‘Owning the space’—person-centred practice in a 100% single-room acute-care environment: an ethnographic study

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- **Author contributions**

  RK, DB, TMcC made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; were involved in drafting the manuscript or revising it critically for important intellectual content; have given final approval of the version to be published. Each author participated sufficiently in the work to take public responsibility for appropriate portions of the content; and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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- **Conflict of interest**

  No conflict of interest has been declared by the authors.

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- **Ethical approval**

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ABSTRACT

Aims and Objectives: Exploring the influence of the 100% single-room environment on staff and patient experience of person-centred practice in an acute-care setting.

Background: Current building guidance for the NHS advocates increasing the single-room inpatient environment. There is little evidence of the impact of this design in adult acute care settings on the experience and delivery of person-centred care.

Design: Ethnography, underpinned by McCormack and McCance's Person-centred Practice Framework.

Methods: Data collection took place between March and June 2018. Staff and patients in a National Health Service hospital in the United Kingdom took part in observations of practice (n=108 hours); face to face inpatient interviews (n=9); and participatory reflective staff groups (n=3). A reflexive journal was kept by the researcher throughout the study. Reporting adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.

Results: Themes relating to care delivery and interactions were identified. Staff and patients' views converged around visibility and isolation. Patients appreciated the privacy afforded by the single-rooms, while staff experienced a psychological shift, being viewed (and viewing themselves) as "visitors." There was space for more sympathetic presencing, encouraging patients to speak more openly, to facilitate knowing and authentic engagement. However, time remained an issue resulting in more task focused care.

Conclusion: Changes to the physical environment have an impact on the delivery and experience of person-centred practice. While the facilities enhance patient experience, the interweaving of engagement, emotional support and the development of therapeutic relationships remain challenging.

Keywords Ethnography; Adult nursing; Attitudes; experiences; communication; nurse-patient relationships; ward design

What does this paper contribute to the wider global clinical community?

- A refocus on key interpersonal skills such as communication and building rapport to support meaningful engagement with patients in this new environment.
- Maintaining and nurturing therapeutic relationships can be exposed in this new physical environment, highlighted by a shift in the perception of 'ownership' of the space. As a result, task-focused care re-emerges, reducing time spent in patients' rooms.

1. INTRODUCTION

The lack of privacy and dignity for patients in Nightingale-type wards or wards with multibedded bays manifested itself with the focus on single sex wards or bays (Department of Health (DOH) 2002), as a pre-cursor to the single-room environment in the United Kingdom (UK). Previous research on the single-room environment focused on patient safety and the reduction in health care-associated infections, with infection prevention and control the major driver towards a 100% single-room environment (Bracco et al., 2007). This thinking has subsequently been challenged in more recent studies where no difference in infection rates between single-room and four-bed bays was found (Ellison et al., 2014). There has also been recognition internationally of nurses' views that patient safety was impacted by both the physical environment and staffing concerns (Aiken et al., 2012).

Recently, there has been an increased focus on the context in which care is delivered, reflecting the design of rooms (Maben et al., 2015), and specific group experiences (Anäker et al., 2019). This demonstrates some potential for understanding more about the reality of practice for all those in this healthcare environment. Alongside the complexity of multiple contexts within healthcare, culture impacts on the care that is delivered. Understanding social connections is key to the development of a healthful culture, influencing how patients and staff feel and act in that environment ((McCance & McCormack, 2021). Involvement, information, and respect can be applied to direct patient care, but also to an organisation's relationship with its staff to make it a truly person-centred culture (Hardiman & Dewing, 2019). The organisational culture will in turn influence how staff treat patients, reflecting how person-centredness is predicated on social beings, being defined by the relationship with others and the world (Wilkins, 2012).

Reflecting the aspiration to deliver person-centred practice, evident in global health and social care policy and strategy (European Health Property Network, 2011), National Health Service (NHS) strategic building planning (Wanless et al., 2002) recommended consideration of more comfortable surroundings as part of patient-centredness in all modernisation plans for the NHS Estate. This has

led to the further development of the single-room design within healthcare facilities.

2. BACKGROUND

While the impact of the environment on care delivery and patient experience has been documented (O'Halloran et al., 2011), there is little evidence relating to single rooms in adult acute care settings. A literature review by Kelly et al., (2019) found that key elements such as communication, authentic engagement and the physical environment were recognised as important. This review also found that while there was increasing evidence of the impact of culture and care processes on patient and staff experience, generally the relationship between the experiences of the two groups were not explored.

Recent policy documents within the four countries of the UK reflect the attributes of person-centredness as central to the patient experience of health care, as it relates to the physical environment (DOH, 2009); the culture within healthcare settings (DOH, 2014); and skill mix (Department of health, Social Services and Public Safety (DHSSPS), 2016). There has however, been less focus on the experience of staff in the single-room environment, while internationally, the focus has also concentrated on patient experience (Australian Commission on Safety and Quality in Health Care, 2011; Ministry of Health, Ontario, 2012).

Person-centred principles underpinning patient experiences of adult NHS services include communication, information, shared decision-making, and education (NICE, 2012). These principles are found within the domains and constructs of the Person-centred Practice Framework, a midrange theory with four key constructs (McCormack & McCance, 2006):

- *Prerequisites* – the attributes of the nurse
- *The care environment* – context where care is delivered
- *Person-centred processes* – activities for delivering care
- *Person-centred outcomes* – results from effective person-centred practice

Further iterations were developed as evidence demonstrated the global adoption of the Framework (McCormack et al., 2015). The most recent iteration, which was used for this study, was designed to be used in a multidisciplinary context as opposed to the previous focus on nursing. It developed the thinking around the care environment with concepts such as power sharing, skill mix, supportive organisational systems and shared decision-making, alongside the physical environment. The *Macro Context* construct was added to reflect the impact of wider health and social care structures (McCormack & McCance, 2017) (Figure 1). The authors of the Framework have defined person-centred practice as: "…an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives." McCormack & McCance (2017, p.3).

