Development of a framework for person-centred nursing

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

Background and rationale. Person-centred is a widely used concept in nursing and health care 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. Whilst 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.

Keywords: caring, clinical, nursing theory, person-centred nursing, practice development

Introduction

In this paper we present a report of the development of a person-centred nursing framework as part of a large-scale project evaluating the effectiveness of the development of person-centred nursing in a hospital setting. The development of a framework for person-centred nursing brought together previous empirical research by McCance *et al.* (2001), McCormack (2001, 2003) and McCance (2003), the synthesis of which was used to generate the person-centred nursing framework. We present here an overview of the evidence from the literature that underpins person-centred nursing, the methods used to generate the framework, underpinning constructs and examples of their use in practice. However, it is important to note that in this paper we do not present findings from the empirical study in which it was located.

Background and context

The concept of 'person-centredness' has become established in approaches to the delivery of health care (Nestel & Betson 1999, Mead & Bower 2000, Carr & Higginson 2001) and particularly within nursing (Binnie & Titchen 1999, McConkey 2000, Wystanski 2000, McCormack 2001, 2003). In the United Kingdom (UK), person-centredness is embedded in many policy initiatives (e.g. The National Service Framework for Older People, Department of Health 2001). In a comprehensive review of the literature, McCormack (2004) identified 110 papers related to aspects of person-centred practice, the majority of which originated from the UK. Whilst it appears that developments in person-centred nursing theory and practice are predominantly taking place in a UK context, there appear to be commonalities with other international nursing perspectives, such as the 'Quality Health Outcomes Model' (Mitchell *et al.* 1998, Radwin & Fawcett 2002), the 'Synergy Model' (Curley 1998) and a model of 'family-centred care' (Wilson *et al.* 2005).

Recent research into person-centredness has attempted to clarify the meaning of the term (e.g. McCormack 2004), explore its implications in practice (Dewing 2004) and determine the cultural and contextual challenges to implementing a person-centred approach (Binnie & Titchen 1999). Evidence from Binnie and Titchen's research suggested that adopting this approach to nursing provides more holistic care. In addition, it may increase patient satisfaction with the level of care, reduce anxiety levels among nurses in the long term, and promote teamworking among staff. However, Binnie and Titchen (1999) did not test these assertions and were therefore unable to provide evidence of the suggested relationships.

Existing evidence is consistent in showing that being person-centred requires the formation of therapeutic relationships between professionals, patients and their significant others, and that these relationships are built on mutual trust, understanding and sharing collective knowledge (McCormack 2001, 2004, Nolan *et al.* 2004, Binnie & Titchen 1999, Dewing 2004). This evidence is also consistent with previous nursing literature on therapeutic caring, where the concept of 'person' is central; for example, Leininger's (1988) theory of culture care, Watson's (1985) theory of human caring, Boykin and Schoenhofer's (1993) theory of nursing as caring, and Roach's (1987) conceptualization of caring relationships. McCance *et al.* (1999) further demonstrated the relationship between person-centredness and caring by illustrating the centrality of concepts that are common to both, such as relationships, values, caring processes and the environment of care (context). This synergistic relationship between caring and person-centredness was reinforced by Dewing (2004), who concluded that the use of humanistic caring frameworks in nursing practice enables person-centredness to be realized.

Few researchers, however, have attempted to evaluate the relationship between a person-centred approach to nursing and the resulting outcomes for patients and nurses. Whilst a number of conceptual frameworks for person-centred practice exist (e.g. Binnie & Titchen 1999, McCormack 2001, 2003, 2004), none of these has been used to evaluate the caring outcomes that may arise from person-centred nursing.

Conceptual and theoretical underpinnings

The person-centred nursing framework 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. The framework was derived from previous conceptual frameworks developed by McCance *et al.* (2001), McCormack (2001, 2003) and McCance (2003). McCance developed a conceptual framework to describe caring in nursing (as perceived by nurses and patients), whereas McCormack's conceptual framework focused on person-centred practice with older people derived from a study of autonomy.

