



Delivering Person-Centred Care in Nursing

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Chapter 1

Person-centred care

Concepts, origins and challenges

NMC Future Nurse Standards of Proficiency for Registered Nurses

This chapter will address the following platforms and proficiencies:

Platform 1: Being an accountable professional

At the point of registration, the registered nurse will be able to:

- 1.8 demonstrate the knowledge, skills and ability to think critically when applying evidence and drawing on experience to make evidence-informed decisions in all situations.
- 1.9 understand the need to base all decisions regarding care and interventions on people's needs and preferences, recognising and addressing any personal and external factors that may unduly influence your decisions.
- 1.10 demonstrate resilience and emotional intelligence and be capable of explaining the rationale that influences your judgements and decisions in routine, complex and challenging situations.

Chapter aims

After reading this chapter, you will be able to:

- outline the origins of person-centred care within nursing and how it might be influenced by other recommendations for care;
- summarise why an understanding of partnership, role and patient expectations of care might all shape the form that person-centred care takes;
- reflect upon how key elements of person-centred care might be influenced by opportunities and challenges in your own chosen field of nursing practice.

Introduction

I want to start this chapter with the clinical context in which person-centred care operates. It is the context of care and competing care recommendations there that are at the heart of understanding both what person-centred care is and why it can be exciting but challenging to practise. You may already have appreciated that applying theory is not easy, so we start with commonly encountered difficulties and needs.

There are three recommended approaches to nursing care delivery and each of these is influential in the clinical environment. First (and central to this book), nurses have to relate successfully, sensitively and effectively with the patient and their family. As it is the person who experiences the injury, disability or illness and who determines what they will do in response to that, we must understand the person (Schellinger et al., 2018). If we are to persuade the patient to respond to health challenges in a beneficial way that also makes sense to them, then we had better work closely with their understanding, feelings, beliefs, values and aspirations. We have to be person-centred. We cannot simply instruct the patient to do what we believe is right. We must persuade them of what might be helpful and indeed arrive at that through exploration of what they feel that they need (King et al., 2019). We negotiate care, assess requirements together and plan strategies that will address needs and counter problems (Maloney et al., 2018). We action the care plan together; some things will be contributed by the nurse and some by the patient or family. Later we jointly evaluate how the care has proceeded. This is the essence of person-centred care.

Two other nursing care approaches compete for your attention. The first of these is evidence-based practice. This approach to nursing care recommends that we direct our work based upon evidence drawn from research and other rigorously arranged means of gathering and collating information (e.g. patient surveys, care audits) (Jolley, 2020). It is argued that the nurse works as a scientist, researching what is important in healthcare – that experienced by patients with the same diagnosis, for example. We focus upon how treatments work and which of them have the widest and longest-lasting beneficial effect. In evidence-based practice it is argued that some knowledge is superior to other knowledge, and that we should trust it more because of the way it was gathered and analysed. This puts a rather different slant on the approach to care because the nurse is often cast as the expert who recommends particular courses of action because of what research has revealed. In evidence-based care the emphasis shifts from patient choice and towards knowledge and its expert application.

The third recommended approach to nursing care comes from a variety of sources, from organisations such as the National Institute for Health and Care Excellence (NICE) (www.nice.org.uk), and from employers and care forums where expert practice has been reviewed and research evidence may have been distilled. Such organisations create a range of standards, protocols and policies that direct how healthcare teams should work

and what provision should be made for patients. Protocols are driven by research, but they are informed too by that which is judged value for money (healthcare resources are finite). In the midst of a pandemic, for example, there is a rapid identification and sharing of best-treatment protocols – that which rescues extremely ill patients. Rather loosely, we might call this approach standardised care, with packages of provision that reassure the public what the healthcare organisation will provide and against which provision can be judged. Whilst care packages might take different and sometimes innovative forms, Sekhon et al. (2017) have highlighted the challenges of weaving client acceptability into the design of healthcare provision. You may have met elements of standardised care upon joining a clinical placement, through care protocols, policies and perhaps standard care packages associated with particular treatments. If in person-centred care the emphasis is upon the person and care negotiated, then in standardised care the emphasis is upon transparent and consistent service to a population of patients. Standardised care sets parameters on what care is counted as desirable, safe and within service constraints.

