ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Concepts of person-centred care: a framework analysis of five studies in daily care practices

Margreet van der Cingel*, Lobke Brandsma, Mirjam van Dam, Marcella van Dorst, Claudia Verkaart and Cilleke van der Velde

*Corresponding author: Windesheim University of Applied Sciences, Zwolle, Netherlands
Email: cjm.vander.cingel@windesheim.nl

Abstract

Background: Person-centred care is used as a term to indicate a 'made to measure' approach in care. But what does this look like in daily practice? The person-centred nursing framework developed by McCormack and McCance (2010) offers specific concepts but these are still described in rather general terms. Empirical studies, therefore, could help to clarify them and make person-centredness more tangible for nurses.

Aims: This paper describes how a framework analysis aimed to clarify the concepts described in the model of McCormack and McCance in order to guide professionals using them in practice.

Methods: Five separate empirical studies focusing on older adults in the Netherlands were used in the framework analysis. The research question was: 'How are concepts of person-centred care made tangible where empirical data are used to describe them?' Analysis was done in five steps, leading to a comparison between the description of the concepts and the empirical significance found in the studies.

Findings: Suitable illustrations were found for the majority of concepts. The results show that an empirically derived specification emerges from the data. In the concept of 'caring relationship' for example, it is shown that the personal character of each relationship is expressed by what the nurse and the older person know about each other. Other findings show the importance of values being present in care practices.

Conclusions: The framework analysis shows that concepts can be clarified when empirical studies are used to make person-centred care tangible so nurses can understand and apply it in practice.

Implications for practice:
The concepts of the person-centred nursing framework are recognised when:

- Nurses know unique characteristics of the person they care for and what is important to them, and act accordingly
- Nurses use values such as trust, involvement and humour in their care practice
- Acknowledgement of emotions and compassion create mutuality in the caring relationship

Keywords: Person-centred care, framework analysis, concept clarification, empirical studies, value-based care, professional nurse behaviour

Introduction

Person-centred care is a relatively new but emerging phenomenon today. It covers a variety of views, theories and conceptual models (McCormack et al., 2015). However, despite this increasing interest, there is a lack of clarity among healthcare professionals about what person-centred care is and how it is to be practised (Morgan and Yoder, 2012). There's a risk that the concept will end up in the same position as the concept of patient-centred care in the last decades of the 20th century, that is to say as fashionable but not practice-driven terminology. The person-centred nursing framework of McCormack and McCance (2010) offers a theoretical model with descriptions of core concepts and their mutual relations. Besides being a framework that offers building blocks for the realisation of good care, the framework is interwoven with a strategy known as transformational practice development and research methodologies that originate from the action research paradigm (McCormack and McCance, 2016). The framework therefore is particularly suitable for empirical studies that aim to develop practical knowledge on the realisation of person-centred care. In addition, the framework was chosen as the theoretical foundation to explore in the research programme since it fitted so well with the mission statement of the university's research group for innovation in care of older adults, in which patient empowerment and participation is central.

A lot of research has already been done on the development and clarification of the concepts of the framework (McCormack et al., 2015). Yet, empirical studies that try to underpin the concepts of person-centred care seem to be less available, at least among research conducted in the Netherlands. In daily practice, nurses and care organisations express a clear need for hands-on knowledge of person-centred care. They wish to know how to practice person-centred care in more detail and, alongside obstacles such as time-pressure and workload, they mention an inability to express person-centredness. The question arises: what are implications for the behaviour of nurses and their interaction with patients or residents? There is also a need for further clarification of the concepts for educational purposes, to translate them into concrete knowledge, skills and attitude. This is necessary if person-centred care is to be recognised in competency descriptions for nursing and nurse educational programmes such as the Canmeds (Canadian Medical Education Directives for Specialists, 2015) competency framework. Therefore the research group's researchers started a research programme in 2013 on person-centred care, with the specific aim to gain knowledge on the empirical underpinning of its concepts. In recent years, several studies have been performed by masters students in nursing sciences under the supervision of the research group. Although they varied in their main research topic, questions and methods, all these studies were theoretically founded on the person-centred nursing framework of McCormack and McCance (2010). The feeling emerged from five of these studies that there was an overall result to be found, besides the valuable findings of each separate study. Such an overall result would 'infuse' the concepts inductively. For this reason a framework analysis was performed.

Aims

The aim of the framework analysis was concept clarification from an inductive perspective of several stakeholders, such as people who need care, their informal carers and nurses and nurse assistants. The overall study specifically aimed to underpin the person-centred care concepts by means of seeking and categorising citations that would fit the theoretical description. The ultimate goal was to give concrete and practice-driven examples to give nurses input into person-centred behaviour.

