
Article:
Ross, H., Tod, A.M. and Clarke, A. (2015) Understanding and achieving person-centred care: the nurse perspective. Journal of Clinical Nursing, 24 (9-10). pp. 1223-1233. ISSN 0962-1067

https://doi.org/10.1111/jocn.12662

UNDERSTANDING AND ACHIEVING PERSON-CENTRED CARE: THE NURSE PERSPECTIVE.

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ABSTRACT

Aim. This paper presents findings from the first stage of an exploratory study investigating nurses' understanding and facilitation of person-centred care within an acute medical ward.

Background. The term 'person-centred care' is used frequently in healthcare policy and practice. However, the ways in which the concept is translated into everyday nursing care continues to present a challenge. Person-centred care has been explored extensively within the care of older people, people with dementia and people with a learning disability. Little empirical research has been conducted in acute ward settings. This paper starts to address that gap.

Design. The study used an Action Research approach.

Methods. Individual semi-structured interviews were conducted with a purposeful sample of 14 nurses. Framework Analysis was used to analyse the data

Results. Nurses had a clear understanding of person-centred care in the context of their work. They acknowledged the importance of relationships, personal qualities of staff and respecting the principles of person-centred care as they strived to provide safe, high quality person-centred care.

Relevance to clinical practice. In the light of recent criticisms of nursing and the implied erosion of public confidence in the provision of high quality healthcare, it is important to recognise good practice and use the findings as a foundation for further and sustained development in providing person-centred care.

Conclusion. The examples of care given by the nurses in this study resonate with the 'six Cs' emphasised by the Chief Nursing Officer for England in 2012, acknowledge the motivation of nurses to provide person-centred care and will contribute to the ongoing debate about nursing practice.

What does the paper contribute to the wider global clinical community?

- Findings build on the existing knowledge of person-centred care.
- Principles are applicable to other clinical settings.
- Results are relevant to clinical practice and pre and post-registration nurse education.

INTRODUCTION

Over recent years, there has been a negative and critical focus on health care and nursing, particularly in the media (Cavendish 2011, Adams & Smith 2012, Patterson 2012). In some cases, this has been in response to specific investigations into care quality; such as the independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust (Francis 2010, 2013) and the abuse of residents of Winterbourne View (Department of Health (DH) 2012). Such events concern both the public and health professionals and have stimulated an on-going appraisal of health care quality and caring roles. (DH 2012, Abraham 2012, Cavendish 2013, Hemingway 2013, Lilley 2013).

As a result of these failings the Chief Nursing Officer for England has called for a rediscovery of compassion in nursing (Department of Health and NHS Commissioning Board 2012) in order to provide high quality care. When reflecting upon the concerns presented in media debates it is easy to blame individuals, managers or government policies (Lilley 2012, 2013). However it is also worth taking into account other aspects of the debate, such as the strength of evidence indicating nursing care quality has diminished and not committed to person-centred care. This paper presents key findings of an on-going research study conducted in a large teaching hospital in the UK. The study seeks to identify nurses' understanding of person-centred care (PCC) and what factors facilitate such an approach to care within an acute medical ward.

Literature and background

The term person-centred care (PCC) is used frequently in healthcare. However, its use and definition varies in different policy, guidance, research and in everyday practice (Goodrich & Cornwell 2008, Goodrich 2009). The ways in which the concept is translated into everyday nursing care continues to present a challenge (McCormack 2004, Price 2006, Edvardsson *et al*. 2008, Goodrich 2009, McCormack & McCance 2010, Nilsson *et al.* 2013).

Whilst much is written about PCC in general terms, there are few empirical studies that examine its use and impact on care quality and outcome in acute care. PCC has previously been explored in the literature, particularly with reference to the care of older people, people who have dementia and

people who have a learning disability (Kitwood 1997, Ford & McCormack 2000, Nolan *et al*. 2002, 2004, Thompson 2004, Brooker 2007, Peek *et al*. 2007, Edvardsson *et al*. 2008, McKeown *et al*. 2010, Kirkley *et al*. 2011).

