



Exploring person-centred practice within acute hospital settings

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Submitted for publication: 29th April 2015

Accepted for publication: 10th July 2015

Abstract

Background: Person-centred cultures have the capacity to make a significant difference in the care experiences of patients and staff. Contextual factors pose the greatest challenge to person-centredness and to the development of cultures that can sustain person-centred care, especially in the acute hospital setting.

Aim of the study: To assess person-centred practice in acute hospital settings.

Method: A cross-sectional survey using the person-centred practice inventory was used to measure current levels of person-centred practice within the acute care environment. A purposive sample of 2,825 registered nurses employed in acute hospital settings drawn from across four organisations was identified to participate in the study. Full ethical approval was obtained.

Findings: A response rate of 24.9% (n=703) was achieved. There was a good spread of responses across demographic details. All 17 constructs of the inventory were scored positively. The lowest scored construct was 'supportive organisational systems' and the highest was 'being committed to the job'. Staff experience and banding had a significant impact on the provision of person-centred practice, with higher banding and experience being associated with higher levels of person-centredness.

Conclusion: The findings indicate that a high level of person-centred care is currently provided in acute hospital settings. They also indicate areas for potential improvement, particularly in the constructs of: clarity of beliefs and values; supportive organisation systems; and potential for innovation and risk-taking. The significance of staff banding and time in role indicate that years of experience is important in terms of expertise in person-centred practice.

Implications for practice:

- Demographic details have a significant impact on the provision of person-centred practice in acute hospitals, indicating variability in practice that must be taken into consideration when designing practice development initiatives
- The person-centred practice inventory helps to identify areas for potential practice development work, and to design targeted interventions and measure the impact of interventions

Keywords: Person-centred practice, practice development, instrument, acute hospital, psychometrics

Introduction

There has been a consistent message in the international literature of the need to promote person-centred cultures to ensure a positive care experience for patients and staff (World Health Organization, 2007; Dewi et al., 2014). There is, however, evidence to suggest that while organisations might aspire to a standard of care that reflects person-centredness, the reality of care experiences is at odds with this goal. This is borne out by several high-level inquiries about substandard care in some hospital wards in the UK (Alzheimer's Society, 2009; Health Service Ombudsman, 2011; Francis, 2013).

There is increasing recognition of the challenges of implementing person-centred practice for teams who are working within complex organisational systems (Smull et al., 2009; Gask and Coventry, 2012; Neitzke, 2013). McCormack et al. (2011) suggest that contextual factors such as organisational culture, the learning environment and the care environment itself pose the greatest challenge to person-centredness and the development of cultures that can sustain person-centred care. A study conducted by McCance et al. (2013) explored how the culture and context within acute care practice settings impacted on the engagement of practitioners in a facilitated practice development programme. The findings highlighted the constant tussle experienced by staff in managing context while trying to develop cultures that supported person-centredness in everyday practice. Laird et al. (2015) has illuminated patients' experience of care in hospital wards during the intervention phase of the same programme. These authors have identified that patients in hospital are exposed to their own vulnerability in the care experience. Experiences of misfits in systems, care processes and nurse responses disempower patients and heighten the sense of vulnerability, confirming that context and culture of care are important components in terms of the development of person-centred practice in acute care settings.

The person-centred practice framework (McCormack and McCance, 2010) is one framework that helps teams to understand what is happening within the practice setting. It has been described as a way to operationalise person-centredness in practice, recognising that the idea of person-centredness is well understood in principle, but the issue is often recognising it in practice. Alongside the framework, a variety of tools have been developed to support this agenda, and the person-centred practice inventory (PCPI) is one such tool. This paper describes the use of the PCPI to explore the relationships within the person-centred practice framework as they apply to acute care.

Methodology

The overall aim of the study was to assess person-centred practice within acute hospital settings.

This was broken down into the following objectives:

- To benchmark person-centred practice in acute hospitals
- To identify differences according to demographic details
- To identify the usefulness of the PCPI in measuring person-centredness in acute care settings

The study adopted a descriptive cross-sectional survey research design, using the PCPI to measure levels of person-centred practice within the acute environment.