Method

When five separate studies on person-centred care (see Table 1) were completed, the research team, which included all this study's authors, decided to address the search for empirical findings in support of the theoretical concepts of the framework. The research question was: 'How are person-centred care concepts made tangible where empirical data is used to describe them?' The additional framework analysis was the chosen method because it offers a flexible but systematic and rigorous way to analyse existing data in a secondary analysis. The framework analysis consisted of five steps derived from Ward et al. (2013) and Ritchie et al. (2003).

1. The findings of each study were classified into the concepts of the framework of McCormack and McCance (2010) by the research team. For this, a translated version of the framework adapted for the Netherlands was used (see Table 2). Translation was kept as close as possible to the original, but adaptation was necessary for better semantic understanding and the use of language in Dutch care contexts. The classification of findings of each study was then screened for face validity by the researcher of each of the individual studies.

2. Researchers of the individual studies then re-read their data in a secondary deductive coding of relevant quotations, using the descriptions of the concepts and categories as branches of a coding tree (which represents all codes that were assigned to quotations).

3. All relevant quotations of each study were positioned into a schedule separately, a framework according to the coding tree of concepts. Subsequently, three external researchers independently performed an analysis of the schedule in order to gain face validity.

4. Their analysis, remarks and argumentation for correct or incorrect placing of quotations into the classification was then discussed by the group of researchers from the original studies. The group was divided into two and each discussed the complete framework again and weighed the analysis and remarks of the external researchers. All quotations that prompted discussion in either group were set aside for further debate by the group of researchers as a whole until consensus was reached or a decision to remove the quotation from the framework was made.

5. Finally, the frameworks of classified quotations of each study was merged into a single framework in which all quotations were classified together into the concepts and preliminary conclusions were drawn. If conclusions could not be made, hypotheses were formed. This was first done by the senior researcher (first author) and then presented to the research group for final categorisation.

Findings

Five studies on person-centred care

The research group at Windesheim is one of the partners of the faculty of nursing science at the University of Utrecht in the Netherlands, which provides traineeships for masters students. The research group describes a broad outline for research projects from which students can make their choice. This outline has a few guidelines: projects need to fit within the aim of a research programme; and studies performed should predominantly have a qualitative or at least a mixed-methods character. Within these boundaries students are allowed to articulate their own research question and to choose their design. When students are allocated to projects and their researchers, they start the traineeship with a literature review on the chosen topic. This is a helpful means of orientation for the student, but also provides the research institute with reviews for their particular research programme. After the review, students conduct their study and write their master thesis. More often than not, the environment in which they work as a nurse is also their research setting. Mentorship of the students for the five person-centred care studies was undertaken by two senior researchers (PhD) and the leading professor of the institute. They met once a month in order to discuss and question each other's work in action learning sessions. All studies were performed between February 2013 and June 2014 and based on qualitative data-gathering and analysis, although study designs varied (see Table 1). Data analysis of the studies was done according to specific methodological rules for qualitative analysis, also referred to as the Quagol method (Dierckx de Casterlé et al., 2012). All studies involving patients as participants were checked for ethical considerations and approved by the regional scientific research ethics committee. In order to understand the findings of the framework analysis, the findings of each separate study are also presented since each study also had its own aim prior to the framework analysis.

Table 1: Five studies on person-centred care, 2013-14		
Study title	**Type of study**	**Concept of study**
Experiences of care in a group living home for people with dementia Aim: to provide a thorough description of the experiences of a person with dementia, her informal caregivers and staff within the context of a group living home	Case study (single embedded) Data: observation, document analysis and semi-structured interviews of 12 participants	Group living home (within nursing home institute at psycho-geriatric unit)
Optimising person-centred care: the interaction process between the older person and the home healthcare nurse during identification of care needs Aim: to describe the development of the interaction process focusing on cue giving and responding behaviour in home healthcare nursing	Multiple case study Data: observations, document review and semi-structured interviews of six participants (three nurse-patient pairs)	Home health care (older people with a chronic disease)
Application of knowledge of the unique individuality of nursing home residents by nurse assistants in daily care Aim: to describe how nurse assisants use knowledge of the unique individuality of residents in nursing homes	Multiple case study Data: observations, care-plan analysis, semi-structured interviews of nine nurse assistants and nine residents	Nursing home (residents with somatic care-needs)
Dementia care provided by self-managing homecare teams Aim: to provide insight in the practical care self-managing homecare teams provide to clients with dementia	Focus group study Data: observation, document analysis of three nurse-client pairs; and two focus group interviews (12-14 participants)	Home health care (people with dementia living at home)
The realisation of person-centred mealtime care: action research based on emancipatory practice development strategies Aim: to realise a person-centred context of care during mealtime practice	Action research (emancipatory practice development) Data: observation, four work/focus group meetings of stakeholders (seven residents and their informal carers, 13 nurse-assistants, one nurse and several other healthcare professionals)	Nursing home (residents with dementia)

