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Exploring the implementation of person-centred care in nursing practice

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Exploring person-centred care

Abstract

Person-centred care is an established concept in nursing and focuses care on the needs of the individual. This involves a partnership, with people at the centre of their healthcare needs and facilitates their autonomy to the greatest possible extent in decision making. Person-centred care should be seen as a dynamic concept which considers a person's relevant biographical and social elements as part of care. This aims to support them in developing knowledge, confidence and skills to make informed decisions and manage their own health care by reinforcing their autonomy where able. This article critiques the concept of person-centred care and consider the challenges within healthcare practice.

Keywords: To be drawn from the Nursing Standard taxonomy

Person-centred care (PCC) has become an established concept in nursing, focusing care upon the needs of the individual. This is a somewhat simplistic definition as literature argues that the concept, although well-known to nurses, remains ill-defined, presents a variety of definitions and a disparity in how it is operationalised in practice (Byrne, Baldwn and Harvey 2020, Giusti et la 2020, Moore et al 2021). McCormack (2020) argues that the use of the term 'person-centred' and its derivations, without offering any definition, is prolific in published research. This does little to help healthcare practitioners develop a clear understanding of person-centredness and the elements on which they need to focus. One of the issues is the variety of terms that have been used to define the concept. "Patient-centred care" initially emerged to promote holism and counter the reductionistic nature of the traditional biomedical model, while a move to "person-centredness" emphasised the concept of the whole person and the broader idea of wellness (Giusti et al 2020). "Person-centredness" is an approach which relies on the creation and fostering of healthy relationships between care providers, services users and others significant to them in their lives (McCance and McCormack, 2017). It is underpinned by values of respect for

persons (personhood), individual right to self-determination, mutual respect and understanding (McCance and McCormack, 2017). The term “people-centredness” has also emerged to consider broader challenges by recognising that before people become patients, they need to be informed and empowered in promoting and protecting their own health (WHO 2013).

One way of considering person-centred care is to focus on the reasons for its emergence and the possible driving factors. Ekman et al (2011) identified the huge burden of long-term conditions, with patients navigating through a fragmented healthcare system and having to adapt to the customs and procedures of healthcare organisations and professionals. This runs counter to receiving care focused on individual needs, preferences and values. In addition, the now strong focus on evidence-based healthcare has by nature applied standardised care models based on cohort response to treatment, with some arguing that it fails to capture the minority response of individuals (Ekman et al 2011). Others have, however, suggested the two can co-exist with authors such as Sackett et al (2007) incorporating person-centred care into a definition of evidence-based medicine that includes a focus on patient preferences. Although, inevitably a tension may exist in applying varying models (Engle et al 2021), person-centred care aims to help nuance the evidence-based model through a focus on the individual (Ekman et al 2011). In addition, Byrne, Baldwin and Harvey (2020) argue that patients and service users now have easier access to healthcare information and are no longer seen as passive recipients of care, but valuable and active members of the healthcare team, an approach person-centred care focuses upon. This may be a somewhat broad view and, in fact, Byrne, Baldwin and Harvey (2020) state this is “on the surface,” with healthcare professionals needing to be mindful that not all patients and service users will view themselves as having easier access to healthcare information or being active members of the healthcare team (Thomas et al, 2023). Lee et al (2021), in using a variety of sources, therefore see person-centred care more as a philosophy that views the individual using health and social care as equal and collaborative partners in planning, design co-creation accomplishment of care to ensure their needs are met. The degree to which this is achievable and indeed desired by individuals is a part of the ongoing discussion around person-centred care.

In the UK, nurses (and in England nursing associates) are now required by their regulatory code (Nursing and Midwifery Council (NMC), 2018) to put the needs of the patient or servicer user

first, whilst considering cultural sensitivities to better understand and respond to people's personal and health needs (NMC, 2018). However, this idea of the nurse putting needs first in itself emphasises a careful use of language, as it may suggest a power imbalance with a passive patient or service user, whereas "working with" or "in partnership" may be more appropriate terms.

Person-centred care is generally seen as a dynamic concept which considers a person's relevant biographical and social elements, for example their gender, age and the elements that mean most to the person such as their family and carers (Health Foundation, 2016). Without this consideration, it is possible that a person's fundamental care needs may be neglected, and inequality to healthcare access may be exacerbated, for example in the elderly population or people with learning disabilities (Tieu et al, 2022).