Sample

A sample of nursing staff drawn from four health and social care organisations in one region in the UK participated in the study. Staff from a range of clinical settings (for example, mental health and learning disabilities, adult services and paediatrics) were invited to participate, with the aim of obtaining a representative sample of nurses working in acute settings. Demographic details of participants were also collected. All nurses in each clinical setting were selected based on the following inclusion criteria:

- A registered nurse
- Employed full time
- Working in the clinical setting for at least six months
- Willing to participate

Instrumentation

The PCPI is a 59-item instrument that measures 17 constructs aligned to the person-centred practice framework (McCormack and McCance, 2010). All items of the PCPI are measured on a five-point scoring range, from 1 (strongly disagree) to 5 (strongly agree). Full psychometric properties of the PCPI will be reported in a future publication.

Procedure

A total of 2,825 questionnaire packs were distributed across the four participating organisations via ward sisters/charge nurses, who provided the number of nurses working within each area. The process of implied consent was made explicit in the participant information sheet; a returned questionnaire indicated consent to the use of the information contained in it for the study. The process ensured total anonymity for participants returning questionnaires. Participants were asked to complete the questionnaire and return it in a supplied SAE for collection by the researcher. A deadline of two weeks was given for the return of questionnaires, with a further week of follow-up visits to retrieve questionnaires.

The PCPI was completed by 703 nurses – a response rate of 24.9%. Due to missing data, the final total of nurses for whom data were collated was 664.

Statistical analysis

All data were analysed using [IBM SPSS Statistics 23.0](#). Frequency scores and descriptive statistics were generated for all demographic details. Item scores were aggregated to the level of the 17 constructs and analysed accordingly. The results are presented according to the main concepts within the person-centred practice framework (prerequisites, care environment and care processes) for ease of interpretation. Statistically significant differences across demographics (banding and length of time in post) were identified accordingly.

Ethical approval

Full ethical approval was sought and gained from the relevant organisational and ethical bodies in line with research governance requirements. The main ethical issues related to informed consent and assuring confidentiality and anonymity for all participants.

Demographic details

There was a good spread of respondents across the key demographics. As Table 1 shows, the majority of the sample were Band 5 nurses (63.7%) and the majority of the sample had more than 10 years' experience in practice (59.8%). Nurse banding levels reflect increasing expertise and corresponding salary. For example: newly qualified nurses will start their career at Band 5, while nurse consultants will be Band 8. The majority of higher band staff had considerably more experience in post. There was a good representation of respondents across the four participating organisations.

Table 1: Demographic spread of overall sample

Participants per Band	Time in practice			
	<1 year	1-5 years	6-10 years	More than 10 years
Band 5 63.7% (n=423)	2.4% (16)	19.9% (n=132)	14.6% (n=97)	26.8% (n=178)
Band 6 20.3% (n=135)	0.2% (n=1)	0.8% (n=5)	2.3% (n=15)	17.2% (n=114)
Band 7 14.8% (n=98)	0	0	0.2% (n=1)	14.6% (n=97)
Band 8 1.2% (n=8)	0	0	0	1.2% (n=8)
TOTAL (n=664)	2.6% (n=17)	20.6% (n=137)	17.0% (n=113)	59.8% (n=397)
<i>Total participants per organisation (n=703)</i>				
Site 1 10.7% (n=76); Site 2 38.4% (n=270); Site 3 6.1% (n=43); Site 4 44.7% (n=314). TOTAL = 703				

Table 2: Mean scores and measures of distribution on the 17 constructs of the person-centred practice inventory (range from 1 to 5)