Experiences with care in a group living home for people with dementia.
The first study was undertaken in order to see whether or not the concept of group living homes provides suitable conditions for person-centred care. Recent standards on dementia care and an

increasing demand for individualised and home-like care for people with dementia oblige residential care institutions to seek to provide more personalised care (Verbeek et al., 2009). This 'housing' care model is defined as one in which six to eight residents live together in a home-like environment and ambience. The model concentrates on care that acknowledges individual needs and preferences of the resident, suggesting it is a model that can foster person-centred care. The results of the study, which focused on the experiences of a person with dementia within the context of the group living home model, show that the residents, informal caregivers and nursing staff have a positive perception of the model. They all appreciate the fact that nursing staff know each resident as a person and respect their preferences. The atmosphere of the living environment feels safe and peaceful for residents. However, nursing staff struggle with combining care tasks with other 'new' tasks, such as housekeeping and making time for leisure activities. Informal carers report unattended residents during specific hours. In conclusion, the study shows that care in a group living home is perceived as care with a person-centred character, although there is room for improvement. Care should be provided by regular nursing staff who know residents as people and have the appropriate skill-mix.

Interaction processes between clients with a chronic disease and home healthcare nurses
This second study looked into the specifics of interaction within a care relationship between older persons with a chronic disease and their nurses. It is known that older persons in healthcare situations seldom offer personal information on what they want or what really matters to them in a direct way (Florin et al., 2005). Instead they give cues or signals, such as dropping a hint or nonverbal facial expressions of emotions (Uitterhoeve et al., 2008). If nurses are able to acknowledge these cues, they are able to use them as relevant information to achieve personalised goals in person-centred care. The study aimed to assess these cues and responses nurses gave to them. Results show that nurses aim to understand 'the bigger picture'. Most of the time nurses acknowledge and explore cues, which in turn helps them identify individual care needs. The study also shows that nurses take the lead to steer the conversation. Nevertheless, the concept of cue giving and responding helps to bring personal information on what matters to clients to the surface. Training nurses to use adequate cue responding behaviour effectively should therefore be enhanced as a professional skill.

Application of knowledge of the unique individuality of nursing home residents by nurse assistants in daily care
The third study was undertaken in order to gain a detailed picture of the application of personal knowledge by nurse assistants about the unique individuality of residents. During daily care interactions, such knowledge can guide the nurse assistant's responses to the resident (Jukema, 2011). For example, does a person like to chat during bathing, or does she have a preference for certain clothing? Whether or not these preferences are met in daily living does influence residents' wellbeing. The study results show how assistants do apply this personal knowledge during interactions, and follow the seven themes of Kukla: interaction; movement; presence and sense of self; needs and desires; privacy; pleasure; and boundaries (Kukla, 2007). It becomes clear how assistants are able to adapt to a resident's preferred daily rhythm or their distinctive ways of moving. They also know what gives pleasure to residents, such as little outings or the use of a body lotion. These specifics are written down in formal care plans, but most of the time applied as a matter of course during daily caregiving. In conclusion, it can be said that nurse assistants do apply specific knowledge in their professional behaviour in a natural and somewhat subconscious way. They do acknowledge the wishes and preferences of residents and in doing so contribute to their wellbeing.

Dementia care provided by self-managing home healthcare teams
This fourth study, into care for older persons with dementia provided by home healthcare teams, was performed in order to shed light on what such care looks like in daily practice. Since the majority of people with dementia live at home, professional care is needed. Some of the providers are small, professional, self-managing teams. Clients as well as nurses who work in such a system report satisfaction with the work and with the care received. Within the domains of person-centred care,

the caring relationship between nurse and older person is seen as crucial for good care (Jansen et al., 2009). The hypothesis is that such caring relationships are more easily made when shifts are shared between a small number of nurses. The results show that nurses mention a diversity of signs that indicate care needs, such as: forgetfulness, loss of weight and nutrition problems, incontinence and loneliness. In care plans such signals are translated to diagnosis. The interventions nurses chose were all traceable to categories as: offering structure, supervision, support and safety. Nurses do also show the inclination to protect clients with dementia from confrontation with their disease. However, nurses believe gaining trust and getting to know the person with dementia is of paramount importance and taking time to do so is a prerequisite. In conclusion, the study emphasises the need for nurses explicitly to discuss outcomes of care with their clients and the clients' informal network in order to make their care more person-centred.