McCormack and colleagues have conducted a series of rigorous studies mostly based in the care of older people (McCormack 2003, McCormack & McCance 2006, McCance *et al.* 2008, McCormack *et al*. 2009, McCormack *et al*. 2011). Their work emphasises the value of the nurse's relationships with the person and their family, but also the need for seeing broader influences on person-centred practice. They identify the importance of elements such as the dynamics of power and control, the effect of institutional discourse, authenticity, the care environment, appropriate skill mix, effective staff relationships and shared values within the team (McCormack & McCance 2006, 2010). These and other concepts drawn from this programme of work were used to develop a person-centred framework for nursing, using it as the basis for a series of practice development programmes (McCormack & McCance 2010).

Other researchers have developed instruments and indicators to measure factors that influence PCC from patients' and nurses' perspectives (McCance *et al*. 2008, Edvardsson 2009, Slater *et al*. 2009). These factors include: relationships in the care setting, involvement in decisions about care and the culture of the care environment. Whilst the focus of these studies is on the individual, many elements have congruence with the relationship centred approach seen as essential to the 'Senses' framework by (Nolan *et al.* 2004, 2006). The framework was developed specifically to address nursing practice and education in the care of older people. It emphasises the need for each person (patients, family and staff alike) to feel valued and recognised as a person through relationships which are satisfying to all. The need for skilled, knowledgeable and enthusiastic staff working in an open and encouraging environment where there is mutual respect and trust are also common features of person-centred frameworks (Kitwood1997, Nolan *et al*. 2004; McCance *et al.* 2011). These factors identified in the literature show how multifaceted PCC is and how realising it in everyday nursing practice can be a challenge.

Some of the challenges to PCC that have been identified include conflict between bureaucratic management systems, which focus on budgets and commissioning, and care givers' concerns about individual care needs (West *et al.* 2005; Innes *et al.* 2006; Kirkley *et al*. 2011, Nilsson *et al.* 2013). This mismatch between priorities of managers and of staff working at the grassroots can cause tension. Instead of creating a positive culture in the care environment, it can result in staff feeling less engaged with care needs (McCormack 2011).

Further research is recommended to facilitate a clearer understanding of the meaning and application of PCC in everyday practice (McCormack 2004, Nilsson *et al.* 2013). Whilst much of the previous research focuses on the care of older people, people with dementia and care home environments, a few publications explore the application of PCC in acute hospital settings (Peek *et al*. 2007, Gribben & McCance cited in McCormack & McCance 2010, NHS Education for Scotland 2012). However there remains limited focus on the staff perspective of their educational needs in relation to PCC in acute hospital care. This paper reports findings from the first stage of a larger study that aims to enhance understanding of PCC and identify recommendations for clinical practice, pre-registration and post-registration healthcare education in higher education. The paper focuses on the findings from the nursing component of the study.

THE STUDY

The research presented here relates to the first stage of a larger qualitative exploratory study investigating nurses' understanding of PCC and the factors that facilitate such an approach to care within an acute medical ward. The study used an Action Research approach, informed by the values of Appreciative Inquiry (Cooperrider & Whitney 2005). Appreciative Inquiry is a strengths based approach to organisational development. It works by looking at the collective strengths of the people working in an organisation with the intention of using this understanding to transform their way of working.

The larger study comprised three stages with stage 1 (presented here) being the biggest component. Stage 1 involved the use of semi-structured interviews and follow-up interviews or discussions with

seven registered nurses, three healthcare support workers and four student nurses working on the ward.

Stages two and three of the larger study involved the use of semi-structured interviews and consultations with key informants, including Allied Health Professionals (AHPs), nursing lecturers, clinical educators and other experienced nurses. These stages explored the similarities and differences between nurses and AHPs, and started the process of developing educational responses.