Construct	Mean (SD)	Skewness	Kurtosis
Prerequisites			
Professionally competent	4.26 (.41)	-.113	.13
Developed interpersonal skills	4.37 (.38)	-.121	.44
Being committed to the job	4.45 (.40)	-.573	.08
Knowing self	4.04 (.52)	-.953	2.7
Clarity of beliefs and values	3.91 (.54)	-.447	.74
The care environment			
Skill mix	4.22 (.45)	-.632	1.8
Shared decision making systems	4.21 (.65)	-.495	.37
Effective staff relationships	4.09 (.62)	-1.08	2.1
Power sharing	3.93 (.58)	-1.02	2.3
Potential for innovation and risk taking	3.85 (.63)	-4.35	.68
The physical environment	4.05 (.51)	-.410	.43
Supportive organisation systems	3.43 (.66)	-.375	.20
Care processes			
Working with patients' beliefs and values	4.19 (.49)	-.105	.55
Shared decision making	4.21 (.52)	-.216	.34
Engagement.	4.18 (.46)	-.138	2.66
Sympathetic presence	4.28 (.44)	.018	.11
Providing holistic care	4.40 (.44)	-.215	-.34

Examination of the normality of distribution of responses indicates a good spread across all factors. Examination of the measures of dispersion (skewness and kurtosis) confirms the appropriateness of parametric tests to examine differences across demographic details. Significant differences are reported at probability level of $P > 0.05$.

Results by concept

Prerequisites

The broad concept of prerequisites comprises five constructs. Each of the five was scored positively (mean score > 2.5), indicating a level of agreement with the construct. As shown in Table 2, the highest scored construct was being committed to the job (4.45 on the PCPI five-point scale). This is defined as a commitment of the individual and the team members to patients demonstrated through intentional engagement that focuses on providing holistic evidence-informed care. The lowest scored construct was clarity of beliefs and values (3.91) defined as awareness of the impact of beliefs and values on care provided by practitioners and the commitment to reconciling beliefs and values in ways that facilitate person-centredness. There was a narrow spread on scores across the constructs.

The care environment

Seven constructs measured the concept of the care environment. Each of the seven was scored positively by the participants, indicating a level of agreement with the presence of the constructs in practice. The highest scored constructs were potential for innovation and risk (4.22) and shared decision making (4.21). Potential for innovation and risk addresses the professional accountability in decision-

making that reflects a balance between the best available evidence, professional judgement, local information and patient preferences. A shared decision making system is the active engagement that facilitates active participation in decision-making by all team members. The lowest scored construct was supportive organisational systems (3.43). This construct relates to the presence of organisational systems that promote initiative, creativity, freedom and safety of persons, underpinned by a governance framework that emphasises culture, relationships, values, communication, professional autonomy and outcomes.

Care processes

Five constructs make up the concept of care processes. Each of the five was very positively scored, (mean scores >4). The highest scored construct was providing holistic care. The provision of holistic care is described as the provision of treatment and care that pays attention to the whole person through the integration of physiological, psychological, socio-cultural and developmental dimensions of persons. The scoring range across the five constructs was again narrow.

Results by demographic factors

Organisation

All constructs were positively scored across all four participating organisations. Examination of the mean figures identify statistically significant differences across organisations on four of the 17 constructs. Three of these are constructs relating to prerequisites (developed interpersonal skills, knowing self, and clarity of beliefs and values) and one relates to a care process: sympathetic presence. Examination of the mean scores for these constructs shows the difference to be focused on one particular organisation having a consistently lower score than the other three.

Length of time in post

All constructs were positively scored irrespective of the length of time staff had been in post. Statistically significant differences were noted across four of the 17 constructs, with three of the four constructs relating to the care environment (skill mix, shared decision making and power sharing) and the remaining construct relating to a prerequisite: professionally competent. Examination of the mean scores shows that with increasing length of time in post, the provision of person-centred practice scores increase. This pattern remains consistent across all four constructs for which there were statistically significant differences. Post hoc tests show that statistically significant differences were noted between the recently in post (<1 year and 1-5 years) and those who had spent more than 10 years in post.

Staff banding

All constructs were positively scored irrespective of staff banding. Statistically significant differences were noted across nine of the 17 constructs, with the majority relating to the care environment (skill mix; shared decision-making; effective staff relationships; power-sharing; the physical environment; and supportive organisational systems). Two fell under prerequisites (professionally competent and clarity of beliefs and values) with the final one being the care process of working with patients' beliefs and values. Examination of the mean scores according to staff band shows that with increasing staff banding person-centred practice scores rose. This pattern remains consistent across all nine statistically significant constructs. Post hoc tests show that statistically significant differences were noted between the lowest band and highest band nurses.