Activity 1.1 Reflection

Review now any recent experience of clinical placements and decide whether Table 1.1 helps explain some of the learning challenges that you encountered there. Were there instances where different nursing care recommendations seemed to clash with each other, where guidance on what you *should do* clashed with what it seemed possible to do?

An outline answer is given at the end of this chapter.

Table 1.1 Approaches to nursing care delivery

Recommended care approach	Short description	Practical implications
Person-centred care	Care that is arranged through a careful analysis of patient experiences and needs, working closely with their coping and preferred objectives. Care is conceived strongly in terms of partnership and the adoption of mutually beneficial roles that advance the jointly agreed plan of care.	In an ideal world person-centred care is tailor-made, entirely focused upon the unique needs of the individual, but cognisant of what research and other sources of evidence has to offer. Care is negotiated, jointly reviewed and updated, implying the availability of significant nursing skills and resources in time and material (McCormack and McCance, 2017).

(Continued)

Table 1.1 (Continued)

Recommended care approach	Short description	Practical implications
Evidence-based care	Care draws critically and consistently upon the growing body of research evidence relating to illness, treatment, therapy and care, and upon research insights into patient coping and motivation. There is a significant emphasis upon nursing as a science – that which examines and utilises the best information available.	Evidence frequently focuses upon that which applies to the many, and that which is more predictive or insightful as regards what happens or is required in healthcare. Powerful evidence is often that which is believed to predict what might happen next, in terms of risk, improvement or deterioration, and that which works consistently (Heaslip and Bruce, 2019). We might then prescribe treatment or care measures on the basis of evidence rather than individual patient capacity or readiness to engage.
Standardised care	Standardised care focuses upon promising the wider population quality-assured treatment and care measures that the healthcare organisation has committed to and which helps to ensure that finite resources are equitably shared, based on an understanding of the challenges posed by different diagnoses. It is typically expressed in treatment protocols – that which healthcare teams commit to and may later be measured by.	This approach offers the nurse reassurance about what is sanctioned by the healthcare organisation. However, standardised care can seem inflexible and bureaucratic. Whilst it helps to cement a multidisciplinary approach to healthcare (all understand what the others are delivering), it admits only limited adjustment to care planning. The care package feels like exactly that: a package, transparent but relatively rigid.

Some of the problems with learning to nurse are associated with translating the different approaches to nursing care into action. Few would pretend that the nurse can afford to entirely tailor-make care with an individual patient (other patients compete for the nurse’s attention). There are system, ethical, financial and skill constraints associated with that (Price, 2020). Nurses are, though, unlikely to espouse rigid care that takes little account of the individual patient. Whilst nurses wish to practise

in an evidence-based way, that which is proven to be valuable and safe, evidence can be incomplete or contradictory and it can be complex to translate into daily care (Renolen et al., 2018). In effect, then, the three approaches to nursing care set checks and balances upon one another. Person-centred care reminds us that patients are people rather than subjects of a bureaucratic system. Evidence-based care reminds us that the nurse should not embark upon flights of fancy when planning care with patients. Standardised care reminds us that we contribute to a healthcare team and through that a service. What we negotiate with the patient often involves conferring with others and referring patients to other resources. The care has to be both realistic and joined up.

Key features of person-centred care

We turn now to what person-centred care is. You might infer from the above that I think it is something used judiciously, in a way that works with the other approaches to care outlined above. Byrne et al. (2020) observe that person-centred care is extremely hard to define, and this is because it has been used to serve different purposes. So, for example, person-centred care can be used to help define nursing and to distinguish it from other professions such as medicine. Person-centred care is polemical, a political discourse on how nursing should be (see, for example, McCormack and McCance, 2017). But person-centred care can also be extremely pragmatic. It can begin from another place where it is observed that patients make very personal decisions about what counts as an illness or problem and decide what they will then do about that (e.g. Brokerhof et al., 2020). No matter what diseases or injuries are diagnosed, patients can and do manage both health and illness in very individual ways. If we don't attend to that, working with their perceptions, definition of events and goals, then we are less likely to care for them successfully. Table 1.2 summarises some of the origins of person-centred nursing care today and notes how such origins have shaped descriptions of the approach.

Table 1.2 Origins of person-centred nursing care

Origin	Notes
Nursing and its professional credentials	For over a century, nurses have fought to detail what characterises their professional practice and to distinguish it in particular from medicine (Meleis, 2018). If nursing was more than an adjunct to medicine, then it became necessary to understand what constituted care. Two key tenets were that care was methodical (arranged in a nursing process) and that it centred firmly upon understanding the person who suffered a healthcare problem or disability. Nurses did not simply counter diseases and injuries.

