an International Community of Practice focused on person-centred practice research. All the authors of this article are members of that community and several were part of the team that undertook the original work. The aims of this article are twofold:

- To outline the process for revising the original WCCAT, making explicit the links to the Person-centred Practice Framework (McCormack and McCance, 2017)
- To provide guidance on the purpose of the revised tool (WCCAT®) and its use as a rigorous and systematic approach to studying and action planning in person-centred research and practice

Background

Practice development is focused on developing person-centred cultures and is supported by nine key principles (see Table 1). These underpinning principles can guide those engaged in developing person-centred practice through research, teaching and practice-based programmes of work. Those involved in practice development and person-centred practice research, irrespective of the context, use a range of methods and tools in collecting data to construct evidence. Examples include: evidence to raise awareness with practitioners about the everyday assumptions they hold about practice; uncovering aspects of workplace culture, including the rituals and routines undertaken; promoting critically creative reflective learning; providing insights into how staff work together and with persons receiving care; and supporting change processes and taking action to improve practice (Wilson and Solman, 2017). A definitive goal is to support people to work together (collaborate), involve people (be inclusive) to collectively transform (participate) and to innovate practice and culture (Manley et al., 2008). The WCCAT is one of several tools used to generate evidence from practice but, unlike some, it is a systematic, participatory method that collects and collates participant observational data, shedding light onto many aspects of practice as well as participatory action planning. This is expanded on later in the article.

Table 1: Principles of practice development (Manley et al., 2008, p 5)

1. It aims to achieve person-centred and evidence-informed care that is manifested through human flourishing and a workplace culture of effectiveness in all healthcare settings and situations
2. It directs its attention at the micro-systems level – the level at which most healthcare is experienced and provided, but requires coherent support from interrelated meso- and macro-systems levels
3. It integrates workbased learning with its focus on active learning and formal systems for enabling learning in the workplace to transform care
4. It integrates and enables both the development of evidence from practice and the use of evidence in practice
5. It integrates creativity with cognition in order to enable practitioners to free their thinking and allow opportunities for human flourishing to emerge
6. It is a complex methodology that can be used across healthcare teams and interfaces to involve all internal and external stakeholders
7. It employs key methods that are used according to the methodological principles being operationalised and the contextual characteristics of the practice development programme of work
8. It is associated with a set of processes, including skilled facilitation, that can be translated into a specific skillset required as near to the interface of care as possible
9. It integrates evaluation approaches that are always inclusive, participative and collaborative

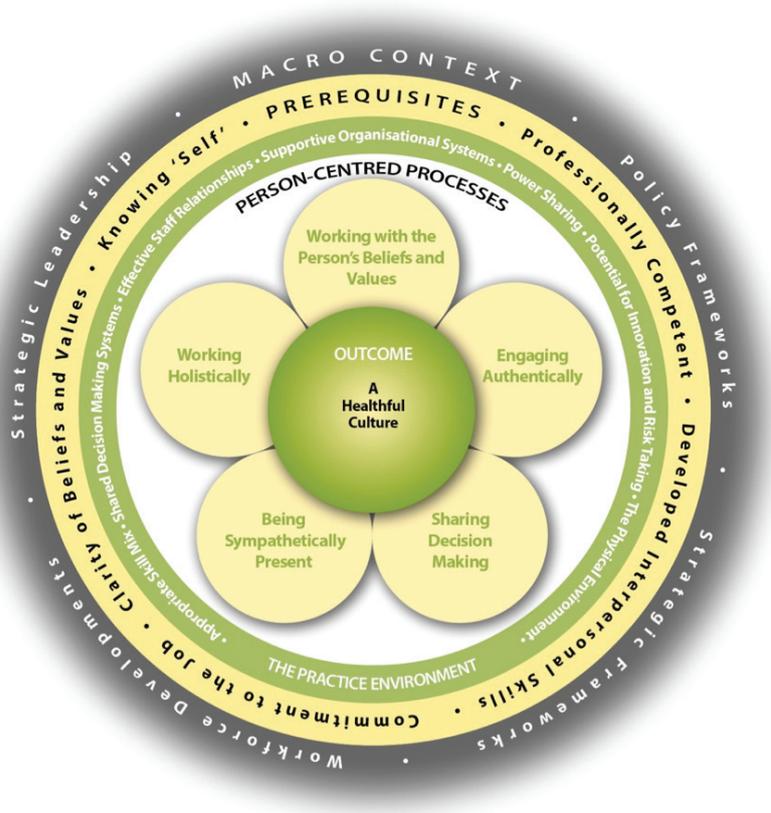
Person-centred practice

Person-centred practice as defined by McCormack and McCance (2017, p 3) is:

'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 the values of respect for persons, individuals' right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development.'