McCance's conceptual framework for caring in nursing focused on three major constructs adapted from Donabedian's (1980) structure, process and outcome model, not unlike the approach used by Mitchell *et al.* (1998) to develop the 'Quality Health Outcomes Model'. Structures were categorized as nurse attributes (professional competence, interpersonal skills, commitment to the job and personal characteristics); organizational issues (time, skill mix and

the nurse's role); and patient attributes. The processes of care covered a wide range of nursing activities that constituted caring as perceived by patients and included providing for patients' physical needs; providing for patients' psychological needs (providing information, providing reassurance, showing concern, communicating); being attentive, getting to know the patient, taking time, being firm, showing respect and the extra touch. The outcomes emanated from the process of caring and included a feeling of well-being (affective and physical), patient satisfaction and the effect on the environment.

McCormack (2001) conducted a hermeneutic study combining methods of conversation analysis to explore the meaning of autonomy for older people in acute care settings. Through the analysis of 14 case studies of nurse–patient relationships, a conceptual framework for person-centred practice was developed based on an understanding of autonomy as 'authentic consciousness' (McCormack 2003). The emerging conceptual-framework for person-centred practice has three constructs. The first construct identified five nursing roles, referred to in the framework as 'imperfect duties' (negotiation, informed flexibility; mutuality; transparency and sympathetic presence). The second construct articulated differing levels of engagement between patients and nurses to sustain a therapeutic caring relationship (engagement, partial disengagement, complete disengagement). The third construct described the factors that affect the quality of the engagement between nurses and patients, including the context of the care environment, the nurse's values history, the patient's values history and the nurse's knowledge and experience.

These two conceptual frameworks were selected for the following reasons:

- They were each derived from a humanistic perspective of caring.
- Initial review of the frameworks indicated a high degree of consistency across individual concepts and thus a high degree of face validity.
- They were both derived from inductive and systematic collaborative research processes.
- Collectively, they represented a synthesis of the then available literature on caring and person-centredness.

The principles underpinning these two conceptual frameworks are consistent with human science principles such as those articulated by Watson (1985), including the centrality of human freedom, choice and responsibility; holism (non-reducible persons interconnected with others and nature); different forms of knowing (empirics, aesthetics, ethics and intuition); the importance of time and space, and relationships. Reflecting on humanistic caring and the relationships between the concept of caring and person-centred nursing, it is not surprising that there are common elements that can be derived from an analysis of McCance's (2003) and McCormack's (2003) conceptual frameworks. Work was undertaken to develop a combined framework, with the ultimate aim of providing a mid-range theory for person-centred nursing. Fawcett (1995) distinguishes between conceptual models and mid-range theories, in that mid-range theories articulate one or more relatively concrete and specific concepts that are derived from a conceptual model. Furthermore, the propositions that describe these concepts propose specific relationships between them. The work presented in this paper meets the criteria of a mid-range theory as described by Fawcett, in that the framework is derived from two abstract conceptual frameworks and the specific relationships between the constructs are outlined, which was not the case in the individual conceptual frameworks. The framework, with its foundations in nursing practice, provides a unique perspective for nursing that conceptually links caring and person-centredness.

Developing the person-centred nursing framework

The process of developing the person-centred nursing framework involved a series of systematic steps which are presented in Figure 1. Identifying the similarities and matched elements of each conceptual framework was an important first step and confirmed the strong relationship between caring and person-centred practice. For example, McCormack (2003) identified contextual factors that reflected many comparable elements captured by McCance (2003) under 'structures'. Similarly, the 'imperfect duties' described by

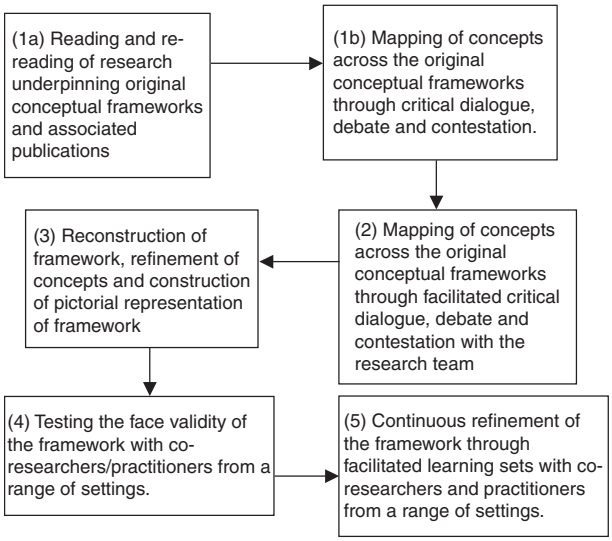

Figure 1 Processes used to develop the person-centred nursing framework.