The realisation of person-centred mealtime care: action research based on emancipatory practice development strategies
The fifth study concerned an action research study that aimed to enhance care during mealtimes for residents with dementia in a nursing home ward. When mealtime care is mainly focused on satisfying physical needs such as providing sufficient intake of nutrients, it fails to support the social needs that go with having a meal (Edvardson et al., 2008). Taking into account personal preferences and social interaction in nursing homes are known factors for a positive mealtime experience (Sjogren et al., 2013). The study focused on how a process of changing and realising person-centred mealtime practice would develop. During the study mealtime practice was changed and one of the changes was the starting time of meals: instead of starting in the early afternoon meals started around a time preferred by residents and family. Another change concerned the preparation and serving of the food; the aim of preparing the food on the ward was to generate more cooking smells, which was believed to increase the sensation of mealtimes and to increase appetite. Also, instead of portioned meals on trays, items of food were offered in bowls. This gave residents the opportunity of choosing food they liked at that moment, and also seemed to have an effect on the amount of food eaten in a positive way. In conclusion, it can be said that the changes brought a more structured, sociable and home-like mealtime experience, compared with the previous practice.

Findings of the framework analysis
The analysis, in which a total of 102 relevant citations from five studies were assigned to all concepts of the person-centred nursing framework, showed that citations were found in all but three of the 19 categories of the five concepts (see Table 2). Since no data were found for these categories, they are not discussed. On eight citations, researchers could not agree on which category to assign them to, so these were excluded. The findings are introduced using the Dutch-adapted version of each concept of the framework; further description is revealed using the assigned citations.

Table 2: Concepts of Person-centred care (translated/adapted Dutch version)	
Concepts and their categories found in the data	**Number of citations (102 total)**
Being unique as a person	***18 (total)***
• Appearance and characteristics	2
• Relations	4
• Emotions	4
• Wishes and preferences	8
Caring relationship	***25 (total)***
• Characteristics of a unique relationship	5
• Power and equality balance	3
• Act of care	6
• Acknowledging person (mutual)	4
• Acknowledging emotions and having compassion/ empathy	7
Professional competencies and personhood of the nurse/ nurse assistant	***23 (total)***
• Educational characteristics and work experience	-
• Narrative/lifestory caregiver	-
• Professional relationship	5
• Professional knowledge and competencies (artistry, skills and attitude/behavior)	18
Context of care	***18 (total)***
• Material	-
• Caring situation and location	4
• Work culture	14
Value and outcomes of care	***10 (total)***
• Physical wellbeing	2
• Psychological wellbeing	2
• Social wellbeing	6
Citations on which no consensus was arrived and could therefore not be categorised	8

Being unique as a person
Every human being has a unique personality and lives life in their own unique way, as a child, adult or older person. A person's individuality becomes clear in their values, relationships with others, characteristic emotional responses and behaviour, wishes and preferences. In others words, in all that represents a personal way of life.

The findings show that, next to information about who someone is as a person, the category 'appearance and characteristics' also releases information on what a person believes to be important at a certain moment or in general. Citations show that appearance goes beyond solid features, such as the colour of someone's eyes; it also has a lot to do with identity and the way a person perceives him or herself. Appearance is about the significance of, for example, clothing, jewellery or make-up to a person's wellbeing.

   'I don't wear trousers, I'm not a man, I'm a lady' (Resident, Study 3).

   'The watch is important to me, I always wear it on my right arm' (Resident, Study 3).

A well as facts about the nature of relationships that persons or residents have, the category 'relations' also contains information on how these relationships are being perceived. Often, direct responses

on an emotional level are given during casual conversations, as well as hints and implicit remarks. Obviously, responses to such remarks are interpretations made by nurses; it is unclear whether or not these interpretations are being checked to determine if they are correct or not. In the example below, the nurse assumes the carer is tired but may not have checked whether the carer intended to say something else.

> Nurse: 'It would be a good thing if you could manage it together'
> Spouse/informal carer: 'I can't do everything…'
> Nurse: 'No, you can't – I'd say listen to your body when you're tired' (Study 2).

The category 'emotions' contains implicitly expressed emotions or emotional responses to events in people's lives as perceived at that very moment. The events mentioned are often related to health problems and their consequences. But nurses and informal carers also express how they 'read' the person's emotions. Such qualifications give information about the assessment that carers make about the wellbeing of the person they care for, or with whom they have a relationship.

> 'She is all about talking, laughing and actually always a friendly person… so if she suddenly, you know, remains silent or has a bit of an angry expression… or I simply notice that she's tensed, I do know then that there's something going on' (Nurse, Study 1).

> 'She is herself as she was before, making jokes and everything, that's my mother in law' (Family of resident, Study 1).