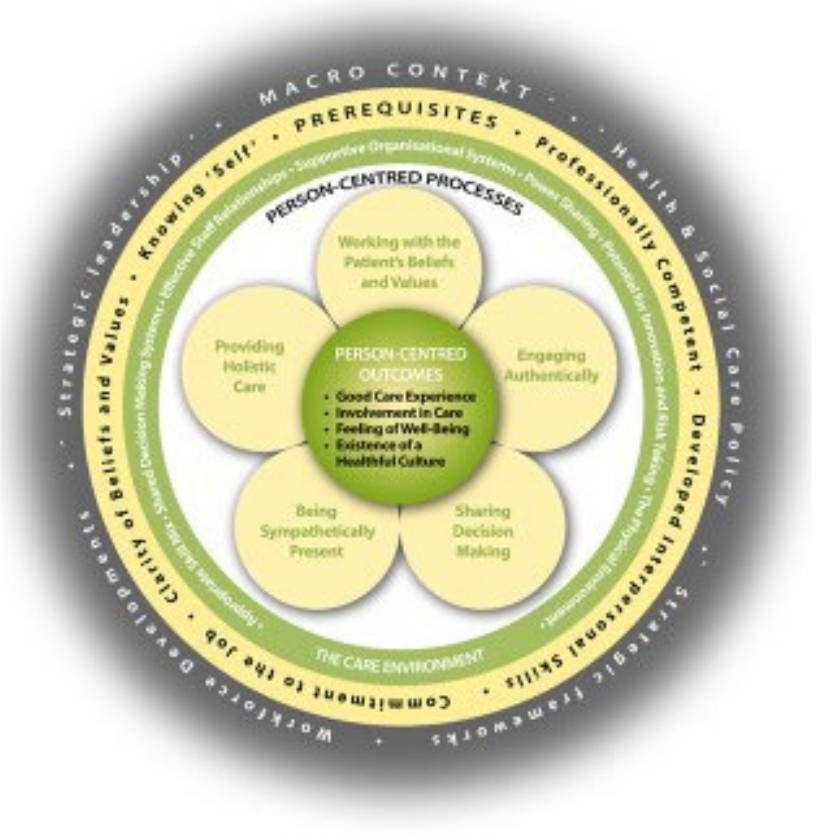

FIGURE 1 Person-centred Practice Framework (McCormack and McCance 2017)

This study sought to explore the influence of a 100% single-room, acute-care environment on the experience of person-centred practice from the perspectives of patients and staff.

3. METHODS

3.1 Study Design

An ethnographic approach was used. Ethnography is "a science about humans by humans" (Reed, 2017). It was chosen for this study as it is commonly employed to explore the social environment and illuminate the context in which activity occurs. It can be used to study the impact of an environment on the everyday reality of a defined population within a social organisation and culture (Pereira de Melo et al., 2014). Ontologically, it recognises that participants and researchers may be working in a shared reality but will have their own reality within that. In the past two decades, ethnography has been increasingly employed in the healthcare environment to study the social groups within, allowing a more intimate exploration of the lived experience of the participants and facilitating a greater understanding of the complexity of societal influences on care delivery (Feddersen et al., 2017). Ethnography aligns itself to person-centred practice, by exploring the influence of the environment, and its impact on patients and staff through the multiplicity of voices and experiences (Wolf et al., 2012). This study sought to establish the existence of person-centredness, through evidence of engagement, decision-making and partnership, using observation, patient interviews and participatory reflective staff groups. The reporting adhered to the Consolidated Criteria for Reporting Qualitative Research checklist **(**COREQ) (Tong et al., 2007) (Supplementary File 1).

3.2 Setting and Sample

The study took place in a new ward block within a large district general hospital in the United Kingdom. The Trust where the hospital is situated serves a population of approximately 361,329 and covers an area of 425 square miles across three local government districts. The wards in the new block are laid out in an 'L' shape with a total of 288 single bedrooms, all with ensuite bathroom facilities. Each ward contains 24 single rooms and the block is made up of general and specialist medical and surgical wards.

The researcher (RK) had previously worked in the organisation participating in the study, but not with any of the staff, or in the area being studied. All the ward sisters in the new ward block were approached collectively and after a presentation of the study proposal, three ward sisters self-selected their wards to participate in the study. These participants expressed a particular keenness to understand the current reality of the experience staff and patients were having. Several preparatory visits were made to talk with staff about the study. The majority of staff had moved across from the old ward block, but there were some newer members who had only worked in the new ward block. All staff, except students and staff members working on the participating wards for less than one week, were eligible to participate in the observations of practice and participatory reflective groups. All staff participating in the observational element of the study provided written consent. Those who did not consent, while present during the observation sessions, were excluded from the recordings. Consent was implicit for the reflective groups, indicated by staffs' voluntary attendance.

All patients over 18 years in the participating wards, and carers/family members of those patients who were unable to indicate consent for themselves, were eligible to participate in the interviews. Patients who could not speak English and declined to use an NHS approved interpreter were excluded. Participants were selected using purposive sampling (Etikan et al., 2016), and all interviews were carried out by the lead author, as part of a PhD. All the patients had experience of open/bay design wards but not necessarily in the hospital featured in this study. The interviews were opportunistic, with patients being selected on the basis of their presence on the ward between 9th May and 20th June 2018, and their ability to consent to be interviewed. In order to be equitable across the three participating wards, three patients from each ward were interviewed. Patients were informed about the observations of practice and reassured that only staffs' actions would be recorded.