This definition clearly links to the principles of practice development. In particular, there is emphasis on the relationship between those providing and those receiving care, the connection between human flourishing and healthful relationships, and the continuous nature of the work to develop and improve practice. The ultimate objective of practice development is to create person-centred cultures with their associated outcomes, and the Person-centred Practice Framework (PCPF, see Figure 1) offers clear prerequisites and components of care that provide a scaffolding for the work needed to foster healthful cultures through transformation of people, practice and care experiences.

Figure 1: Person-centred Practice Framework (McCormack and McCance, 2017)



The PCPF has been used in research and practice development work for a considerable time (McCance et al., 2012, 2013, 2016; Lynch, 2015; Lynch et al., 2018), employing a variety of approaches and tools to gather data to construct evidence about person-centred care, processes, culture and outcomes (see examples in Table 2). While such tools can be used to gather evidence about person-centred practice, using the WCCAT[®] can capture data that may elude other approaches such as patient or staff satisfaction surveys. There may indeed be occasions where multiple datasets are required to outline certain aspects of person-centred practice; an example is the work undertaken by McCance et al. (2012, 2016), which used a set of eight key performance indicators to determine person-centredness from the perspective of the patient, and also used surveys, observation, stories and audits to generate evidence.

Table 2: Methods and tools used to explore person-centred practice

Person-centred Practice Framework	Components of each thread	Examples of methods/tools for accessing and/or generating evidence
Macro context	<ul style="list-style-type: none"> • Health and social care policy • Strategic frameworks • Workforce development • Strategic leadership 	Metrics and audits Use and/or secondary use of existing data within an organisation and workplace
Prerequisites	<ul style="list-style-type: none"> • Professionally competent • Developed interpersonal skills • Commitment to the job • Clarity of values and beliefs • Knowing self 	Surveys Person-centred practice inventories (for example, from staff or students) Patient survey using person-centred KPIs
The care environment	<ul style="list-style-type: none"> • Appropriate skill mix • Shared decision making • Effective staff relationships • Supportive organisational strategies • Power sharing • Potential for innovation and risk taking • The physical environment 	Stakeholder engagement Claims concerns and issues SWOT/TOWS analysis Workplace culture tool Feedback from patients and staff Emotional touchpoints Patient and staff interviews
Person-centred processes	<ul style="list-style-type: none"> • Providing holistic care • Working with patients values and beliefs • Engaging authentically • Shared decision making • Being sympathetically present 	Staff development 360-degree feedback Staff appraisal Participant observation of practice WCCAT® 12-step process
Outcomes	<ul style="list-style-type: none"> • Healthful culture 	

Measures of context and culture

There are several established methods to determine the context of a workplace – for example, the Context Assessment Index (McCormack et al., 2009b) and the Alberta Context Tool (Estabrooks et al., 2011). The WCCAT® is primarily used to capture participant-observable data to construct evidence about a workplace culture and context. The original WCCAT was underpinned by a range of theoretical and policy frameworks as well as a range of development methods, including the Person-centred Nursing Framework (McCormack and McCance, 2006), workplace culture (Manley, 2000a,b) and critical companionship (Titchen, 2001). Further information about the frameworks and processes can be found in the original article by McCormack et al. (2009a). The WCCAT® has been devised to link explicitly with the PCPF, as outlined in Figure 1, and it therefore must be viewed as a tool for use in person-centred research and practice. It does not supersede the original tool, which still has relevance in other areas of research and practice. The WCCAT® has the benefit of being a flexible tool that can be used for participant observation at the micro, meso and macro levels of an organisation, including wards, community settings, care homes and so forth. It is therefore recommended that this revised version of the tool be used alongside the PCPF – indeed, its use may not be appropriate where teams are unfamiliar with the framework. While it is acknowledged that the tool cannot be used for all situations and contexts, it can be used more broadly than many other methods for collecting evidence in and about practice.