Noticing 'wishes and preferences' or disapproval, the last category in the concept of being unique as a person, is cited by participants in several ways. It sometimes is expressed straightforwardly, other times a bit wrapped up in humour, or denoted by physical behaviour such as the way someone (emotionally) responds to food, certain objects or daily activities. Straightforward verbal and non-verbal expressions of preferences are the most helpful expressions for nurses and caregivers to assess:

> 'At home, me and my husband used to drink a glass of wine during mealtimes' (Spouse, Study 5).

The caring relationship
The heart of person-centred care shows itself within the caring relationship. Most of the time this is not a chosen relationship; nurses are assigned to patients, it is not a choice for either of them. It is not an equal relationship either, patients are on the dependent and more vulnerable side of the relationship. A good caring relation is an important prerequisite for good care, in which compassion, respect, personal and professional involvement and closeness can flourish. Getting to know each other mutually is of importance as such for a relationship, but also has the benefit of providing information that can be used to set relevant outcomes of care.

The category 'characteristics of a unique relationship' reveals that the personal character of every unique caring relationship shows in three ways: what both people know about each other; the way they address and speak to each other; and the way the nurse or carer adjusts her behaviour to the person cared for. On the other hand, it becomes clear that, even though people who need care know their caregivers well, in the end the nurse is less 'known' as a person than the other way around.

> 'I have a resident in care who was a captain on a ship and he likes it when I say: "Hello, captain". This requires knowledge of the resident, because residents don't always appreciate it if you say things like that if you don't know them' (Nurse assistant, Study 3).

Remarkably, the characteristics of the unique relationship always seem to be specific. In other words, you can only say that it's a personal relationship if it is possible to speak of its uniqueness in tangible and concrete specifics that differentiate that relationship from other relationships.

Few quotations were found that could be assigned to the category 'power and equality balance', although the ones that did fit were clear enough. They reveal that carers steer the conversation when it comes to professional dialogues, such as an intake interview. It also shows that those being cared for submit to that more or less willingly. This illustrates that there is an inequality in caring relationships, almost by definition.

> *'Well yes, she was the one who takes the initiative, she indicates it and then you answer the question, that's how it goes.* (Home care client, Study 2).

Most of the quotations about the category 'act of care' and the relevant professional behaviour seem to express underlying values of care and what good care looks like. It also makes mutuality an obvious feature of the relationship, since quotations in this category show reciprocal conversations.

> *'Most of the times I wash him in the same order'* (Nurse assistant, Study 3).

> *'I like it that they wash me in the same order'* (Resident, Study 3)*.*

The category 'acknowledging person' is grounded in citations of nurses and nurse assistants that express personal knowledge on what is important to those being cared for. The category again emphasises the fact that the aspect of knowing the person is to be found in person-centredness.

> *'And… yes we do connect, it does feel quite good, she's a very cheerful and energetic lady'* (Nurse, Study 2).

> *'For her it is important that she still can do something'* (Nurse-assistant, Study 3).

The category 'acknowledging emotions and having compassion' contained citations showing emotions are part of the game in a professional relationship. By means of showing emotions during contact and conversations, both the nurse and the person receiving care confirm their relationship and create mutuality in the relationship. Compassion within the relationship is expressed in several ways: in affirmative statements, in behaviour that shows attentiveness, and through interest and concern for each other. The fact that compassion also contains sharing joyful events is confirmed in this category.

> *'I feel for her. I try to comfort and support her and give her the opportunity to call her daughter'* (Nurse assistant, Study 3).

> *'She really is involved. She asks out of interest and supports me. She knows my daughter as well, you know'* (Resident, Study 3).

The professional competencies and person of the nurse

As much as the caring relationship is of importance, so is the professional expertise of the nurse. Providing good care depends on up-to-date professional knowledge and skills. This knowledge specifically concerns nursing diagnoses and interventions, and outcomes. But clinical reasoning is not only about knowledge and skills; it is as important for good practice to take professional and personal experience into account as a source of knowledge. Moreover, professional knowledge is about an appropriate attitude, good communication skills and about authenticity and being kind and friendly. Therefore, the nurse needs to know herself and her personal qualities.

The skill to shape the professional relationship is, among other things, expressed by nurses' ability to notice and mention habits or values that play an important role for the person they care for.

> *'I try to inspire confidence during the conversation in such a way that it is for her also… You see for her it is important to speak her dialect'* (Nurse, Study 2).

According to nurses themselves their 'professional knowledge and competence' shows in specific behaviour in which they use their knowledge and skills and display the correct attitude. Their expertise is demonstrated by direct and concrete actions based on observation and specific knowledge, such as nursing diagnosis, but also by a good sense of timing.

> *'Sometimes we refrain from care activities for weeks, only for the purpose of gaining trust and opening the door for us'* (Homecare nurse, Study 4).