(Continued)

Table 1.2 (Continued)

Origin	Notes
Nursing models of care	In the second half of the 20th century a series of different models were created that conceptualised care (McKenna et al., 2014). These often focused heavily upon the care relationship. Orem, for example, described nursing care as something that supplemented self-care – what the patient could do for themselves (Orem et al., 2003). In such models there was a strong emphasis on partnering patients, something that person-centred care also emphasises.
Holism	Holism is the philosophy that we best understand human beings from a full appreciation of their different dimensions. People are physical, psychological, social and spiritual (Donnelly, 2012). It was therefore not adequate to simply manage a problem in one dimension; treating a wound, for example. The clinician had to understand how the wound made the patient feel; how it might impact on their daily living. Holism as a philosophy is not unique to nursing, but it has mandated enquiry into the patient’s experiences and need. We need to understand how an illness, injury or disability fits into the individual’s world.
Discourses on patient compliance, self-care and successful longer-term management.	There has been growing social and psychology evidence relating to how patients make use of healthcare guidance and treatment (e.g. consumerism) (Latimer et al., 2017; Marx and Padmanabhan, 2021). In some instances patients have failed to heed the advice offered and may even have continued with lifestyles likely to damage their health. Attention has therefore focused increasingly upon how patients interpret risks, needs and goals and how they evaluate and utilise healthcare services. An appreciation of health beliefs and values has challenged clinicians to work more closely with the patient’s own perceptions.

In this book person-centred care is defined as a judicious approach used by the nurse to help patients and their relatives make the most meaningful use of the healthcare services available to them. It centres upon the patient as a person, someone who interprets their own healthcare circumstances and who tries to fit illness, injury or disability (health changes) into what it means to lead a meaningful life. Person-centred care describes the way in which the nurse offers a partnership to the patient, respecting what the patient believes confronts them and then helping them to make plans that counter the problems identified. Person-centred care alerts the patient to relevant evidence about what might be helpful and it honestly acquaints the individual with what is available through healthcare services. Person-centred care describes a professional and supportive relationship that enacts and reviews jointly agreed care measures and which evaluates progress thereafter.

People, practice and power

Byrne et al. (2020), in their literature review, describe person-centred care as premising things about people, practice and power. People are understood as regards their uniqueness – the very individual way in which they live and manage their health or

illness. There is an emphasis upon partnering the patient in the business of understanding and managing changed health circumstances. Put bluntly, nurses don't tell the patient what to do.

Practice involves the adoption of roles – those that are mutually beneficial and which demonstrate the nurse's empathetic interest in the patient. The partners in care decide who does what and how those contributions relate to one another. Practice also involves what Byrne et al. (2020) call space. The patient has the right to choose what to do. They can give or withhold consent to treatment, but more than that, they commit effort and energy to varying degrees to work that has been judged as important to treatment, recovery or rehabilitation. With such space comes responsibility. The patient is jointly responsible for care outcomes, at least where they have committed to make contributions of their own.

Power is expressed with regard to patients choosing care options with the nurse (they share planning), but it also refers to the need for nurses to sometimes advocate patient needs within a healthcare system that might not always recognise personal needs or care opportunities.

Concerning the person

Let's look more closely at the person and what this care approach presumes there.

Activity 1.2 Critical thinking

Consider now the following statements, which are implicit in getting to know a patient as a person, and which help build a working rapport with them. Speculate why you think each is important and what limits there might be to the same. As you think about this, base your thoughts on your own field of nursing. What make these essential or problematic in mental health, child health, learning disability needs or adult nursing, for example? Then read on to review my reasoning.

1. Patients start as strangers, so we have to anticipate possible concerns, interests and needs before they arrive. We have (as it were) to cue ourselves in to likely worries and needs – that which upon subsequent meeting assures them that we are concerned for their wellbeing.
2. Patients vary in the extent to which they permit nurse enquiry, evaluating what seems necessary to enable them to secure desired assistance. Some patients are more private than others.
3. People attend as much to their symptoms as any signs of illness or injury. If we are to establish a rapport, then we must pay attention to both. If we are to successfully know the person, then we must start with their experiences.