McCormack (2003) incorporated elements of the process of caring described by McCance (2003). The second step involved the exploration of areas of difference, using a critical dialogue with co-researchers ($n = 6$) and with lead practitioners from a range of clinical settings ($n = 16$) as a means of reaching agreement about where these elements might fit within the new framework. The concepts underpinning both conceptual frameworks were then discussed in focused discussions, using critical questioning techniques to unravel each concept. The original sources of the literature and data were consulted to ensure shared clarity of meaning of key terms in each framework. These conversations were tape-recorded and listened to after each discussion to identify key elements of each framework that needed to be retained or amended in the combined framework. Key concepts from both conceptual frameworks were listed and a first draft of the person-centred nursing framework was constructed.

A period of testing the framework was then undertaken. Two focus groups were held – one with co-researchers ($n = 6$) and one with lead practitioners from a range of clinical settings ($n = 16$). The draft framework was presented and their views on clarity, coherence and comprehensibility sought. Prior to the focus groups, the individual frameworks (McCance 2003 and McCormack 2003) were provided as background for the discussion. Significantly, the ease with which these practitioners engaged with the framework and were able to contextualize elements within their clinical environments was the most important indicator of the relevance of the framework for practice. Further, co-researchers were able to identify ways in which the framework could be used in their research to focus decision-making. For example, the framework was used by facilitation teams to analyse the rationales underpinning barriers to change (arising, for example, from differences in beliefs and values), focus on particular developments (for example, the sharing of 'power' with patients), or evaluate progress in intervention studies (for example, changes made to the care environment). The framework has been refined with co-researchers and project participants throughout the intervention period of the larger quasi-experimental project referred to earlier. The following sections describe the key constructs comprising the framework and examples of its use.

The person-centred nursing framework

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;
- *expected outcomes*, which are the results of effective person-centred nursing.

The relationship between the constructs of the framework is indicated in Figure 2. Thus, to reach the centre of the framework, the prerequisites must first be considered, and the necessary care environment for providing effective care through the care processes. This ordering, ultimately leads to the achievement of the outcomes – the central component of the framework. It is also acknowledged that there are relationships between the constructs.

Prerequisites

The prerequisites focus on the attributes of the nurse and include being professionally competent, having developed interpersonal skills, being committed to the job, being able to demonstrate clarity of beliefs and values, and knowing self. Professional competence focuses on the knowledge and skills of the nurse to make decisions and prioritize care, and includes competence in physical or technical aspects of care. Having developed interpersonal skills reflects the ability to communicate at a variety of levels. Commitment to the job is indicative of dedication and a sense that the nurse wants to provide care that is best for the patient. Clarity of beliefs and values highlights the importance of the nurse knowing their own views and being aware of how these can have an impact on decisions made by the patient (Warfield & Manley 1990). This is closely linked to knowing self and the assumption that before we can help others we need to have insight into how we function as a person. The competence of nurses, particularly in relation to interpersonal and communication skills, has been described in a recent qualitative study by McCabe (2004), who concluded that nurses can communicate well with patients when they use a person-centred approach, but that the ability to do so is heavily influenced by the work and culture of the organization, i.e. the care environment.

The care environment

The care environment construct focuses on the context in which care is delivered and includes an appropriate skill mix; systems that facilitate shared decision-making; effective staff relationships; supportive organizational systems, the sharing of power, and the potential for innovation and risk-taking. These characteristics of context are consistent with the conceptual development of the concept undertaken by McCormack *et al.* (2002) and Rycroft-Malone *et al.*