No capacity assessments were performed on patients. Where there was any question of the patient's cognitive ability to give consent, staff and family members who knew the patient best judged whether the patient should be approached to participate. This reflected the concept of "interdependence and connectedness through relationships" described by Dewing, (2002) as a feature of person-centred

process consent. Patients were able to provide verbal consent witnessed by a family or staff member.

3.3 Data collection

Data collection took place between March and June 2018, one year after the move to the new ward block had taken place. The qualitative methods used in this study are presented in Figure 2. The Workplace Culture Critical Analysis Tool (McCormack et al., 2009) addressed the subjectivity associated with qualitative data collection, linking ethnography to person-centredness through its participatory, observational and reflective elements (Supplementary File 2). The observation periods covered 2 hour slots, over all shift patterns, to cover 24 hours in total on each ward. A total of 108.45 hours of observation were completed. The researcher stood at various vantage points along the corridors in each ward but did not enter patient rooms to preserve patient privacy. While conversations that took place behind a closed door could not be recorded, the door was often left open so both conversations and actions could be observed and recorded. Following each period of observation an informal meeting was planned to review issues which arose (Clarification and Problematisation). This process gave staff the opportunity to relate the observations to their practice at that time, as opposed to the PRGs which took place some weeks after the observation phase.

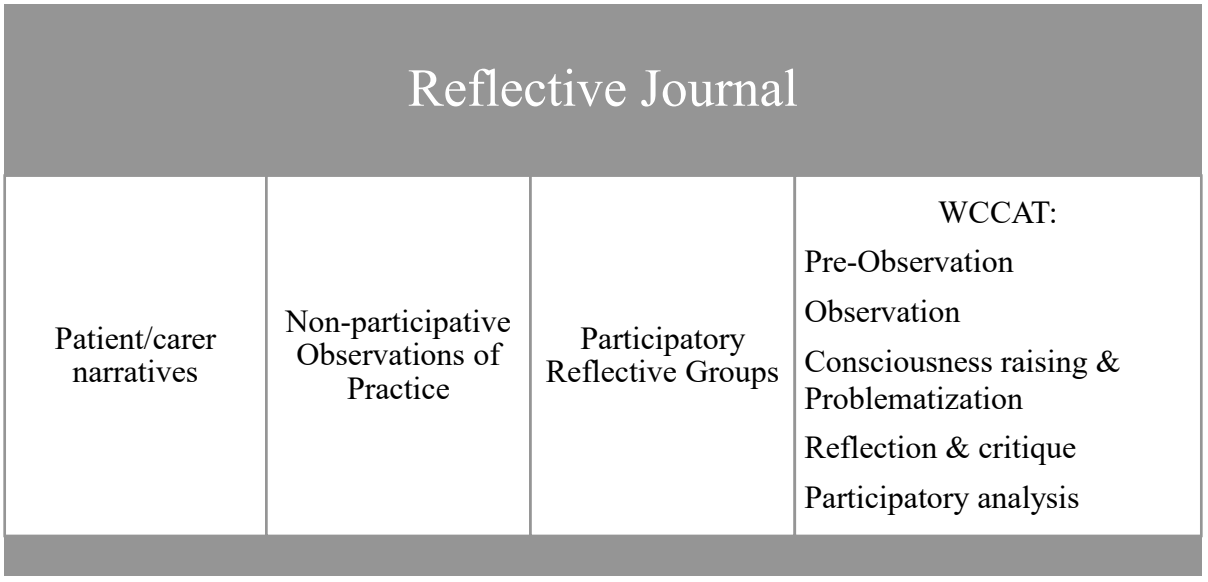

FIGURE 2 Data collection methods

The reflective group sessions were a collaborative enterprise, enabling staff to reflect on and discuss, the issues arising (Figure 3). This design was based on the participatory action element of the WCCAT. Although no intervention was being designed, adaption of the tool was used to engage practitioners in reflection and critique of the observational findings. Additional data were then collected through audio recordings and written notes when staff critically discussed the findings to date. They also had an opportunity to reflect on their experience to date in the new wards. As a result, new data was provided in the form of thoughts and experiences. The groups were planned with multidisciplinary teams on each participating ward, however, only nursing staff (Registered Nurses and Nursing Assistants) attended, with a minimum of 4 and a maximum of 7 participants in each group.

