An exploration of the learning-performance gap in relation to the implementation of Person Centred Plans in Disability Service.

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DECLARATION PAGE

Signed Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award

M.Sc. Education and Training Management (Leadership Strand)

Is entirely my own work and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my own work.

Signed & dated:

________________________

29th June 2010.
Acknowledgements:

I would like to thank all the staff of Disability Services for their input, time, thoughts and willingness to share their knowledge with me. I thank the Management Team in my PCCC area for their financial support and encouragement. I would like to thank my family, friends and colleagues for indulging me and allowing me the time and space to complete this study.

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Abstract:

Title: An exploration of the learning-performance gap in relation to the implementation of Person Centred Plans in Disability Service.

Aim: This paper is a report of a study designed to explore and identify the variables, from the employees’ perspective, that have impacted on the transfer of learning to practice relating to the implementation of Person Centred Planning in Disability Services. The aim was to identify measures that will enhance learning transfer in order to contribute to the body of knowledge surrounding PCP’s and positively impact on the lives of the service user.

Background: Quality & Fairness (2001) clearly states that all service provision should radiate from the needs of the service user, the NDA further developed this concept when they published the draft guidelines supporting good practice in person centred planning which will help the government to deliver on its commitment to provide quality services for people with disabilities. These National Standards for Disability Services explicit reference to person centred planning, as a key reference point, for the development and delivery of services for people with disabilities. In order to be effective, it is important that person centred planning be adopted thoughtfully, carefully and in a way that is tailored to the individual at the centre of the planning effort. National Disability Authority (2005)

Methods: The research was conducted through a phenomenological approach, representing the viewpoint of those under study. Questionnaires were sent out to seventy staff members who were trained in person centred planning, the cover letter requested that interested participants would self nominate to be part of an in-depth interview. The information gathered from the questionnaires was then analysed and divided into the emerging themes. These themes and reflections were the basis of the interview discussions.

Findings: The findings indicated that there are three variables impacting on the implementation of PCP in Disability Service. Firstly, confusion, staff do not fully understand the concept of PCP and the differences between PCP and individual programme planning, secondly, confusion is evident at leadership level and finally the impact of the current transformation programme is having on services. These variables are discussed at length in the text.
Conclusion: The study has highlighted that there are a number of variables impacting on the implementation of PCP’s into practice. For training transfer to be achieved a number of issues need to be addressed.

- Training needs to concentrate on developing a deeper understanding of the complexities of PCP.
- Training needs to address areas of leadership and facilitate the development of positive transfer environments
- The organisational structures and processes need to change to facilitate implementation.

Limitations: Limitations of the study are its explorative nature based on the phenomenological approach and that the study is confined to one organisation and may have limited transferability. Secondly, the researcher was responsible for supporting the implementation of PCP’s and therefore acknowledges the possibility of bias in the data generated.

Keywords: Person Centred Planning, Adult Learning Theory, Learning Transfer, Transfer Environment and Performance Gap.
1. Chapter One

1.1 Introduction
The publication of Quality & Fairness: A Health System for You (2001) placed an onus on all health services to realign how services were developed and delivered to services users. Similar principles have been adopted with The White Paper, Valuing People: A New Strategy for Learning Disability for the 21st Century (Department of Health 2001) in England, The Same as You? (SE 2000) in Scotland, and Fulfilling the Promises (WAG 2001) in Wales.

The publication of National Disability Authority (NDA) Draft Standards (2004) gave direction on how services could achieve the objectives outlined in Quality & Fairness. Underpinning these standards is the commitment to person centred services, where the needs of the individual are paramount to how the service is delivered. In 2007, the Health Information and Quality Authority published National Quality Standards: Residential Services for People with Disabilities. These standards are underpinned by the principle of person centeredness.

The commitment to person centeredness posses a fundamental change for the majority of staff working within Disability Services where the predominant approach is care giving as apposed to care provision. In 2004-2005, Disability Service had piloted the introduction of Personal Outcomes Measures but the impetuous faded and regionally a decision was taken to become involved in a pilot project introducing person centred planning. In planning for this transition and change in work practice, Regional Disability Services organised a two day training course for staff in person centred planning. The learning outcome from this training course was that each staff attending would complete a person centred plan in conjunction with a service user.

The driver for this initiative was the publication of the National Disability Authority’s Draft Standards and the services awareness that there will be an onus on them to comply with the Standard in the near future.
1.2 What is Person Centred Planning?
Person centred planning is a way of discovering how a person wants to live their life and what is required to make that possible. Person centeredness is defined in the draft National Standards for Disability Services as ‘seeking to put the person first’ (National Disability Authority and Department of Health and Children, 2004). Person centred planning has its roots in normalisation and independent living movements. It is grounded in a social model of disability and a strengths-based approach. (O’Connor 2006). The overall aim of person centred planning is “good planning leading to positive changes in people’s lives and services. (Richie et al, 2003). Person centred planning guidance state that, ‘When we use the term “person centred” we mean activities which are based upon what is important to the person from their own perspective and which contribute to their full inclusion in society’ (Department of Health, 2001)

From a historical and social context, service provision for people with intellectual disability plays a large role in controlling and influencing decisions about this group of people and their life experiences (Kilbane and Thompson, 2004). Wolfensberger (1972) noted the ‘extraordinary control’ over people as a result of the mass segregation of people with learning disabilities and though service structures are now changing, control over people is proving trickier to dispense with. (Thompson et al, 2008)

Person Centred Planning is an individual approach to care ensuring people with disabilities and their families are central to the decision making process. (Lyle O’Brien & O’Brien 1997, Sanderson 2000, Emerson et al 2005). The development of systems for personalising services and supports to the needs and aspirations of service users has been fundamental to current health and social care policies in Ireland and the United Kingdom. (Cabinet Office, 2005, Department of Health, 2001, Scottish Executive, 2000) as cited in (Wigham, 2008), (DoHC, 2001).

A study by Holburn et al (2004) in the United States concluded that the PCP model had a significantly greater impact in achieving outcomes for the service user …..
compared with the outcomes for a similar group using the traditional model of individual service planning. In a series of UK studies, findings indicate positive effects on the lives of individuals with intellectual disabilities without additional service costs once initial training costs were taken into account. (Robertson, 2005, 2006, 2007a, 2007b) as cited in Wigham (2008). The shift in service provision from traditional forms of care giving to person centred planning, represents a huge change for staff also.

In 2006, Disability Services became involved in a regional pilot project with the objective of assessing the Services compliance with the then draft National Disability Authority’s Draft Standards for Disability Services. During the project, staff were given training in Person Centred Planning, Protection of Vulnerable Adults and unit managers were trained in Personal Development Planning with a view to cascading this training at a later stage down to all frontline staff. Staff buy in was paramount to the success of this pilot project and communication was premium. While the project was in motion change activity such as PCP meetings and development of plans appeared rapid. Progress reports were developed to track the implementation of the PCP. A newsletter was developed and circulated to all staff supporting ongoing communication. These changes were positively impacting on the lives of the service users. Input from families was evident and some service users went on European holidays for the first time ever but had real lasting change taken place?

In a study by Elton Mayo (1927) known as the Hawthorne Studies, he examined the physical and environmental work conditions of a group of employees and this work can be summarized as employees are more productive because the employees know they are being studied. It is interesting to consider if the Hawthorne Effect was applicable to the pilot project, as the staff were aware they were under study. There was constant interaction from senior management, leadership was evident. In other words their work was subject to examination.

A study conducted by Coyle & Moloney (1999) examining the introduction of PCP in an Irish agency for people with intellectual disabilities concluded that 33 per cent of staff surveyed indicated that training in the implementing the plan did not meet their needs to manage the system adequately and a further 59 per cent thought some
coaching-mentoring would be helpful. Lyle O’Brien et al (1997) claim agencies often act as if person centred planning were a sort of tool box of techniques which staff could be trained to use… but deprives the learner of the kinds of social supports for inventive action that were available to the people who developed the first approaches.

While the literature strongly supports person centred planning as the way forward for people with a learning disability to achieve control, respect and independence in their lives, we need to acknowledge the challenges that person centred planning can present for professionals. Kilbane and Thompson (2004) identified four challenges that person centred planning and thinking can present to professionals.

1. Relinquishing control over what happens in a person’s life in order to take up a support role.
2. Professional responsibilities and duty of care.
3. Conflict with ‘fix it’ thinking.
4. The growing emphasis on natural supports.

Sanderson (2000) concludes that person centred planning requires a flexible and responsive approach to meeting an individual person’s needs and changing circumstances, guided by the principles of good practice rather than a standard procedure

1.3 Conclusion
The concept of person centred planning in bringing about change is strongly reflected in the literature, it’s impact leading to positive change in the lives and services for people is clearly documented. Yet there appears to be a lack of clear evidence around the training for staff in the implementation of the person centred planning, the necessary changes in thinking and practice that support the move from traditional care services to services that are truly person centred, as Thompson et al (2008) stated control over people is proving trickier to dispense with.
1.4 Learning –Performance Gap
Considering the support in the literature for the implementation of person centred planning and the organisational emphasis placed on the development of such plans, one must question why the progress in implementation is so slow. Kinsella (2000) suggests that endemic incompetence may contribute to the barriers to person centred planning. Rhodes and Hamilton (2006) conclude that adequate leadership was essential to ensure changes in service provision.

While many skill deficits are identified among frontline staff, there is also an acknowledgement in the literature that the full range of skills that practitioners possess are not always recognised or used (Dowling et al, 2006)

Dowling et al (2007) describe a number of inhibiting factors relating to the implementation of PCP, they outline a number of issues state that it is widely argued that the culture of the services is a major factor in shaping how they are planned and delivered (Duffy, 2004; Emerson and Stancliffe, 2004; Mansell and Beadle-Brown, 2004; Parley, 2001; Sanderson, 2000; Towel and Sanderson, 2004)

Studies have examined the association between the learning climate of an organisation and employees’ motivation to transfer learning. In a study by Egan et al (2004) they concluded that organisational learning culture had significant influences on both job satisfaction and motivation to transfer learning. Achieving learning transfer is a difficult challenge and can be disappointing (Holton & Baldwin, 2003). To achieve this transfer, an appropriate transfer climate needs to be created (Huczynksi & Lewis, 1980). In a study by Lohead (1985) he found that eighty to ninety percent of American college students are not really able to solve problems that require the application of ninth-grade algebraic principles.
1.5 Background to Study
In the autumn of 2006 Regional Disability Services began to engage in a consultative process to assess the level of compliance with the then draft National Disability Authority standards and establish a framework to support the development and implementation of person centred planning across the service.

A business consultant was sourced to act as a change agent and prominent senior managers were named as champions for each area of work. Work commenced across the disability sector within the geographic region formally known as the North Eastern Health Board area. Following the completion of the National Disability Authority Mock Audit Tool and the Business Excellence Self Assessment six areas for improvement were identified and adapted to address deficits across the service and develop strategies for improvements. For the purpose of this study, the researcher has chosen to focus on three. Seven pilot sites were selected from a sample range of services. These included residential services, respite services (physical & sensory) and day care facilities.

A report template was completed on the outcomes from the self assessment and this identified the areas for improvement.

The following key areas were identified:

- Person Centred Planning
- Personal Development Plans
- Training on the Protection of Vulnerable Adults

1.5.1 Person Centred Planning
The Service’s decided to design, develop and implement a consistent and user-friendly PCP process (including a plan for and assessment of care using person centred approach) by October 2006. A template for person centred planning was created. A training package was developed, agreed and rolled out. Evaluation of the training was based on ‘comfort factors’ (Tennant & Field 2004) at the end of the training day, with no emphasis on application to practice and performance. A major
indicator of success, when audited, was that each service user had a live person centred plan.

1.5.2 Personal Development Plans
The Service’s completed a personal development plan for each Coordinator/Line Manager and Clinical Nurse Manager in each of the seven units involved in the pilot project by October 2006. This was an inaugural plan with a view to continuing the process and encouraging others members of staff to become involved as part of their continuous professional development.

1.5.3 Training on the Protection of Vulnerable Adults
The services designed, developed and implemented a programme of training for staff, on the protection of vulnerable adults, and roll out to each of the seven units in the pilot study by October 2006.

The pilot sites were audited in 2006 each site was examined on the following criteria based on a prioritisation matrix.

The prioritisation criteria consisted of the following

(a) Feasibility of introducing the change in the context of the current changing environment in the HSE.
(b) Critically to improving supports and quality of service to the service users.
(c) Achieving compliance with the draft NDA Standards

Each of the seven pilot areas was successful in attaining accreditation and a decision was taken to extend the project to include all the residential services, the respite service and the adult day unit within the researcher’s work area. Work commenced in early 2007 on the roll out of the project. A steering committee established during the pilot phase continued at regional level and the initial criteria became the key performance indicators for the continuing project.
The memorandum from HSE Corporate in 2008 curtailing travel, reducing meetings and cancelling training had a huge impact on the progress of the project. Key senior people were transferred to different locations with different portfolios. However within our local Disability Services a decision was taken to continue with the rollout of the project at local level.