Nurses describe 'professional artistry' as being involved with the people they care for – an involvement that, for example, would be shown by a willingness to stay with the person if needed, even though a shift is over. Also the use of humour is mentioned as a means to an end. Personal qualities such as courage, patience, empathy and self-confidence showed throughout quotations in this category.

> *'I won't say: "I'm paid until three o'clock, so find someone else". So, when I see this lady is incontinent I'll help her anyway'* (Nurse, Study 1).

Context of care

Care always takes place in a specific environment. Whether this is at home, in hospital or in a nursing home, the location, atmosphere, space and furniture is of influence. In addition, the culture of care in an organisation matters. Who makes the decisions? Is it the team in consensus or is there top-down management? What are the written and unwritten rules and regulations? Another factor is an organisation's approach towards care of its personnel, for example in healthy rostering of shifts or providing time for tuition and schooling.

The category 'caring situation and location' contains mostly citations on caring for a group of persons. While it did contain one comment on the 'physical surroundings', in terms of their not being adequate for a vulnerable older couple, it generally refers to the importance of a good atmosphere and a smooth caring processes.

> *'The music resulted in residents humming, tapping with the music or even at some point residents were singing songs of their past'* (Observation, Study 5).

There's an overlap in the category 'work culture' with the category 'caring situation and location'. The context in which care takes place influences the working culture. Obviously, caring in a home situation is different from a setting in which group living takes place. Citations in this category often implicitly relate to values such as good fellowship among nurses, and the importance for residents of feeling at home, peacefulness, continuity of care and trust. Also, the need for measures related to reducing work stress and time pressure is mentioned.

> *'Sometimes you're the only registered nurse on the ward and you have to do medication rounds in time for your own clients, as well as for other rooms with seven or eight patients, and at the same time get your own clients out of bed, take care of their daytime activities, etc. It is a lot of pressure'* (Nurse, Study 1).

Value and outcomes of care

The ultimate goal of good person-centred care is to cherish, preserve and protect someone's uniqueness as a person and their wellbeing. This kind of care fits a person's needs and acknowledges and gives priority to what is of importance for them. These priorities inform and define personal outcomes of care. Person-centred care also is of value for nurses and caregivers because they are able to express themselves as the person behind the professional role.

The categories 'physical wellbeing', 'psychological wellbeing' and 'social wellbeing' all show either a measure of those aspects known to be important to a person from earlier assessment or an evaluation of something in the moment itself. The value of wellbeing can be assessed if there has been previous assessment of what is of importance to someone. Only when personal characteristics and preferences are known is it possible to see if these are met and if a person's wellbeing is being cherished or even advanced. Of course, wellbeing is not always a clear and concise thing, and preferences can be fluid. Nevertheless, outcomes of care in terms of wellbeing are mostly related to specific preferences or to what is of importance to people.

> *'The first thing I noticed was the fact that they're cooking and preparing their own meals. I love that! When I bring her back, I think that's so cosy and homely'* (Informal carer, Study 1).

Discussion
The framework analysis offers a new insight into the ways person-centredness is expressed in practical situations. While concepts and their categories are described as separate entities in theory, in practice concepts are not mutually exclusive and appear to be multi-layered. The concepts of being unique as a person, caring relationships and professional competencies specifically seem to have significant overlap when it comes to knowing the person from the perspective of the nurse or carer. Professional competency, based on nurses' ability to acknowledge unique characteristics of a person and recognise specific wishes and preferences, enhances the caring relationship in which a person can flourish. This is in line with notions in the literature on the importance of 'knowing the patient', which also underline how this specific knowledge positively influences the development of the caring relationship and provision of good and compassionate care (Dewar, 2011; Zolnierik, 2014). As a model, person-centred care gives an artificial classification of concepts and their categories, even though schematic representation of the framework suggests overlap between the concepts. (McCormack and McCance, 2012). For practical usability of the framework, such overlap does not seem to be too problematic; it may even help practitioners to see that practising person-centredness can be more simple than it seems in theory.

The analysis also feeds the hypothesis that professional artistry is key to practising person-centred care. Shaping a professional and caring relationship based on appreciation of what is important to the one being cared for, whether expressed verbally or non-verbally, obviously is a skill (Titchen, 2009; Uitterhoeve, 2009). In practice and in professional education, however, this particular skill is not yet accorded as much importance as recognising signs and symptoms for nursing diagnosis, or observation of health problems. Although it is now recognised that personal knowledge of patients and their wishes and preferences should be taken into account when it comes to evidence-based practice (Munten et al., 1996), it is not yet common practice for nurses who do so to be viewed as role models, or for appreciating personal characteristics to be discussed in the classroom. This points to a need for formal teaching to acknowledge the power of role modelling and discussing cases in which students learn to recognise the importance of this form of knowledge, as Benner also argues (2010).