Aim

The research presented here (stage one of the larger study) aimed to identify the facilitators of PCC from the perspective of nurses (within this study the term 'nurses' included registered nurses, support workers and student nurses) working in an acute hospital medical ward and the implications for education. The purpose was to generate practical and applied outcomes that would be useful in educational terms to help nurses understand what person-centred care is and consider how the principles can be applied in their own practice.

The following research questions were explored:

- What do nurses understand by the term PCC?
- How is PCC facilitated in the acute hospital medical ward?
- What are the implications for nurse education?

METHODS

Methods included individual and group interviews which were analysed using Framework Analysis (Ritchie & Spencer 1994). An Action Research approach was adopted. The study was initiated following discussions between nurses and the lead researcher (in the role as link lecturer from the local university) about the care of a man who had been admitted to the ward following a stroke and was resisting the help offered to him by the nurses. The discussions considered whether understanding more about the man's life and interests might aid nurses (including student nurses)

to care for him in a more beneficial manner. It was also questioned whether meeting his needs more effectively would in turn have a positive impact on nurses' sense of fulfilment in their work and enhance their understanding of the value of PCC. This prompted the development of this research study exploring factors influencing PCC delivery.

Action Research is seen as a way of encouraging practitioners to explore and take control of their own practice in the context of their working environment (McNiff 2002). It is approached in cycles and is emergent in nature. In the later cycles, the interpretations developed in the early cycles can be tested, challenged and refined. This study was the first cycle of an Action Research study and consisted of the stages shown in Box 1:

Box 1: **Stages of Action Research**	**Features of the study**
Planning	Identifying the need for the study Reviewing the literature Developing the research proposal
Acting	Collecting and analysing the data (review of current practice)
Developing	Identification of the educational needs
Reviewing	Dissemination of findings Reflecting on the results Planning for the implementation of recommendations (second cycle)

The four principles of Appreciative Inquiry of being: appreciative, applicable, provocative and collaborative were applied when framing the questions, analysing the data and making recommendations within the study in order to avoid critical connotations (Cooperider & Whitney 2005). Both Action Research and Appreciative Inquiry acknowledge the significance of individual values and

their influence on human practices and recognise the worth of subjective knowledge as much as objective (Ritchie & Lewis 2003).

Ethical considerations

University and NHS ethics and governance approvals were obtained. The ward managers gave verbal information about the study to nurses on the ward and written information sheets provided potential participants with more detail about the study. The lead researcher visited the ward regularly to answer any queries. Written consent was sought once potential participants had read the information sheet and had the opportunity to ask questions. The voluntary nature of participation was made clear and it was emphasised that participants could withdraw from the study at any time.

Sample

A purposive sample of 14 participants (nurses) was recruited from an acute medical ward in a large teaching hospital in the UK for stage one of the study. Purposive sampling was used in order to select participants who had specific knowledge and experience of providing nursing care (Morse *&* Field 1996; Holloway & Wheeler 2010). See Table1 for characteristics of the research participants for stage one of the study.

Table 1: Characteristics of the research participants (N = 21)

Stage of Study	Role and Identifier	Age Band	Length of time in healthcare
Stage one (N = 14)	Staff Nurse (RN1)	30-39	5 years
	Ward Sister (RN2)	50-59	36 years
	Ward Sister (RN3)	40-49	30 years
	Staff Nurse (RN4)	20-29	4 years
	Ward Sister (RN5)	50-59	30 years
	Staff Nurse (RN6)	50-59	30 years
	Staff Nurse (RN7)	40-49	25 years
	Support Worker (SW1)	40-49	20 years
	Support Worker (SW2)	40-49	25 years

	Support Worker (SW3)	40-49	4 years
	Student Nurse (StN1)	Under 20	1.5 years
	Student Nurse (StN2)	20-29	2 years
	Student Nurse (StN3)	Under 20	1 year
	Student Nurse (StN4)	20-29	2.5 years

Data collection

Semi-structured interviews were chosen to explore participants' understanding of the term PCC and to seek their views on the facilitators to this in practice. An interview schedule was used, and adapted throughout the period of data collection as participants introduced new ideas for further investigation. Interviews were digitally recorded and, transcribed. Although demographic information was collected, all identifying details were removed from the transcripts.