The Researcher’s has a background in Intellectual Disability Nursing but is presently employed in the role of Training and Standards Coordinator. The question of why was the training not impacting on practice began to intrigue her when progress on the implementation person centred planning did not seem to be impacting on the service as expected. Nolan (2001) contends that client centeredness is likely to be in vogue, progress in the implementation of person-centred planning in practice is slow. The researcher began to question why the training was not translating into practice. With this question in mind the researcher began to explore the possibilities involved which lead her to this study.

The aim of this study was to indentify the variables impacting on the translating knowledge into application. Luongo (2007) claims that despite an increase in treatment approached determined to be efficacious, increased awareness of what evidence based practice is, and an appreciation for EBP in human services, few approaches with proven efficacy have actually transferred into the clinical setting. Sanderson et al (2005) conclude in their article that person centred planning has now being identified as evidence based practice. The first objective of this study was to explore and identify the variables, from the employees’ perspective that have impacted on the transfer of learning to practice relating to the implementation of PCP in Disability Service. Secondly, to identify measures that may enhance learning transfer.
2 Chapter Two

2.1 Literature Review
A comprehensive literature review search of databases such as Emerald, CINAHL and EBSCO were completed. Libraries in Dublin City University, Irish Management Institute and Health Service Executive were searched for printed material. Keywords searched were person centred planning, learning-performance gap and transfer environment.

2.1.1 Person Centred Planning
2.1.1a Description and Background
Person Centred Planning can be described as activities which are based upon what is important to the person from their own perspective and which contribute to their full inclusion in society (Department of Health, 2001)

Kinsella (2000) refers to PCP as a complex process, he suggests that it requires sophisticated judgement, an ability to think quickly……..and a propensity to not need to be in control, he continues to state that these facets seldom feature in professional training and to a lesser extend are a feature of any training. Person centred planning is not an activity ‘done’ to people with an intellectual disability: rather it is about the person taking a lead with those who are important to them (Duffy and Sanderson 2004).

Person Centred Planning has it’s foundations in the social model of care and is one of the underpinning concepts of the Quality & Fairness: A Health System for You; (2001). This is supported by Valuing People (2001) the English national strategy which is founded on the principles of self-determination and social inclusion (Towell and Sanderson, 2004). Person centred planning is a collection of approaches and techniques that share certain characteristics. Mansell and Beadle-Brown (2004)
Person centred planning is an individual approach to care ensuring people with disabilities and their families are central to the decision making process. (Lyle O’Brien & O’Brien 1997, Emerson et al 2005). Sanderson (2000) describes person centred planning as a process of continual listening, and learning; focussed on what is important to someone now, and for the future; and acting upon this in alliance with their family and friends….. However, many people are dependent upon service systems and we need to struggle with the problems and dilemmas of sharing power in person centred planning.

Sanderson (2000) acknowledges the transition from traditional models of care provision can present challenges for staff and organisations. Person centred planning requires a flexible and responsive approach to meeting an individual person’s needs and changing circumstances, guided by the principles of good practice rather than standard procedure.

Person centred planning differs from other forms of individual programme planning in that PCP emphasises three other characteristics found wanting in them.

- Firstly, PCP aims to consider aspirations and capacities expressed by the service user or those speaking on their behalf.

- Secondly, PCP attempts to include and mobilise the individual’s family and wider social network

- Thirdly, PCP emphasises providing the support required to achieve goals, rather than limiting goals to what the services typically can manage. (Mansell & Beadle-Brown, 2004).

Van Dam et al (2008) carried out a comprehensive review of the literature relating to person centred planning where they quote Mount (2002), one of the originators of PCP, in his description of PCP as “both a philosophy and a set of related activities that leads to simultaneous multilevel change”. O’ Brien & Lovett (2004) describe it as essentially a family of approaches to organise and guide community change in alliance with people with disabilities, their families and their friends.
Person centred planning is not simply a collection of new techniques for planning to replace Individual Programme Planning. It is based on a completely different way of seeing and working with people with disabilities, which is fundamentally about sharing power and community inclusion (Sanderson, 2000). PCP incorporates fundamental change in thinking that involves discovering what the individual wants, needs, desires and dreams and seeking ways to deliver this bespoke service to each individual. It requires a wide range of actions at individual, organisational and systemic levels to support and facilitate development of person centred plans (Beadle-Brown, 2005; Cambridge & Carnaby, 2005b).

According to the literature when creating the PCP, the following are considered essential:

- Convening a group of individuals committed to the person for whom the plan will be developed, including, at the centre of the group, the focal person.
- Gathering information about who the person is, their passions, needs and desires.
- Developing a vision or dream for a desirable future based on the person’s gifts, interests and desires.
- Developing a plan to achieve the vision or dream.
- Taking actions to achieve the vision or dream.
- Reviewing actions and making changes to the plan as needed (Kilbane & Thompson, 2004b; Kim & Turnbull, 2004; Medora & Ledger, 2005) as cited in Van Dam et al (2008).

2.1.1b Service Changes

Whilst the above represent activities and principles that guide the development of a plan, it needs to be understood that the adoption of PCP impacts dramatically on professionals and the structures that support people with disabilities (Van Dam et al, 2008). Mount (2002) states that PCP requires those in human services to radically re-examine assumptions, commitments and investments, and to change the way they
relate to people with disabilities, each other, and their organisations. This view of PCP extending beyond the individual plan to a broad collection of practices that requires widespread and fundamental systems and organisational change, is common in much of the literature about PCP (O’Brien & Towell, n.d; Parley, 2001; Kendrick, 2004; Michaels & Ferrara, 2005; Robertson et al., 2007a; Robertson et al., 2007b; Kilbane et al, 2008) as cited in Van Dam et al (2008)

Kilbane et al (2008) discuss the difficulty of the change in thinking required from traditional service provision to a person centred service, because they suggest that such a shift in thinking may appear subtle. They note that it is easy to see the similarities between individual planning and PCP and to believe that what is being achieved is person centred.

“There more that we think person centred thinking, planning and practices as more of the same as we have always done, then it is more likely that PCP morphs in to exactly that, as we minimise the differences and only look for similarities. The power of person centred practice lies in those differences” (Kilbane et al, 2008, p.30)

There is also a danger that choice is interpreted as a range of predetermined options: person centeredness becomes enacted as merely asking people for their views, rather than acting on them; participation becomes a euphemism for asking people to attend a meeting and empowerment becomes just consultation (Cambridge & Carnaby, 2005b) The fundamental difference to traditional approaches to service provision is that the service works to, adjusts to, and provides to the person what they want in life, rather than the person being expected to fit into an existing service. Person centred approaches works with the generic mainstream services and the community rather than limiting actions to what can be provided by specialist disability sector (Kilbane et al., 2008)

Kilbane et al (2008) note that deep listening that is required often creates a tension between how things are right now and how they should be. This can challenge the ethics of practitioners because it invites engagement in another person’s life. It will
illuminating contradictions between a service’s espoused values and actual performance (O’Brien, 2002)

Lyle O’Brien and O’Brien (2000) noticed that agencies that want to benefit from person-centred planning often act as if person-centred planning were a sort of tool box of techniques which staff could be trained to use in workshops by studying protocols, hearing about ideas, and perhaps trying out a technique or even two for homework. Such context-free training no doubt teaches something, but we think it deprives learners of the kinds of social supports for inventive action that were available to the people that developed the first approaches to person-centred planning. This seems to us like a prescription for a system fix destined to fail on its purpose of promoting better lives by disclosing people’s capacities and gifts. (page 3)

In the absence of effective financial information systems enabling devolved budgets, the freedom for care managers to design individually tailored arrangements is likely to be constrained. Administrative culture may therefore be as important as legal entitlement in promoting meaningful individual planning (Mansell & Beadle-Brown, 2004). For person-centred planning to really change people’s lives it needs to be linked to the way resources are allocated and used. (Routledge & Gitsham, 2004).

2.1.1c Shift of Power

Power is a central issue to PCP because people with disabilities are often powerless. (Van Dam et al, 2008) PCP does not take away the role of the professional, rather it uses the expertise and knowledge of professionals to achieve what is important in the lives of people with disabilities (Sanderson, 2000).

“Power over others is the most common and familiar form of power. People expect its use, feel uncomfortable in its absence, fear the uncertain consequences of denying it, and easily fall back upon it in times of stress...But power over others poisons the relationships necessary to support people with disabilities in taking their rightful places in community life”. John O’Brien and Connie Lyle O’Brien, 1994

The shift of power from professionals to family is important because family care about the person in a different way to anyone else and will likely be involved in the
person’s support for their entire lives (Sanderson, 2005) Gregson (2007) states that family members often make the best PCP champions. Kendrick (2004) cautions that many people and their families are unaware of what is possible in their lives and that achieving innovative options may entail more difficulties than accepting what is currently available and will need to be well supported through the planning processes. He continues to state that unless we see a new generation of service leaders who commit to this goal, the entrenched nature of our service and systems will preclude many people from exploring the real potential of their lives.


2.1.1d Effectiveness and Difficulties
According to Robertson (2007a) the body of research on PCP has been growing and clearly demonstrate that PCP can be effective. A common concern however has been the lack of large studies to measure it widespread effectiveness (Mansell & Beadle-Brown, 2004; Beadle-Brown, 2005)

In the largest international study of the outcomes of PCP undertaken by Robertson et al (2005) with 93 people with intellectual disabilities they found that whilst no change had occurred in people’s lives prior to the introduction of PCP. Clear positive changes were apparent after the introduction in areas of:

- Social Networks
- Contact with family
- Contact with friends
- Community based activities
- Scheduled day activities
- Choice making
While these outcomes were significant, the research also demonstrated that of the 93 participants in the study, only 65 actually had plans developed during the study period indicating difficulties, even in service systems that adopt PCP, in ensuring that the plans are actually developed for all intended recipients. They found that the probability of plans being developed was likely to be linked to issues of leadership, staff stability and the existence of prior person centred approaches. However the strongest predictor of plan development was attributed to the commitment of the facilitator to PCP.

Their research also showed that people with difficulties such as mental health, emotional or behavioural problems, and people with autism, people with restricted mobility and people with health problems were less likely to receive a plan. Medora & Ledger (2005) found that the PCP process produced good outcomes for people with complex needs, dual diagnosis and people with communication difficulties, but that there as a need to provide supplementary training in communication skills to support the planning process and increase the involvement of people with communication difficulties.

Mansell & Beadle-Brown (2004) cite evidence that staff often misjudges the receptive language skills of people with intellectual disabilities and this may impact on the effectiveness of the PCP processes. This concurs with O’Brien’s (2004) view that failure in PCP may reflect an inability to adequately assist a person’s participation or communication. They go on to discuss what they describe as the implementation gap – the failure to carry through plans into practice. They offer two possible explanations for this, firstly that there is insufficient understanding on how to do person-centred planning and alternatively they suggest the lack of resources prevents implementation and undermines the motivation to take planning seriously.

Van Dam et al (2008) cite concerns that have arisen during the implementation of the ‘Valuing People’ initiatives including:

- Failure by organisations to really change how people are listened to and responded to resulting in superficial changes
Focus on staff training to the exclusion of families and self-advocates
Failure to pay attention to the implementation of plans
Disconnection between seeing what is important to people in the process of PCP and how resources are allocated and used
Focus on technical training and failure to pay attention to follow up support, management action, and embedding person centred values in organisational culture.
Implementation of PCP without good connections to other plans and strategies
Failure to get person centred plans developed for the main target groups
Failure of organisations to work effectively together (Routledge & Gitsham, 2004)

Medora & Ledger (2005) note that there is a “paradox between the apparent simplicity of PCP and the complexity of doing it well” The illusion of the simplicity of PCP has also been discussed by Kilbane and Thompson (2004b) who state:

*It sounds so simple. Read logically, it makes sense to us. When we first explore what PCP means, it has a visceral ‘rightness’. It feels as though the concept expresses all we have ever aspired to in our professional practice... we like to think that we are warm, caring individuals who would not dream of putting someone we work with anywhere else than in a centre of their life planning...only by constantly exploring and revisiting the PCP approach will we truly be able to practice in a person-centred way and understand the implications of our actions*

2.1.1e Understanding Person Centred Planning
It is essential to gain a deep understanding of PCP and its implications or there is a risk that all that has been learned is the rhetoric of PCP; Medora & Ledger (2005) as cited in Van Dam et al, (2008). Because of the fundamental culture shift required, the messages consistent with PCP must be given frequently and consistently (Routledge & Gitsham, 2004; Gregson, 2007; Sanderson as cited in Holburn, 2002) and Medora & Ledger (2005) found that managers need to own the values of PCP and ensure that they lead by example if good outcomes are to be achieved The significance of
management support to enable staff teams to adopt a person-centred approach is widely accepted (Dowling et al, 2007).