Last but not least, the study evokes questions about the significance and role of values-based care related to the context of care and working cultures. The findings refer quite often to explicit or underlying values of care, such as compassion, respect for equality in the power balance, trust and involvement. These findings feed the idea that values steer practice. If values become clear in specific behaviour and concrete acts of care, it would help practitioners to identify best practice for person-centred care. The acknowledgement of emotions as being important for good nursing – that is to say the emotions of patients and nurses – still isn't common practice. There's a gap between daily practice and theoretical notions about the importance of emotions, despite the fact this is expressed in several (national and international) codes of ethics (van der Cingel, 2014). The findings also include a number of citations about the working culture in which work stress and a lack of time play a role. As we know, work cultures do have a significant influence as a primary condition for person-centred care (Cardiff,

2014). It therefore seems paramount to question what values steer working cultures again and again. If productivity overrules values-based practice, or cost effectiveness dictates work processes, it should become clear to patients as well as care professionals how this affects the ability to act according to values in practice.

Limitations of the study
A framework analysis based on other separate studies has its methodological limitations. The analysis was at times a rather complicated, iterative process, even though a strict methodology was followed in order to enhance rigour. Researchers' bias, for example, was a serious methodological problem. All researchers in the team were familiar with the theoretical concepts of the person-centred nursing framework of McCormack and McCance (2010). Interpreting and categorising citations was therefore done with rigour and external researchers were asked for their feedback. Despite these measures, one of the recommendations emerging from this study is the possibility of the same framework analysis being conducted by another research team that is less familiar with the concepts.

Another limitation is the number of suitable citations. Since it is a secondary analysis, the original research perspectives were different. Therefore a lot of the original data were not suitable for the purpose of the framework analysis, which resulted in only 102 suitable citations and no data saturation was reached. This rather limited the scope of the study. Nevertheless, the adequacy of the citations that did prove suitable confirms the hypothesis of the study that empirical data can help to gain an understanding of concrete person-centredness in daily practice.

Conclusion
Nurses and care organisations are gaining interest in person-centred care but often do not know how to recognise or put person-centredness into their daily practice and use it to inform concrete professional behaviour. This study was undertaken to further clarify the concepts and categories of the person-centred nursing framework in order to provide tangible examples and descriptions. This was done by using existing empirical data from five studies. The framework analysis showed that concepts can be illustrated with concrete behaviour and conversations when compared with the theoretical description. Although concepts were not fully infused with empirical evidence, a general view of each concept and specifics of the concepts could be described inductively. Most of all, the study shows that person-centred care in daily practice is there to be found and can be recognised concretely, if only we make it visible.

Implications for practice
Concepts of the person-centred care framework of McCormack and McCance (2010) are recognised in nurse behaviour and conversations in daily practice when nurses show their knowledge of the unique characteristics of those they care for, and of what is important to them. It is also recognised when nurses act according to this knowledge. Remarkably, every unique relationship is only a personal and unique relationship if its specific uniqueness can be distinguished from that of other relationships. In daily practice this means we need to acknowledge that caring relations are different for every nurse and patient – and should be if they are to be recognised as person centred. Since the study also implies quite strongly that values steer practice, values-based care could be a promising and practice-driven way to enhance person-centred care because nurses already have an intrinsic motivation to act according to values. Last but not least, the importance of reflecting on emotions, learning to interpret them and accept them as part and parcel of good care, should have a place in care practices, since it creates mutuality in caring relations.

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Margreet van der Cingel (PhD, MScN, RN), College Professor and Senior Researcher, Research Group Innovating with Older Adults, Windesheim University of Applied Sciences, Zwolle, Netherlands.

Lobke Brandsma (MScN, RN), Home Healthcare Nurse, Buurtzorg Nederland, Netherlands.

Mirjam van Dam (MScN, RN), Senior Nurse, Woonzorgcentra Haaglanden, Den Haag, Netherlands.

Marcella van Dorst (MScN, RN), Nurse and Student Nurse Specialist, Woonzorgcentra Haaglanden, Den Haag, Netherlands.

Claudia Verkaart (MScN, RN), Project Researcher, Woonzorgcentra Haaglanden, Den Haag, Netherlands.

Cilleke van der Velde (MScN, RN), Home Healthcare Nurse and Quality of Care Officer, Icare Home Health Care Organisation, Netherlands.

A commentary by Joanna Goodrich follows on the next page.