Data analysis

Data analysis was guided by the principles of Framework Analysis, especially useful when it is anticipated that research recommendations will influence practice (Ritchie & Spencer 1994). This uses a matrix to develop an analytical hierarchy, which ensures a systematic approach to data analysis. Framework Analysis includes discrete but interrelated stages: familiarisation; identifying a thematic framework; indexing; charting and mapping and interpretation.

Framework Analysis allows integration of '*a priori' knowledge* into the analysis alongside emerging codes obtained directly from the data. The *'a priori'* knowledge in this study related to the personal and professional knowledge of the researcher and existing literature. The interview transcripts were coded using a qualitative data management system (NVivo Version 9). The process began by reading the transcripts closely and coding them as topics emerged. At the familiarisation stage the analysis generated broad themes. The themes were then explored in more depth to ensure they were generated directly from the data. This produced a more refined thematic framework (see themes in the findings section). The thematic framework was used to reanalyse the data, challenge

the framework and check its correlation to the original transcripts to aid accurate interpretation of the findings.

During data analysis, a sample of transcripts was checked by the supervisory team in order to substantiate the emerging themes. Then, the thematic framework was shared with five participants to gain feedback on its congruence with their interpretation of the interview themes. It was also shared with experienced health care professionals by consulting with an existing research interest group that is active in promoting the application of research into practice in the host NHS Trust. This established the clarity of the framework and resulted in minor changes to the terms used; however the three main themes remained as originally identified from the data.

FINDINGS

The findings are presented in two sections. The first section illustrates what the participants understood by the term PCC. The second section describes how the facilitation of PCC was perceived by the participants and is presented in three themes:

- Characteristics of relationships
- Personal qualities of staff
- Principles of person-centred care

Section 1 - Understanding of person-centred care

At the outset of data analysis it was necessary to gain insight into the participants' understanding of the term 'person-centred care'. This enabled analysis of how understanding of the term translated into everyday care delivery in the study setting. Participants demonstrated a good understanding of what the term PCC meant in the context of their work. They provided examples which showed understanding of PCC both when it worked well and sometimes when the challenges of everyday practice got in the way.

One Registered Nurse (RN) described the care of a woman who had a severe learning disability, which motivated the nursing team to become familiar with her routine. Participants recognised that the same effort should be made for someone who did not have such obvious needs.

This attention to detail was seen by many participants as the key to PCC. Understanding more about the person and their personal identity was seen as vital in facilitating PCC; however this was sometimes seen as happening in a haphazard way in the midst of busy ward routines:

> *'...We've had to get to know her routine, how she lived at home, how she was cared for... so that has been a growing experience for us... It is a relationship that's been built from scratch and now we know her and she knows most of us and we know how to deal with her so that's a really good working relationship. Although it's quite stressful at times, it does work*.' (RN1)

The same nurse went on to explain about the care of another woman who had been on the ward following a stroke and had difficulty communicating her needs:

> *'I think one of the main things is to get to know your patients, see what they would find valuable...we were tidying up her locker and we found a bag of make-up and we thought 'we've never seen her in make-up'... She obviously does wear make-up because she'd brought it with her and we asked her about it and her eyes brightened up and we were able to make her face up and from that date it was like a different person emerged.'* (RN1)

Some participants acknowledged that an acute care environment can lead to a problem based approach to care, separating the person from their normal relationships and interactions:

> *'I think we still, as nurses, see people as patients and not people'.* (RN2)