Cambridge & Carnaby (2005b) argue that in order to operate from a person centred perspective, services need to devolve authority and resources to service users and staff and structures need to be non-hierarchical with lateral management systems. This view is supported by Mansell & Beadle- Brown (2004a) who note the “the bureaucratization of management processes and the reservation of funding decisions to higher-level managers removed from direct contact with services users” are impediments to effective PCP.

Medora & Ledger (2005) observe that difficulties in PCP can occur because existing organisational policies are contradictory to the philosophy of PCP. Structural and organisational practice issues have been cited as common reasons for person centred plans being developed and remaining in filing cabinets, never to be implemented (Centre for Development Disability Studies, 2004) as cited in Dowling et al (2007). Kendrick (2004) discusses how much easier it is for organisations, when faced with multiple priorities, to offer people a selection from an existing service rather than create something from scratch that is built around a person’s particular needs.

Kilbane & Thompson (2004a) identify possible conflicts in achieving person centred goals and managing duty of care issues and Medora & Ledger (2005) note tensions regarding issues of consent and appropriate staff roles. Duffy (2004) as cited in Van Dam (2008) discusses the tensions that exist between organisational planning and individual planning. Planning for what one person desires may conflict with what others using a service may desire, or need, or with the constraints of what is available. Duffy sees PCP and systems planning as tensions that can be managed. Organisational and system issues appear very significantly as barriers, the outcomes of PCP demonstrate that barriers can be overcome (Robertson et al, 2005; Mendora & Ledger, 2005; Johnson, 2007; Robertson 2007a; Parley, 2008) as cited in Van Dam (2008).
2.1.1 f Staff Development and Leadership

The role of the frontline worker is central to the realisation of services that are based around person-centred planning. The needs and views of frontline workers must be taken into account, in order for services to succeed in its implementation (Dowling et al, 2006). Parley (2001) states that the capacity of service personnel to deliver creative and individualized strategies as they move away from traditional care models to more person centred approaches needs to be developed and encouraged by strong leadership. The development of competent personnel to facilitate and participate in PCP requires thoughtful education and training programmes (LeRoy et al., 2007).

Research has demonstrated that short one-day didactic training programs are not sufficient to enable participants to demonstrate PCP skills (LeRoy et al., 2007).

Robertson et al. (2007) found that by far the most common reason for the failure of a person centred plan being implemented was problems related to facilitators, such as facilitators leaving their position or not being available. Routledge, Sanderson & Greig (n.d.) note that intensive initial training will be needed for facilitators and that this will need to be followed up with ongoing supports and strategies to support their work. The services that seemed most successful had received a large amount of training in the workplace itself, in addition to the input provided in the training environment. (Rhodes & Hamilton, 2006)

Gregson (2007) discusses the difficulties that may occur in relying on one person as the key component in making the planning process happen and difficulty in recruiting people to the facilitator role. He goes on to point out the importance of ensuring that the person centred plan is not a one-off event. Likewise Michaels & Ferrara (2005) emphasise that good PCP is really about implementation, evaluation and the day-to-day work that is needed over the long haul (As cited in Van Dam et al, 2008). Sheard (2004) notes that there is no continuous learning culture within many services, and argues that staff need training that will empower and encourage them to be proud of their work.

In light of many barriers that face the achievement of PCP, positive leadership at all levels is seen as an essential component (Van Dam et al, 2008). Rhodes & Hamilton
(2006) in their paper on reflections on the implementation of Person-Centred Active Support they clearly state that “Adequate leadership was essential to ensure changes in service provision.”

2.1.1g Resources and Organisational Supports
Medora & Ledger (2005) state that “PCP cannot exist in isolation, only within the broader service system and policy context locally and nationally”. The literature strongly supports the argument for a radical change to how resources are allocated to services and individuals (Felce, 2004; Mansell & Beadle-Brown, 2004; Routledge & Gitsham, 2004; Dowling et al, 2007). As required by Section 6 of the Disability Act (2005) there is an entitlement to an independent assessment of need for health and personal support services. Unfortunately the Act has only, so far concentrated on children under five years of age, but five years on, the positive expectations of its implementation are disappearing.

The literature contains many themes relating to the current way services are funded and the impact this may have on the implementation of PCP’s. Mansell & Beadle-Brown (2004) argue that funding should be allocated on an assessment of needs basis. They also urge caution to be taken to ensure that PCP, with its focus on natural supports, does not mask the social costs of insignificant public expenditure on supports for people with disabilities. While organisational and system issues appear significantly as barriers, the outcomes of PCP demonstrates that barriers can be overcome (Mendora & Ledger, 2005; Robertson, 2007a)

The gap between what is currently available from disability services and what is needed to work in a person centred way is often very large. Difficulties noted in England include:

- The bureaucratic processes and systems that stifle creativity
- Priority placed on targets and statistics rather than outcomes for the individual
- Conflict between roles such as gatekeeper of resources
- Limited financial resources to implement PCP
- Eligibility criteria
Confusion over whether service managers should lead planning, assist in planning or whether planning should be separate from services

Conflicts between duty of care and person centred approaches

Pressure between producing good plans and ensuring that everyone has a plan (Johnson, 2006 as cited in Van Dam, 2008).

Similarly Robertson et al. (2007a) found that system issues such as limited choice of day services, waiting lists, limited housing and lack of accessible community activities were significant barriers to the implementation of plans. Kendrick (2004) notes that very few services and service systems that adopt PCP also foster the capacity for supports to be redesigned to better suit the needs and requirements of individuals. Funds must be ‘un-bundled’ and resources used in new ways and this must be done at a system level. This is further compounded by the current HSE Transformation Programme 2007-2010 and the restructuring of Disability Services.

In conclusion, the literature has demonstrated that good PCP planning outcomes are achievable with innovation (Rouget, 2003) and this is supported by large scale studies. It has described the barriers to implementation and what is required if person centred planning is to be achieved.

- Develop a deep understanding of the complexities of PCP
- Fundamentally changing organisational structures and processes
- Ensuring strong leadership to support the development of PCP approaches
- Ensuring the people with disabilities, families and staff are well supported and educated
- Ensuring that systems and practices are in place to achieve the implementation of PCP initiatives
- Developing commitment, leadership and support at a systemic level to facilitate PCP development. (Van Dam et al, 2008)
2.1.2 Learning Performance Gap

As adults are said to learn experientially according to Kolb (1984) the practical link between theory and practice becomes particularly important. This is even more important when we examine a practical profession like nursing and social care. Haskell (2000) claims that despite its importance, research and experience clearly show that significant transfer of learning in either the classroom or in everyday life seldom occurs. Brinkerhoff (1997) suggests that most organisations measure training success on the number of trainees attending the course and not on how the training programme met the needs of the organisation, the employee or the customer. He goes on to cite studies that show as little as 8 to 12 per cent of what trainees learn translate into improved job performance. Curry et al (2005) put that figure at 10-13%.

Johnston (1995) states that “as teachers we assume that what we teach will be learned and applied by our students in other classes, their daily lives and their future careers. Unfortunately the research on ‘learning transfer’ does not support this”. Kydd (2004) contends that staff often know what they would like to do but lack the confidence, time or resources to put this into action. Gallagher (2007) describes theory as information found in textbooks and other educational formats, while practice is associated with the actual work carried out at ward level. A gap exists between these two entities and Gallagher cites (Ekbergh et al., 2004, Falk-Rafael, 2005, Ferguson and Jinks, 1994) to support this claim.

A study conducted by Swain et al (2003) affirms that there is a theory-practice gap and that there are complex relationships within nursing teams that affect what nurses do. Skill based training programmes often do not result in the application of new skills, knowledge or learned behaviour on the job (Mayer et al, 2007). Mayer et al (2007) claim they were able to gather substantial evidence about what practices enable or hinder learning transfer, the relevance of the training intervention to course attendees’ job roles emerged as an important factor. Appropriate match of staff needs and job roles to specific training interventions and to course outcomes was important and they also refer to the use of learning contracts. They go on to state that the learning contract seems to be a particularly efficient way to ensure transfer of learning and dissemination of skills.
Evidence of the theory-practice gap has been identified in the literature as resulting from the use of ‘specialist educators whose sense of their mandate is rather different from those who are involved in the everyday delivery of the service’ (Glen 2004) as cited in Mayer et al (2007). The literature provides evidence of the existence of the learning performance gap, according to the studies the transfer of learning can be between 8-13%.

Currently, no learning performance gap analysis exists within Disability Services, staff are not appraised on a formal or informal basis, there are no learning contracts or personal development plans in place. Supervision in nursing and among care assistants is ad hoc with little or no structured feedback on performance. The drive to engage staff in personal development plans, as part of the pilot study lost momentum and never progressed past the assessment stage.

2.1.3 Transfer Environment

Effective training is reflected by participant reaction, learning of skills, knowledge and attitude, behavioural changes in job performance, and results such as cost savings, quality and production improvements (Kirkpatrick, 1994). Transfer of training—the degree to which trainees apply to their jobs the knowledge, skills, and behaviours learned in training—is now widely acknowledged to be the paramount concern of organisational training initiatives (Baldwin & Ford, 1988, Tannenbaum & Yukl, 1992) as cited in Burke & Baldwin (1999). It is therefore important to look at the learning cycle, where the employee questions, analyses, models, negotiates, implements, reviews and consolidates learning (Sloman, 2003). There are many opportunities and barriers to successful learning transfer. Successful learning and skills transfer has been associated with social support and opportunity to use the newly acquired learning (Day, 2000; Clarke, 2002) as cited in Meyer et al (2007) who suggest that the context of learning, as well as the ability to support application of this new learning, is pivotal in the transfer process.
A growing body of empirical work supports the notion that the work environment is a critical aspect in determining whether trainees apply skills on the job (Burke & Baldwin, 1999) Close supervision and frequency of follow-up post intervention are associated with more successful skills transfer (Clarke, 2002). Clarke (2002) divides the concepts of training and learning and describes them as Transfer of Training, that is effectively and continuing applying the skills, knowledge, and/or attitudes that were learned in a learning environment to the job environment.

Transfer of Learning is the application of skills, knowledge, and /or attitudes that were learned in one situation to another learning situation. Baldwin & Ford (1988) as cited in Austin et al (2006) define the transfer of learning as the degree to which trainees effectively apply knowledge, skills attitudes acquired in a training programme to on-the job work performance. In Baldwin & Ford’s (1988) conceptual framework they describe three components relating to positive learning transfer.

- **Trainee Characteristics**
  These included skill, ability, motivation and personality factors

- **Training Design**
  These included learning principles, sequencing of learning material, training content and self-management techniques.

- **Work Environment**
  These included organisational climate, peer and supervisory support and opportunities to perform learned behaviours on the job.

Transfer climate refers to those perception describing characteristics of the work environment that may facilitate or inhibit the use of trained skills. These characteristics can include immediate supervisors’ influence, the nature of employee attitudes towards training, and the extent of formal training policies and practices that exist to support training initiatives. Training climates may, therefore, be described as either supportive or unsupportive (Burke & Baldwin, 1999).
According to Holton et al (2003) cultural variations across organisations suggest that not all organisations will or should build the same types of transfer systems. They state that one organisation in which they worked had a very strong team culture that made peer support a more powerful predictor of learning transfer than supervisor support. In a state government agency, the exact opposite was the case. Clark (2002) states in his findings relating to training transfer that failure of training to penetrate as far as behaviour change in the workplace is a result of skills not being actually taught on the training programme to the extent that they can actually transfer,

In Holton et al (2003) study, they use the Learning Transfer Systems Inventory (LTSI): Conceptual Model of Instrument Constructs (Holton et al, 2000) which categorized the sixteen constructs (Concept Frames) into four major groups:

1. Trainee characteristics including learner readiness and performance self-efficacy constructs
2. Motivation including motivation to transfer, transfer effort and performance expectations, performance outcomes and outcome expectations
3. Work environment including performance coaching, supervisor support, supervisor sanctions, peer support, resistance-openness to change, positive personal outcomes and negative personal outcomes
4. Abilities including opportunity to use personal capacity for transfer, perceived content validity and transfer design.

All of the items use a five-point Likert-type scales from 1 = strongly disagree to 5 = strongly agree.

Seyler et al. (1998) as cited in Austin et al. (2006) found that trainees entered training with some level of commitment to the transfer of learning; their commitment was tempered by the perception that environmental obstacles would be encountered upon return to the workplace that would negatively affect the transfer of learning. Austin et al. (2006) suggest that building the transfer of learning expectations and activities into the training programme design is critical to the application of new learning to the workplace.