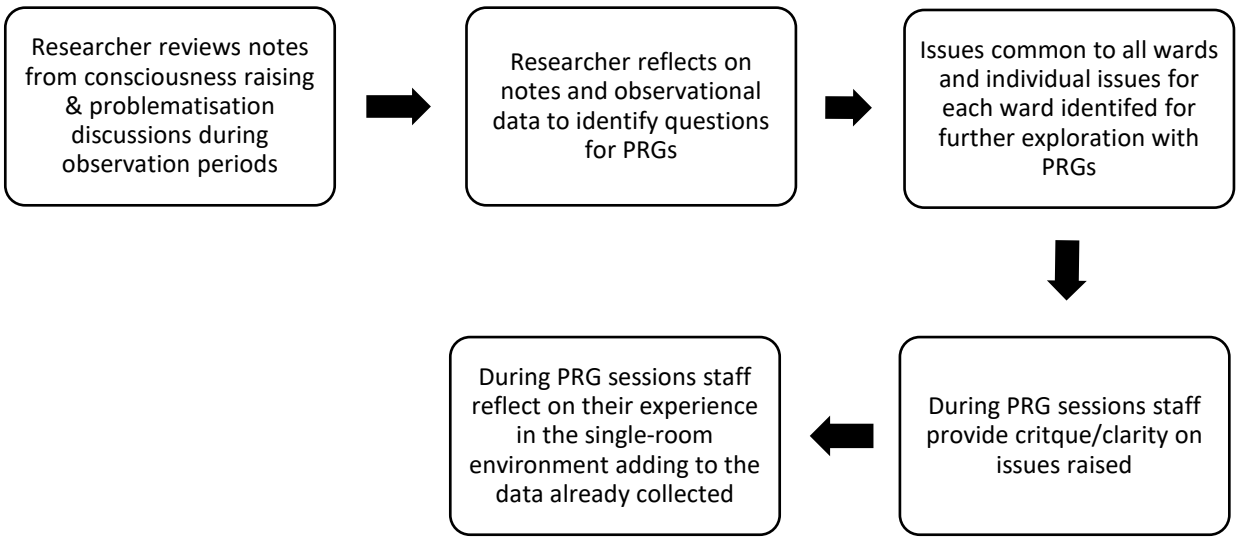

FIGURE 3 Process for Participatory Reflective Group data collection

The nine patient interviews took place in the clinical environment. Ages ranged from 19 to 100 years old. The interviews were audio recorded and lasted on average 30 minutes. An interview guide (Figure 4) was created based on the findings of a literature review (Kelly et al., 2019), and on person-centred outcomes from the Person-centred Practice Framework (McCormack & McCance, 2017). Questions were open-ended with prompts where required. Notes were also taken on nonverbal cues during the interview to provide context for the researcher when reflecting on the interviews in the reflective journal. While some interviews were longer than others, it was clear by the time the nine interviews had been completed that many themes were recurring. This reflected Low's argument (2019) of "pragmatic saturation", accepting that the information gathered related to the reality for this group of patients in this time and place. Transcripts were not returned to patients as all had been discharged by the time the transcripts were completed.

A journal was kept throughout the study using both reflective and reflexive processes to explore the researcher's experience (excerpts from this journal are provided in Supplementary File 3). Such

documentation captured the researcher's prior knowledge which could be revisited throughout the study. This reflects the underlying theory of Subtle Realism (Hammersley, 1992, pp. 50-51), which provided an epistemological base for the study to capture the multiplicity of voices (including the researcher's) present in the study. It also provided an assurance relating to any potential influence on what was being seen and heard from patients and staff. Finally, it represented part of the decision-making trail, adding to the trustworthiness of the data.

Starting point	Main question ideas	Sample questions
Background details	Length of stay at time of interview Experience of inpatient stay	
Single-room environment	Dignity Rest Isolation	*How do you feel being looked after in this single room?* *What are the main things you notice about being in a room of your own?*
Person-centred Practice Framework – person-centred outcomes	Good care experience Involvement in care Feeling of well-being Communication	*Tell me what staff have been doing for you* *What worries you most about being in hospital?* *What aspects of your care do you talk to staff about?* *How do staff involve you in the decisions about your care?*
Any other issues		*What do you think about the food?* *Is there anything I haven't asked you about in relation to being looked after in this new ward that you would like me to know about?*

FIGURE 4 Interview guide

3.4 Ethical considerations

These findings form part of a doctoral study. Standard ethical principles of conducting scientific

studies as outlined in the Helsinki Declaration (World Medical Association, 2013) were followed. Prior to undertaking the study, ethical clearance was obtained from the Office for Research Ethics Committee Northern Ireland (NO: 224670) and the Research Governance office of the participating organisation.

3.5 Data analysis

The interviews and participatory reflective group material was transcribed verbatim from the audio recordings by the lead author. Each data set was analysed using a six-step approach (Braun & Clarke, 2006). This systematic approach supports transcribing and repeated reading of the data to enhance familiarisation. The audio recordings and transcripts were reviewed repeatedly to ensure all data was captured. Codes were extracted from each of the transcripts across the 3 data sets and patterns identified and entered onto Excel spreadsheets. It was also important to ensure that those codes that did not fit any pattern were recorded, to enhance the trustworthiness of the analysis. Once all possible codes were identified, they were clustered into themes and subthemes, initially within the datasets. Commonalities and patterns were sought across all the data sets to produce one set of themes and subthemes. These were then reviewed and refined by all the authors to produce the final set of themes and subthemes used to describe staff and patients' experiences.

3.6 Ensuring rigour

Trustworthiness is regarded by some as a way of holding ethnographers to account around the credibility of their findings (Pool, 2017). Peräkylä (2016) describes the need for researchers to be aware of conflicting issues including interpretation and generalisability when addressing validity. Other authors advise against becoming so engrossed in proving rigour that the more important issues around ethics and the "artfulness of qualitative inquiry" are forgotten. (Bochner, 2018). Taking

account of these concerns, trustworthiness was addressed in this study through the five pillars of:

- Participation *(of research participants in data collection, and the supervision team in the data analysis process)*
- Reflexivity *(by the researcher throughout the study)*
- Preparing self *(by the researcher prior to entering the field)*
- Competence *(of the researcher in preparation for the study)*
- Dependability and transferability *(of the findings through dissemination)*

4. RESULTS

A total of 138 staff consented to be observed across the three wards. This included nursing, medical, AHP and support staff. A total of 14 staff attended the three PRGs. Three patients from each area were recruited for interview (total n = 9).

The study revealed two themes and several subthemes relating to care delivery and the interaction between people within that environment. *Organising and delivering care* relates to the changing perception of the environment, in relation to the layout and ways of working, and the potential impact on care delivery. Three subthemes were identified to reflect the challenges for both staff and patients in adapting to the new surroundings: *promoting a hotel culture; task focused care; and spending time*. This aligns to *The Care Environment* within the PcPF. The second theme *Nature of interactions,* which aligns to *Person-centred Processes* in the PcPF, describes the interaction between staff, patients and others within that environment. A further three subthemes helped to clarify the key elements of the theme: *feeling isolated and vulnerable; engaging in meaningful conversations; and opportunities to socialise*.

