# The Person-centred Nursing and Person-centred Practice Frameworks: from conceptual development to programmatic impact

**by Brendan McCormack (FRCN 2014)**

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The development of the Person-centred Nursing and Person-centred Practice Frameworks has spanned over 20 years of research, practice development and evaluation activities. The original framework published in 2006, was developed for use in the intervention stage of a large quasi-experimental project that focused on measuring the effectiveness of the implementation of person-centred nursing in a tertiary hospital setting (McCormack and McCance 2006).

## Development of a framework for person-centred nursing

### Abstract

**Aim** This article presents the development and content of a person-centred nursing framework.

**Background** Person-centred is a widely used concept in nursing and healthcare generally, and a range of literature articulates key components of person-centred nursing. This evidence base highlights the links between this approach and previous work on therapeutic caring.

**Methods** The framework was developed through an iterative process and involved a series of systematic steps to combine two existing conceptual frameworks derived from empirical studies. The process included the mapping of original conceptual frameworks against the person-centred nursing and caring literature, critical dialogue to develop a combined framework, and focus groups with practitioners and co‐researchers in a larger person-centred nursing development and research project to test its face validity.

**Findings** The person-centred nursing framework comprises four constructs – prerequisites, which focus on the attributes of the nurse; the care environment, which focuses on the context in which care is delivered; person-centred processes, which focus on delivering care through a range of activities; and expected outcomes, which are the results of effective person-centred nursing. The relationship between the constructs suggests that, to deliver person-centred outcomes, account must be taken of the prerequisites and the care environment that are necessary for providing effective care through the care processes.

**Conclusion** The framework described here has been tested in a development and research project in an acute hospital setting. While there is an increasing empirical base for person-centred nursing, as yet little research has been undertaken to determine its outcomes for patients and nurses. The framework developed can be described as a mid‐range theory. Further testing of the framework through empirical research is required to establish its utility for nursing practice and research.

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## Introduction and background

The 2006 version of the Person-centred Nursing Framework (PCNF) was derived by combining the conceptual framework that I had developed (McCormack 2001, 2003) focusing on person-centred practice with older people and Tanya McCance's (2003) framework that focused on patients' and nurses' experience of caring in nursing. Our first joint publication (McCormack and McCance 2006) – the article that underpins this article – set out the processes involved in developing the framework. More significantly, the specific shared philosophical underpinnings that enabled two conceptual frameworks to be combined into one theoretical framework were described. This shared philosophical starting point enabled us to set out the key aspects of what it means to be a 'person' that were consistent with a philosophy of human science and embraced key human science principles of freedom, holism, relationality, time and knowledge (McCance and McCormack 2017). A diagram of the original PCNF can be found in our original publication, and as shown, comprised four domains:

1. Prerequisites focus on the attributes of the nurse.
2. The care environment focuses on the context in which care is delivered.
3. Person-centred processes focus on delivering care through a range of activities.
4. Expected outcome is the result of effective person-centred nursing.

Each domain had several constructs that enable users of the framework to engage in a systematic consideration of the key elements of person-centred nursing and its complexity. The pictorial representation of the framework was deliberately chosen to reflect that complexity. We wanted to show that achieving person-centred outcomes is not something that happens through a particular intervention or indeed a meaningful moment of care, compassion or kindness. Instead, person-centred nursing outcomes are achieved through systematically attending to each of the domains (prerequisites, care environment and care processes), working towards the achievement of person-centred outcomes for a person, people or populations. From the outset, we described the PCNF as a mid-range theory, which is a theory generated through research and used as an evidence base to develop practice or interventions for practice. We made explicit its place on the continuum of theory development in our follow-on publication (McCormack and McCance 2010), where we drew on the seminal work of Fawcett (1995).

The exposure of the PCNF to nursing communities internationally following its publication in 2006, resulted in much critical debate about the domains and constructs, and its general applicability in practice. This was helpful and to be expected as the work was published at a time when models and theories of nursing were far from fashionable, 'armchair' theorising was scorned on (McKenna 2005), and nursing-specific knowledge was sacrificed at the altar of evidence-based practice. However, this period also represented a time in nursing and healthcare where a focus on modernising and improving practice through a variety of implementation science and quality improvement methodologies were being promoted and given a lot of attention.

We chose to integrate the PCNF with the international work we were engaged with – practice development – making explicit that the ultimate outcome from practice development was the creation of effective person-centred cultures (McCormack et al 2013). This integrated approach resulted in the international adoption of the framework and a desire for it to reflect multidisciplinary and interprofessional practice more explicitly. This challenge has been continuously responded to.

## Influence and impact

Since the publication of the original PCNF, we have continued to revise and develop it (McCormack and McCance 2010, McCance and McCormack 2017) resulting in the development of a multidisciplinary version: the Person-centred Practice Framework (PCPF) (McCormack and McCance 2017, 2019a). Despite these revisions, the fundamental building blocks (the domains), and the key elements (the constructs), have remained stable over time. They have been refined to reflect increased engagement with the framework and its implementation in a variety of contexts. However, with the emergence of the PCPF as the most adopted framework among multidisciplinary and interprofessional teams, the most recent iteration of the PCNF reflects its firm location in the meta-paradigm of nursing (Fawcett 1995) and its recognition as a model of nursing (McCormack and McCance 2016). While today, the majority of our work and those of collaborators adopt the PCPF, we have always remained committed to contributing to the ongoing development of nursing-specific knowledge, and so we chose to

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develop a revised PCNF in 2019 (McCormack and McCance 2019b).