Supervisory support is another element of training transfer that requires attention and discussion. Meyer et al. (2007) reinforce the findings of Glen (2004) and Curry et al.
(2005) demonstrating that the absence of the required level of supervision or guidance is detrimental to the application and transfer of learning. Employees in public sector organisations perceive that their supervisor is more likely to oppose their use of new methods learned in training, that they are more likely to encounter resistance to change, and that they are more likely to have negative personal outcomes if they do not apply their training (Holton et al, 2003).

Supervisor support was also rated low across all training types, confirming the widely held belief that supervisors do not generally support training as they should. Holton et al (2003) go on to state that the results of their study supports the notion that organisational systems’ support for transfer varies depending on the type of training. Holton et al (2003) conclude that their results point to the importance of using a diagnostic instrument such as the LTSI in planning human resource development interventions and organisations need to diagnose their transfer systems strategically and identify the key factor or factors that will have an influential effect on trainees’ transfer of learning.

In conclusion it is clear from the substantial body of knowledge in the literature that a positive transfer climate is essential in order to facilitate the transfer of learning into practice and embedding it there. Concepts such as selection of attendees, learning contracts, supervisor’s support
3 Chapter Three

3.1 Research Approaches

3.1.1 The Evolution of the Study

This explorative study has evolved from the researcher’s interest in the two main questions under investigation. The first objective of this study was to explore and identify the variables, from the employees’ perspective that have impacted on the transfer of learning to practice relating to the implementation of PCP in Disability Service. Secondly, to identify measures that may enhance learning transfer.

The background to this study evolved from Disability Services involvement in a pilot project, in 2006, to assess, the Service’s, compliance with the National Disability Authority’s Draft Standards for Disability Services. One of the aspects of this project involved developing and implementing a person centred plan for each service user in the pilot sites. A template for the PCP was developed and a two day training package was delivered to all staff in the pilot sites. There were seven sites involved in the pilot project and staff were released on a phased based to attend the training.

The training was evaluated. The method used was the evaluation sheets on the final day of the course and accepted by all involved as successful. On reflection, the evaluation sheets were completed and returned to the course organisers for analysis but the data only generated information on comfort factors. Kirkpatrick (1994) regards this level of evaluation, as he describes those “happy sheets” as reactionary. While information on comfort factors is useful this evaluation is not extensive enough.

The evaluation and accreditation of the pilot project involved each pilot site being subject to an assessment by an external agency against the National Disability Authority criteria. The pilot project was deemed successful. However, true development of the PCP process remained limited, pockets of good practice existed with staff appearing willing to engage in the process. Real change was minimal and
actions limited and this lead the researcher to question why the training was not translating into practice and what were the factors that were affecting it.

The researcher had managed one of the pilot sites during the project and now is employed as the training and standards coordinator for the Service. The question of why the training was not translating into practice as expected was puzzling. In an effort to discover the reasons why person centred planning was not developing throughout the service as expected, the researcher decided to engage in research to identify the barriers to training transfer. Having considered the context, the researcher set about indentifying the variables that were impacting on the translation of training into practice. Polit et al (2001) contends that the qualitative researcher enters the study “not knowing what is not known” i.e. not knowing what it is about the phenomenon that will drive the inquiry forward. The researcher proposed to examine the areas under study from the employees perspective to gain insight into what are the contributing factors to the seemingly absent learning-performance-transfer process and to identify measures that may enhance the transfer from the employees’ perspective.

3.1.2 The Reason for the Approach Adopted

The methodology chosen for this research is the phenomenological approach, reflecting Heidegger’s beliefs that the influence of gender, culture, history and related life experiences prohibit an objective viewpoint (Byrne, 2001). Because phenomenological inquiry requires that the integrated whole be explored, it is a suitable method for the investigation of phenomena important to nursing practice, education and administration (Streubert & Carpenter, 1999). Hermeneutic science involves the act of reading a text so that the intention and meaning behind appears and are fully understood (Moustakas, 1994). The phenomenological paradigm represents a major alternative system for conducting disciplined enquiry in the field of nursing, according to Polit et al, (2001) who continues to suggest that the voices and interpretations of those under study are key to understanding the phenomenon of interest, the learning–performance gap, and subjective interactions are the primary way to access them. The narrative interviews are an appropriate method for disclosing the meaning of experiences (Kindblom-Rising et al, 2007) thus supporting
the use of a phenomenological approach for this particular research project, as it facilitates such information generation.

Creswell (1998) contends that writers agree that one undertakes qualitative research in a natural setting where the researcher is an instrument of data collection who gathers words or pictures, analyzes then inductively, focuses on the meaning of participants, and describes a process that is expressive and persuasive in language. There is extensive literature available regarding barriers to person centred planning but it is limited or somewhat absent when discussing effective training in the process and the facilitation of training transfer. Very little research has been done to elicit what are the elements that impact on the implementation of person centred planning into services, from a training perspective and what factors accommodate learning transfer from the perspective of the employee.

For the naturalistic inquirer, reality is not a fixed entity. Instead, it is a construction of the individuals participating in the research; reality exists within a context and many constructions are possible (Polit et al, 2001). Creswell (1998) urges the researcher to ensure that they understand the philosophical perspective behind this approach and encourages the researcher to ensure that the concept of epoche is upheld, to understand it through the voices of the informants (Field and Morse, 1985). Latimer (2003) argues that through qualitative methods, deep experiences and views of the researched are drawn safely into the public sphere in ways that permit them to be heard, and perhaps influence policy.

3.1.3 The Precise Research Methods Undertaken

3.1.3a Research Design

The explorative design was developed to uncover the full nature of the lack of apparent learning transfer, the reasons the learning transfer was not taking place and the experiences of those directly involved, the staff. The researcher decided to use the data mode of self-reporting as a tool for data collection and designed a questionnaire (Appendix 4) based on a review of the relevant literature (Holton, 2003) and planned
to use focus group interviews to further develop emerging themes from data supplied through the questionnaires.

The researcher completed an application form, which duplicated as an outline plan for the study and applied to the Ethics Committee for approval in January 2009 prior to the commencement of the study. Application one, was returned seeking clarity on the role of the gatekeeper and application two, was returned seeking additional information relating to vulnerable groups. The application was resubmitted, following detailed clarification and approval was granted in October 2009. The researcher carried out a pilot study on the suitability of the questionnaires among a small number of colleagues and the results indicated the sequence of questions needed revising and one question was removed. The questionnaire was adjusted accordingly and the study commenced in January 2010.

The study involved a purposeful sample of seventy staff, including nursing and care staff, clinical nurse managers and the service coordinator. “The logic and power of purposeful sampling lies in selecting information rich cases for study in depth” Patton (1990, p.169) as cited in Streubert and Carpenter, (1999). A participants’ explanation letter (Appendix 2) was distributed. Bowling (1997) contends that it is important to give respondents a covering letter about the study to keep for reference and reassurance that the organisation and study are bona fide, a research information leaflet (Appendix 4) and a consent form for the focus group (Appendix 1) were distributed to each staff member via their line manager.

The questionnaires were designed (Holton, 2000) to maximise the possible number of respondents, allow the respondent anonymity, seeking the perspective of the respondent and illicit themes. The questionnaires included open ended questions, which allow participants to respond to questions in their own words. It was anticipated that the questionnaires would identify issues that could be further explored through the focus groups. Two weeks after the initial contact with the respondents, the questionnaires were distributed to each staff member again via their line managers. The researcher contacted the nominated gatekeeper, each unit manager, and requested that remind the staff to complete the questionnaires. The return rate from the questionnaires was very low; the return equalled 24.3 per cent in total. This data was
compiled in a file management system and used to develop questions for the in-depth interviews. (See sample of data available in Figure 1)

The researcher decided to change the research plan, in effort to generate more data. The researcher contacted the respondents of the self nominating consent forms for the focus groups. There were twelve respondents who had indicated that they would be willing to partake in the focus groups and invited them to become involved in the in-depth interviews. Nine people consented and were subsequently invited to take part in the in-depth interviews.

3.1.4 Data Collection Methods
3.1.4a Questionnaires

The questionnaire (Appendix 3) was structured to allow participants to respond to the open ended questions in a flexible way allowing participants to reveal relevant information in a naturalistic way (Polit et al, 2001). Data was collected from the returned questionnaires, recorded and arranged into themes. The questionnaire response rate was 24.3 per cent. The returned questionnaires were read a number of times to illicit themes. A data management file was created to capture and structure themes. Through free imaginative variation, researchers make connections between statements obtained (Streubert and Carpenter, 1999). See Figure 1.
### Themes

<table>
<thead>
<tr>
<th></th>
<th>D1</th>
<th>D2</th>
<th>D3</th>
<th>D4</th>
<th>D5</th>
<th>D6</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time Frames</strong></td>
<td>Not commenced</td>
<td>2 yr later</td>
<td>2 yr later</td>
<td>2 yr later</td>
<td>2 yr later</td>
<td>4-8 weeks</td>
</tr>
<tr>
<td></td>
<td>Valid template, Support from Unit Manager</td>
<td>Valid Template, Support from Unit Manager</td>
<td>Valid Template, Support from Unit Manager</td>
<td>Valid Template, Support from Unit Manager</td>
<td>Valid Template, Support from Unit Manager</td>
<td>Valid template, Support from Unit Manager</td>
</tr>
<tr>
<td><strong>Supports</strong></td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td><strong>Training Needs</strong></td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td><strong>Recourses</strong></td>
<td>Additional Staff</td>
<td>Recourses from Services</td>
<td>Individual to Service User</td>
<td>Individual &amp; unique</td>
<td>Individual needs</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Reflexion</strong></td>
<td>Yes (no elaboration)</td>
<td>No</td>
<td>Individual to Service User</td>
<td>Individual &amp; unique</td>
<td>Individual needs</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>SU Needs &amp; Wants</strong></td>
<td>focus on Service User</td>
<td>Met &amp; understood</td>
<td>Individual to Service User</td>
<td>Individual &amp; unique</td>
<td>Individual needs</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Training Location</strong></td>
<td>Off site</td>
<td>On site</td>
<td>On site</td>
<td>On site</td>
<td>Off site</td>
<td></td>
</tr>
<tr>
<td><strong>PCP Process</strong></td>
<td>Process in place before training</td>
<td>All parties in place prior to training</td>
<td>Family involvement, teamwork</td>
<td>Putting SU needs first, team working.</td>
<td>SU needs require support</td>
<td></td>
</tr>
<tr>
<td><strong>Benefits of training</strong></td>
<td>Awareness of PCP Template</td>
<td>All parties in place before training</td>
<td>Family involvement, teamwork.</td>
<td>Putting SU needs first, team working.</td>
<td>SU needs require support</td>
<td></td>
</tr>
<tr>
<td><strong>Assistance with Implementation</strong></td>
<td>Additional supported to put PCP in place</td>
<td>Refresher training</td>
<td>Receipt of additional staff</td>
<td>Refresher training</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 1.** (Each Unit D1, D2 etc represents a sample of data from the questionnaires)

#### 3.1.4b Data from Questionnaires

The data generated from the questionnaires described the staff’s thoughts on the PCP process to date. There is an obvious indication that there had been a significant time delay in commencing the process following the training, this prompted further questioning in the in-depth interviews. Supports available suggested that a valid template and support from the unit manager were important to the staff. A high percentage of those returning questionnaires reported that training had met their training needs yet the time delay in implementation was perplexing. The suggestion that the PCP process should be in place prior to training was puzzling, perhaps there was a lack of understanding of the expectations of the training. The benefits of the training appeared positive with a focus placed on the needs of the service user, an understanding of the template and family involvement been highlighted as benefits. On initial examination of the findings from the questionnaires there appears to be a
general acceptance of PCP within the service, but the issue of implementation delay and limited reference to ongoing training suggests a lack of true understanding relating to the expectations of the training outcomes. The unit manager appears an important driver for the staff.

3.1.4c In-depth Interviews
The researcher, in an effort to enhance the data generated engaged in in-depth interviews consistent with the phenomenological approach ‘the backbone of qualitative research is extensive data collection’ (Creswell, 1998 p.19). Researchers engaged in studies within all five traditions, Biography Grounded Theory, Ethnography, Case Study and Phenomenology, face issues in the field when gathering data….some common issues are the need to change or adjust the form of data collection (Creswell, 1998). The questions in the interviews were based on the limited data generated from the returned questionnaires together with the scripts and reflections from each the interviews, as described in Figure 1.

Each interview typically lasted an hour and a half. Rapport was established easily as the researcher was a former colleague of the respondents. The nature of the researcher – participant relationships has an impact on the data collected and their interpretation. These people are not research subjects in the usual sense of the word, but rather colleagues (Burn & Grove, 1999). The researcher was conscious of her need to bracket out the world and any presuppositions in an effort to confront the data in pure form (Polit et al, 2001).

