Exploring the implementation of person-centred care in nursing practice

Lucille Kelsall-Knight and Rhian Stevens

Abstract

Person-centred care involves nurses working in partnership with patients to ensure their needs and preferences are at the centre of their healthcare, as well as considering the biographical and social factors that are relevant to the person’s health. This aims to support patients in developing the knowledge, confidence and skills to make informed decisions about treatment and to manage their own care where possible. This article discusses the concept of person-centred care and considers some of the facilitators and barriers that may affect its implementation in healthcare practice. It also explores some of the approaches that nurses can use to support person-centred care, such as cultural humility and role modelling.

Keywords

holistic care, nursing care, patient-centred care, patient experience, patients, person-centred care, practice development, professional, professional issues

Person-centred care has become an established concept in nursing, focusing care on the needs of the individual. However, several authors have suggested that although the concept is well known to nurses, it remains ill-defined and there are disparities in how it is operationalised (Byrne et al 2020, Giusti et al 2020, Moore et al 2021). McCormack (2020) asserted that the use of terms such as ‘person-centred’, without offering a definition, is prolific in research. This means that it can be challenging for nurses and other healthcare professionals to develop a clear understanding of person-centredness and the elements they need to focus on to implement it effectively in practice.

One issue is that various terms have been used to define the concept. ‘Patient-centred care’ emerged to promote holism and to counter the reductionistic nature of the traditional biomedical model and disease-oriented approach, 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 that relies on the development of effective therapeutic relationships between healthcare professionals, patients and others who are significant in their lives (McCance and McCormack 2017). It is underpinned by values such as respect for personhood, the individual right to self-determination and 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 (World Health Organization 2007).

There is a wide range 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 outlines some of the definitions, principles and benefits...
Emergence of person-centred care

One way to consider person-centred care is to focus on the reasons for its emergence and the possible driving factors behind this approach. Ekman et al (2011) identified the significant burden of long-term conditions, with patients navigating 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 individuals’ needs, preferences and values.

In addition, the increased focus on evidence-based healthcare has meant that standardised care models are often applied based on the response of cohorts to treatment, which some authors have suggested fails to capture the responses of individuals (Ekman et al 2011). Other authors have suggested that person-centred care and evidence-based healthcare can co-exist; for example, Sackett et al (1996) incorporated person-centred care into a definition of evidence-based medicine that includes a focus on patient preferences. Although there may be tensions when applying varying models (Engle et al 2021), person-centred care aims to provide nuance to the evidence-based care model through its focus on the individual (Ekman et al 2011).

Byrne et al (2020) suggested that patients can now easily access healthcare information and are no longer seen as passive recipients of care but as valuable and active members of the healthcare team – which is an important aspect of person-centred care. However, healthcare professionals need to be mindful that not all patients want to access healthcare information or be active members of the healthcare team (Thomas et al 2023). Lee et al (2021), therefore, regard person-centred care more as a philosophy that views people using health and social care services as equal and collaborative partners in planning, designing and achieving effective care to ensure their needs are met. The extent to which this is achievable and desired by individuals is part of the ongoing discussion about person-centred care.

In the UK, it is a requirement of The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (Nursing and Midwifery Council (NMC) (2018) that nurses put the needs of those receiving care first, while considering cultural sensitivities to better understand and respond to people’s personal and health needs. It should be noted that this idea of the nurse putting needs first demonstrates the requirement for careful use of language, as it may suggest a power imbalance with a passive patient or service user; ‘working with’ or ‘in partnership with’ may be more appropriate terms.

Applying person-centred care in practice

Person-centred care is a concept that may appear obvious and understandable yet is challenging to operationalise in healthcare research and practice, partly due to its complexity and the lack of a single agreed definition (Burgers et al 2021). Therefore, it is important to carefully examine individual studies as the conceptualisation of person-centred care used in research varies (Burgers et al 2021, Rennie et al 2021).