In addition, its application remains dynamic - it is much more than the interaction between the healthcare professional and the patient or service user. Indeed, Smith et al (2022) argue that person-centred care can be best understood as the collection of principles it operates under, rather than a strict definition of an approach to care (Smith et al, 2022). Byrne, Baldwin and Harvey (2020) and Vennedey et al (2020) view the concept from a macro, meso and micro level. The macro level includes government policy, financing and any regulatory interpretation of person-centred care, the meso level indicates the health and social care organisations and the micro level focuses upon the patient/person-provider interaction at a local level. Considering this wider application of person-centred care is important. It can offer a window into how the concept is embedded into an organisation's culture, in its values and beliefs, or if the organization is well-intentioned, but offers an inconsistent application of person-centred care. There is now a wide variety of literature exploring the concept of person-centred care in healthcare and nursing practice (Vennedey et al, 2020, Dewing et al, 2021, Engle et al, 2021, McCormack et al, 2021). This article explores a number of key aspects that affect application to practice and illustrates the dynamic nature of the concept.

Person-centred care in practice

There is growing evidence of the effectiveness of person-centred care in areas such as improved general health, utilisation of health services and hospital admissions (Bertakis and Azari, 2011, Wynia et al, 2018), as well benefits for specific conditions such as dementia (Kim and Park, 2017). McCormack (2020) noted a variety of positive benefits of person-centred care in a number of environments, such as nursing home settings. Here implementation studies have resulted in improvements to the care environment, greater resident satisfaction, improved staff well-being, reduction in falls and reduced use of psychotropic medications (McCormack et al 2010, McCormack 2020, Buckley et al 2014, Mekki et al 2017). Although in some areas, such as serious illness there remains a paucity of theoretical models based in empirical data (Giusti et al, 2020).

In addition, person-centered care is a concept that may appear obvious and understandable, yet is complex to operationalize in all areas of healthcare, including research, partly due to its complexity and no single agreed definition (Burgers, van der Weijden and Bischoff, 2021). It is therefore important to carefully examine individual studies because the conceptualisation of person-centred care does vary (Burgers, van der Weijden and Bischoff, 2021; Rennie, Gibson and Saev 2021). However, McCormack and McCance have developed a person-centred nursing framework for application in a nursing and research environment (McCormack and McCance, 2006, McCormack 2020).

Person-centred care can help enable healthcare providers and service users to work jointly to develop treatment plans, which may improve health outcomes and increase patient satisfaction with care (Ekman et al 2011 and Phelan et al, 2020). For example, collaboration in creating an asthma management or coronary heart disease plan. For this to occur, nurses need to listen and respond to concerns and preferences. In practice this involves ensuring a relationship is built with patients/service users to enable them to understand information in a way decided by them and which respects their own views on treatment and care (Moore et al 2021). Person-centred care therefore aims to understand broad differences people may have and embrace and incorporate these into care approaches.

Nurses need to ensure diversity is included and addressed and, rather than following a traditional perspective of doing something ‘to’ or ‘for’ the person. Santana at al (2018) suggest that person-

centred promotes doing something ‘with’ the patient or service user. This requires reflecting on and listening to what makes each person unique and putting their needs first (NMC 2018). In the UK, the independent charity and think tank, The Health Foundation (2016) define 4 key principles in delivering person-centred care:

1. Affording people dignity, compassion, and respect
2. Offering coordinated care, support, or treatment
3. Offering personalised care, support, or treatment
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life

Of note, is the fact the principles are now a number of years old and it is worth reflecting whether terms such as “affording” and “offering” still places the power more towards the healthcare practitioner or service**.**

Moving to a person-centred approach to care

Implementing person-centred care remains challenging. Ekman et al (2011) highlighted their own studies exploring person-centred care in practice, from the perspective of the person, the healthcare professional and the organisation. They noted that person-centered care is generally regarded by healthcare professionals as an important facet of care, yet a key challenge was not in persuading staff to practice it, but to convince them that they were at times *not* practising it, at least not consistently. Person-centred care takes time and Ekman et al (2011) noted that when time was pressured, healthcare staff tended to cease its application and temporarily return to a disease-orientated approach.