A total of nine in-depth interviews were conducted, this interview group were selected from a convenience sample group, who had completed the consent form for the focus group. The interviews were taped (Bowling, 1997; Burns & Grove, 1999; Creswell, 1998, Streubert & Carpenter, 1999). Although many respondents are self-conscious when their conversation is recorded, they typically forget about the presence of recording equipment after a few minutes (Polit et al, 2001, p.266). The researcher sought permission from the respondents to use the recording device at the time of consent. ‘Researcher’s should contact the participants, once they have agreed to participate, before the interview to prepare them for the actual meeting and to answer and preliminary questions’ Streubert & Carpenter (1999 p.58). The data generated
from the in-depth interviews was analysed using, Colaizzi’s method as cited in Polit et al (2001, p393).

3.1.4d Colaizzi Method (1978)

1. Read all protocols to acquire a feel for them
2. Review each protocol and extract significant statements
3. Spell out the meaning of each significant statement
4. Organise the formulated meanings into clusters of themes
5. Integrate the results into an exhaustive description of the phenomenon under study
6. Formulate an exhaustive description of the phenomenon under study in as unequivocal a statement of identification as possible
7. Ask participants about the findings thus far as a final validating step.

The researcher also sought consent from the respondents to engage in data analysis when the researcher provided feedback to respondents regarding preliminary findings and interpretations and securing the respondents reactions and as a final validating step.

3.1.5 Methodology
3.1.5a The methodology used to analyse data

The phenomenological approach is primarily an attempt to understand empirical matters from the perspective of those being studied (Creswell, 1998) The focus is on obtaining an authentic insight into the participants experience (Burns and Grove, 1999) Analysis begins by going back to the intent of the study (Kruger, 1994). The questionnaires were designed to elicit the views of the staff trained in Person Centred Planning; they focused on the themes highlighted in the literature as barriers to the implementation of PCP’s. Staff were requested to complete the questionnaires anonymously, the researcher did not use a coding system to identity respondents but coded the results from the questionnaires as returned and logged the information in the data management file.
The response rate from the questionnaires was less than expected. The data was read, analysed and divided into emerging themes using a data management file designed in Microsoft Excel. Respondents who had consented to partake in the focus groups were contacted by phone and asked to partake in face-to-face interviews with the researcher. This convenience sample group was audio-tape recorded (Bowling, 1997) with the respondents’ permission, in order that the content could be analysed in detail later. Data analysis requires that researchers dwell with or become immersed in the data (Streubert & Carpenter, 1999). See Figure 2.

3.1.5b Data Analysis

- **Step 1**
  All text from the tape recorded interviews was listened to, transcribed and read by the researcher in their entirety, a number of times.

- **Step 2**
  The researcher then extracted significant statements from each interview and compiled the statements in a data management file to facilitate the construct of meaning.

- **Step 3**
  The researcher sought to understand each significant statement.

- **Step 4**
  The researcher organised and formulated the meanings into clusters of themes.

- **Step 5**
  The researcher integrated the results into exhaustive description of the phenomenon under study.

- **Step 6**
  The researcher formulated a thorough description of the phenomenon in a clear statement in the findings.

- **Step 7**
  The researcher then reverted to the participants of the in-depth interviews and asked them about the findings.

*Figure 2: Based on Colaizzi’s (1978) method.*
The data gathered from the in-dept interviews, was transcribed verbatim, read and analysed for emerging themes. Qualitative researchers typically scrutinize their data carefully and deliberatively (Polit, 2001). This involved reading the transcripts in their entirety, accumulating the data into themes, reflecting on the themes and attributing possible meanings. Morse and Field (1995) note that qualitative analysis is “a process of fitting data together, of making the invisible obvious, of linking and attributing consequences to antecedents”.

3.1.6 Issues relating to ethics, limitations of research, validity

3.1.6a Ethical Considerations

The researcher endeavoured to uphold the ethical principle governing research that respondents should not be harmed as a result of participating in the study (An Bord Altranais, 2007; Bowling, 1997). The researcher applied to the Ethics Committee within her work area for approval and approval was granted when the application fulfilled the conditions of the committee on the third application. Concerns were raised by the committee relating to gatekeepers for the respondents and vulnerable groups. Both concerns were resolved prior to receipt of ethical approval from the board.

Implied consent was sought from respondents via the first question on the questionnaire (Appendix 4) seeking them to confirm consent by circling the YES response on the questionnaire. The research information letter (Appendix 2) informed respondents that they were free to withdraw from the study at anytime, therefore implying the principle of self-determination and full disclosure.

Following the poor response rate from the questionnaires, the researcher sought process consent (Polit, 2001) from the convenience sample, the researcher continuously renegotiated consent, allowing respondents to play a collaborative role in the decision making process regarding their ongoing participation.
3.1.6b Limitations of the Study

The initial expectation of the researcher was that the data generated from the questionnaires would serve as the basis to further develop information gathering in the focus groups. Within the phenomenological design of the study, the evolving methodology is very much in keeping with the process. The sample size is small, response rate from the questionnaire was low. Polit et al (2001) state that because evidence for nursing research comes primarily from human study participants, the need for human cooperation is essential. The study included the data generated from the questionnaires and data from nine in-dept interviews, the gender ratio was one male and eight females. The study is confined to one specific work area therefore the transferability of the conclusions maybe limited.

Out of the returned data the researcher did analyse the findings and incorporated those findings into the research questions for the face-to-face interviews. The researcher has endeavoured to ensure that thick descriptions (Polit 2001, page 316) are incorporated in the text to enable someone interested in making transfer to reach a conclusion about whether transfer can be achieved.

3.1.6c Validity

It is important to acknowledge that the researcher was a clinical nurse manager during the pilot project and transferred into the post of training and standards coordinator. Therefore the implementation of person centred planning into practice was an important aspect of her daily work life.

The debate surrounding reliability and validity, relating to qualitative research, have been considered by the researcher. Golafshani (2003) concludes that reliability and validity can be conceptualized as trustworthiness, rigor and quality in the qualitative paradigm.

The researcher, in an attempt to validate the study sought to invest sufficient time in data collection to have an in-dept understanding of the culture, language, or views of the group under study (Polit et al, 2001). Patton (2002) with regarding the researcher’s
ability and skill in any qualitative research states that reliability is a consequence of the validity in the study. The researcher sought to validate the data via member checks (Polit et al, 2001) presenting the preliminary thematic analysis to the available informants by providing feedback and interpretations and securing the respondents reactions.

3.1.7 Conclusions
True to the style of the naturalistic paradigm, this phenomenological study altered from the original study plan. The returns from the questionnaires were less than expected. The researcher decided to contact respondents who had consented to become involved in the focus groups to seek their consent to engage in the in-depth interviews. Three-quarters of those contacted consented resulting in nine in-depth interviews been carried out. The researcher adapted the study plan accordingly to assist with data generation. The analysis of the findings followed Colaizzi’s method as described in Figure 2.
4 Chapter Four

4.1 Presentation and analysis of findings

4.1.1 Treatment of the Data

Data analysis is not off-the-shelf; rather, it is custom-built, revised, and “choreographed” (Huberman & Miles, 1994). Creswell (1998) contends that he believes that the analysis process conforms to a general contour. The data from the questionnaires was arranged into themes, reflected on and used to support the interview process. The data generated from the interviews was analysed, coded up (Fielding, 1993a) and searched for emerging themes. Bowling (1997) states that in order to analyse and present qualitative data the investigator must be thoroughly familiar with the field notes, the tape recordings and their transcriptions and any other data collected. The researcher divided the data into significant statements, then into clusters of meaning and finally, the meanings were bundled together as textural description of what was experienced and structural description of how it was experienced (Moustakas, 1994). As the interview progressed the researcher reverted to a number of the interviewees to clarify meaning relating to themes.

4.1.2 Analysis of the Data

The purpose of this study was to explore and identify the variables, from the employees’ perspective that have impacted on the transfer of learning to practice relating to the implementation of PCP in Disability Service and secondly, to identify measures that may enhance learning transfer.

The phenomenon was explored through a phenomenological approach, representing the viewpoint of those under study. Questionnaires were sent out to staff who had received training in person centred planning, the response rate from the questionnaires were low. The researcher altered the research plan and sought consent from a purposeful sample to engage in in-depth interviews. Nine in-depth interviews were conducted. The data from the in-depth interviews was taped and transcribed and
significant statements examined using Colaizzi’s (1978) method. These findings have been arranged in Figure 3.
<table>
<thead>
<tr>
<th>PCP</th>
<th>Staff</th>
<th>Training</th>
<th>Advocacy</th>
<th>Budgets</th>
<th>Resources</th>
<th>Power</th>
<th>Obstacles</th>
</tr>
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<tbody>
<tr>
<td>Ethos</td>
<td>Poor understanding</td>
<td>Different approach</td>
<td>Importance of</td>
<td>Not cheap option</td>
<td>Leadership</td>
<td>Disillusioned service user</td>
<td>Missing the point</td>
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<tr>
<td>Around the person</td>
<td>Flexible approach</td>
<td>Refresher training</td>
<td>Asking the awkward questions</td>
<td>Staffing issues</td>
<td>Supports</td>
<td>Power of speech</td>
<td>Doing PCP because it is checked</td>
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<tr>
<td>Type of approach</td>
<td>Values &amp; attitudes</td>
<td>Team building</td>
<td>False advocacy</td>
<td>Inflexible rosters</td>
<td>CNS</td>
<td>Depending on staff member</td>
<td>Abdicated responsibility</td>
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<tr>
<td>Great buzz</td>
<td>Staff who have “it”</td>
<td>Invest in managers</td>
<td>Current Climate</td>
<td>Administration</td>
<td>Needing the service</td>
<td>Doing it to have it done</td>
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<tr>
<td>Community presence</td>
<td>The X factor</td>
<td></td>
<td>Time resource</td>
<td>Policies</td>
<td>Ownership</td>
<td>Policies</td>
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<tr>
<td>Choice</td>
<td>Flexible staff</td>
<td></td>
<td>Peer group support</td>
<td>Sharing with families</td>
<td>System can let you down</td>
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<tr>
<td>Poor understanding</td>
<td>Abdicating responsibility</td>
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<td>Paperwork/template</td>
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<td></td>
<td></td>
<td>Poor understanding</td>
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</tbody>
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Figure 3: Clusters of themes.
Having analysed the data as outlined on pages 38-39, the researcher identified a range of significant statements, (See Appendix 5) at this point the researcher has identified the emerging themes which could be grouped into the following headings

- Person Centred Planning
- Staff
- Training

The researcher re read the data a number of times, reflecting on the themes, continued to identify significant statements until the data was exhausted. Colaizzi’s suggests formulating an exhaustive description in a statement. At this point one statement would not encompass the phenomenon; however the researcher presents three statements.

1. Confusion impacting on staff
2. Confusion impacting on leadership
3. Current Climate within Disability Services.

The significant statements were read again in the context of the transcribed interview, reflected on and the meaning was formulated. Each significant statement was constructed into clusters of themes. Related concepts were grouped together to facilitate coding (Polit et al, 2001). The themes were divided into driving forces for the implementation of PCP’s and obstacles to implementation. They were then further divided in the emerging themes of confusion, confusion impacting on leadership and the current climate in Disabilities Services. Each theme will be further discussed in the text.
4.2 Presentation of the Findings

4.2.1 Confusion around the concept of Person Centred Planning

Person Centred Planning is a way of discovering how a person wants to live their life and what is required to make that possible. Person Centred Planning has it’s foundations in the social model of care and is one of the underpinning concepts of the Quality & Fairness: A Health System for You. In 2009 the Health Information and Quality Authority published the National Quality Standards: Residential Services for People with Disabilities again citing person centeredness as an underpinning concept to delivery of services.

Disability Services has made many efforts over the past years to develop its service based on the fundamental principle of person centeredness. It is acknowledged by staff that person centeredness is the way forward for the service, however there is evidence that there is a lack of understanding of what person centred planning actually is and how front line staff facilitate service users to achieve it. There are pockets of good practice across the service that may not be accounted for by training or alternate intervention.

Interview 1: I talk about staff who have it, the X factor, we do have staff who just do person centeredness, I don’t think we can take any credit for training them, I think they were just born like that and if we could get to a point maybe where we could demonstrate with them how things have been and what has happened, maybe and just maybe some of the staff would be enthused. ........I have been fortunate to work in a team who seem to be person centred without giving it any thought.

This is reinforced by another Interviewee stating that

Interview 5: I think it is a very good ethos with regards getting goals for service users.... I see it as a great change in getting what they wanted not what the services could provide.

Despite many efforts there remains a struggle between the social model of care and a nursing-medical model. This struggle becomes even more evident especially when
challenges around duty of care and professional responsibility emerge. During the course of this study one of the interviewees refers to this ongoing struggle and the impact it was having on the implementation of person centred planning, commencing with the design of the template for PCP’s.