4.1 Organising & delivering care

4.1.1 Promoting a hotel culture

Nurses reported some anxiety as they tried to maintain a clinical working environment while feeling the public now expected the hospital to be run as an hotel because of the new facilities. They revealed a sense of frustration that because the patients now had more 'clutter' in their rooms, it could be difficult to find a clean, clear space to work.

> but patients have stuff, like they have a lot more stuff in those rooms. There's a guy in yesterday with a PS4 and all attached to his tv in his room. (Focus Group 2)

This was in line with staffs' perception of the patients regarding the rooms as 'theirs'. As a result, nurses felt they were invading the patient's space when they went into the room, and this made them uncomfortable:

> I feel it's like the patient's space…It's like a bedroom and you're invading their space. (Focus Group 2).

while another staff member reflected:

> "It is like a hotel and we're serving them. That's just what it's like. You know there's no 'I'm in hospital will you help me please'." (Focus Group 2).

Patients also noted the similarity to an hotel:

> Say if right now I wanted a cup of tea I'd just press the buzzer and say nurse can I have a cup of tea? (Patient1)

> It's beautiful. I mean, you know, if I had of been feeling better, I'd have been very impressed, like a very, very good class hotel really (Patient 8)

While the patient reaction was likely to continue given that at that stage, many patients were experiencing the new environment for the first time, it was surprising that a year after the move, staff were still struggling with this concept.

4.1.2 Spending time

Other staff groups however, found the new design allowed for improved ways of person-centred working. During a period of observing staff entering/exiting rooms to collect/administer medications, one staff member reflected on how the environment had improved some aspects of communication with patients/families:

> An AHP noted the single rooms made it easier to have conversations with patients about medications because of the increased privacy and confidentiality. She clarified that if visitors were present, she asked the patient if they were happy for the visitors to stay. She felt it could be helpful to have family members present as they sometimes knew more than the nurses about the medications. (Observation Ward 2).

Being able to spend time with patients was clearly what staff valued most. While nurses were in and out of the rooms regularly, the observational data evidenced some AHPs and medical staff using the periods when patients had no visitors to go through care plans or discuss treatment or investigation results in the patients' rooms. Nurses meanwhile, equated adequate staffing levels with being able to deliver enhanced quality of care:

> Like today we had loads of staff down there and I just said, I was in with …, and I must have been in nearly a good hour with her. And I just thought… it

was just lovely. I knew there was like 3 other nurses then I was able to spend that whole time and just do everything with her at once and be able to get a bit more of a rapport. We don't seem to be spending the same amount of time, because you've just got to do what you have to do there and then go to something else and maybe come back and do the other thing you need to do. (Focus Group1).

The NHS mantra 'no decisions about me without me' that helps to create a culture of shared decision-making is evident in the PcPF. While single rooms appeared to offer an opportunity for staff to review decisions made about patient care with patients in privacy, observations suggest that the changed physical environment has not encouraged a move toward more bedside documentation. Best practice guidance advises: *When possible, the person in your care should be involved in the record keeping and should be able to understand what the records say* (RCN 2017). Despite the desire to be person-centred, it was suggested that taking the patient notes into the rooms to complete them with the patients would inconvenience other staff and cause confusion:

And I think the thing is too there's so many disciplines and different things like dieticians, doctors and that, always wanting notes, so you could really never take them away. Cos if you're sitting then in the side room or in the rooms, you're going to have constant interruptions. You know…you're going to have dieticians and speech and language and all sorts wanting… then I think that's where things become…go missing, disorganised. (Focus Group1).

4.1.3 Task focused care

It was observed that many of the nursing entries in the patient notes appeared very task focused, something also noted by some patients:

> I never saw them writing up notes as such...you know they come in and record
>
> your temperature and that there...as far as writing up your notes or anything…
>
> they wouldn't be doing it in here. (Patient 2).

Nursing staff agreed that not everything was recorded, rather that they reflected conversations with patients and documented what they thought was relevant. They felt that they documented crucial information in the notes and provided more verbal information at handover. It was clear that nursing handovers were an integral part of any shift. The main handover, which took place at the staff base or in one of the interview rooms, tended to be very medicalised. It consisted mainly of reports on observations, medications and treatment. The mini handovers at break times often included more social information about the patients and families.

Many tasks appeared to be carried out in a patient-centred way on every shift, with evidence of authentic engagement between patients and clinical and support staff:

> Nurse talking to patient about discharge. Checking dressing supplies and pharmacy.
>
> Chatting about how patient will manage at home and what support she has. Sat by patient's
>
> side. Spoke calmly and reassuringly. (Observation Ward 2)

However, there was an indication of how the task-centred nature of care could be reinforced during some shifts:

> A list of patients on hourly observations was found on the staff base during

one observation period. It was ticked each time the observations were performed.

Another piece of paper was left sitting at a staff base headed “washes.” It contained a list of room numbers - with either a check box or “refused” beside each room number. During one observation period, it was noted that all the patients who needed dressings changed seemed to be in one part of the ward. When asked about this during a clarification and problematisation conversation, staff said this intentional room allocation (where possible) made it easier for one team to do all the dressings. (Observation Ward 3)

4.2 Nature of interactions

4.2.1 Engaging in meaningful conversations

The single-room environment suggests enhanced opportunities for staff to be with patients in surroundings which enable meaningful conversations. The observational data revealed the myriad ways staff used the rooms for meaningful engagement. All groups of staff spent time in the rooms talking to patients and their families about treatment plans (doctors); activities and progress (AHPs); discharge planning, medication, and diagnosis (nurses). During the observations:

A nursing assistant spends fifteen minutes with a patient experiencing delirium.