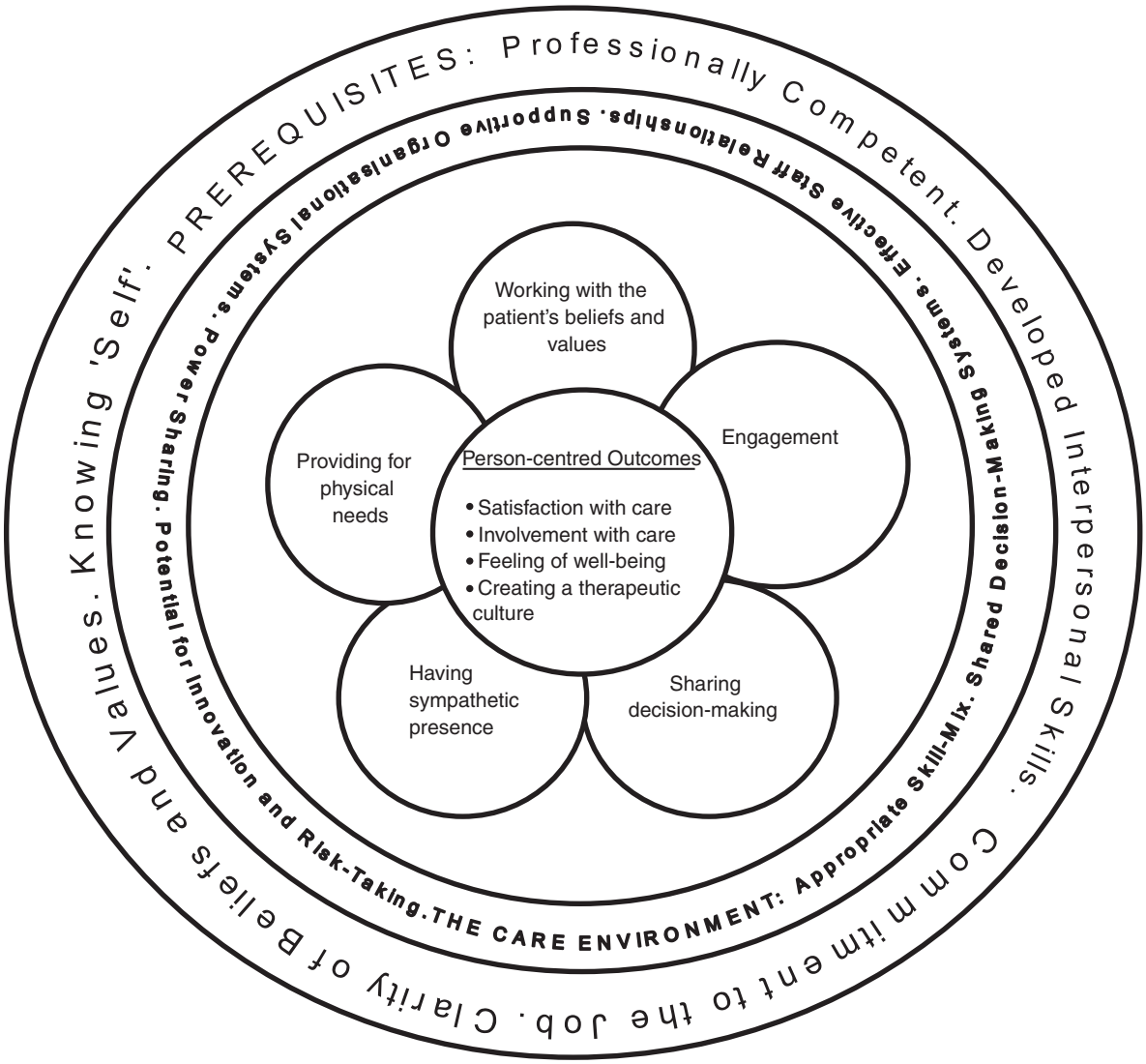

Figure 2 The person-centred nursing framework.

(2002). Key characteristics of context arising from these studies include the culture of the workplace, the quality of nursing leadership and the commitment of the organization to the use of multiple sources of evidence to evaluate the quality of care delivery. It is acknowledged, however, that the care environment has a major impact on the operationalization of person-centred nursing, and has the greatest potential to limit or enhance the facilitation of person-centred processes (McCormack 2004).

Person-centred processes

Person-centred processes focus on delivering care through a range of activities that operationalize person-centred nursing and include working with patient's beliefs and values, engagement, having sympathetic presence, sharing decision-making and providing for physical needs. This is the component of the framework that specifically focuses on the patient, describing person-centred nursing in the context of care delivery.