Interview 1: “I would like to review again the template. We need to review the paperwork we are using because I think, unwittingly, it has a medical bias”.

This theme continued throughout the interviews with staff referring to the template as poorly designed and confusing.

Interview 2: “There was a lot of stuff that may not be relevant, I would have said that you can take it out, just remove it from the plan, if you don’t need it, the functional analysis stuff. It wouldn’t apply to our group”.

Interview 5: “I know other colleagues have found it very difficult and have had major problems with paperwork and filling in reports, I did have some problems with the way people were filling in reports but we just twicked them and made them a little more user friendly”.

In Interview six, one of the frontline staff stated clearly that she felt the Assessment Part of the PCP, was very much in keeping with a nurse led service and felt that it precluded Care Assistants from engaging in the process as readily as they would have liked.

Interview 6: “I felt that the first bit of the PCP, the assessment part was for the nurses to complete and it was a while before I’ve seen anyone doing it, I wasn’t going to take it on”.

In three of the interviews there was reference to the fact that Personal Outcomes Measures (POM) had been piloted within the service prior to the introduction of this Person Centred Planning Model and there appeared to be some scepticism regarding the validity of a new model when the Personal Outcomes Model had not been fully utilised.
Interview 2: “It was like the same old chestnut we did all this before with Personal Outcomes Model and then we did something else before that and it never came to anything it just ended up on the shelf”.

This theme is continued with more emphasis on the tool itself and the perception that the Personal Outcomes Model was easier to use for the staff and explain to the service user.

Interview 4: I think Personal Outcomes Measures Model is more simplistic in its format…. I thought it was easier for the service users and the families to get their heads around it. There is big resistance from staff because of the change.

The emphasis placed on the tool itself indicates that true understanding of person centred planning is lacking, as the recording tool is merely a document to assist with monitoring and review and facilities good planning rather than it’s completion being the ultimate goal. In reference to the completion being the ultimate goal, the service managers have struggled with this issue and this will be discussed under leadership and confusion in the next section of findings.

Continuing with the theme that the service made an error in judgement in changing the model of person centred planning it was using throughout the service, this interviewee contends

Interview 1: *I would like to go back and review the process and go back to the Personal Outcomes Model because we threw out the baby with the bath water.*

Interestingly one hundred percent of the results from the returned questionnaires all reported the valid PCP template as a support mechanism to commencing the person centred planning process on their return from the training. In interview 4, reference was made to the use of a completed sample model of a good Person Centred Plan to assist staff in learning the process. Sanderson (2000) acknowledges that person centred planning is guided by the principle of good practice rather than standard procedure. This concept was a highlighted to the auditor by some staff during the accreditation interviews in 2006 as a way forward and recorded as part of the EFQA
Report (2006) recommendations but no action was ever taken on this recommendation.

Experiences regarding staff’s engagement in the person centred planning process appear subjective and related to the role of the interviewee. One interviewee, a line manager, described the staff as “desperately wanting to do the right thing and to give their clients greater opportunity” but remain stifled by the constraints of the organisation. Medora & Ledger (2005) note tensions regarding issues of consent and appropriate staff roles.

Another staff member stated that “I find that staff are very flexible, I have seen a change in them in the last couple of years.” Another Interviewee clearly stated that they felt staff would take opportunity to opt out of the PCP process if given the opportunity “it’s also if someone else is prepared to do it great”.

This may indicate a willingness on behalf of the frontline staff to engage in the process but reluctance due to the lack of understanding of PCP and thus an inability to drive the process forward. In an attempt to better understand the staff member’s perspective the researcher asked them to clarify what they meant regarding “never quite sure if you are doing right or wrong”?

Interview 7: “It is just if you do something and those in charge don’t approve it can be very difficult. You are not always agreed with. I don’t think they know what they are at themselves”.

The perception of person centred planning as an additional activity as opposed to a core function appears to militate against the concept being fully consumed into the culture and lifestyle. This may be as a result of a lack of understanding of the concept of person centred planning or perhaps it is a more complex phenomenon. The information presented during the course of the interviews indicated that there is evidence that suggests person centred planning is practiced in places as an additional activity.
Interview 2: *It is all about the client and they are very person centred but I think they get a bit bogged down in the paperwork…. I suppose I would have said about planning who completes the PCP, what we don’t want is someone sitting in the house, doing paperwork just to have it done when you could be out with your clients.*

There is a clear indication here that the staff believe that the managers, or leadership, don’t fully understand the PCP process and thus doubt their commitment to it. It is easy to understand from that point of view why staff are unwilling to get too involved perhaps if they believe that the managers are not fully committed that the process will change again and they will have a new “chestnut”.

In another interview the respondent stated that perhaps there is a “conflict of interest” on behalf of the staff

*Interview 5: “It’s a conflict of interest the staff are happier doing an eight am to eight pm rather than a ten am to ten pm….. I think there needs to be more flexibility with the roster”.*

Difficulties with structured rosters militating against goals in PCP’s have been an ongoing issue. The reference linked to staff flexibility and willingness to put the service user at the centre of service delivery is fundamental to a person centred service. Without staff engagement the process will not work but training will not address this issue this caveat will not be addressed by training. This matter requires addressing by strong leadership.

The concept of person centred planning as a common goal, uniting staff as a way forward for the service was identified as needing to be fostered further in the opinion of this interviewee.

*Interview 3: “channels everyone into a common goal… when they meet other people who are positive about their job and they are doing things it will spread and I think that’s needed”*

*Interview 5: “Initially I found there was a great buzz about the unit, and people were being very inventive and it was all about PCP’s and needs lead, and what the person wanted not service driven”.*
The researcher concludes that the data generated from the interviews would indicate that there is evidence of person centred planning within Disability Services. One of the identified variables which have impacted on the transfer of training into practice is a confusion around the principles of person centred planning. There is ample evidence that staff understand how to do the basics but the difficulties arise when the encounter inhibitors in the form of policies, procedures, bureaucracy and the requirement for real change to take place regarding service provision.

This confusion is driven by a lack of understanding of how person centred planning differs from individual programmes. Sanderson (2000) acknowledges the transition from traditional models of care provision can present challenges for staff and organisations. Person centred planning requires a flexible and responsive approach to meeting an individual person’s needs and changing circumstances, guided by the principles of good practice rather than standard procedure.

Facilitating staff to develop skills that are flexible and responsive requires ongoing training and development. The organisation needs to assure staff that risk taking will be supported. A frontline staff member describes her lack of clarity around the PCP’s as

Interview 7: “We are willing to do anything that’s asked of us but sometimes you are not sure if you are right or wrong, there are that many different policies about this and that, that you are never quite sure if you are doing right or wrong.”

The findings from this study relating to confusion around person centred planning are reflective of those discussed by Medora & Ledger (2005) where they describe the “paradox between the apparent simplicity of PCP and the complexity of doing it well”.

The training was positively accepted as adequate. All questionnaires and interviews considered the training sufficient. Statements such as

Interview 2: I would have said it was very well presented plan, it was in-depth, the training, the only thing I would say, the staff would have said the training was very good etc, etc, but when it came back to base and you had to try to
implement it, they wouldn’t have said they didn’t understand it. They wouldn’t have said they didn’t know how they worked, what they would have said was the time resource involved, that kind of stuff.

The was no refresher training or ongoing learning facilitated for the staff following the initial training, staff managed the development of the PCP’s with little external guidance. The provision of ongoing training was a reoccurring theme throughout the interviews, reviewing the role of the key worker and team building were also cited as important training elements.

Interview 5: After the initial training that there is refresher, that you go back to basics what is the key worker role, team building also because I think, because she is the named nurse but if somebody puts their head through the window your are not going to wait until the named nurse comes back, it shouldn’t be like that while they are the people leading out on it and they are the people taking the lead role you shouldn’t have to wait for the named nurse or the key staff to bring them here there and everywhere. We are all there for the four service users or the six or the eight service users. So I think key worker role needs to be drummed into people, what it is and what it isn’t, the importance of advocating on behalf of the clients, record keeping, that you can have, not loads of records, but you can sell yourself in the report every month.

Another comment on the training stated that

Interviewee 4: Again it pigged back (the training) on the Personal Outcomes Model, very close together. Going back to the same old chestnut why change?

This is something that may have not been considered by the management team when deciding to change the model of service delivery but it does provoke the question that if the concept of person centred planning was really understood would it really matter what model was used? Sheard (2004) contends that continuous learning development should offer staff training in ownership to be proud of their work. Again it brings to mind the question of the underlying understanding of the philosophy of person centred planning. The focus must therefore be on understanding and enacting the principles and characteristics, rather than focusing on particular tools. Van Dam et al, 2008) As Kilbane et al, (2008) contend that it is easy to see the similarities between individual planning and PCP and to believe that what is being achieved is person centred.
While confusion exists there is evidence that a support system like ongoing additional training, learning sets, involvement with external agencies and support from senior management would assist in the development of expertise in the area. However with all training, it needs to be supported by appropriate leadership and facilitated by the development of transfer environments. The service needs to adopt a vision that incorporates person centred planning in its core. Because of the fundamental culture shift requires, the message consistent with PCP must be given frequently and consistently. (Routledge & Gitsham, 2004)

4.2.2 Confusion impacting on Leadership

Data from the interviews indicates that there appears to be a lack of leadership driving the person centred process. Dowling et al (2006) states that frontline workers require strong leadership and management support. The data from the interviews would indicate that some managers have appeared to relinquish their responsibility for driving PCP’s and have chosen to use the supposed treat of the Health Information and Quality Authority (HIQA) as a tool to acquire the desired conformity from frontline staff.

Interview1: *At the moment I’m blaming HIQA, and I’m working my way around the houses telling the staff that if their CNM 2 are cracking the whip around them that is because I’m cracking the whip around them. We must comply with the HIQA Residential Standards and sorry that’s how it has to be.*

A similar theme emerges from a subsequent interview

Interview 4: *What will make a difference is HIQA and trying to attain the HIQA standards and getting ready for them. Their audit is the thing that’s going to push these through.*
Perhaps what is being identified throughout the interviews is a sense of management but an evident lack of leadership. The managers appear to be focusing on the task ahead, with the goal to be achieved with some transient reason for the previous task failing, lack of resources, change in focus, staff unwilling to engage. Medora & Ledger (2005) found that managers need to own the values of PCP and ensure that they lead by example if good outcomes are to be achieved. The significance of management support to enable staff teams to adopt a person-centred approach is widely accepted (Dowling et al, 2007).

In another interview the respondent clearly described her engagement in Action Leadership (Adair, 1983) in managing the team and as she describes:

Interview 5: “You had to keep on top of things, you had to keep saying I am auditing them, I am checking them, and I am looking”.

Parley (2001) states that the capacity of service personnel to deliver creative and individualised strategies as they move away from traditional care models to more person centred approaches needs to be developed and encouraged by strong leadership.

Interview 2: Well you know the starting point is what resources you have there, to facilitate somebody’s goals in their PCP, there are restrictions around say someone who wants to go on holidays.

According to this Interviewee, the starting point was the resources already available, the possibility of creatively redesigning the service to accommodate the needs of the service user did not appear paramount. Perhaps that is due to the imposing of PCP’s on the staff rather then developing the service with person centred planning as the central driving ethos. However, the lack of training and development afforded to staff could also account for this confusion, Lyle O’Brien et al (1997) refers to the services as sometimes treating person centred planning as a toolbox of techniques to implement PCP depriving the learner of the kind of social supports for inventive action available to those developing earlier models. On one hand the service is demanding reduction in allocated resources without equipping managers with as Lyle O’Brien states that inventive action.
This is reflective of some of the problems cited during the implementation of the ‘Valuing People’ initiatives in England where they describe a disconnection between seeing what is important to people in the process of PCP and how resources are allocated and used.

This theme is further compounded by the underlying suggestion that there was a possibility that not all managers fully understood or embraced the philosophy of person centred planning.

Interview 3: *I don’t know, I think the managers needs to trained and re-trained and questioned about do they know what it is about because I think it will all feed down..... it could have been introduced to the managers more and instead of them passing the buck and saying you have to have PCP’s, you have to have them done or else, it should have been down to the managers to have more meetings with the staff and get them to attend to it first because sometimes they just pass the words down and they don’t walk the talk so they are confusing the staff who are not really sure of it and then sometimes that is because the managers aren’t that really sure of it themselves and they hope the staff have picked it up and they’ll do it.*

This statement suggests that there is a perception among some of the service managers that they don’t quite fully understand the concept of person centeredness themselves. Parley (2001) states that the capacity of service personnel to deliver creative and individualized strategies as they move away from traditional care models to more person centred approaches needs to be developed and encouraged by strong leadership.