As this answer is based on your own reflection, there is no outline answer at the end of this chapter.

It may have surprised you that I think person-centred care starts before you even meet the patient. It begins with identifying the more common concerns, difficulties and challenges that patients experience when they come into your care. So, for example, in mental healthcare the nurse had better begin with an already working appreciation of what it feels like to experience hallucinations and delusions before they start to personalise care for a patient suffering from psychosis (Price, 2016; Ratcliffe, 2017). In child health nursing the nurse has to anticipate how children might conceive of pain before a problem can be confirmed (Pate et al., 2019). The cataloguing of commonly occurring worries and needs, met by patients, in your own field of nursing cues you into how questions might be directed during history taking. The emphasis on what *might* worry the individual patient increases the likelihood that they find your enquiries knowledgeable, empathetic and reassuring. This has significant implications for nurses working in clinical specialisms. They need to remain up to date, reading about relevant worries and needs as well as developments associated with treatments. For you as a student, this has implications when going on clinical placement. It is important for you to conduct some preparatory reading about recurrent patient concerns and needs in that area of practice.

To anticipate possible patient concerns and anxieties is not to assume that all patients experience the same things. Human beings vary markedly in their past experience of illness and their confidence in dealing with change (Heffer and Willoughby, 2017). We are not requiring patients to fit a formula of care requirements. We do, however, need to manage the number of questions that we pose when taking a patient history. We are not interrogating the patient. By starting with questions that are more likely to be of concern to the patient, however, we might encourage report of their experiences. It is important to ask open questions – those that are not easily answered with yes or no. So, for example, ‘Can you describe how this has felt these last few days?’ not only invites a recounting of experiences but might also signal what constitutes ‘the problem’ for the patient.

Much of person-centred care is predicated upon a patient’s willingness to open up to the nurse’s enquiries, to reveal what the problem means to them (Riding et al., 2017). Your own clinical experience to date may already have revealed that some patients are more private than others. Some assume that doctors and nurses confine themselves to discrete areas, such as altered body function, or the presence or otherwise of pain. Patients come from different cultures and have different expectations of how the nurse should behave (Galanti, 2015). In some cultures, for example, it is the head of the household who responds to the nurse’s questions. If you are studying child health nursing, you may have already observed that children can be very circumspect about revealing their concerns to you. The readiness and ability of patients to reveal more about themselves varies markedly and liaison with the parent becomes vital. In child health nursing, person-centred care is expressed as family-centred care for that reason (Dennis et al., 2017). A patient with a learning difficulty may struggle to represent their experiences and feelings. These are important points because what the patient sometimes conceives of as coping might be part of the problem. Abuse of

alcohol or drugs, for instance, might be a coping mechanism, but unless the nurse can help the patient profile the problem, then care is more difficult to negotiate (Linden-Carmichael et al., 2019).

In person-centred care the nurse has to develop skills in enabling the patient to reveal more about their perceptions of the problem – what represents coping and progress to them and what might sustain them in recovery or rehabilitation. The nurse will not necessarily become a psychotherapist, but they must strive to be a confidant. This is especially important when patients deal with chronic illnesses and must learn to manage their own treatment (Russell et al., 2019). However, clinical settings then profoundly affect the extent to which the nurse can advance an understanding of the patient. In the casualty department, for example, there is usually scant time to explore coping (Noble et al., 2019). Instead, the nurse is focused more upon risk and its management. In chronic illness care, in many mental health settings and in palliative care the opportunities to know and understand the patient are clearly greater. If you start with a rather idealised notion of person-centred care, one in which the patient quickly reveals everything of concern, you may be disappointed. In reality, some patients may only reveal a very limited amount about their selves and negotiate a more superficial partnership with you (Launer, 2018). Nonetheless, where you respect that preference, they may still evaluate the care as excellent.

I would encourage you to focus just as much on the patient's symptoms as on any signs or tests that might attend the opening of the care relationship. Signs and tests are dispassionate and they seem like the realm of the medical rather than the personal problem. Symptoms seem rather more the realm of the person and for a very good reason. The ways in which patients describe their symptoms are very individual and they enable the nurse to access the narrative that the patient runs concerning what is needed (Launer, 2018). When human beings face an illness or confront an injury, they develop a storyline (a narrative) to explain the matter to themselves and indeed any trusted listener. The person-centred care nurse wishes to understand that narrative. For example, a patient typically describes how the problem felt (perhaps as a type of pain), the context of it happening (when it came on and how long it lasted), what they thought was wrong ('goodness, I thought it was cancer') and what they then did about it. A great deal can be learned from patients as you listen to their symptoms and encourage them to extend that into an account of experiences. So, person-centred care accesses the person through signs and symptoms and, beyond that, through narratives.