Observing practice

Participant-observation approaches are generally based in an ethnographic paradigm. For example, in traditional ethnography, data collection includes participant observation, interviewing (including focus

groups) and document review (Armstrong and Lowndes, 2018). The ethnographer immerses him/herself into the workplace culture under investigation and learns about the persons by participating in everyday life situations. As a participant observer, the ethnographer notes daily workplace happenings and situations by seeing, hearing and perceiving what is going on. Recently, ethnographic work has evolved to entail research with persons rather than research on them – that is, critical ethnography (Marcus, 1998; Madison, 2012; Shih, 2018). Critical ethnography fits well with the tradition of practice development, since it emphasises ethical responsibility and promotes emancipatory knowledge, illuminating aspects of care that are taken for granted. As a critical companion, the ethnographer will also seek to shed light on unacknowledged biases that may be derived from our implied values, as a way of fostering reflexive inquiry and critical conversations around workplace transformation and improvement (Foley and Valenzuela, 2005). The observed behaviour and practices of research subjects will often be analysed within historical, cultural and social frameworks (see for example Marcus, 1998; Madison, 2012) thereby illustrating care practices and implicit values in the light of cultural and structural frames. Accordingly, the knowledge produced is partial and situated in a critical reflexive dialogue within the context of collaboration to resolve problems or issues, and improve or innovate work and relationships. Research in this tradition is therefore understood as a process of co-construction of knowledge between researcher and participants (Shih, 2018) and, as such, is in line with the person-centred research and practice development focus on principles that are ‘inclusive, participative and collaborative’ (Manley et al., 2008, p 5).

Development of the method for the revised WCCAT

With permission from the original authors to revise the first version of the tool (McCormack et al., 2009a), an iterative, six-step process was led by JD so that members of the research group (the authors) and practitioners from several contexts could contribute to its development and refinement. An overview of the process is outlined below, and a future article will outline this work in greater detail.

Review of the original frameworks for best practice, such as critical companionship, deemed them unsuitable for this revised tool due to the complex nature of the theoretical model, and the critical ally and critical friend frameworks were added as they better support novice facilitators (Hardiman and Dewing, 2019). The original WCCAT categories were mapped onto the domains of the PCPF for fit. Following group consensus, these were reduced to four domains for the revised tool. Once this was agreed, the cues from the original WCCAT were mapped onto the four domains of the WCCAT®; this process ensured the evidence within the PCPF was translated into the cues used under each construct of the revised tool. The matching of cues and addition of a summary question or cue/statement resulted in a comprehensive set of cues for piloting by practitioners. As a face validity check, items from the revised Person-centred Practice Inventory for Staff (Slater et al., 2017) were mapped against the proposed cues, with a very good alignment.

The tool was piloted at three sites in Scotland and one site in Ireland by novice practitioner observers unfamiliar with the original tool but engaged in culture development work drawing on the PCPF. Evaluation of working with the tool revealed its usability in practice by practitioners familiar with the PCPF, and threw up suggestions for beginners to document observations onto blank sheets before retrospectively aligning them with cues and domains on the tool until they became familiar with the cues. In addition, practitioners advised keeping cues to a minimum and the development of a separate guideline document to support novices through the whole process, in particular with the challenging process of feeding back observations to individuals and/or the whole staff team. Piloting was repeated as the tool was refined and as further honing of terminology and language took place. Currently, the WCCAT® is being piloted again in a national person-centred practice quality improvement programme in Ireland, as well as being translated into German and Dutch for piloting in these countries.

The authors propose that the WCCAT® is a research-derived actionable tool. Such tools have the potential to improve the uptake and transfer of research findings, (in this case the PCPF) across the

fields of policy and practice in different types of organisations around the world (Hampshaw et al., 2018). The WCCAT[®] qualifies as a research-derived actionable tool because it has all three essential elements: (i) the knowledge within the tool can be both recognised and tracked back to the PCPF; (ii) the tool has a targeted group for which it is relevant; and (iii) the tool contains a planned process for a call to action that facilitates activities to improve and innovate practice.