An additional issue would appear to be the clash of “ownership” of the PCP between the service user’s day service and their residential service. When the researcher sought clarification on this point the Interviewee explained that there was a

Interview 4: *Another stumbling block was the clash of ownership between the day service and the residential service, in that it was, you found that the PCP had just been done in the day service so we decided to wean it off them.*
One is unsure if this is about power or if it can be explained as a lack of true understanding of the guiding principles of PCP by the all staff. Additional data suggests that person centred planning is fully understood and embraced by the service “it was all about PCP’s and needs lead and what the person wanted”.

In conclusion, there appears to be a significant variance in the level of understanding of PCP presented by staff. There is an observable difference in the level of understanding of those staff involved in the pilot project and those who had worked in other services where the PCP model operated. Thus suggesting that with training and mentoring the possibility of adopting the model significantly increases. This is an encouraging discovery.

4.2.3 Current Climate within Disability Service

The organisational structure of Disability Service has changed significantly over the past year and a half, the effect of the current economic climate and the Health Service Executive’s Transformation Programme 2007-2010 has impacted on the overall service landscape. The service, while existing within the external structures of the HSE, was a relatively flat structure and operated semi-independently of the wider HSE community. These structures have been eroded and replaced by three management silos under the tight control of the General Manager. The role of Area Manager is dispensed with and the three services managers are now reporting directly to the General Manager. The changes have presented challenges around the staff’s perception of the senior management’s knowledge base relating to PCP and their belief that the focus is budget driven.

Interview 1: At the moment in the current climate everything is budget driven and person centeredness does not come into it despite my best efforts and an example of this is senior management’s latest suggestion that one of the group homes needs closing and we will move the four people to another organisation, hardly person centred. So no, unless I can demonstrate not just cost neutral but a saving in money then no. I have managed that with one or two things, but actually its cheaper, its not person centred person driven. Its budget centred and general manager driven.
The role of Area Manager was an influential one and was perceived by staff as a driver or buffer. The service has always had that additional layer of management to filter unwelcome polices or directives and address issues at a more local level allowing the staff some perceived shelter from the external environment. Organisational structures appear to play a vital role in whether or not PCP is effective (Dowling et al, 2007).

Continuing the theme of budget driven service delivery, the second interviewee considered that the lack of resources or more specifically the lack of replacement of human resources was impacting on the delivery of person centred services.

Interview 2: On one hand we are saying we are a person centred service, we all realise that none of us would be there only for our clients but at the same time you are struggling then with, two point something whole time equivalent staff down here and no maternity leave being replaced and someone sick and nobody replaced, and you have to think how am I supposed to achieve, we are only up to a certain amount of goals, and we have only got a certain amount of people to facilitate, so one kind of contradicts the other.

This suggested contradiction runs throughout all the interviews, on one hand there are the published National Quality Standards requiring the organisation to provide a person centred service and resources both financial and human are being continually reduced and eroded.

The attempts to centralise the structures within Disability Service and align them to the wider HSE has impacted on the flexibility afforded to staff and service users. Routledge, Sanderson & Greig (n.d.) state that PCP is a philosophy and process that requires fundamental organisational change because it will come into conflict with existing practices and cannot be just added on to the existing practices in the area of resource allocation, operational procedures, staff priorities and strategic planning. This continual colliding of traditional and emerging philosophies have halted the progression of the implementation of PCP. There appears to be an opportunity for more senior management, commencing with Regional Director Of Operations, Local Health Manager and General Manager to become involved in the training to discover
the supporting philosophy otherwise person centred planning will never be fully incorporated into policy.

Interview 1: Because we have missed that point, about it becoming a way of life, and a way of thinking and that you should always try and walk the mile in the other mans shoes. It’s not just about we have only two members on the next shift so we can’t do his PCP outcomes.

There appears to be a major lack of change, multilevel change (Mount 2002) from the organisation regarding the structures and policies. Perhaps it could be argued that the structures became even more rigid and crippling to frontline staff and managers and the flexible approach that Sanderson (2000) refers to is none existent.

There is a stated sense of increased cost when implementing PCP’s, the literature contradicts this assumption yet the staff contend that there is an increased cost associated with a person centred service

Interview 1: There is a resource issue it is not a cheap option to do a person centred plan because we have to arrange ourselves around that individual and there is little point identifying that what would be hugely beneficial and what they would like to do is involves an element of respite service or maybe home support and then turn around and say I’m sorry I don’t have the budget for that. That said if we could reach a point where we were more willing to arrange what we have got including ourselves, I think that is the crux of it, we don’t want arrange, as staff we don’t want to arrange us around the person, and if we could get over that some of the resource issues might be reduced a little bit.

The issue of the staff reorganising themselves, changing patterns of work to facilitate the implementation of person centred planning appears somewhat controversial. Managers interviewed content that staff need to be more flexible.

Interview 1: If we could reach a point where we were more willing to arrange what we have got including ourselves, I think that is the crux of it, as staff we don’t want to arrange us around the person, and if we could get over that some of the resource issues might be reduced a little bit.

This is supported by the respondent in interview who states
Interview 5: I think there needs to be more flexibility with the roster; you are running the unit, you are doing the returns, you are in charge but not when it comes to people’s rosters, as in flexibility. I might not need four eight-to-eight’s, I might need two eight-to-eight’s, two ten-to-ten’s, I might need two eight-to-eight’s, a ten-to-six and two twelve-to-twelve’s, but before it was grand because you had overtime and time owing, and all that and because now with the pressure of the job that you are not able to approve overtime, and time owing is frowned upon, now people are not that flexible anymore and they don’t want to deviate from an eight to eight to a ten-to-ten.

Frontline staff contend that facilitating service users to attend occasional outings is demonstrating flexibility.

Interview 8: We are going on overnights, and we go to concerts every month, we are going wherever the clients want to go, we work around it we manage it

Reference has also been made to staff carrying out PCP’s because they have been “instructed” to

Interview 4: I think it’s something that they do because it’s something that they have been instructed to do.

The is a worrying concept as it portrays the person centred plans as existing in isolation rather than being the fundamental driving force for service delivery. This again leads the researcher to question the level of understanding of the concept of PCP. Is this a case of some predetermined list of activities available? Another aspect of the culture is the perception of power that the service appears to have over some families and their perceptible fear for their relatives.

Interview 2: When you mention that in front of parents you can see the colour draining because they think oh God bless us are they going to have to come home to us now.

Perhaps if families had been included in the training on PCP’s initially, they would not harbour such fear. Continuing this theme another interviewee states that some families are very good at advocating for their relatives where others are afraid to “rock the boat”

Interview 4: Some families are very good at pushing for everything and screaming and shouting and getting everything they want for the service user
and other families are afraid to say anything in case they rock the boat, families are afraid if they say the wrong thing that their family member be landed back at them.

The data generated indicates that there remains a group of families that accept current practices due to a perceived perception that “the service” may react negatively towards them or they have handed over responsibility to the ‘professional’ because they know best. Traditionally the power to determine what a person needs and how to meet those needs has been held by professionals (O’Brien, 2002).

There appears to be an imbalance in the power base of the service user’s family as well as the perceived loss of power of the individual with a disability. Perhaps there is an opportunity for inclusion of families and significant others in training on PCP, thus allaying fears that some families may have regarding what the expectations of them are. One interviewee expressed concern for a family member who had been invited to his brother’s PCP meeting and was informed on the phone that he was going to be scolded. This problem is most likely reflective of the staff’s lack of understanding of the concept of PCP as discussed earlier but could have been addressed if the families and significant others were also trained in the process. Gregson (2007) states that families have the emotional commitment drive and motivation to be one of the main driving forces in PCP and family members often make the best PCP champions.

The current culture in Disability Services is impacting on the implementation of person centred planning. Person centred planning has been adopted in a void of any other change in relation to core procedures or processes. Mansell & Beadle-Brown (2004) note that the bureaucratization of management processes and the reservation of funding decisions to higher-level managers removed from direct contact with service user’s are impediments to effective PCP. In fact one may suggest that the current climate is an inhibiter the implementation of PCP.

Interview 1: “The management accountant, paled visibly, when I proposed to him with the GM’s blessing that we put biscuit tin money management back into two of our group homes. The poor man blanched and blustered and stated that it is a very unsafe method of doing thing and I confess I have not pursued with him yet because he was so negative”.

56
In conclusion despite significant obstacles, there is substantial evidence to indicate that organisations can work out ways of ensuring the intention of applying person centred approaches can be achieved alongside organisational goals. (Kilbane et al, 2008)
5 Chapter Five

5.1 Summary and Analysis

The objective of this study was to explore and identify the variables, from the employees’ perspective that have impacted on the transfer of learning to practice relating to the implementation of PCP in Disability Service. The researcher has engaged in a phenomenological study examining the viewpoint of those under study.

The data was collected, analysed, constructed into themes and clusters of meaning and presented the data in a descriptive narrative that typifies the experiences of all of the participants under study.

There is ample evidence existing in the literature that demonstrates that person centred planning can achieve significant outcomes for service user’s but implementation requires the service to radically re-examine assumptions, commitments and investments and to change the way they relate to people with disabilities, each other and their organisation (Mount, 2002). However, the literature remains sparse relating to specific training for staff regarding implementation of person centred planning. This exploratory study sought the views of the staff themselves, seeking their lived experiences on the implementation of person centred planning in Disability Services and their views on how training could be altered to improve the training transfer and reduce the learning performance gap.

During the course of the study the researcher, as a novice, found bracketing one’s own experiences in order to focus on the experiences of those under study was a much simpler concept in theory than in practice. Interpretation of the data, reflection and construct took a substantial amount of thought, reflection, more thought and time.

The findings of this phenomenological study concurs with the literature available in relation to the implementation of person centred planning. However, considering the findings from a training perspective, there is evidence that this study can add credibility to the argument that Disability Services needs to re-examine how training in person centred planning is provided and give consideration to the results of the
study regarding the level of confusion of staff and the leadership and the impact the current climate is having on implementation of person centred planning.

5.2 Understanding Person Centred Planning: Allaying the Confusion
The findings from this study, while limited to a small purposeful sample, indicate that confusion exists among the staff regarding their understanding of person centred planning, what it actually is and how it differs from traditional individual programme plans. Person centred planning differs from other forms of individual programme planning in that PCP emphasises three other characteristics found wanting in them.

- Firstly, PCP aims to consider aspirations and capacities expressed by the service user or those speaking on their behalf.
- Secondly, PCP attempts to include and mobilise the individual’s family and wider social network
- Thirdly, PCP emphasises providing the support required to achieve goals, rather than limiting goals to what the services typically can manage. (Mansell & Beadle-Brown, 2004).

One could suggest a sense that continuing to provide services as before with the same predetermined options and calling it person centred is providing a person centred service because the underlying differences are not clear to the staff.

An issue for Disability Services is that 94 per cent of the respondent from the questionnaires agreed that the training met their needs yet implementation is slow. Perhaps there is a sense that they “don’t know what they don’t now”. A question in the questionnaire seeking information on what additional resources were required to assist with implementation of PCP’s only 11.2 per cent (two respondents) requested refresher training. Kinsella (2000) refers to PCP as a complex process, he suggests that it requires sophisticated judgement, an ability to think quickly……. he continues to state that these facets seldom feature in professional training and to a lesser extend are a feature of any training. There appears to have been a concentration on the similarities between the two processes to the diriment of PCP. Kilbane et al, (2008) states that “the more that we think person centred thinking, planning and practices as more of the same as we have always done, then it is more likely that PCP morphs in to exactly that, as we minimise the differences and only look for similarities. The power
of person centred practice lies in those differences”. This outcome indicates that the focus of training should be altered to concentrate more on developing a deep understanding of the principles of person centred planning and highlight the differences between the traditional models of service provision and PCP. Mansell & Beadle –Brown (2004) recommend that staff training emphasises action that makes tangible differences in the lives of people with disabilities rather than focusing on the planning system itself. Staff require strong leadership in this area and additional training specific to their needs. Sheard (2004) notes that there is no continuous learning culture within many services, and argues that staff need training that will empower and encourage them to be proud of their work.

5.3 Understanding Person Centred Planning: The Leadership Role

The findings of this study support the fact that the majority of managers-leaders in the service do not have a complete understanding of the fundamental principles of person centred planning and this has curtailed the implementation. This phenomenon is more likely due to the assumption that service managers had an innate understanding and no additional training was provided for them to lead the implementation of PCP. Robertson et al (2007a) emphasise the need to balance the desire to develop person centred plans for everyone with the capacity to deliver them in terms of the required time, energy and resources needed to develop and implement high quality plans that produce meaningful results for people with disabilities.

Van Dam et al (2008) cite concerns that have arisen during the implementation of ‘Valuing People’ initiatives in England.

- Failure to pay attention to the implementation of plans
- Focus on technical training and failure to pay attention to follow up support, management action, and embedding person centred values in organisational culture.