Participants described seeing their patients in bed with a 'set of problems' rather than seeing them as a person within a social network. Initially this was often a necessity as patient safety was paramount, particularly when a patient had been admitted as an emergency:

> *'…you have got to make sure your patients are safe first and foremost and then build relationships after.'* (RN4)

Support workers (SW) had similar feelings to registered nurses, recognising that it sometimes took extra effort to provide care that was person-centred in an acute setting. One way of enhancing PCC was to build relationships with the family:

'…you can always go that one step further for that person... you've got to listen to what the patient's telling you and sometimes you get to know the families as well and that gives you a good understanding.... I think you get a lot of satisfaction, I'm not going to say you feel part of the family but you feel closer to that person, as families get to know you...' (SW1)

Participants said it was particularly important to get to know the family when the people themselves were unable to make their wishes known. This is illustrated below as another support worker told of the complex and compassionate care given to a woman at the end of her life:

'It was quite upsetting, but it was very satisfying towards the end of her life because he (her husband) wanted us to be with him all the time. I think he was quite scared about what was going to happen, apprehensive and he had particular ways that he wanted us to do things. He had a certain nightie he wanted her to wear and underwear she'd got to wear and she had to have her hair done a certain way.... he wanted his own music playing. He'd got an IPod and he was playing his own music in the room for her and it was a very peaceful ending for her... when I went home I was upset but, I was satisfied that we'd done everything that he wanted and that she probably would have wanted. Yeah, it was good really.' (SW3)

The standard of care described above is exemplary; however can the same be assumed of everyday nursing practice in an acute care environment?

Section 2 – Presentation of the themes

Characteristics of relationships

Participants highlighted the importance of relationships and communication with the person, their family and the care team in order to facilitate PCC and described some strategies for achieving this. Being friendly and approachable was seen as crucial by participants to the initial stages of building trusting relationships. This involved finding the time to listen and talk with the patients and their relatives in order to give information and help ease anxieties. Participants also identified that involving patients and relatives in care decisions and care delivery in a compassionate manner

supported PCC. Empathy was referred to in many of the interviews, even if the exact term was not used:

> *'Involving the family is a massive part of person-centred care, as their family know everything about them; they just know them inside out. It's about building trusting relationships... definitely and respecting the person, they are not just a patient, they are a person.'* (RN4)

> *'Some families come in and spend a day here learning how to care for their relative. I think to get the family in and help provide care while they're supported in hospital is a big thing.'* (RN3)

The interview findings also indicated that the characteristics of the relationships within the care team were crucial in supporting PCC. For example, acknowledging team contributions and working together towards shared goals. This was articulated well by the student nurses in the study:

> *'I think communicating with other members of staff is a big issue, especially in handover for example saying "oh he likes to eat his breakfast in bed first and then get up...he didn't want to wash before his breakfast," so it's about finding out their plan...'* (StN2)

> *'Students obviously don't know more than the (registered) nurses but sometimes they might have done assignments on different things. I've just done an assignment on dignity and privacy, so sometimes we can bring little bits of things (information) onto the ward…just reminding some staff and other students as well.'* (StN3)

In summary; participants recognised the influence of constructive team relationships upon PCC and had insight into their role in supporting a positive care environment by using their communication skills within the team to enhance care: Student nurses (StN) noticed that constructive communication in the team and a relaxed, yet professional approach to care reduced stress levels for all involved and improved the experience of care for the patient and their family. These views were echoed by other participants.

