Chapter 1
Introduction

Person-centred care has a long association with nursing, and at a level of principle is well understood as that which is concerned with: treating people as individuals; respecting their rights as a person; building mutual trust and understanding, and developing therapeutic relationships. As nurses we have an expectation that people should receive a standard of care that reflects these principles. The inherent good of providing care within a philosophy of person-centredness is irrefutable, but it has been recognised that translating the core concepts into everyday practice is challenging (McCormack & McCance, 2006). The reasons for this come in many forms and are often indicative of the context in which care is being delivered, and the fact that we are living in times of constant change, particularly within health and social care.

The promotion of ‘person-centredness’ is consistent with international policy developments and is reflected in approaches to the delivery of healthcare. Within the United Kingdom, person-centredness is embedded in many policy initiatives such as The National Service Framework for Older People (DoH, 2001a) and the Dignity in Care Campaign (DoH, 2006). Furthermore, from a professional perspective, there is a desire to reaffirm the importance of the fundamentals of care, emphasised by the recent publication of a report by the Royal College of Nursing (RCN) (2008), which highlights the challenges for nurses and midwives in providing sensitive and dignified care. Similarly, within a Northern Ireland context there has been an increasing emphasis on improving the service user experience (DHSSPS, 2008), where the focus is explicitly on the promotion of person-centred standards across the health and social care sector. The drive, however, within the health service to demonstrate effectiveness and efficiency through performance management processes has never been greater. This has resulted in a range of quality and clinical indicators, which pay little attention to how patients, clients and their families experience care (DHSSPS, 2007a; Nolan, 2007). Whilst nurses have a significant contribution to make in determining the quality of care provided to patients/clients and their families, a review of the evidence reveals a greater emphasis
on areas of nursing and midwifery practice that can be quantified, for example, pressure ulcer incidence, rates of healthcare associated infection and incidence of falls generally referred to as metrics. In contrast, there are fewer indicators that are person-centred in their orientation, which can evidence the impact of nursing and midwifery care on the patient experience (National Nursing Research Unit, 2008). In this context, we would argue that the time is ripe for promoting new ways of working that can deliver effective person-centred practice, and using approaches that can demonstrate positive outcomes as a result.

Whilst the term ‘person-centred’ care is most often seen in the UK health and social care literature and policy documents, the foci that underpin person-centred care are synonymous with international movements that focus on humanising the health and social care experience. For example, in 1994 Wagner reported on action research that focused on integrated health and social care for older people in relation to preventative work and ensuring that residents in care homes had the same rights as citizens in society (Wagner, 1994). The ‘Skaevinge Project’ model as it became known influenced the future shape of residential care and the design of care homes internationally. Principles such as autonomy, citizenship, dignity and respect (that also underpin principles of person-centred care) are central to this model and ways of working. Healthcare policy around the world embraces these same principles and underpins many policy frameworks for health and social care. For example, in Australia the ‘Aged Care Standards and Accreditation Agency’ have principles of person-centred care as a central building block of facility accreditation. Whilst the New South Wales Nursing Department has a focus on developing practices and models of care to support person-centredness across all specialities. This is important to emphasise, as for many professionals, person-centred care is often seen as being synonymous with older-person care/services. Whilst the majority of literature has focused on older people, mainly because of the influences of early writers/researchers such as Tom Kitwood, person-centred care is not exclusive to older people. Developing models of care that enable person-centred principles to be realised across all services is a key issue in health and social care reform. Most notably is the influence of the ‘Institute for Healthcare Improvement (IHI)’ in the United States of America. The transformation of health and social care services is a focus of many western governments and many of the innovation frameworks and tools have emanated from the IHI. The focus of much of the work is on the development of person-centred care mainly through the transformation of healthcare systems, structures and the redesign of clinical services.