Interestingly, one manager who was part of the pilot project had an extensive knowledge and understanding and another manager who was a facilitor also presented with a deep understanding. There exists an opportunity for managers to be educated
and skilled up to become key drivers for the PCP’s. Training in development of learning transfer environments and coaching-mentoring (Coyle & Moloney, 1999) would prove hugely advantageous. Part of the researcher’s role was the facilitation of the implementation of person centred plans within the service, the role of facilitator is void without the driving influence of the Unit Managers. Gregson (2007) discusses the difficulties that may occur in relying on one person as the key component in making the planning process happen and difficulty in recruiting people to the facilitator role.

5.4 Person Centred Planning: The Current Climate within Disability Services

In 2006 when the pilot project was commenced there was an examination of the feasibility of achieving the implementation of person centred planning under the then current climate of change. Nobody had ever envisaged the emergence of the current climate. The literature clearly outlines the importance of a suitable facilitative transfer climate to enhance the development of person centred planning. From the textural descriptions in the proceeding chapter it is evident that that climate does not exist in Disability Services presently. Person centred planning is one hand the fundamental guiding principle for service development and on the other hand tussled with via every policy and procedure produced at HSE Corporate level. There is a perception among staff in Disability Service that nationally we are the “forgotten” service.

If person centred planning is to be adopted properly, the service requires the support of national policies and procedures to fundamentally change operational procedures and enhance facilitation. These policies and procedures need to be reflective of the individual environment of Disability Service and the uniqueness of the service it provides. Adaption of policies that are produced for acute services is not appropriate for Disability Services. The service coordinator needs to be facilitated to promote the adopted of true person centred planning by means of a change in policy focus and development and support from more senior management.
5.5 The recommendations from the Study

1. Ongoing training in person centred planning for all staff
2. Leadership training for Unit Managers
3. Unit Manager’s to become facilitator / drivers for the PCP’s.
4. National recognition that strategic planning in Disability Service requires review and reconfiguration to facilitate implementation of person centred planning.
5. Further researcher is required to substantiate these findings.

In conclusion, this phenomenological study has explored the variables, from the employee’s perspective that have impacted on the transfer of learning to practice relating to the implementation of person centred planning in Disability Service and secondly to identified measures that may enhance transfer.

- Changing the focus of training
- Including refresher training on an ongoing basis.
- Special training and development packages for service managers-leaders to enhance implementation.
- Change in focus for policy development in Disability Service to adequately reflect the uniqueness of the service
- Support and involvement from senior management to embed the ethos in the service.

The methodology chosen for the study was a phenomenological approach, representing the voices of those under study. The Colaizzi’s (1978) method of data analysis was followed. The study sought to understand from the employee’s perspective why the training on person centred planning was not transferring into practice. A number of issues were identified and they are presented in their original form.

Reflection on the meaning of the descriptive text took time and the researcher acknowledges as a novice researcher that experience will enhance this process but having sincerely aimed to remain faithfully to the original meaning.
The phenomenological report ends with the reader understanding better the essential, invariant structure of the experience (Creswell, 1998)
Appendices

6.1 Appendix 1  Consent Form for Focus Group

Working title of study: An exploration of the learning-performance gap in relation to the implementation of Person Centered Planning in Disability Services

Name of researcher(s):
Patricia Bannon, Training & Standards Coordinator, Meath Disability Services.
Mary King, Academic Supervisor, Dublin City University, Dublin.

Part 1 – Declaration of Participant

State:
I have read or have had information sheet read to me. I understand same.
I have been given opportunity to ask questions and am satisfied with answers.
I understand that participation is voluntary and can withdraw at any time.
I am aware that I can withdraw at any stage during the study.

Request:
I consent to possible publication of results.
I consent to take part in the study.

I would be interested in taking part in the focus group  Yes  No
(Please circle yes or no as appropriate)

Signature of participant and date:
Signature: ________________________ Date: ________________________

Participations Contact Details
_________________________________________________________________
_________________________________________________________________

Part 2 – Declaration of Researcher

State:
I have explained the study.
I have answered questions.
I feel the participant understands and is freely giving consent.

Signature of researcher and date
Signature: ________________________ Date: ________________________
6.2 Appendix 2

Training & Standards Department,  
Meath Disability Services,  
Bailis Resource Centre,  
Johnstown,  
Navan,  
Co. Meath

Date:

Dear Participant,

I am currently undertaking an Applied MSc in Training & Education Management (Leadership Module) in Dublin City University. The final module of this programme involves submitting a research dissertation. The research topic is “An exploration of the learning/practice gap in relation to the implementation of Person centred planning in Disability Services.”

The study will commence in October 2009 with the administration of a questionnaire to a group of frontline staff. I am enclosing an Information leaflet and a consent form for you to complete if you are interested in taking part in the study. Participation is voluntary. Because the surveys are anonymous, once you have submitted your questionnaire, it will not be possible to withdraw from the study, so please give careful consideration before consenting to participate. Completed questionnaires should be returned in a sealed envelope to the collection point at Reception, Bailis Resource Centre, Johnstown, Navan, Co. Meath.

Further investigation of emerging themes will be facilitated through focus groups. I am seeking volunteers, 6 – 8 approximately, to participate. Anyone interested in engaging in the focus groups should inform their Unit Manager of their interest and complete the relevant section on the consent form. In the event of a high level of consent for the focus group, random selection will be used to select those agreeing to partake.

Thank you in advance for your time and participation.

Yours Sincerely,

Patricia Bannon,  
Training & Standards Coordinator,  
Meath Disability Services.
6.3 Appendix 3
Questionnaire

_I consent to taking part in this study by completing this anonymous questionnaire._

YES

NO

_Please indicate your consent by circling yes or no._

Q1. When did you receive training in Person Centred Planning? Date

Q2. Did you volunteer to attend the course or were you requested by your line manager to attend?

Volunteered Requested

Q3. When did you commence the Person Centred Planning process following training?

Within 1-4 weeks  4 – 8 weeks  3 months  6 months  Not commenced
(Please circle to indicate your answer)

Q4. What supports were in place for you to commence the Person Centred Planning process when you returned to your place of work?

Please circle as appropriate.

Valid template.  Additional Training.

On the job training.  Others: ____________________

Support from unit manager.

Q5. Did you find the training beneficial?

No  Yes  
[___1__2__3__4__5__6__7]

Q6. What were the benefits? ___________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Q7. What aspects of the training in Person Centered Planning were most beneficial?
_____________________________________________________________________
_____________________________________________________________________

Q8. Did the training meet your needs in relation to implementing the Person Centered Planning in your workplace?

No
Yes
[ 1  2  3  4  5  6  7 ]

Q9. In your opinion, is training on site or off site more beneficial?

Please give details:
_____________________________________________________________________
_____________________________________________________________________

Q10. Did you feel supported to implement the learning on return to the unit?

Yes
No

Please give details:
_____________________________________________________________________
_____________________________________________________________________

Q11. What, if any, additional supports could supplement the training?
_____________________________________________________________________
_____________________________________________________________________

Q12. Did you have time to reflect on what your learnt following the training in Person Centered Planning?
_____________________________________________________________________
_____________________________________________________________________

Q13. What in your opinion would have assisted you in implementing the learning more successfully on return to work location?
_____________________________________________________________________
_____________________________________________________________________

Q14. Any additional information that you feel would improve the training in relation to Person Centered Planning.
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Thank you, please return in the pre-addressed envelope provided.
Appendix 4

Title of Study:
An exploration of the learning-performance gap in relation to the implementation of Person Centred Planning in Disability Services.

Introduction:
This research study intends to explore the learning-performance gap experienced in the implementation of person centred planning, for people with an intellectual disability. The researcher intends to identify the variables, from the employees’ perspective, that have impacted on the transfer of learning into practice.

Procedure:
The criteria for participation in the research study, requires the participants to have undergone training in the implementation of person centred planning and have been involved in the development and implementation of a person centred plan. The study requires that participants complete a questionnaire relating to the implementation of person centered planning and if willing self-nominate to become involved in a focus group to facilitate the discussion of themes further. Focus groups will involve a hour and half long meeting, with the possibility of a further hour long meeting if discussions have not concluded. A recording device will be used to capture data from the discussion but all data will be securely stored in a locked cabinet in the researcher office. Rules of participation will be agreed upon on the first day of the focus group.

Benefits:
The potential benefit of the study will be to identify measures that will enhance learning transfer relating to person centred planning and therefore positively impact on the lives of the service users.

Risks:
You are under no obligation to partake in this study.

Exclusion from participation:
You cannot partake in this study if

(a) You have not been trained in the implementation of person centred planning
(b) You work in an area that has not adopted this model of service delivery to date.

7. Confidentiality:
Your identity will remain confidential. Your name will not be published and will not be disclosed to anyone outside the study. Details of the focus group will be coded and only identifiable by the researcher.
8. Compensation:
This study is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

9. Voluntary Participation:
Your participation in this study is voluntary.

10. Stopping the Study:
You understand that the investigators may stop your participation in the study at any time without your consent.

11. Permission:
The study has Research Ethics Committee approval from the Healthcare Research Advisory Committee, HSE Dublin North East.

12. Further Information:
You can get further information or answers to your questions about the study, your participation in the study, and your rights from Patricia Bannon at 041 9091400.

Thank You.
### 6.5 Appendix 5

**Significant Statements**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1.</td>
<td>PCP Should be an ethos</td>
</tr>
<tr>
<td>2.</td>
<td>Medical bias</td>
</tr>
<tr>
<td>3.</td>
<td>Staff desperately trying to do the right thing</td>
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<td>4.</td>
<td>Perception that PCP had to be done</td>
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<tr>
<td>5.</td>
<td>Something they do and finish</td>
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<tr>
<td>6.</td>
<td>Change ourselves</td>
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<td>7.</td>
<td>Arrange ourselves around the person</td>
</tr>
<tr>
<td>8.</td>
<td>We have missed the point</td>
</tr>
<tr>
<td>9.</td>
<td>They came into the service knowing they were going to be asked to work flexible hours</td>
</tr>
<tr>
<td>10.</td>
<td>Values and attitudes</td>
</tr>
<tr>
<td>11.</td>
<td>That sends out a message before you have even started</td>
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<tr>
<td>12.</td>
<td>Not a cheap option</td>
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<tr>
<td>13.</td>
<td>As staff we don’t want to arrange us around the person</td>
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<tr>
<td>14.</td>
<td>Current climate</td>
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<td>15.</td>
<td>I don’t think we can take credit for training them</td>
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<td>16.</td>
<td>The X factor</td>
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<td>17.</td>
<td>The perception that we do PCP because it’s checked</td>
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<td>18.</td>
<td>Abdicated responsibility</td>
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<td>19.</td>
<td>I can’t understand what the problem is</td>
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<td>20.</td>
<td>Do the training differently</td>
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<td>21.</td>
<td>The time resource</td>
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<td>22.</td>
<td>Doing paperwork just to have it done.</td>
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<td>23.</td>
<td>Advocacy</td>
</tr>
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<td>24.</td>
<td>Personal Outcomes Measures</td>
</tr>
<tr>
<td>25.</td>
<td>We did all this before</td>
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<tr>
<td>26.</td>
<td>It just ended up on the shelf</td>
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<tr>
<td>27.</td>
<td>Get a bit bogged down in the paperwork</td>
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<td>28.</td>
<td>A lot of stuff that may not be relevant</td>
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<td>29.</td>
<td>I suppose from our peer group</td>
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<td>30.</td>
<td>The starting point is what resources you have there</td>
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<td>31.</td>
<td>Staff are very flexible</td>
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<td>32.</td>
<td>One kind of contradicts the other</td>
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<td>33.</td>
<td>They will probably be disillusioned</td>
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<td>34.</td>
<td>Highlight the obstacles they come across</td>
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<td>35.</td>
<td>People who verbalise do manage to achieve things</td>
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<td>36.</td>
<td>The key worker would have control</td>
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<td>37.</td>
<td>The smallest of choices make a to someone.</td>
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<td>38.</td>
<td>It depends on the staff member</td>
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<td>39.</td>
<td>So appreciative to have a service they will go along with anything</td>
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<tr>
<td>40.</td>
<td>Channels everyone in a common goal</td>
</tr>
<tr>
<td>41.</td>
<td>Learning sets</td>
</tr>
<tr>
<td>42.</td>
<td>Use the tool to get their own way on things.</td>
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<tr>
<td>43.</td>
<td>Staff didn’t understand it</td>
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<td>44.</td>
<td>Goals picked for clients without any experimentation</td>
</tr>
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<td>45.</td>
<td>Meaningful goals</td>
</tr>
<tr>
<td>46.</td>
<td>Down to managers</td>
</tr>
<tr>
<td>47.</td>
<td>Clash of “ownership”</td>
</tr>
<tr>
<td>48.</td>
<td>If someone else is prepared to do it great.</td>
</tr>
</tbody>
</table>
7 References

An Bord Altranais (2007)


Disability Act (2005)