Taking a person-centred approach to care involves focusing on the elements of support and treatment that matter most to the patient, their family and/or carers (The Health Foundation 2016). It also considers biographical and social factors that are relevant to the person and their health, for example their age, gender, race and disabilities. If these factors are not considered, the person’s fundamental care needs might be neglected and inequalities in healthcare access may be exacerbated, for example in the older adult population or for people with learning disabilities (Tieu et al 2022). Furthermore, rather than following a traditional perspective of doing something ‘to’ or ‘for’ a patient, Santana et al (2018) suggested that person-centred care promotes doing something ‘with’ the patient or service user. This requires listening to and reflecting on what makes each person unique and putting their needs first (NMC 2018).

In addition, the application of person-centred care is dynamic – it is much more than the interaction between the healthcare professional and the patient or service user. Smith et al (2022) asserted 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. Some authors view the concept at three levels (Byrne et al 2020, Vennedy et al 2020):

- **Macro level** – this includes government policy, financing and regulatory interpretation of person-centred care.
- **Meso level** – this focuses on health and social care organisations.
- **Micro level** – this focuses on the patient-provider interaction at a local level.

Considering this wider application of person-centred care is important and can indicate how well the concept is embedded in an organisation’s culture, values and beliefs; some organisations may be well-intentioned but offer an inconsistent application of person-centred care.

Principles and benefits of person-centred care

The Health Foundation (2016) outlined four principles of person-centred care:

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

It should be noted that these principles were developed several years ago, and it is worth reflecting on whether terms such as
affording' and 'offering' still place the power more with the healthcare professional or service. McCormack and McCance (2006, 2021) developed a person-centred nursing framework which comprises four domains: prerequisites of the nurse; the care environment; person-centred processes; and expected outcomes. These domains determine the provision of effective care through the person-centred care processes of: 
» Working with the patient’s beliefs and values. 
» Engagement. 
» Shared decision-making. 
» Having sympathetic presence. 
» Providing holistic care. 
There is growing evidence of the effectiveness of person-centred care in areas such as improved general health, more appropriate use of health services and reduced hospital admissions (Bertakis and Azari 2011, Wynia et al 2018) and of benefits for people with specific conditions, such as dementia (Kim and Park 2017). McCormack (2020) noted a variety of benefits of person-centred care in several environments. For example, in nursing home settings person-centred care has led to improvements in the care environment, greater resident satisfaction, improved staff well-being, reduction in falls and reduced use of psychotropic medicines (McCormack et al 2010, Buckley et al 2014, Mekki et al 2017, McCormack 2020). However, there remains a lack of theoretical frameworks based on empirical evidence that could be used to implement person-centred care in areas such as serious illness (Giusti et al 2020).

Person-centred care can enable healthcare professionals and patients to work jointly to develop treatment plans, which may improve health outcomes and increase patient satisfaction with care (Ekman et al 2011, Phelan et al 2020). For this to occur, nurses need to listen and respond to patients’ concerns and preferences. In practice this involves developing a therapeutic relationship with patients, which enables the provision of information in a way that is conducive to the individual’s communication style and level of understanding and which respects their views on treatment and care (Moore et al 2021).

Key points
- The lack of a clear definition of person-centred care makes it challenging to implement effectively in practice.
- Person-centred care may be best understood as the collection of principles under which it operates.
- Identifying the facilitators and barriers to person-centred care is an essential early step in its implementation.
- Cultural humility and role modelling may support effective implementation of person-centred care.

Facilitators and barriers to person-centred care
Identifying the facilitators and barriers to person-centred care is an essential early step in the implementation of this approach within healthcare services (Hower et al 2019). Several studies have explored these facilitators and barriers, often based on the patient or person perspective (Moore et al 2017, Lloyd et al 2018, Vennedey et al 2020). These studies have recognised that one notable facilitator is effective leadership, which encompasses support from senior leaders acting as champions for change, a core team to drive change, role modelling, training in person-centred communication and multidisciplinary teams that view patients as equal partners. Vennedey et al (2020) explored the views of 25 people with chronic conditions on the facilitators and barriers to person-centred care. Participants felt that person-centred care was compromised when the organisational climate felt like a ‘conveyor belt’. They expected healthcare professionals to possess a comprehensive knowledge base and take a holistic view that considered their family history, their current personal situation and the social environment.