Working with patients' beliefs and values reinforces one of the fundamental principles of person-centred nursing, which places importance on developing a clear picture of what the patient values about their life and how they make sense of what is happening. This is closely linked to shared decision-making, i.e. nurses facilitating patient participation through giving information and integrating newly formed perspectives into established practices. This must involve a process of negotiation that takes account of individual values to form a legitimate basis for decision-making, the success of which rests on good processes of communication. McCormack (2004, p. 35) illustrates the links between these processes,

stating that 'knowing what is important forms a foundation for decision-making that adopts a 'negotiated' approach between practitioner and patient'. Furthermore, Hedberg and Larsson (2004) evidence the link between environmental elements (the care environment) and decision-making processes, concluding that interruptions and work procedures are two of the environmental elements that nurses face in their daily work and that contribute to the complexity of decision-making.

Engagement reflects the quality of the nurse–patient relationship, and three levels are described in the framework (McCormack 2003): full engagement is present when the patient and nurse are connected in the relationship, partial disengagement can arise when a problem affects the way the nurse or patient are able to work together, and complete disengagement occurs while the nurse and patient take stock of the situation and formulate the problem. A skilled nurse can adopt these different stances at different times. Having sympathetic presence highlights an engagement that recognizes the uniqueness and value of the individual by appropriately responding to cues. Interestingly, McQueen (2004) highlights the concept of emotional intelligence, described by Goleman (1998) as self-awareness, self-regulation, motivation, empathy and social skills (elements of which are reflected in the prerequisites), and its potential impact on levels of emotional engagement with patients. Finally, the provision of physical care by a nurse who is professionally competent and the value placed on this by patients (McCance 2003) should not be underestimated as an important care process. Indeed, it is argued that physical care provision by Registered Nurses is essential, as it is a 'way in' to operationalizing person-centred processes and achieving person-centred outcomes (James 1992, Hallsdorsdottir & Hamrin 1997, McCance *et al.* 1997, McCance 2003).

Outcomes

Outcomes are the results expected from effective person-centred nursing and include satisfaction with care, involvement in care, feeling of well-being, and creating a therapeutic environment described as one in which decision-making is shared, staff relationships are collaborative, leadership is transformational and innovative practices are supported. Patient satisfaction reflects the evaluation a patient places on their care experience and is well-documented in the literature as an indicator of quality care (Edwards & Staniszewska 2000, Edwards *et al.* 2004). Furthermore, its relationship with other elements of the person-centred nursing framework has also been shown. For example, Wanzer *et al.* (2004) /link> explored the relationship between patient-centred communication and satisfaction and concluded that communicative behaviours, such as listening and immediacy, are strongly related to satisfaction with the healthcare experience. The other outcome indicators identified within the framework are less evident in the literature, although a *feeling of well-being* engendered by a positive care experience was clearly highlighted by McCance (2003) and is indicative of the patient feeling valued. The importance of identifying outcomes that are measurable was an essential aspect of the research study in which this framework was being tested, and tools have been identified from the literature and some further developed to facilitate outcome measurement.

The framework in practice

Currently, the framework is being used by practitioners and co-researchers to guide decision-making about aspects of team processes that need to be changed (e.g. the need to adjust shift patterns to enhance opportunities for *engagement* between nurses and patients), to challenge beliefs and values about practice to create a shared vision for person-centred practice (e.g. the meaning of *shared decision-making* in a busy general medical ward), to facilitate team developments with multidisciplinary clinical teams to enhance the *effectiveness of staff relationships*, and to identify practice developments to affect patient *outcomes* (e.g. communication of diagnostic test results to patients). Box 1 illustrates how the

Box 1. An example to illustrate how the framework has been used in development projects focusing on person-centredness

The nursing team in a rehabilitation unit for older people (one of the participating sites) used the framework in their learning set to explore the differences between 'chatting' with patients and 'showing sympathetic presence'. They discussed the meaning of sympathetic presence (defined in the framework as recognizing the uniqueness and value of the individual, by appropriately responding to cues through providing reassurance and showing concern) and how they understood the definition in the person-centred nursing framework within the context of their own practice. The contextualized de-construction of this concept enabled the team to explore developments in practice that would enable them to engage in sympathetic presence. These included reorganizing staffing rotas to maximize opportunities for relationship-building with patients; erosion of some routines in practice to ensure that 'tasks' provided opportunities for engagement with patients rather than 'a task to be completed in a given time'; and critical discussion of research data to identify the range of 'cues' from patients that would enable nurses to understand their social circumstances more clearly. Each time the group met to review the developments, they analysed their progress using the person-centred nursing framework and supported by the data from the wider project. Each review led to further developments in practice.