Also, there is a growing empirical evidence base that focuses on person-centredness as highlighted from a comprehensive literature review undertaken by McCormack (2004). This review identified a total of 110 papers that related to aspects of person-centred practice research. In summary, research into person-centredness has attempted to clarify the meaning of the term (e.g. McCormack, 2004), explore the implications of the term in practice (Dewing, 2004) and determine the
cultural and contextual challenges to implementing a person-centred approach (Binnie & Titchen, 1999; McCormack et al., 2008b). Whilst a number of conceptual frameworks for person-centred nursing exist (e.g. Binnie & Titchen, 1999; McCormack, 2001b, 2003, 2004; Nolan et al., 2004), there are few studies that enhance our understanding of how we can effectively operationalise person-centredness in practice, or evaluate the relationship between a person-centred approach to nursing and the resulting outcomes for patients and nurses. The Person-Centred Nursing Framework (McCormack & McCance, 2006) described in this book has been developed as a tool to facilitate nurses to explore person-centred care in their practice. We believe the Framework can provide a lens that enables the operationalisation of person-centred care and can be used to evaluate developments in practice and hence demonstrate outcomes.

The Person-Centred Nursing Framework

The Person-Centred Nursing (PCN) Framework was developed by McCormack and McCance (2006) and was derived from previous empirical research focusing on person-centred practice with older people (McCormack, 2001) and the experience of caring in nursing (McCance et al., 2001). In summary, the original framework comprised the following four constructs:

1. **Prerequisites**, which focus on the attributes of 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.
2. **Care environment**, which focuses on the context in which care is delivered and includes: appropriate skill mix; systems that facilitate shared decision-making; effective staff relationships; organisational systems that are supportive; the sharing of power; and the potential for innovation and risk taking.
3. **Person-centred processes**, which focus on delivering care through a range of activities and include: working with patient’s beliefs and values; engagement; having sympathetic presence; sharing decision-making; and providing for physical needs.
4. **Outcomes**, the central component of the Framework, are the results of effective PCN and include: satisfaction with care; involvement in care; feeling of well-being; and creating a therapeutic environment.

The relationship between the constructs suggest that in order to deliver positive outcomes for both patients and staff, account must first be taken of the prerequisites, which impact on the nurses’ ability to manage the care environment and the care environment, which in turn are necessary for providing effective care through person-centred processes.

This book aims to provide a more comprehensive explanation of the four constructs that comprise the Person-Centred Nursing Framework and the core elements within each construct. It is useful, however, at
the outset to highlight some issues that will enhance understanding for the reader.

- The following terminology used within the Framework requires clarification to ensure accurate interpretation:
  - **person** refers to all those involved in a caring interaction and therefore encompasses patients, clients, families/carers, nursing colleagues and other members of the multidisciplinary team
  - **patient** is the term used throughout for ease of reading, but denotes *patients, clients, families, carers*

- Since our original publication we have continued to test the Framework in practice with a view to further refinement. As a result of this activity we have made the following two changes:
  - added the physical environment as an additional element to the care environment construct in recognition of the impact of our physical surroundings on person-centred practice
  - amended ‘providing for physical needs’ to read ‘providing holistic care’, in recognition of the range of interventions undertaken by nurses that are not always physical in nature.

(The amended Framework is presented in Chapter 3.)

- The four constructs and elements within the Framework, whilst presented separately, are interconnected. One idea is often closely related to another and there will be many examples of this highlighted throughout the book. As a consequence we will often cross reference enabling the reader to make important connections.

**Structure of the Book**

This book is presented in seven sequential chapters, with each chapter building on previous chapters. Chapters 2 and 3 are philosophical, theoretical and conceptual in their content, and whilst potentially complex, are important in terms of understanding the origins of the Framework and its development. Chapters 4–7 focus on each of the four constructs and attempt to promote an understanding of elements within each construct in context of the existing evidence and through practice examples. The final chapter draws on real projects from practice that have used the Person-Centred Nursing Framework in a variety of different ways, but with the common aim of promoting person-centred cultures.

We have written this book with a broad target audience in mind, and have tried to ensure that it is accessible to nurses working at different levels. We believe the use of stories should help accomplish this goal. It is important to acknowledge that some stories presented are drawn from the published literature, whilst others are ‘factions’ (fiction that draws on personal experience). We have also tried to ensure the patient’s voice is heard throughout, hence the use of extracts, which again have been drawn from a variety of sources. Finally, in the spirit of critical reflection we have peppered throughout the book some ‘thoughts to ponder’, which are presented as reflective questions. We hope this activity will provide personal insights that lead to new and exciting discoveries about PCN.