She used family photos in the room to orientate the patient to time and place.

(Observation Ward 2).

On another occasion:

A registered nurse spent time with a high dependency patient at end of her night duty shift providing reassurance and info about plans for the day. (Observation Ward 1).

However, observations of practice also revealed there seemed to be less social interaction with patients than may have been witnessed in multibedded wards. Staff agreed that the single rooms were less conducive to conversation:

> …they all would have bounced off each other, or like, if you were having a conversation with one, someone else would've chirped in and the whole bay would've been in conversation…and I would have enjoyed that a lot more. (Focus Group 2).

While there was *space* for more sympathetic presencing, encouraging patients to speak more openly, *time* remained an issue as far as staff were concerned. It was notable however, that during some observations, the issue was less about time, and more about the discomfort of invading the patient's space. During the observation periods, staff commented generally on how the multibedded bays had reduced opportunities for talking to patients about their care plans and sharing the decisions about their treatment because of the lack of privacy. However, now that the patients were in single rooms, nurses on the participating wards found new inhibitors to spending time with patients:

> I think if you went in and started writing notes in rooms you would never get anything done. (Focus Group1).

While staff acknowledged the importance of the concept of engagement with patients, they identified a lack of engagement with staff on the part of the organisation. Nursing staff in particular, expressed frustration over the lack of shared decision-making in designing the new unit:

> Like I know some of the people showed us round had been nurses, but when was the last time they were maybe on a ward in a clinical area? They should have had input from the modern-day nurses working now. (Focus Group1).

4.2.2 Feeling isolated and vulnerable

Some older patients expressed how not being able to see what was going on, so having fewer points of reference to time passing, left them feeling disorientated in the rooms:

> I said to somebody what time is it? …and they said' it's about five minutes to two' I couldn't believe it. I thought it must be at least near bedtime. (Patient 5).

It was not only older patients who felt isolated. Staff seemed surprised at the lengths younger patients would go to so as to not be left alone in the rooms:

> … we've had a few people in their 30s, 40s who maybe had never been ill before and all of a sudden had been admitted to hospital and, they didn't want to be in the room alone. They felt that you should be with them, just literally standing at the door... (Focus Group 2).

Meanwhile during the interviews, a younger patient was concerned about safety, being out of view in one of the end rooms:

> If something does happen or you collapse, no-one will know. (Patient 4).

On a more positive note, some staff felt the single rooms could feel less threatening to older, confused patients because there was less activity going on and their surroundings were less clinical:

> I think it goes back to the whole them thinking of their bedroom…Whereas when they were in a bay and they wake up and see three other…like say it's a bay of four, and you're looking at these other people and why are they in my room? Why are they looking at me like that? (Focus Group 2).

Nursing staff also expressed feeling isolated, being unable to see across to the other wards as in the

old ward block. They related this to a need for additional staff to feel safe. They also expressed a lack of solidarity with colleagues facing similar pressures in other wards:

> Well part of the staffing ratio problem is to do with the isolation you feel sometimes on your ward, because in the old build you could see people all across the floor, so you'd know there would be help there and there was other people, and you could see that other people were busy and you thought, oh that's alright, cos we're having a better night than them. But here, you just see your own wee world. (Focus Group 2).

This view was not expressed by other members of the ward team, who were more likely to be visiting several wards in the performance of their duties. AHPs and medical staff in particular did seem to regard themselves more as visitors, so were more comfortable with the concept than the nursing staff:

> Doctor is observed visiting patients on the ward. Spends time talking to them, asking them how they are, discussing plans for care/treatment. Doesn't give any impression of being in a hurry. Allows patients to talk and asks questions when the patient stops talking. (Observation Ward1).

All staff recognised their vulnerability when they were in the rooms on their own. There was a heightened sense of fear of dealing with confused/aggressive patients/visitors because staff are isolated:

> I think people were less likely to kick off [in the old ward]. Like if somebody's going to kick off and be verbally abusive, they're going to do it, but I think with being in a side room, people don't really care what they say to you. They can be really rude to you because there's nobody about there to judge them. (Focus Group1).

4.2.3 Opportunities to socialise

One plan to address the potential isolation of patients was to have space at strategic points on each ward with soft chairs and a small table, where patients could meet to socialise. The introduction of undesignated beds to manage capacity pressures however, resulted in the beds being situated in the social spaces. Staff recognised this was a concern:

> I think too the thing with the elderly patients, they're very isolated in those rooms all day and I think a big thing missing here which I've noticed would've been a common area. Where there would have been a tv or a radio or nice pictures on the wall you know, it would engage in conversation you know. A lot of the elderly people have asked is there anywhere where I can go to sit? (Focus Group1).

Sharing experiences often helps to reassure patients, and this was now missing because there were no obvious opportunities for socialising. As a result, staff recognised that older patients in particular, wanted them to stay in the rooms for longer. One staff member's view implied that patient vulnerability increased staffs' vulnerability in being unable to meet patients' needs:

> I find it hard sometimes even if I'm in checking a blood pressure and it's like an elderly lady or an elderly gentleman, and they are lonely. You're nearly feeling yourself walking backwards to get out of the room. You're like Ok I'll see you later and like rushing cos you're thinking I've got 9 million things to do and all they're wanting to do is have a chat and I don't have time. And like, that is really sad. (Focus Group1)

Since there was nowhere else for the patients to go, the rooms became their whole world for the duration of their stay. This resulted in the 'ownership' of the rooms coming into sharper focus, correlating with the tension between the rooms as social spaces versus clinical spaces:

> The number of patients who, during the day, close the blinds and close the door, and then I go in and open them cos I like to be able to see them, not necessarily through the door but through one or the other when I walk down the corridor. And then as soon as you've gone, they close the blinds again and close the door, and you wouldn't do that if you didn't feel that was your private area. But then we miss things because we can't see. (Focus Group 2).