Personal qualities of staff

It was also acknowledged by participants that the personal qualities of nurses were equally important to relationships in encouraging a positive team approach to PCC. Personal values and beliefs that were congruent with PCC emerged as being vital if PCC was to be realised:

> *'I think it's staff attitude and understanding and time also has a lot to do with it… it is a lot to do with leadership, but I think it is also quite an individual thing… for me it (person-centred care) is my bread and butter, but I don't know if it's the same for everybody'.* (RN4)

The nurses interviewed held similar beliefs regarding PCC being a fundamental requirement for providing high quality care. These personal values were also discussed by the support workers in the study:

> *'I like to spend time, if I'm helping a patient, to talk to them about their life because they're not just a person in a bed who's ill, they have got a life and a family… because you've sat and had that time with them and you're a friendly face and they know they've already told their concerns to you so they will let you help them.*' (SW3)

There was a clear recognition from participants that listening to and recognising the importance of people's stories was valuable in facilitating PCC. This was more likely to lead to flexible care delivery in order to meet the specific needs of the patient:

> *'It is important to empathise with their situation and to use a bit of judgement and discretion and maybe relax certain rules…Can't we do this because it'll mean so much more to that person?"'(RN2)*

Flexibility in ward routines was spoken about as a facilitator to PCC, however for this to occur the leadership style had to be congruent with PCC:

> '*If you've got a ward manager that is aware of people as individuals and encourages that, then you take your lead from them or your senior nurses…when you get new staff you should be encouraging them and setting a good example.' (RN3)*

Role modelling was not seen as being solely the remit of the senior nurses. Student nurses and support workers also discussed how they could influence the way care was delivered. This was linked to personal confidence within the team and professional maturity, not necessarily to age or length of time in post.

Respecting the principles of person-centred care

Participants recognised that providing PCC takes effort to ensure positive outcomes and needs not only a team approach, but a philosophy of care which flows throughout the whole establishment. The principles of providing PCC involved recognising the importance of a person's wishes when considering care decisions. Even when the patient him/herself was unable to make the decision, the nurses and multidisciplinary team worked with families to consider what the best interests of the person would be. This often involved supporting the person or their family to ask questions when unsure about treatment or care decisions:

> *'Lots of the times we are advocates for them (patients)... when the doctor walks away we say "Are you alright with everything you have been told, do you want to ask any questions?" They sometimes say they don't understand what has been said... I think as long as the person has (mental) capacity, then I think it (their view) does get listened to. I think on this ward they are really good, they really try to meet people's needs and take into account their beliefs and what they want.'* (RN4)

Responsive assessment of individual needs was also described by participants as an important aspect of PCC; this involved paying attention to all aspects of care that were important to the person:

> *'I think the little things make the most difference because it's a person's dignity. I think just everyday personal things make more impact to the person's stay in hospital than the medical care or whatever else. I think it does impact on somebody's recovery if they feel more comfortable… and if you can make it easier, from the beginning, I think it does make a difference to the person's stay and it probably makes a difference to how they recover.'* (RN2)

'I'd say most shifts you can dedicate a small amount of time to little things that patients find important. Taking them for a little walk round the ward and having a chat with other patients, little things like that, otherwise they're just sat on their own in the chair with their own company. I wouldn't like to be sat on my own.' (RN1)

Job satisfaction was important to the participants; this often involved a personal connection being made with individual patients. 'Getting to know the person' featured strongly in the interviews and making time for the *'little things'*. The little things (like making a cup of tea in the night when someone can't sleep) often seemed to make a big difference to the person being cared for from the nurses perspective.

DISCUSSION

Findings show that the participants recognise the value of delivering PCC and the positive impact this can have for all involved in the care situation. Their examples of care delivery resonate with the 'six Cs' emphasised by the Chief Nursing Officer for England, Jane Cummings (DH and NHS Commissioning Board 2012): care, compassion, competence, communication, courage and commitment. The experiences of nurses in this study illustrate their understanding of the term PCC and the importance of high quality safe practice in facilitating excellence in care. The insight presented by student nurses suggests that they also have an understanding of the nuances of care and the type of care environment that promotes person-centredness, despite literature that suggests that practice learning is lacking (Patterson 2012, Willis 2012).