Process for using the WCCAT[®]

While the tool for participant observation is grounded within the PCPF, it requires careful consideration to maximise the capture of meaningful observational data. Participant observational data can be collected as a single source of data but are often collected in addition to other datasets, such as staff surveys and interviews. Combining these datasets can then provide a more complex picture of the care setting. Discussions need to take place with the team that is undertaking the quality improvement, practice development or research initiative. A clear aim for the study/project is an essential first step, alongside the approach to be used – for example, a quality improvement method, a participatory research design or an evaluation approach. It is most applicable where a team is working with the PCPF and has sufficient knowledge of the framework to use and interpret the observations successfully. Knowing the approach and the aim will help to decide the appropriateness of undertaking an observation using the WCCAT[®] to collect data.

Observation is an approach to determine the culture and ‘the way things are done around here’, which includes the way people interact, rituals and routines, the care environment and so forth (Armstrong and Lowndes, 2018). The tool does not aim to describe traits or attitudes of individuals within the care setting, but to detect patterns that exist across multiple datasets. Staff should therefore be reassured that data collection is not about ‘checking up’ on them, but about the process of highlighting traits of the culture of that particular care setting, such as norms, routines, rituals and practices. Thought needs to be given to the process, including when and where the data will be collected.

While anyone can learn to be a participant observer through training, it does take time, support and guidance to develop the skills to engage in the steps that come after collation of the observational data. In order to support the effective use of the WCCAT[®] the following guidelines are provided. They draw on those used in the original method (McCormack et al., 2009a), as they remain fundamentally unchanged, although they have been updated to reflect current practice. There are five distinct phases to the method:

1. Pre participant observation
2. Participant observation
3. Raising awareness
4. Engaging in reflective dialogues
5. Participatory analysis and action planning

Phase 1: Pre participant observation

As already stated, preparation is key to effective observation and should include preparation of the observers and of the observed.

Step A: Preparing the team being observed

Preparing a team for participant observation is an essential component of the method. Staff who may be observed can experience anxiety or uneasiness about the process. Engagement and preparation activities allow them to raise concerns, discuss what is involved and when it will take place, and have the participant observation processes explained. It is important to:

- Discuss the project and place the WCCAT[®], data collection and feedback within this work. After outlining the overall purpose of the observation, outline how the data will be used and who owns the data
- Discuss ethical implications, such as the need for formal ethical approval. If this is not required, the organisation should still approve the participant observations. Information about the study/

initiative should be available for staff and patients (where applicable), for example, through written information and informed consent forms. Explicit consideration should be given to ethical issues such as confidentiality, anonymising data and the observer being inconspicuous by maintaining their distance from work practices and only stepping in if there is an instance of unsafe practice. Process consent (a verbal approval from patients and staff) should be undertaken before each participant observation period (Dewing, 2008)

- Outline the participant observation procedure: where the observers will stand, how often observations will take place, who will be undertaking the observation and what they will record. It is important to be flexible in negotiating the observation processes with staff
- Be prepared to respond to questions truthfully

Step B: Preparing to undertake participant observation

The key is to collect comprehensive and accurate data methodically. To do this, those observing need to have (or develop) participant observation skills and knowledge. These include an aptitude for focus even when the context being observed is chaotic and noisy, as well as the ability to stand back and merely observe without making assumptions or judgements about what is being observed. Reflecting on one's own subjectivity and how it may influence the participant observation process is also important (Fawcett, 1996). While practice helps the observer build the necessary skills, a deeper level of knowledge is established through engagement with preparatory (and ongoing) activities, such as studying research literature relevant to the healthcare setting and topic, and consulting experienced observers.

Familiarisation with the PCPF and the WCCAT[®] tool is key to preparation. When working with a group of observers, a shared understanding of both, as well as of how to obtain and document data will enhance consistency. The guidelines provided in the original article (McCormack et al., 2009a) were adapted from the work of Fawcett (1996) and remain relevant in preparing and undertaking an observation using the WCCAT[®]. Table 3 is reprinted with permission (McCormack et al., 2009a, pp 34-35)