Patient narrative is defined in this book as the way in which the individual accounts for their experience of illness, injury or health difficulty, and that which may shape their attitudes and values regarding what it means to cope and to accept or reject assistance. The patient narrative is not necessarily rational; it might be based on folk beliefs and it could form a defence against change. The narrative of an individual who persists with cigarette smoking despite respiratory problems, for example, is every bit as important to understand as one that demonstrates insight into risk. Patient narratives can have

a profound effect on how patients interpret healthcare. We can only understand the patient narrative through sensitive questioning and the building of a trusting and supportive care relationship. Through such questions patients sometimes uncover a previously unrecognised and unspoken narrative, one relating to deeply felt attitudes and values. So learning about a narrative can sometimes be challenging for the patient and nurse alike.

Activity 1.3 Critical thinking

Jot down what you think the implications of a patient narrative might be for nursing care. Have you used a narrative to make sense of a health change that you have experienced? Have you listened to others' narratives outside of the hospital, for example a child describing their worries about going to school?

An outline answer is given at the end of this chapter.

Concerning practice

At one level, person-centred care sounds as though the nurse is simply nice. It would be easy to suggest that the concept is an overly complex way of saying be polite towards patients. Person-centred care, though, involves rather more than that. It involves not only considerate communication, but partnership and collaborative work as well (Backman et al., 2019). When you first thought about becoming a nurse you might have anticipated all the things that you would do for the patient. That would seem especially fulfilling when patients are incapacitated and when they necessarily rely on what others provide. For example, a patient in Covid-19 respiratory distress requires comprehensive care. This is nursing as traditionally conceived as service, a vocation to care for the incapacitated. Person-centred care, however, presumes that in a majority of cases, when the patient is conscious and able to provide at least some self-care, collaboration and shared planning will be the order of the day.

It is worth pausing to consider the significance of this. What does partnering in care entail? What will it mean to engage the patient in joint planning of care measures, those that draw heavily upon the patient's experiences and perceived needs? The first thing it entails is the building of a professional working rapport (Senteio and Yoon, 2020). Patients need to feel that they can trust you and that requires you to demonstrate an obvious concern for their continued wellbeing. Understanding the patient and how they feel is not limited to first assessment. You will need to signal an enthusiastic interest in how they experience your care too. The next thing that it involves is the development of collaborative roles that the nurse and the patient fulfil. Table 1.3 indicates some of the roles that may be used in a person-centred care relationship.

Table 1.3 Possible person-centred care roles

Role	Notes
Problem analyst	In some instances patients come to care without a clear diagnosis and then the nature of a healthcare problem has to be analysed. Both patient and nurse may bring expertise to the problem analysis, the patient, for instance, reviewing how they typically think of problems, approach risks and motivate themselves. Problem analysis has a large part to play in mental health nursing and it can be important too in children's care as nurse, child and parent analyse the difficulties faced.
Advisor-counsellor	Nurses frequently function as advisors to patients; indeed, this role is critical when patients determine what course of action they will follow. It is important, though, to note that the advisory role extends towards counselling only to the extent of the nurse's advance skills education. Person-centred care does not assume that all nurses are psychotherapists, with the skill, confidence and education to equip them to guide patients through difficult personal insights. Quite frequently person-centred care nurses utilise their experience of what past patients have found useful to better advise a new patient. Nurses are uniquely well placed to explain the different ways in which patients have previously tackled challenges.
Listener	Person-centred care nurses listen to strategic purpose. Everything that the patient feels able to share signals something about their current state, confidence and progress. At the heart of person-centred care is the argument that perceptions are as powerful as facts. The nurse works with the patient's perceptions the better to address problems and advance towards agreed goals.
Teacher or coach	Nurses explain a great deal (e.g. about treatment, grief reactions, stages of rehabilitation) and this quickly becomes teaching or coaching. Of course, where there are teachers or coaches, there are learners, and learning is especially important where a patient tackles a chronic illness. Some advanced practice roles major in teaching and coaching patients using the specialist knowledge of the nurse. Sometimes, however, patients teach nurses, especially where the patient is accomplished in coping strategies (e.g. managing diabetes).
Critical reviewer	The nurse might be asked to review progress with the patient, to explore doubts about the direction of rehabilitation or the patient's confidence in self-care. The nurse will need to be both empathetic and honest as progress is reviewed.
Strategist	Both patients and nurses might act as strategists, anticipating the challenges ahead and what might work best. At the start of the care relationship it is often the nurse that is the strategist because of their greater knowledge of care facilities. Later, however, strategy leadership is likely to be shared and even to shift towards the patient as the problems are better understood.
Consultant	Here consultant is used in the sense of someone who introduces the individual to resources and opportunities; who helps the patient to realise possibilities. Expert nurses are aware of a wide range of resources that patients might tap into.