Their solution focused upon three specific routines to ensure systematic and consistent practice in person-centred care. These were firstly to initiate a partnership early on by inviting the patient or person to talk about their disease, the symptoms and its impact. This, they believe, sends an early message that the person’s feelings, beliefs and preferences are valued and important. The second routine focuses upon shared decision-making, through sharing information, its

deliberation and decision-making, building on this initial invitation. Finally, is the need to document person-centred care to make it a recognised and valued part of care within the organisation. This documentation can include patient or person preferences, beliefs and values.

When implementing a service that is person-centred, potential and actual barriers in the setting need consideration (Hower et al 2019). Barriers to delivering person-centred care can be due to a simple lack of understanding of patient needs (Moore et 2017 and Lloyd et al 2018). In a recent study of twenty-five chronically ill people's views on the facilitators and barriers to person-centred care, service users felt the model was compromised when care felt like a "conveyor belt" (Vennedy et al 2020). Participants expected healthcare providers to possess a comprehensive knowledge-base, and take a holistic view, considering family history, the current personal situation and the social environment. In addition, was a required variety of personal characteristics of the healthcare practitioner. These included a focus on the patient or person without being distracted or pressured. In many ways this links to the idea in the person-centred nursing framework (McCance and McCormack, 2021), of being "sympathetically present" - engagement that recognises the uniqueness and value of the individual, including recognising the important agendas in that person's life. Further, was the creation of a pleasant and friendly atmosphere and time to answer questions and explain treatment options. Flexibility was highlighted in making treatment plans, as people seek individualised care based on personal needs and circumstance.

Of note was the participants' view that they themselves had a role to play, with a need to be "active patients", interested and willing to facilitate person-centred care, but they noted they needed guidance and access to easily understood information and therapies to do this. Implementation of person-centred care needs to be oriented towards offering a clear and facilitative relationship in any given situation; including empathy, genuineness and positive regard.

Cultural humility and patient-centred care

In professional practice, personal beliefs, attitudes and biases may also provide additional challenges to the successful implementation of person-centred care. A personal commitment to delivering cultural humility and person-centred care in tandem can help address this (Kelsall-Knight 2022). Cultural humility has been described as a process of being aware of how people's culture can impact their health behaviours and, in turn, using this awareness to cultivate sensitive approaches when treating patients (Miller 2009).

More recently, it has been contrasted with cultural competence, which has been viewed more as learning a set of attitudes and communication skills for effective working with the patient or person's cultural context. By nature this is limiting, Lekas et al (2020) arguing that culture is not stagnant and the ability to become "competent" in any culture suggests that there is a set of values and beliefs that remain unchanged and are shared by all members of specific group. This seems to be the anthesis of the flexibility of person-centred care.

In contrast, cultural humility is devoid of a specific end point. There are no set skills to learn, but a need to be culturally sensitive as a continual process; being open to personal biases (Lekas et al 2020), for example when making incorrect assumptions about a person's culture due to a lack of knowledge. To more readily achieve this, self-reflection and self-critique towards interactions with people are central (Prasad et al 2016). This may be new and challenging due to unfamiliarity, and authors such as Prasad et al (2016) suggest approaches such as active listening to the patient or person's individual point of view, while activities such as reading about cultures can allow personal or group refection on the content, and writing personal reflections on attitudes and thoughts on care provided can be explored with a skilled lecturer or through and approach such as clinical supervision. This may make clearer factors such as unintentional bias – a bias that a person is unaware of - one example being language or general conversation that makes the assumption that all patients or servicer users are heterosexual (Grundy-Bowers and Read, 2019). However, although recommended, as a strategy to enhance person-centred practices, Edgar, Moroney and Wilson (2023) argue that currently clinical supervision remains under-researched.

As nurses, it is important to remember that UK law requires us to make reasonable adjustments on the basis of protected characteristics, with a need to consider personal and institutional biases

in relation to person-centred care, and how these may manifest with diverse populations. The Equality Act (2010) applies in England, Scotland, and Wales, and identifies nine 'protected characteristics'– age, gender reassignment, sex, race, religion or belief, pregnancy and maternity, marriage and civil partnership, sexual orientation, and disability (Royal College of Nursing, 2021). These protected characteristics identify people at a higher risk of oppression and discrimination. A person may have none, one, or more than one of these characteristics.

These characteristics, or identities, can also be known as intersections. A person's intersections can impact multiple levels (for example, home life, work, social circle) and this can result in unique opportunities, experiences and barriers for each person. The identity of a person is made of many intersections (importantly sometimes an intersection is not a protected characteristic) but having an increased knowledge about the impact of intersections, and acknowledging that impact on a person, can aid nurses in delivering person-centred care and best practice, which is specifically tailored to an individual's needs (Ruiz et al 2021).