Table 3: Preparing and undertaking a participant observation using the WCCAT®

Guideline	Rationale
<p>Preparing for participant observation</p> <p>1. What is the focus of the observation (for example, aspects of the care environment)?</p> <p>2. How will you document your findings?</p> <p>3. Gaining access to the site</p> <p>4. Preparing yourself</p>	<p>It is not possible to observe everything within a multisensory environment so you need to choose a focus for your observation. You may be required to observe on a number of occasions (at different time periods) to build up a picture of what is happening in a workplace. You need to take into account the environment, verbal and non-verbal communication, actions, events and people</p> <p>It is helpful to develop a system for documenting your findings that enables you to capture data during the observation in a timely manner. Consider what abbreviations or codes you may use to document findings. Using large margins allows you to capture your thoughts during and after the observation. You will need to take note of things such as place/date/time</p> <p>You need to negotiate access to the site, so think about how often and for how long you might want to observe practice. You also need to inform staff about the purpose of your observation and obtain consent where appropriate</p> <p>It is best to observe with a colleague in order to validate your findings and agree on key issues. When choosing a partner for observation, consider the need for an insider/ outsider approach (if you are insider to the setting then perhaps someone from outside the setting would be most appropriate as a partner, and vice versa). Consider having a trial observation with a colleague; that way you can both observe the same thing and then compare notes about what you observed</p>
<p>Undertaking an observation</p> <p>1. Positioning yourself (+ other observer if required)</p> <p>2. Time</p> <p>3. Recording data</p>	<p>Consider the best vantage point for you to observe practice. In particular, you need to take into consideration how easy it will be for you to observe what is happening while remaining unobtrusive</p> <p>As you are developing your observation skills, you may find the high level of concentration required means you can only spend 15 to 30 minutes observing practice at a time. As you become proficient, this time can be increased</p> <p>Try to capture as much data as possible. Ensure your notes are clear and concise</p>
<p>After participant observation</p> <p>1. Review your notes</p> <p>2. Review the process</p> <p>3. Do you require more observation?</p> <p>4. Preparing for the next phase</p>	<p>Write additional comments as soon as possible after the observation, as well as any questions you are posing about what you have observed. Compare notes with the other observer to develop a greater understanding about what was happening</p> <p>This can be done as an individual or group activity. What worked well during the observation? What things could you improve on? What did you learn about observation skills and techniques? What impact did your own value judgements have on what you observed? It may be helpful to capture your answers (and future development opportunities) for your learning portfolio</p> <p>Consider whether you (and any other observers) have enough material at this stage to move onto the next phase. If not, you need to consider what the focus of future observations will be, when they will take place and who will undertake them</p> <p>If you feel you have enough material to undertake phase 2 (raising awareness), you then need to prepare your observations for feedback to staff and to facilitate a discussion in relation to what you observed</p>

Phase 2: Participant observation

This phase is about collecting evidence around what is observed in the setting, such as practices, rituals and communication between staff. The data (observational evidence) are then shared with staff as a means of checking if they resonate with the staff's perception of practice and the context in which they work. Working in pairs with at least one experienced observer is advised. Participant observers should discuss the focus of the observation beforehand, covering which domain(s) and/or components are they focusing on. The participant observers may vary throughout the timeframe of the observation using the WCCAT®, so it is important to be systematic in capturing observational data

and maintaining field notes about the process. This will assist in creating a rigorous process and enable observers to evaluate the success of the overall observation and the data generated. It is important to note that undertaking a whole-picture participant observation (across all domains) can be quite complex and is most certainly beyond the capability of a novice participant observer. As an example, one domain (prerequisites) is presented in Figure 2.

Figure 2: Excerpt of WCCAT® tool

Observation area 1: PREREQUISITIES		
Observer prompts	Observation notes including clarifying questions	Critical questions for the team
<p>What do you observe that indicates:</p> <p>Professional competence Development/use of knowledge, skills and attitudes to negotiate and provide care. For example:</p> <ul style="list-style-type: none"> • Delivering competent care • The knowledge and learning that is privileged in the care setting • Practitioners learning and/or developing their professional competence <p>Developed interpersonal skills Communicating and engaging with service-users and significant others. For example:</p> <ul style="list-style-type: none"> • Paying attention to non-verbal communication and how this might impact on others • Using interpersonal skills to negotiate care • Demonstrating respect for self and others <p>Commitment to the job Commitment to person-centred, evidence-informed care. For example:</p> <ul style="list-style-type: none"> • Delivering high-quality care that is informed by evidence • Spending time with people receiving care <p>Clarity of beliefs and values Being clear about the values and beliefs that influence care. For example:</p> <ul style="list-style-type: none"> • Demonstrating actions that reflect core values and beliefs • Working with a shared vision • Consistency between desired values and beliefs and those experienced by others <p>Knowing self Awareness of self when engaging with others. For example:</p> <ul style="list-style-type: none"> • Drawing on own and others' strengths and skills • Seeking out and making use of feedback • Providing challenge and support in the setting 		