In the next chapter we will be exploring the relationship between person-centred care and the nursing process. Suffice to say here, however, that the practice relationship with the patient is a dynamic one. What might start with the nurse leading a great deal, and perhaps providing a majority of the care, gradually becomes a relationship where the patient expresses much more of their own coping and self-care skills, making decisions that fit their personal circumstances. That this is both morally and economically important is perhaps evident. In chronic illness, for example, there are insufficient resources for all care to be delivered by the nurse. In any case, patients build self-esteem and confidence from shouldering incrementally greater amounts of care responsibility.

Concerning power

Person-centred care is committed to empowering patients, enabling them to take charge of their personal healthcare circumstances and to represent their needs to service providers (McCormack and McCance, 2017). The basis for this is informed consent (the moral and legal right of most patients to determine what happens to their body) and then, too, an empathetic commitment to helping patients to live well. In many cases an illness or injury cannot be entirely corrected. The patient must manage residual problems whilst hopefully sustaining a good quality of life. Successful nursing care is then not about the patient necessarily becoming better, but about them feeling whole, dignified and purposeful again.

Activity 1.4 Critical thinking

Jot down now some of the circumstances that you already know about when it is unrealistic for patients to give entirely informed consent to suggested treatment and care measures. What do you think this means for the delivery of person-centred care?

An outline answer is given at the end of this chapter.

Whilst the goal of patient empowerment has featured quite strongly within person-centred care, rather less has been discussed as regards its practical implications (Ocloc and Matthews, 2015). It is assumed, for example, that the patient wishes to be empowered; to take charge of a share of the care decision making. In some situations a patient might observe that such empowerment involves offloading the responsibilities of care onto themselves or their family. Patients or lay carers may protest that they do not have the skills or the resources to shoulder a greater responsibility for care. In these circumstances person-centred care finds itself at the uncomfortable junction between patient advocacy (representing the patient's needs) and acknowledgement of service limitations. Healthcare resources are limited; the provision has to be shared amongst multiple

patients with pressing demands. In some instances the patient might be referred to other care agencies that can support them (e.g. charities, self-help support groups) and encouraged to explore different ways in which felt needs can be met. However, the uncomfortable fact remains that if the patient and family cannot achieve a greater degree of self-care, then some future deficits and problems may arise. Such frank analysis might surprise you in a book about person-centred care. However, the nurse has only so much to offer the patient. That such care is articulated well, adjusted as far as possible to meet individual care needs, is central to the ethos of person-centred care. It remains a fact, however, that you will be unable to address every felt need of the patient.

Central to the power component of person-centred care is the concept of dignity (Zirak et al., 2017). The nurse works both to protect the dignity of the person and to promote it through the discovery of what the patient can achieve. This is one of the reasons why nurses so often act as advisors, teachers and coaches when practising person-centred care. The nurse teaches the patient, illustrating what might be attempted. Nurses have a responsibility under the NMC code of conduct (NMC, 2018) to alert their superiors and, if necessary, the NMC itself to deficits in care provision that threaten the integrity and wellbeing of the patient. Where patients are left unattended in parlous condition, it is both the professional and the person-centred care responsibility of the nurse to alert their superiors to deficits in care and to record their concerns. This is important in person-centred care because the nurse cannot build an effective relationship with the patient unless trust is established. The patient must know that if they raise reasonable concerns with the nurse, this will be adequately represented to those in charge of resources and policy in that area.