Examination of the concepts of the PCPI

Examination of the measures of skewness and kurtosis reflect normality of distribution across the three concepts. The mean scores for all concepts were positive (see Table 3).

Table 3: Mean scores and measures of distribution on the three concepts of the person-centred practice inventory

Concept	Mean (SD)	Skewness	Kurtosis
Prerequisites	4.21 (0.31)	-0.06	.253
Care environment	3.89 (0.40)	0.40	.671
Care process	4.26 (0.37)	0.38	1.66

Statistically significant differences in scores were noted across bands on prerequisites and the care environment. Higher scores on the concepts were reported by higher band nurses. The length of time in post had a statistically significant impact on scores on the care environment concept. Nurses who had spent less time in post had lower scores on the care environment concept. The organisational site had a statistically significant impact on the prerequisites concept, with one site having statistically significantly lower scores than the remaining three sites. There were no differences in scoring across the remaining three sites.

Discussion

The person-centred practice framework (McCance and McCormack, 2010) provides a detailed understanding of the complexity of organisational systems. A better understanding of the contextual elements that comprise the acute hospital work environment and their interplay may help prevent the incidence of substandard care such as that highlighted in the Francis Report (Francis, 2013). This study benchmarks the factors in care environments that are essential to the establishment and maintenance of person-centred practice across acute hospital settings (McCormack et al., 2011; Laird et al., 2015). Examination of the mean scores indicates that the respondents believed that all 17 constructs were being provided in the acute setting; the measures of dispersion indicate a moderate spread of scores around the means and levels of skewness and kurtosis are broadly acceptable. Examination of the positive scores on the constructs show that nurses felt that they possessed the knowledge, skills and attitudes to provide negotiated care options, notably:

- Effective communication skills
- Ability to provide holistic evidence informed care
- Appreciation of the importance of reflective practices and self-awareness
- The knowledge that beliefs and values impact on practice

The scores indicate that the sample has a clear picture of the impact that patients' values and beliefs have on care as well as the value of shared decision-making and connectedness between patients and practitioners. The evidence shows for the first time how these skills work to enable the achievement of holistic care and its connection with sympathetic presence. If effective change towards person-centred practice is to be initiated and sustained, the measurement of key components of practice needs to be accomplished at all levels of an organisation (Smull et al., 2009) in order to ensure that the care environment factors that help or hinder person-centredness are given sufficient attention (McCance et al., 2013). The study reported here is the first to evaluate systematically those factors that impact on person-centredness in an acute hospital setting and the PCPI has proved to be a useful instrument in doing this.

Having such an instrument to indicate these correlations is helpful in the ongoing development of practice. The findings of this study indicate areas for potential improvement in further interventions designed to develop person-centred practice. They clearly demonstrate the impact that staff banding and length of time in post have on person-centred practice. While the relationship between length of time in practice and clinical expertise has been explored and evaluated in previous research (McCance et al., 2013; Laird et al., 2015), this study goes further and has been able to correlate these issues statistically. The design and application of practice development interventions that are focused on content and target groups would help produce more effective outcomes in terms of developing the nursing expertise needed for effective person-centred practice. McCance and colleagues (2013) argue

the need to identify effectively the components of culture and context in order to deliver practice development programmes as a richer understanding of the context of care promotes engagement of practitioners. The statistically significant differences in construct scores across the different groups in this study indicate the usefulness of the PCPI in identifying areas for future focused development and in evaluating the impact of interventions.

Furthermore, the development of a tool to measure care environment issues in person-centred practice and its strong theoretical basis, like the PCPI, provides an opportunity to directly quantitatively test the theoretical framework. Previously, few such instruments existed and proxy measures were used to indicate changes in the environment of practice in the acute sector (Edvardsson and Innes, 2010). Edvardsson and Innes (2010) criticised existing instruments designed to measure person-centred practice as failing to identify conceptual underpinnings and thereby limiting comparability across findings. The PCPI redresses this shortcoming by being explicitly linked to the person-centred practice framework of McCormack and McCance (2010) and providing a tool to examine the correlations between constructs of the framework as they are operationalised in different practice settings. The evidence presented in this study provides a benchmark for person-centred practice in acute hospitals, but it offers a greater potential to be used across different settings and from different perspectives, as well as promoting comparability of findings across studies. The accumulation of evidence will provide a deeper understanding of the mechanisms needed for effectiveness in person-centred practice.