Phase 3: Raising awareness

At the conclusion of each participant observation period the observers may speak with staff to address any queries that have arisen. They should ask open-ended, relevant questions related to the context of the observation. For example, a question about the physical environment, as outlined in the WCCAT® tool, might be: 'I noticed that there is a lot of equipment taking up space in the corridor, is it usually kept there?' It is important to capture staff responses to the question so as to avoid assumptions about what has been observed; it is usual for staff teams to ask, or in other ways indicate a wish for initial feedback, how processes and patterns came across in the observation. Providing staff with a verbal summary of initial feedback can help clarify what has been observed and how it promotes or hinders a healthful culture (see the WCCAT® tool for further details, at cpcpr.org/resources).

Phase 4: Engaging in reflective dialogues

The goal of this phase is to collate the observational data and prepare it to be presented to team members in a meaningful way. Feedback of the data is undertaken using a facilitated person-centred process that reaches as many team members as possible, which may necessitate a number of feedback sessions. The principles of inclusion, participation and collaboration (Manley et al., 2008) should be used to support staff through this process. The aim is to enable them to reflect on the observational data in relation to their experience of the workplace and how care takes place, and to raise questions in relation to the data and the process.

Before feedback, the participant observers need to build consensus about what they have observed and agree on a common set of data to be shared with staff (this may include trends, patterns and rituals). In the feedback sessions the participant observers share the findings and facilitate a critical discussion with staff about the findings. It is important to remember that those receiving the feedback may be anxious, so an encouraging, person-centred approach is important. Establish with the staff group a way of working for the feedback sessions that supports open conversations, sharing of perspectives, reflexivity, stimulating and probing questions, and recognition of positive factors illuminated by the data. In facilitating the feedback, consider how you frame the observations, the intent being for staff to gain insights into their everyday practice, rather than feeling judged or criticised. There is an opportunity for staff to compare and contrast what has been observed in relation to how they believe they are practising (rhetoric) and the expectations of the practice setting (for example, the espoused model of care). Consensus of the data patterns is achieved with staff through open discussion that may take place in feedback sessions held over several days, or weeks, to ensure as many staff as possible can participate.

Phase 5: Participatory analysis and action planning

The next stage is to make sense of the common set of patterns in relation to the prevailing culture ('how things are done around here'). It is now time to co-create an action plan with staff. In this phase you are taking into account the reflections that have taken place during phases 3 and 4. There are two steps to this process: analysing the data into themes and co-creating the action plan.

Step A: Participatory analysis of the data

This phase should be undertaken as a participatory analysis with the team. It is important to work with as many members of the team as is feasible and to ensure there is representation across the team as well as from the team manager or leader. Participants move back and forth between individual and collective analysis, co-creating shared understandings. In facilitating this process with staff, it is important to ask questions that enable them to highlight their own ideas about the data: the words, pictures or feelings that come to mind, and the main messages that emerge. This will support them to identify themes for future action. Through this iterative process, tentative themes and issues are first established and then confirmed, with examples from the data used to highlight each theme. Boomer and McCormack (2010) offer one participatory method that can be used to support this process (see Table 4).

Table 4: A six-step process adapted from Boomer and McCormack (2010)

Step	Description
Step 1	Participants are invited to read several times through all the information gathered. They are asked: What stands out for you from the data? It may be something that happens frequently, something that concerns you or something that is really positive
Step 2	Participants are invited to individually create their 'image' of the data. This can be done creatively (using cards, drawing, words or imagery) to help capture their overall impression of the data. The images are then discussed with the participants. Sharing the images in this way enables a collective understanding of the whole dataset to emerge
Step 3	Participants are then invited to re-read the data and to reflect on how the data connect to aspects of the PCPF. For instance, a nurse asks a patient: 'Would you like a shower today?' When the patient says yes, the nurse goes on to say: 'Do you want it now, or would you rather wait until after breakfast?' The nurse is seen to be sharing decisions about the patient's care with the patient, taking the time to listen to them and managing to incorporate their wishes into care delivery. This could be themed as 'giving choice' and may be placed within the 'shared decision making' component of the person-centred processes (within the PCPF)
Step 4	Participants reconsider the data in cultivating themes, driven by the 'image' they created in step 2, which embodies the overall data. They are invited to make links between the emerging themes and the image. Questions that arise at this time include: What is the association between the image and each theme? Which themes are more convincing?
Step 5	Collating and refining of themes can now take place. Each participant provides an explanation of their themes. It is usual at this stage to have lots of themes which, through the collation and refinement process, can be reduced in number. Each theme is captured on a whiteboard or flipchart and, using sticky notes, participants indicate where there are similarities between themes and whether these can be condensed to create provisional combined themes. Try to include as much as possible, it is important to be wary of making assumptions about the themes/data
Step 6	Once a number of provisional themes have been derived, critical dialogue ensues until agreement has been achieved on a common set of themes. The individual data sources can then be identified and linked to these themes