Paradoxically, the nervousness some staff expressed around working in the rooms seemed to relate more to being under closer scrutiny. This resulted from the introduction of an open visiting policy meaning visitors could visit any time between 11am and 9pm. The policy was implemented by the organisation as a direct result of the single-room environment. One consequence was some nursing staff feeling justified in not being in the room because:

> …you've got all the family in there… we can't practically sit in the room and do our writing when they're all sitting having their conversation in the room. (Focus Group 2).

However, most staff and patients welcomed this change, with staff recognising that family members found the open visiting more reassuring, witnessing the care their relative was receiving more spontaneously:

> And I think they can see you, cos when they used to come from the 2 o'clock visiting, you tried to clear the decks and let them spend time, and I think they thought you weren't doing anything for their relative, but now they can see clearly

that you are. (Focus Group 2).

A memo provides a description encapsulating the challenges around owning the space described in these findings (Figure 5).

MEMO 1

A patient was being 'specialled' after surgery. The nurse did not sit in the room, but at the staff base opposite. The door to the room was open as were the blinds. The nurse went in to check how the patient was feeling and to perform mouth care, because the patient was nil by mouth. She then left the room. The physiotherapist arrived and tried to encourage the patient to get out of bed, but he refused. The physiotherapist went to the staff base and asked the nurse to help her persuade the patient to get up. Again, the patient refused saying he was tired because he had been unable to sleep all night. He said the ward was noisy and staff refused to close the door. A discussion followed at the staff base. A more senior nurse suggested closing the door but keeping the blind open so the patient could be seen. The nurse looking after the patient moved her position at the staff base, so the patient was visible to her. The patient fell asleep for 30 minutes, woke up, pressed the buzzer, and requested to be helped out of bed into a chair. (Observation Ward 1)

FIGURE 5 Memo illustrating 'owning the space'

5. DISCUSSION

Staff in the current study were clear, that to be person-centred practitioners required time, which the current staffing compliment did not allow for. The literature would suggest this is a common perception among staff, highlighting their concern about the amount of time it took to be person-centred (Bolster & Manias 2010). Stajduhar et al., (2010) however, discovered that it was not the "time in minutes" that mattered to the patients, but the quality of time for interactions. The current study found examples of some staff using time in the rooms to engage meaningfully with patients and families, while others appeared to neglect opportunities for person-centredness while carrying out routine tasks. This issue of time spent, highlights the tension between the organisational vision to provide person-centred practice, and the reality of workforce challenges currently being experienced world-wide. The contexts of the working environment, managerial support for nursing, shared

decision-making, and good doctor-nurse relationships described by Aiken et al., (2012) reflect a person-centred ethos, linking the impact of the care environment to patient outcomes. These authors also report improved patient satisfaction, quality, and safety of care in those hospitals with appropriate nurse staffing levels. This contrasts with reports noting a lack of credible evidence to support the connection between staffing levels and patient outcomes (Griffiths et al., 2014).

The complexity of multiple contexts such as staffing levels; quality of the work environment; and quality and safety of patient care are reflected in the current study, with staff describing spending quality time with patients when staffing levels permitted. This illustrates how staff view the interconnectedness of a person-centred culture and the practice environment. It also demonstrates the challenge facing the organisation in the current study. Despite recognising the anxiety around staffing in the new environment and attempting to provide some additionality, this proved to have little effect given the ever-present vacancy levels.

This study highlights the advantages and challenges a 100% single-room environment offers to patients and staff. Nursing staff expressed anxiety about the design in terms of the physical environment and the lack of visibility of colleagues; new care processes; and the relational shift with patients, around control of the environment when compared to the previous wards. The tension between ensuring privacy and maintaining safety is an example of the sense of ambivalence that recognises the patient's right to privacy, but challenges nurses' accountability for their patients' well-being (Fawcett & Rhymas, 2014). This was illustrated by the patients, who valued the privacy of their own rooms rather than sharing an open space as previously, but expressed anxiety that staff were not regularly in the rooms thereby echoing staff concerns about visibility. The study also found that patients perceive communication to be poorer, relating it to a perception of staff spending less time in the rooms. In contrast, while staff acknowledged the challenges of spending time with patients, they did not appear to feel this impacted on communication. Bosch et al. (2016) found that while the single-room environment resulted in nurses spending *more* time with the patients, the patients also perceived communication to be slightly worse than previously. This may be reflective of the impact of the single-

room design on social connections, resulting in both patients and staff feeling more isolated, thus inhibiting the development of a healthful culture within the environment.

It appeared that staff in the current study were experiencing changes to their ways of working that had not been anticipated in advance of the move, equating to a change in the psychological contract for staff (Thompson & Hart, 2006). Their professional beliefs and values were challenged in the new environment, leaving them unsure of the new surroundings and expressing a sense of disquiet around the changes to their ways of working, which they felt unprepared for. It was evident from the findings that nursing staff in particular, felt a loss of control over their work environment. This included a change to their cultural identity of being in control, and the psychological shift to feeling themselves to be 'visitors' in the rooms. Other authors found that personalisation of the rooms made the patients feel less anxious (Clissett et al., 2013) providing them with a sense of identity and connectedness to their life outside the hospital. While patients in this study did not make any comments to support this, nurses did talk about their anxiety in relation to "the clutter" in patients' rooms. The perception among some nursing staff was that having more personal items in the rooms made it difficult to navigate the room to perform clinical tasks, perhaps failing to recognise that need for connectedness with the patient's other life.