Until the development of the PCPI, few tools enabled a whole-system evaluation of person-centred practice. The PCPI offers an opportunity to measure change across and within acute clinical settings, providing evidence at individual, team, organisational and systems levels. In this study the PCPI was used as a measure of practice at organisational and systems levels as well as across different groups. The instrument can be further used to measure person-centred practice on each of the constructs. Further analysis to an item response level will provide insight into potential areas for improvement.

Limitations

The positivity of the scores may indicate that further work is needed to help tease out whether the findings are reflective of aspirations rather than an actual position in relation to providing care. Further examination is required to validate the findings. Additional work is required to help identify other standardised instrument or qualitative measures and cross-validate these measures with the findings of the PCPI to provide validity and confidence in the questionnaire findings.

In this study the PCPI was applied in the acute setting. Further investigation across other healthcare settings is required to test its wider effectiveness.

Conclusion

The contextual factors that help establish and maintain person-centred practice are being provided in acute hospitals but these are affected by staff banding and length of time in post. The PCPI provides an accurate measure of the contextual indicators and is sensitive to measuring differences across (demographic) groups. The PCPI offers an opportunity quantitatively to benchmark person-centred practice, and identify areas for improvement and evaluate change.

References

- Alzheimer's Society (2009) *Counting the Cost: Caring for People with Dementia on Hospital Wards*. Retrieved from: tinyurl.com/AlzheimersSoc-countingthecost (Last accessed 5th February 2013).
- Dewi, W., Evans, D., Bradley, H. and Ullrich, S. (2014) Person-centred care in the Indonesian healthcare system. *International Journal of Nursing Practice*. Vol. 20. No. 6. pp 616-622.
- Edvardsson, D. and Innes, A. (2010) Measuring person-centred care: a critical comparative review of published tools. *Gerontologist*. Vol. 50. No. 6. pp 834- 846.
- Francis, R. (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. London: The Stationery Office.

- Gask, L. and Coventry, P. (2012) Person-centred mental health care: the challenge of implementation. *Epidemiology and Psychiatric Sciences*. Vol. 21. No. 2. pp 139-144.
- Health Service Ombudsman (2011) *Care and Compassion? Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People*. London: The Stationery Office.
- Laird, E., McCance, T., McCormack, B. and Gribben, B. (2015) Patients' experiences of in-hospital care when nursing staff were engaged in a practice development programme to promote person-centredness: a narrative analysis study. *International Journal of Nursing Studies*. Vol. 52. pp 1454-1462.
- McCance, T., Gribben, B., McCormack, B. and Laird, E. (2013) Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme. *International Practice Development Journal*. Vol. 3. No. 1. Article 2. Retrieved from: fons.org/library/journal/volume3-issue1/article2 (Last accessed 6th July 2015). pp 1-17.
- McCormack, B. and McCance, T. (2010) *Person-centred Nursing: Theory and Practice*. London: Wiley-Blackwell.
- McCormack, B., Dewing, J. and McCance, T. (2011) Developing person-centred care: addressing contextual challenges through practice development. *Online Journal of Issues in Nursing*. Vol. 16. No. 2. Manuscript 13. Retrieved from: tinyurl.com/PCC-contextualchallenges (Last accessed 6th July 2015).
- Neitzke, A. (2013) Bringing a critical structural frame to person-centered care. *American Journal of Bioethics*. Vol. 13. No. 8. pp 57-58.
- Smull, M., Bourne, M. and Sanderson, H. (2009) *Becoming a Person-centered System: A Brief Overview of What We are Learning in the USA and UK*. Retrieved from: tinyurl.com/SADA-personcentredlearning (Last accessed 6th July 2015).
- World Health Organization (2007) *Person-centred Healthcare: A Policy Framework*. Geneva: WHO.

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