Step B: Process for devising action plans

Once the common set of themes has been identified, action planning can begin. Again, it is important to take a participatory approach and include as many staff as possible along with the team leader/manager who will play a key role in supporting the implementation and evaluation of the plan. Using the themes established in step A, the staff develop actions to address these. While there may be one action per theme, it may be possible to devise an action that addresses more than one theme. Staff may wish to prioritise certain themes in relation to taking action, rather than trying to address them all at once. The action plan should include elements displayed in the columns shown in Table 5: issues identified; actions; who; when; and progress. The data sources for the theme should be identified. In the example in Table 5, this includes the observational data (WCCAT), as well as patient complaints and a patient survey relating to a specific key performance indicator (McCance et al., 2016). It is important as part of this process to take time with staff to celebrate positive aspects of person-centred care that have been captured as part of the data process.

Table 5: Action plan example

Ward 16 South		Acute medical	Example action plan		
Issues identified (focus of the action)	Actions (include policies that may impact on the action)	Who? (roles and responsibilities)	When?	Progress to date	
Delayed answering of patient buzzer at times	New buzzer system to be installed in May/June 2019	Nurse unit manager to organise new buzzer installation	Review date: October 2019	June New buzzer system installed for first half of ward (second half will be installed by September)	
Informed by data. Patient complaints and survey, and participant observation data for key performance indicator 5 (KPI5): time spent by nurses with the patient	Educating patients on admission that while buzzers are answered as soon as possible, sometimes there can be a delay Educating staff on informing patients when ward needs are high and delays become more likely	Clinical nurse educator and clinical champions to drive education about buzzers and staff response Audit new system, review patient complaints and re-collect data for KPI5			
Action plan approved: Jenny Smith, nursing unit manager. Date: March 2019 Review: 1 August 2019					

Benefits of using the WCCAT®

If you are undertaking work to transform person-centred care/practice then the WCCAT® provides an easy-to-use participant observational tool that is explicitly linked to the PCPF and supports the collection and analysis of data that can then be used to support change. The tool is reproducible and provides cues for observation and guidance for its use, from preparing the observation setting to facilitating feedback and supporting the change process. It can be used by groups of observers simultaneously and the data can then be combined. It provides an audit trail of the process from preparation to action. The tool complements other approaches to data collection in evidencing person-centred practice, such as the Person-centred Practice Inventory (Slater et al., 2017), which aims to capture the perceptions of individuals. As a complementary tool, the data from WCCAT® observations can be used within mixed-methods studies and for data-triangulation purposes. The tool is free to use and can be accessed online at cpcpr.org/resources, where you will find a detailed outline of the process used for the revision of the WCCAT and additional materials relating to person-centred practice.

Limitations

It is acknowledged that this revised tool has not yet been widely tested across different contexts or in different languages. The next phase of the work will be to translate the tool in a range of languages, such as Norwegian, to ensure a wider application. To get the most benefit from using the WCCAT®, users need to have an understanding of the PCPF and the participant observation needs to be related to capturing data (evidence) and person-centred practice. Any tool is only as useful as the person operationalising it, so careful consideration is required in terms of equipping participant observers with the knowledge and skills for the observer/facilitator role. Those less skilled may focus only on the example cues on the tool and therefore could risk not capturing observational data of what they are seeing, hearing and perceiving, resulting in the tool being used for audit rather than observation.

Summary

The revision process for the WCCAT® has been outlined, as well as the way in which it has been explicitly linked to the PCPF. This article also provides guidance on why and how to use the tool to gain useful data to evidence person-centred practice within a variety of settings. The WCCAT® is now available as a useful, reliable tool for the systematic collection of participant observational data. The authors welcome your commentary and feedback.

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