What is already known about this topic

- The term person-centred practice is widely used and its underlying principles have been articulated.
- There is little evidence demonstrating the relationship between person-centred practice in nursing and the resulting outcomes for patients and nurses.
- There is a synergistic relationship between person-centred processes and therapeutic caring in nursing.

What this paper adds

- A new framework that articulates person-centred nursing.
- Development of a mid-range theory for nursing practice and research.
- Identification of key constructs and their relationships.

framework has been used and its potential in development projects focusing on person-centredness.

Implications for person-centred nursing

Given the challenges of developing person-centred nursing and the attitudinal and organizational barriers that hinder such changes, there is a need to consider ways in which this framework could be used in future practice developments. It is clear from the constructs within the framework that implementation and the practice changes required are beyond the scope of individual nurses. While individual nurses clearly have a responsibility for the quality of their practice and the way in which that practice develops, much organizational change is needed to realize the full potential of the proposed framework. Elsewhere it has been suggested that, for practice to develop in the way proposed, changes in service delivery are required at individual, organizational and strategic levels (Garbett & McCormack 2002). The person-centred nursing framework provides a basis for benchmarking existing practices and determining changes needed for practice to be based on principles of person-centredness. Our experience of using the framework suggests that an approach to lifelong learning is needed that enables practitioners to articulate their values, develop practice knowledge and take risks. These are the core principles that guided the intervention in our wider project. The facilitation of learning in practice through contracted learning was an example of one approach used. The learning needed by nurses to continuously develop their own person-centredness becomes explicit through reflection on the constructs and their relevance to practice. The use of the framework requires a systematic approach to practice development, integrated with research, education and policy developments, as previously argued by McCormack *et al.* (2004).

The framework highlights the complexity of person-centred nursing. Through the articulation of the key constructs underpinning the framework, the contextual, attitudinal and moral dimensions of humanistic caring practices are exposed. These are not presented as disengaged concepts, driven by a desire to recreate the boundaries of nursing practice. Instead, the discourse of practice and the dialogue created between nurses and patients illustrate the potentials of person-centred nursing. The framework makes explicit the need for nurses to move beyond a focus on technical competence, and requires nurses to engage in authentic humanistic caring practices that embrace all forms of knowing and acting to promote choice and partnership in care decision-making. The choices available to patients often appear to be hindered by numerous contextual and attitudinal factors. Gaining an understanding of an individual's values base is essential to person-centred nursing and, while we acknowledge that the demands of everyday nursing practice can often work against this approach, we also recognize that there is potential for much attitudinal and behavioural change that could enable this philosophy to be achieved.

Conclusion

Despite the humanistic ideal underpinning person-centredness, it needs to be recognized that there are few robust studies in nursing that articulate the benefits (or otherwise) of person-centred nursing from individual (patient and nurse) and organizational perspectives. The framework proposed in this paper espouses particular values and practices. However, no studies have been published that demonstrate through systematic inquiry whether the use of a mid-range theory such as this really does lead to person-centred practice. The theory described here has been tested in a development and research project in an acute hospital setting. Whilst there is an increasing empirical base for person-centred nursing, as yet there little research has been undertaken to determine its outcomes for patients and nurses. The development of a mid-range theory through the critical analysis of existing conceptual frameworks enables its testing in practice with practitioners to determine the outcomes arising from such developments.

Author contributions

BMcC and TMcC were responsible for the study conception and design and drafting of the manuscript. BMcC and TMcC

performed the data collection and data analysis. BMcC and TMcC provided administrative support. BMcC and TMcC made critical revisions to the paper.

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