The person-centred care environment

To practise in a person-centred way is synonymous with helping patients (Doherty and Thompson, 2014; Sharp et al., 2016). You may already have realised, however, that if the environment surrounding the nurse does not also espouse person-centred care, then difficulties will arise. Juggling the three different care approaches requires judgement and support from colleagues and superiors.

McCormack and McCance (2017) observe that for person-centred care to advance, four things must be firmly in place:

1. Nurses must be emotionally and skill-competent. They must have the necessary interpersonal skills, commitment, and clarity of beliefs and values associated with what seems most desirable in care activity. Table 1.3, for example, suggests a number of roles that make skill demands upon the nurse.
2. There must be a conducive care environment – one that accepts the necessity of shared decision making between clinicians and patients. There are significant implications here for the resourcing of the health service and role responsibilities when risk is assessed.

3. There must be person-centred care processes in place – the means by which agreed care can be planned and documented. The Gothenburg University Centre for Person-centred Care commissioned a series of studies exploring what was involved in delivering person-centred care (Brittan et al., 2016). While there were similarities as regards the ethos of care, local practical measures were needed to accommodate the different care environments.
4. Expected outcomes have to be better explained. There are multiple ways in which person-centred care might be evaluated, for example in terms of expressed patient satisfaction, success in rehabilitation programmes, statistical improvements in body functions and exercise tolerance. Without being clear about what is a claimed result of person-centred care, it is harder to persuade others to adopt it.

Significantly, modern healthcare organisations increasingly involve members of the public and often patients in their clinical governance systems. Public governors contribute to the running of healthcare organisations and the strategies they develop to improve services. It is recognised that if organisations are to reduce the risk of complaints, there is an advantage in engaging patients in shared decision making in the first instance. When we evaluate progress in a jointly negotiated plan of care, we assess what has been achieved by patient, nurse, and others in partnership. The success of this, however, depends upon a clear and well-articulated plan of action and that involves the nurse in revisiting the nursing process. It is to this that we turn in the next chapter.

Activity 1.5 Reflection

Think now of a recent clinical placement that you have completed or indeed a healthcare organisation that you have received service from either as a patient or a relative. What about that organisation seemed especially person-centred? What seemed more difficult to personalise in their provision?

An outline answer is given at the end of this chapter.

Chapter summary

This chapter started by exploring the complexity of clinical practice, where different recommendations compete for the guidance of your nursing care work. Person-centred care, evidence-based care and standardised care are not entirely mutually exclusive – each emphasises something of merit within healthcare – but different care approaches do help explain why clinical practice and learning can seem rather confusing. Each of the approaches raises checks and balances on the others, requiring the nurse to think carefully

about how they proceed. Having started from that commonly encountered experience, the chapter offered a definition of person-centred care and encouraged you to review what that entails with regard to the person, to practice and to power within nursing care. The origins of person-centred care help to shape how different writers discuss the concept, but what remains central to the approach is a professional regard for the individual patient's experiences, perceptions and needs, and their right to negotiate care with the nurse and others who provide healthcare services. That negotiation is mediated by a variety of factors: the roles that nurses and patients might play, the level of intrusion that seems tolerable to the patient, and the practical resources and limitations that might be associated with a given care environment.

Activities: Brief outline answers

Activity 1.1 Reflection (p9)

In my experience, standardised care can dominate reasoning within clinical practice, in part because managers are hard-pressed to allocate precious resources and in part because patients and families have become increasingly discerning 'consumers' of healthcare services. Arranging care so as to minimise the risk of complaint can come to dominate the healthcare agenda. Culturally we think of healthcare as a service, detailing what is done for us, rather than what we collaborate upon, making contributions of our own as patients. Public health (that which prevents or limits illness) has been conceived elsewhere well away from the hospital environment. This means that for person-centred care to thrive, not only must we persuade colleagues to invest in it, but we must also convince patients and families that there are material benefits in collaborating on care.

Beyond this, it can be taxing to weave evidence into shared care planning with a patient. One of the reasons for this is that evidence is sometimes fragmented or contradictory. There is much more evidence available as regards treatments than there is about the psychology of illness, coping and recovery. In consequence, the nurse has to imagine how evidence of a more medical kind might be introduced to the patient as personally advantageous. The evidence has not only to be robust but utilisable as well. For that reason, the nurse often uses evidence to suggest ways to narrow down options when debating future plans with the patient.