The PCPF has now been translated into 10 languages (Dutch, German, Danish, Norwegian, Portuguese, Spanish, Mandarin, Slovenian, Swedish and French) and tested in multiple healthcare contexts in more than 22 countries, with the framework and associated tools/instruments appealing to a wide range of stakeholders. Research and development undertaken with international partners in the United Kingdom, Sweden, Norway, Finland, the Netherlands, Spain, Portugal, the Republic of Ireland, Australia, South Africa, the United States and Canada, has resulted in the development of five evaluation instruments and through various implementation studies with these and other international partners, we have identified key outcomes from the implementation of person-centred practice (Slater et al 2009, 2017, Wilson et al 2020).

In nursing home settings, implementation studies have resulted in improvements to the care environment, greater resident satisfaction, improved staff well-being, reduction in falls and reduced use of psychotropic medications (McCormack et al 2010, Buckley et al 2014, Mekki et al 2017). In acute care settings, evidence of better engagement between staff and patients as well as improved retention of staff, greater job satisfaction and staff wellbeing have been identified (McCance et al 2008, Parlour et al 2014, Hahtela et al 2015, Laird et al 2015). In palliative care, the evaluation of practice development programmes has shown improvements in regulator quality indicators, as well as improvements to the quality of the care environment, better and more effective staff communication, increased staff development, and better retention of staff (Yalden et al 2013, McCormack et al 2018, Haraldsdottir et al 2020).

An international programme of work leading to the development and testing of eight person-centred nursing key performance indicators (KPIs) also offers a mechanism to measure aspects of person-centred practice (McCance et al 2012). The eight KPIs align to the processes in the PCNF. Tanya McCance has led the development of a set of measurement tools to accompany the KPIs (McCance and Wilson 2015). The eight KPIs and measurement tools have been tested through a series of international implementation studies in a range of clinical settings (McCance and Wilson 2015, McCance et al 2015, 2016). Findings from these studies confirmed that using the eight KPIs generated evidence of patient experience that facilitated engagement of nurses to develop person-centred practice, contributing to an enhanced care experience.

## Current and future relevance

This unrelenting attention to theory development in person-centred nursing and healthcare could be considered 'overkill' in paying attention to issues that, for some people, are routine everyday current practice. It is precisely that tension that challenges all of us in the development of person-centred nursing and healthcare practices, in learning about person-centredness and in embodying it in everyday work. 'We do it but we don't call it that' is a retort that is familiar to all of us and it challenges us to use language describing person-centred practice to demonstrate its uniqueness, worthwhileness and transferability across contexts.

The 'we do it but we don't call it' mantra among practitioners, academics and researchers leads to a view that person-centredness is a nebulous concept, devoid of clear definition and something that can be substituted with other concepts such as compassionate care and dignified care. While there are (a few) clear definitions of person-centredness and person-centred nursing/healthcare, the use of the term 'person-centred' and its derivations without offering any definition is prolific in published research and does little to help practitioners develop a clear understanding of person-centredness and the elements on which they need to focus.

There is also a tendency to focus exclusively on the service-user at the centre of care and decision-making. While nobody could object to such an important focus, it is only part of the story. We have always contended that it is immoral for an organisation to expect high-quality, evidence-informed, person-centred care to be provided to service-users without an equal focus on the personhood of staff and their well-being (McCormack and McCance 2010, 2017). We have challenged the dominance of focusing on person-centred care provided to, with and for service-users/families at the expense of staff well-being. This values-informed position has been reinforced through the systematic development, implementation and evaluation of the PCNF and PCPF, and is now a more accepted focus in many quality improvement activities. It remains the case, though, that the person-centredness of

care providers is placed at a lower level of importance and significance to that of service users – and this has been abundantly evident during the COVID-19 pandemic.

For person-centredness to become more normalised in nursing and healthcare discourse, there is a need for thought-leaders, strategic planners, managers and decision-makers to stop using the 'it's too difficult to define' and 'we do it anyway' arguments to defend organisational cultures that are non-conducive to the achievement of person-centred care for service-users; but instead, strive to make sense of what person-centredness could look like for all people in an organisation. For too many managers, an obsession with 'quick-fix' solutions means that the time needed to achieve such clarity is sacrificed at the altar of expediency.

Person-centred practice needs to be understood as a concept that is embedded in every strategy and policy that shapes healthcare planning and delivery. It needs to be based on conceptual and theoretical frameworks that are inclusive of all people and that clearly articulate how these concepts are to be embedded in everyday practices at macro, mezzo and micro levels.

If healthcare organisations are committed to developing person-centred cultures for all people, we need decision-makers to think about how they create opportunities for all people to have spaces 'to be' with others, and explore opportunities for increasing connections that further develop person-centred practices. Developing complex systems is not the answer, but neither are simple quick fixes to complex problems.

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