In addition, Vennedey et al (2020) found that healthcare professionals required various personal characteristics and skills to facilitate person-centred care, including ‘being present’ by focusing on the person without being distracted or pressured. This links to the idea of ‘having sympathetic presence’ as detailed in McCormack and McCance’s (2006, 2021) person-centred nursing framework. Other facilitators identified in Vennedey et al’s (2020) study were a pleasant and friendly atmosphere and healthcare professionals having time to answer questions and explain treatment options. Flexibility was also mentioned as important when developing treatment plans, since patients seek individualised care based on their personal needs and circumstances. Of note was participants’ need to be active, interested and willing to facilitate person-centred care. However, the researchers emphasised that patients require guidance and access to easily understandable information and therapies to do this (Vennedey et al 2020).

Barriers to delivering person-centred care can be due to a simple lack of understanding of patient needs (Moore et al 2017, Lloyd et al 2018). The Health Foundation (2016) suggested that a potential barrier is that person-centred care may take additional time in the short term, for example adopting shared decision-making may take longer than a standard consultation. However, they also emphasised that a resulting medicine prescription that does not meet the person’s needs, for example, may result in increasing care time due to non-adherence and worsening symptoms. Ekman et al (2011) undertook a series of studies exploring person-centred care in practice from the perspective of the person, the healthcare professional and the organisation. They observed that person-centred care is generally regarded by healthcare professionals as an important facet of care, yet one of the main challenges was not persuading staff to practise person-centred care but convincing them that they were not practising it at times, at least not consistently. Ekman et al (2011) noted that providing person-centred care can
be time-consuming and that when time was pressured, healthcare staff tended to stop applying it and returned temporarily to a disease-oriented approach. Ekman et al’s (2011) solution focused on three specific routines to ensure systematic and consistent practice in person-centred care:

» Initiate a partnership early on by inviting the patient or person to talk about their disease, the symptoms and its effects. This sends an early message that the person’s feelings, beliefs and preferences are valued and important.

» Focus on shared decision-making, through giving information and making decisions about care and treatment, building on the initial invitation.

» Document person-centred care to ensure it is a recognised and valued part of care in the organisation. This documentation can include the person’s preferences, beliefs and values. Measuring person-centred care in practice is challenging, with no single solution; however, using patient-reported measures in evaluation is essential because the person is best positioned to determine whether care aligns with their values, preferences and needs (The Health Foundation 2016).

**Cultural humility**

In healthcare practice, personal beliefs, attitudes and biases may be additional challenges to the effective implementation of person-centred care. A personal commitment to practising cultural humility and delivering person-centred care concurrently can assist in addressing these challenges (Kelsall-Knight 2022). Cultural humility has been described as a process of being aware of how people’s culture can influence their health behaviours, then using this awareness to cultivate sensitive approaches to their treatment (Miller 2009).

The concept of cultural humility has been contrasted with that of cultural competence, which has been viewed more as learning a set of attitudes and communication skills for effective working within a person’s cultural context. Lekas et al (2020) asserted that the concept of cultural competence may be limiting, since 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 a specific group. This appears to be opposed to the flexibility and individualised approach taken in person-centred care.

In contrast, cultural humility does not have a specific end point. There are no set skills to learn; instead there is a need to be culturally sensitive as a continual process. This includes being aware that one’s personal biases may lead to incorrect assumptions about a person’s culture due to a lack of knowledge (Lekas et al 2020). To practise cultural humility, self-reflection on one’s interactions with other people is essential (Prasad et al 2016). This may be challenging initially due to unfamiliarity, so authors such as Prasad et al (2016) suggested that approaches such as self-questioning, immersion in the individual patient’s point of view, active listening and flexibility can assist in addressing cultural biases or assumptions.