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COMMENTARY

Concepts of person-centred care: a framework analysis of five studies in daily care practices

Joanna Goodrich

Patient experience is seen as one of the three components of quality in healthcare (along with safety and clinical effectiveness) but unlike the other two is not often described in concrete terms. In 2009, when dignity in care was a policy priority, the UK Nursing and Midwifery Council issued its *Guidance for the Care of Older People*, which set out clearly, using examples, ways to treat patients with dignity. While some commentators at the time expressed surprised that this was needed, it was one of the few efforts to set out in practical terms what dignity in care meant in action. Margreet van der Cingel and colleagues have made a contribution to describing what person-centred care means in concrete terms – and this is welcome.

The Point of Care Foundation is a charity with a mission 'to radically change how we care and are cared for'. In other words we work, through teaching and supporting practical interventions, to make the experience of both patients and healthcare staff better. Our origins are as a programme that began at The King's Fund in 2007, and was launched with the publication of *Seeing the Person in the Patient* (Goodrich and Cornwell, 2008). Our aim at the time was to improve patient-centred care and to support staff to provide compassionate care. The review looked at the state of patient-centred care, based on available quantitative and qualitative evidence, and what promising interventions were being tested to improve it. We also took some time trying to define what we meant by patient-centred care, and decided on the Institute of Medicine's (2001) definition because it had grown out of research conducted in the 1980s (Gerteis et al., 2002), into what patients said was important to them. We would argue therefore that the idea of patient-centred care was not a temporarily fashionable notion then, and has become more acceptable and more talked about since. The six components in the institute's definition are:

- Respect for values, preferences, and expressed needs
- Coordination and integration of care
- Information, communication and education
- Physical comfort
- Emotional support
- Involvement of family and friends

To these we have added two more for our work: transition and continuity; and access (in line with the definition used by the NHS). The Institute of Medicine elaborates on each of its themes – for example saying for the first one that it means 'providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions'.

'Person-centred care' was another term used in healthcare at the same time in England, and in the practice development context had the advantage of including both patient and nurse. It is a term that has long been used in England by social care as well as healthcare, is particularly associated with caring for people with long-term conditions, and emphasises the importance of shared decision making and

planning. National Voices, the umbrella organisation for patients' organisations, puts the concept in the first person: 'I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.'

We would argue that patient-centred care is a broader definition than person-centred. It covers both 'relational' and 'transactional aspects' of care and works in a variety of settings, even where contact with patients is brief – like the emergency department.

'Relationship-centred care' is another concept (with its own body of literature), which embraces staff, the patient and the patient's family. Its origins were in the care of older people, and with the Senses Framework (Nolan et al., 2006) it has been used helpfully in nursing homes, care homes and hospitals. The six senses are (My Home Life, 2016):
- A sense of security (to feel safe)
- A sense of continuity (to experience links and connections)
- A sense of belonging (to feel part of things);
- A sense of purpose (to have goals to aspire to)
- A sense of fulfilment (to make progress towards these goals)
- A sense of significance (to feel that you matter as a person)

The authors refer to the possibility that frameworks are artificial ways of classifying concepts. It could also be argued that there are too many phrases that sound alike, and it sometimes seems as though we are getting bogged down in the pros and cons of different definitions. The Point of Care programme carried out a small piece of qualitative research before we launched our programme to find out what language would appeal to people who work in hospitals. At that time we were talking about improving the 'humanity' of care – but when we tested that with a range of staff including nurses, doctors, porters, and managers, it did not go down well! Neither did patient-centred care or any of the other phrases that had been used by policymakers and others. Staff said that they preferred everyday language like 'kindness', 'friendly', 'welcoming' and 'warm'. But for professionals, frameworks do have a place. The authors of this paper, by mapping five studies of the care of older people (at home, in a nursing home and a residential home) to McCormack and McCance's person-centred framework (2010), have demonstrated what person-centred care means in practice.

The result chimes well with the NMC's guidance, which stated in its introduction that 'the essence of nursing care for older people is about getting to know and value people as individuals through effective assessment, finding out how they want to be cared for from their perspective, and providing care which ensures that respect, dignity and fairness are maintained'.

The authors acknowledge at the end that work culture and lack of time might be a barrier to practising person-centred care and it would be interesting to explore this further. They also refer briefly to the importance of acknowledging that emotions (both patients' and staff's) are important for good nursing. This is something that is being taken increasingly seriously [in the UK], with The Senses Framework being used with staff as well as patients, and the increasing uptake of Schwartz Rounds by NHS organisations and hospices (Point of Care Foundation, nd). These rounds provide an opportunity for all healthcare staff to reflect together on the emotional challenges of their work. The authors rightly say that values are important to underpin care practice, and this goes hand in hand with understanding that emotions and compassion strengthen the relationship between professional and patient.

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Joanna Goodrich (MA), Head of Evidence and Learning, Point of Care Foundation, London, UK.