Activity 1.3 Critical thinking (p16)

I wonder if you noted that patient narratives can complicate what seems acceptable care and what then is counted as a successful care relationship. You see, if the patient narrative is powerful, framing how the patient negotiates care with the nurse, it can become a limiting factor on what is achievable. A patient open to sharing their narrative and perhaps modifying it may achieve more than a patient who is resistant to all change. One of the challenges of person-centred care is to help the patient tell their story. This forms the basis of our assessment of what patients then already know and what they believe coping to consist of. That can raise some difficulties, for example if we have to gently refute their understanding of an illness, or of a risk such as obesity or cigarette smoking.

Other places where you may have heard narratives in use often centre on where something has gone wrong. Narratives are, for instance, exercised around marital divorce, or when an individual fails to secure a promotion or is made redundant. But narratives can explain success as well – for instance, the 'self-made individual'. Success is not simply about luck! Our first reaction

towards narratives may be to see them as excuses, perhaps as distortions of reality, but in fact human beings routinely story their lives, making it possible to discern what counts as progress, good fortune or a critical period in their life.

Nurses routinely ask about signs, symptoms and problems, but the person-centred nurse asks about how the individual explains these issues to themselves and how that then shapes how they respond. It is from this unique beginning that the nurse can then negotiate care that seems tailor-made. The person-centred nurse helps the patient see the fit offered by care measures to their individual needs. The person-centred care nurse helps the patient understand how they can use, adapt or develop available resources.

Activity 1.4 Critical thinking (p18)

Your answers here may be closely associated with your own field of nursing. So, for example, if you work with clients who have difficulties learning, understanding complex healthcare information can be difficult. Information may have to be delivered in smaller chunks and understanding checked at each stage before you can ascertain that consent is informed and care can advance. It is clearly impossible for an unconscious patient to give informed consent to care, whilst in child health nursing the child's level of reasoning development might not be equal to the treatment decisions that have to be jointly made. In such circumstances a family member might have to assist in the negotiation of care. Beyond these examples you may have noted that person-centred care faces difficulties too when the patient's reasoning ability varies over time, for example associated with dementia.

Activity 1.5 Reflection (p20)

My example comes from hospice care and visits made to a dying relative there. Hospices have an excellent reputation for delivering very individual care. I stopped to consider what it was about the care approach that seemed especially good. I noted two things:

1. How much the nurses knew about how my relative fitted the illness to living, and her preferred daily activities. They knew what my relative liked to do and how the illness interrupted that.
2. The way the nurses interpreted therapy – in this case, the available analgesia regimen. My relative valued alertness over comfort; she defined herself through her ability to reason. Too much analgesia interrupted that, making her sleepy, so she preferred to tolerate some pain as a trade-off. The nurses then used non-pharmacological measures (physiotherapy and massage) to counter the residual pain.

Further reading

Buetow, S (2016) *Person-Centred Health Care: Balancing the Welfare of Clinicians and Patients*. London: Routledge.

Reading the more philosophical/polemical texts on person-centred care, you might wonder just what it takes for the clinician to meet all of the possible expectations of some patients. Consumerism and person-centred care could combine to fuel a relentless series of demands upon the resources, skills and knowledge of the practitioner. Buetow, though, searches for a balance between clinician and patient welfare that I think is refreshing. Person-centred care is about protecting humanity within care, and that extends to the endeavours of healthcare professionals as well as patients and their families.

Tees, S (ed.) (2016) *Person-Centred Approaches in Healthcare: A Handbook for Nurses and Midwives*. London: Open University Press.

One of the problems with most person-centred care textbooks is that they are relatively theoretical. There is a paucity of practice application. Not so this text, which compiles contributions from different chapter authors, illustrating using vignettes how care philosophy is expressed in a range of settings. Examples of care in action are necessarily selective (as in my own volume) – not everything can be illustrated – but there is a range of thoughtful discussion available.

Useful websites

What person-centred care means: RCNI 2017 (access through www.rcni.com and search ‘what person-centred care means’).

This feature, which extends to 91 pages of down-to-earth explanation, sets person-centred care in the context of the role of the healthcare assistant. The explanation is contextualised against healthcare settings as potentially dangerous, imposing and alien environments into which patients come. It emphasises the clinician’s role in protecting the rights of patients and advancing their role in deciding how health problems are investigated and tackled. At base, person-centred care exemplifies what patient informed consent entails and it begins with an understanding of why patients may feel or be vulnerable.