Furthermore, activities such as reading about different cultures can support personal or group reflection, while writing personal reflections on one’s attitudes and thoughts regarding the care provided to patients can be explored with a skilled lecturer or during clinical supervision. Such activities may reveal factors that affect care such as unintentional bias – that is, a bias that a person is unaware of. An example of unintentional bias would be language or general conversation that assumes patients are heterosexual (Grundy-Bowers and Read 2019). Although clinical supervision is recommended as a strategy to enhance person-centred care, Edgar et al (2023) suggested that it remains under-researched at present.

**Addressing biases and discrimination**

It is important that nurses are aware that UK law requires them to make reasonable adjustments on the basis of protected characteristics, with a need to consider personal and institutional biases in the context of person-centred care, and how these may manifest in diverse populations. The Equality Act 2010, which applies in England, Scotland and Wales, identifies nine protected characteristics – age, gender reassignment, sex, race, religion or belief, pregnancy and maternity, marriage and civil partnership, sexual orientation and disability. These protected characteristics identify people at increased risk of oppression and discrimination, and a person may have none, one or more than one of them.

Protected characteristics, as well as other aspects of a person’s identity, may affect multiple areas of their lives – for example, their home life, work and social circle – and can result in unique opportunities, experiences and challenges. Having an increased knowledge and understanding of these aspects, and acknowledging their effects on a person, can assist nurses in delivering person-centred care that is tailored to an individual’s needs (Ruiz et al 2021). This can also enable nurses to ensure appropriate reasonable adjustments are made as part of providing person-centred care, for example by altering the communication style used with a person with a learning disability or ensuring that a food menu meets a person’s dietary needs based on their religious beliefs.

Regardless of whether a person has protected characteristics, it is important that nurses recognise, assess and respond to their individual needs without making assumptions, such as their preferred pronouns, sexuality or religious affiliation, about them (Kelsall-Knight 2022). Such biases may also occur at an organisational level; for example, assumptions may be made about gender and/or sexuality in hospital documentation, such as identifying a family as only consisting of two parents of different genders (Kelsall-Knight 2021, 2022).

If biases are present at an organisational level it may be more challenging for individuals to address them, since they are considered ‘the cultural norm’
(Adams et al 2020). However, witnessing nurses challenging discriminatory practice and behaviours can foster belonging, inclusion and empowerment of individuals, which is in keeping with person-centred care.

Role modelling

Role models are essential to effective implementation of person-centred care and to address the challenges that patients may experience because of, but not limited to, their protected characteristics. Any nurse or other healthcare professional can be a role model; it is not determined by seniority. A role model and advocate for person-centred care should actively listen to staff, patients and their families and/ or carers, show empathy and recognise people’s diversity. Where appropriate, role models should also work towards overcoming any challenges that the patient may experience, for example in relation to their religious beliefs, family dynamics or altered communication style (Sprik and Gentle 2019, Moore et al 2021).

A role implemented in the nursing workforce in England is the professional nurse advocate (PNA) (NHS England 2023). PNAs can act as role models by demonstrating leadership through emotional intelligence and by supporting a culture of autonomy, belonging and contribution to inspire continuous improvement and empower staff in all positions to innovate and provide optimal patient care. The PNA training programme aims to provide nurses with the skills, competencies and confidence to lead improvement programmes, fostering a culture of learning and development in their clinical settings. The PNA role could be used to support person-centred care as it aims to enable nurses to continuously improve the quality of care they provide to patients and their families and/or carers (NHS England 2023).

Conclusion

Ensuring patients receive person-centred care should be a priority for all nurses when developing, implementing and delivering healthcare. This involves developing a therapeutic relationship with patients, listening and responding to their concerns and preferences, working in partnership with them to develop treatment plans and providing them with appropriate information. It is also important to recognise and understand people’s individual differences and to incorporate these into care approaches. The promotion of cultural humility and role modelling by reflecting on one’s own biases and advocating for open and honest healthcare environments can foster belonging and inclusion in healthcare.

References

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