McCormack & McCance (2010) believe that, in many care settings, rather than delivering PCC continually, nurses experience 'PCC moments'. These moments are apparent in this study showing their significance in everyday interactions in acute medical ward settings. 'Person-centred moments' become more evident and consistent where the healthcare team share humanistic values such as mutual respect for individuals and their rights (McCance *et al.* 2011). The consistency of PCC is affected by the shared values across the whole organisation (Nolan *et al.* 2004, 2006, Webster 2004, Kirkley *et al*. 2011, McCormack *et al*. 2011, Nilsson *et al*. 2013). This facilitates a work (care) environment where staff feel valued, there is strong leadership and management styles

are perceived as enabling a more person-centred approach to care (Lynch, *et al.* 2011, Francis 2013).

It is evident from the findings here that delivering PCC in a busy acute environment is a challenge. There is recognition of the competing demands in healthcare and some feelings of frustration when it is not possible to achieve the level of PCC that nurses would desire. Communication can become task centred, rather than people centred when nurses are busy (McCabe 2004, Francis 2013). Participants indicate that workload can be outside of the nurses' control and refer to the need for appropriate resources to be available to support PCC; this is reinforced by campaigns which support front line staff (Scott 2013). However, there is an argument that the nursing profession needs to look beyond the claim of staff being too busy (short staffed) or poorly resourced to provide PCC (Kirkley *et al*. 2011, Hemmingway 2013).

It is a financially challenging time in health care (O'Neill 2013); nevertheless, healthcare professionals need to ensure they are able to identify and uphold the characteristics of care that demonstrate a person-centred, holistic and collaborative approach to care (Nursing and Midwifery Council (NMC) and General Medical Council (GMC) 2012). The findings show that when care is focused on the person's unique needs it has a positive effect upon the person receiving care, their family and the job satisfaction of nursing staff. The managers of health and social care need to consider the necessity to strive for high quality PCC by developing an organisational culture where staff are encouraged and enabled to see the individual needs of the person in their care as paramount through the use of education and practice development (McCance *et al*. 2011, Francis 2013, Hemmingway 2013).

LIMITATIONS TO THE STUDY

The findings presented here relate to the first stage of an exploratory study investigating nurses' understanding of PCC and the factors that facilitate such an approach to care within an acute medical ward. The sample was small (n=14), however this represented 50% of the staff on the ward and

included registered nurses, support workers and student nurses. This gave a fair representation of the workforce involved in delivering nursing care on the ward and was sufficient to give relevant data about the approaches used on a single ward (Baker & Edwards 2012). However, the findings do need to be tested across a more diverse area in an acute care setting. Future studies would benefit from including patient and family perspectives in order to explore congruence between professional perspectives and those of people in receipt of care.

CONCLUSION

In conclusion, findings from the data indicate that characteristics of relationships, personal qualities of staff and respecting the principles of person-centred care act together to shape the philosophy of care on the medical ward. In turn, this philosophy influences how staff perceive and facilitate PCC. This affects the way they interact with each other, with the person being cared for and their family, which all impact on the level of person-centredness within that environment. There are some parallels from this study to the findings of other studies which explore PCC. Therefore the findings of this study will strengthen the body of work which explores the understanding and application of PCC, particularly in acute medical ward settings.

RELEVANCE TO CLINICAL PRACTICE

The implications for practice arising from the first stage of this study relate to three key points. The first is that in the light of recent criticisms of nursing and the implied erosion of public confidence in the provision of high quality care it is important to recognise good practice and understand the motivations to achieve this. The second is a proposal that the study findings and thematic framework should be used in clinical practice and education. It can be used to promote the positive attributes of nursing and act as a building block for further and sustained education and development in providing PCC. Finally, the findings support the ‘six Cs’ emphasised by the Chief Nursing Officer for England in 2012 and will contribute to the ongoing debate and consultation about the Nursing and Midwifery Council Code (NMC 2013).

There was no funding for this study.

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Word Count 5086 (excluding abstract, references and tables)