Regardless of whether a person has protected characteristics, as a nurse it is important that a person's individual needs are recognised and assessed and responded to without assumptions being made (Kelsall-Knight, 2022). Examples of assumptions could be in relation to the use of pronouns, religious affiliation based upon a person's name or assuming a person sexuality. Organisations themselves may also carry their own biases, for example through gender and/or sexuality assumptions on hospital documentation, such as identifying a family as only consisting of two parents and of different sexes (Kelsall-Knight, 2021; Kelsall-Knight, 2022), or an association of certain racial ethnicities with specific diagnoses (for example a black person with sickle-cell anaemia) (Marcelin et al, 2019).

If an organisation displays these biases, then it may be more difficult for individuals to challenge them on a personal level, as they are determined as being 'the cultural norm.' However, nurses challenging discriminatory practice can lead to empowerment of individuals, which is in keeping with person-centred care. The promotion of cultural humility and active role-modelling of people in leadership roles by reflection of self-bias (acknowledging any shortcomings by reflecting on

our own steroetypes or prejudices) and advocating for open and honest healthcare environments serves as a way of creating belonging and inclusion in healthcare (Adams et al, 2020).

Role modelling

Furthermore, to achieve person-centred care and overcome challenges that others face because of, but not limited to, their protected characteristics, it is imperative that role models exist within organisations. Any nurse, or healthcare worker, can be a role model and role-modelling is not determined by seniority. A role-model and advocate for person-centred care should actively listen to staff, patients/service users and their families/carers, show empathy and recognise the diversities of people and, where appropriate, any challenges that they may face (for example religious values and beliefs, family dynamics, altered communication style) (Sprik and Gentile, 2019; Moore et al 2021).

A more recent role implemented in the nursing workforce in England is the Professional Nurse Advocate (PNA), implemented by NHS England (2021). The PNA training programme aims to provide nurses with the skills, competencies and confidence to lead programmes of improvement, fostering a culture of learning and development within their clinical settings. The model may lend itself to further supporting person-centred care as it supports a continuous improvement process which seeks to build on both the personal and professional clinical leadership of nurses, whilst enhancing the quality of care for patients (NHS England, 2021).

The future of person-centred care

Challenges remain in instigating person-centred care, particularly when a small number of studies suggest that staff may believe they are providing care in this way, but may not, and when time pressures result in care reverting to a disease-orientated approach. The Health Foundation (2016) suggest that person-centred care can take additional time, such as shared decision-making taking longer than a standard consultation. Yet a resulting medicine prescription that fails to fit to the person’s own needs, for example, may result in greater care time due to non-adherence and worsening symptoms (Heath Foundation, 2016).

A number of studies have now explored the barriers and facilitators to implementing person-centred care, and much of this comes from the patient or person perspective (Moore et al, 2017, Lloyd, Elkins and Innes, 2018, Venneday et al 2020). Of note in facilitation, is strong leadership, with a buy-in from senior leaders acting as champions for change, a core team to drive change, the aforementioned role modelling, education in person-centred communication and working in multidisciplinary teams that see patients/service users as equal partners. Exploring these facilitators and the associated barriers is an essential early step in moving to an effective person-centred model.

Measurement of person-centred care

Measuring person-centred care in practice remains a challenge, with the Health Foundation (2016) suggesting there is no single "off the shelf" solution. Yet a number of studies have explored measurement indicators (Tzelepis et al, 2015, Santana et al, 2019). Tzelepis et al (2015) argue that key to measuring person-centred care is to use patient-reported measures because the person is best positioned to determine whether care aligns with their values, preferences and needs. They used the Institute of Medicine's six dimensions of patient-centred care, which includes being respectful to patients' values, preferences and expressed needs and providing information, communication and education, and aligned these to what they felt were the most appropriate tools to measure this (Tzelepis et al, 2015).

Conclusion

Ensuring services users receive person-centred should be a key priority for nursing in all roles, regardless of the level of seniority. Individually, nurses need to be reflective and challenge biases. From a wider viewpoint, person-centred care and its evolution and dynamic nature needs to be considered by all nurses when developing, implementing, and delivering services. Providing care for patients/service users and their significant others will require regular review to ensure that the care meets their requirements in relation to their medical needs alongside their societal and biographical context.

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