Staff in the current study experienced challenges in understanding how to share the space with the patients; how to engage authentically given the time constraints; and empathizing with patients' fears about the new environment given the 'busyness' of the clinical environment. Changing or adapting the culture to work in the new environment can present challenges. The lack of time given to considering what behaviours might need to change to facilitate new ways of working, may lead to a lack of acceptance of the need to make changes related to the more intangible aspects of the job. Consideration of such concerns, using the lens of strategic leadership within the Person-centred Practice Framework (McCormack & McCance, 2017) supports the engagement of staff in strategic planning. This is even more crucial at an operational level, to ensure "the development of self and others" to meet the challenges within healthcare (Solman & Wilson 2017, p.79), enhancing the

concept of a healthful culture.

For staff and patients in this new environment, the organisation had been clear about its purpose of providing new improved facilities for delivering healthcare. At the same time, it appears to have changed the relational contract between staff, patients and the organisation. As a result, there was a perceived change of ownership within the space. A culture where staff and managers are required to work in a stressful environment compounded by increasing pressures and capacity demands, is unlikely to change as a result of changing the physical environment. Visible leadership, high support, and trust all engender a feeling of psychological safety in staff according to Brown and McCormack (2016). Engaging staff in decision-making around the development of beliefs and values and promoting collaboration at all stages of their development promotes an organisation's values of person-centredness. What remains absent from the current literature is evidence to support pre-conceived assumptions that staff will be happy, and care will be of a higher standard, as a result of an improved physical environment. The evidence from the current study would suggest that while everyone agrees the physical environment has improved, concerns about staff and patient experience remain.

Using ethnography to understand the context and culture within a new physical healthcare environment is one of the strengths of this study. It highlighted the disorientation staff may feel when they have not been provided with sufficient facilitated time to explore their beliefs and values around person-centred care in the new environment. Previous researchers have identified that healthcare teams perform better when they establish caring and respectful relationships within and across teams (Amundson, 2005). However, the introduction of the single-room environment provides a new focus for understanding it's impact on sustaining or developing healthful cultures. More recently, researchers have sought to measure the relational aspects of health care such as communication, time spent and patient involvement in care (McCance et al., 2015). The findings from the current study would suggest there is a need for further exploration of how therapeutic relationships are developed in this new environment, including issues of socialisation and existential loneliness for staff and

patients.

While this study explored the experiences of the multidisciplinary ward team, there is a recognition that nurses spend most time in the ward environment, and with the patients. Further exploration of what sharing the space means for this group might develop awareness around the 'on stage' and 'off stage' priorities, and how and where these are delivered. Exploring this might better equip nurses to cope with the psychological shift they experienced.

Linking these findings to the Person-centred Practice Framework (McCormack & McCance, 2017) enhances our understanding of potential impact of the behaviours within this environment on the experience and delivery of care. This is illustrated in Table 1.

Findings	Description	PcPF
Providing a sharper focus of what constitutes a healthful culture	To see and be seen	Person-centred Outcomes
	Privacy and dignity	Person-centred Outcomes
	Authentic engagement and sympathetic presence	Person-centred Processes
Working with patients' beliefs and values	Amplified need for physical, emotional and spiritual needs of patients (providing holistic care)	Person-centred Processes
	Risk assessment	The Care Environment
	Increased interaction with families and social networks	Person-centred Processes
Uncovering a sense of unease about who 'owns' the space	Sharing the space	The Care Environment
	Revisiting beliefs and values	Prerequisites

TABLE 1 Findings linked to the Person-centred Practice Framework

5.1 Limitations

Ethnography is about understanding the participant's view of the world under study, without

influencing that view. It can be challenging to achieve this when undertaking non-participant observation, with the researcher deliberately maintaining a distance from the participants. However, participant observation provides more opportunities for the researcher to influence participant behaviour, altering the reality as normally experienced. By selecting non-participant observation, some events were unobserved. However, staff were able to reflect on these potential gaps during the participatory reflective groups. The data collection period was relatively short, but the use of multiple data collection methods ensures the generation of in-depth rich data, demonstrating how many valuable insights can be obtained in a shorter time period. This can be particularly applicable in an acute-care environment where access may be limited. Capturing behaviours across all the shift patterns, authenticates the findings. The insider/outsider role of the researcher can also be viewed as both a strength and a limitation. Nurse researchers understand the culture and setting so gaining access to the site, working with gatekeepers and approaching the participants may be less problematic. However, staffs' perceptions of the researcher as a previous employee and the researcher's organisational knowledge had potential to influence the "off stage" information being collected. The reflective journal was used to capture any managerial or nursing conclusions being drawn from personal experience to facilitate understanding of personal influences on what was being observed or heard during the data collection. Finally, results are limited to the context of the research. The findings are not transferrable to other single-room settings that are less than 100%. It could be argued however, that the findings relating to person-centred practice are transferable to other inpatient environments.

6. CONCLUSION

Within the published literature of studies such as this, there is a lack of evidence exploring the relationship between the 100% single-room environment and person-centred practice. This study reveals that changing the physical environment does have an impact on person-centred practice by sharpening the focus on what constitutes a good experience of care; a heightening of public

expectations about being treated as individuals and uncovering a sense of unease about who "owns" the space, creating an additional barrier to delivering person-centred care. The findings of this study have important implications for understanding the impact of the environment on person-centred practice. There are several elements which would benefit from further study including embedding ongoing authentic engagement with staff and patients to develop and promote a person-centred culture; person-centred engagement in building design; socialisation in the single-room environment; and how psychological contracts within healthcare are understood and managed.

7. RELEVANCE TO CLINICAL PRACTICE

Visible social presencing increases the perception of receiving and delivering high quality care. Staff must be supported to practice person-centredness in a new shared space with careful consideration of the challenges of a shifting dynamic between patients and staff.

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