



Original Article

Limping along in implementing patient-centered care: Qualitative study

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ABSTRACT

Background & Aim: Patient-centered care is considered a pivotal element of the mission of the healthcare system around the world. However implementing Patient-centered care is not always easy and nurses have admitted this fact reluctantly. The evidence suggests that the first step in implementing Patient-centered care is to change the professionals' viewpoint, behavior, and understanding. This study examined nurses' perceptions of the components of Patient-centered care and its delivery.

Methods & Materials: This was qualitative descriptive research with a conventional content analysis approach. Face-to-face interviews were conducted with 21 nurses, working in teaching hospitals in Tabriz, Iran, and 5 field notes were collected. Data were analyzed using the Zhang and Wildemuth method of content analysis.

Results: Three main themes and eleven sub-themes were extracted. Nurses identified "Effective Communication", "Careful Care of Distinctive Needs", and "Valuing the Patients and Their Rights" as the main elements of Patient-centered care.

Conclusion: Nurses implement some components of Patient-centered care. Yet Patient-centered care remains an ad hoc practice requiring more improvement. This study provided a deeper understanding of nurses' perceptions about the implementation of Patient-centered care and their weaknesses. The finding is consistent with current knowledge, shedding light on Patient-centered care-related practices performed by Iranian nurses and pointing to areas for improvement in implementing Patient-centered care.

Introduction

Patient-Centered Care (PCC) is described as providing care while respecting the individual's preferences, needs, and values; and ensuring that patient's values guide clinical decisions (1). PCC was found to improve the quality of care, patient experience, and health outcomes such as quality of life (2, 3). A study involving 12 Malaysian hospitals found that PCC reduces the negative impact of nursing shortage on hospital performance and safety (4). Hence, PCC is considered a pivotal element of the mission of the healthcare system around the world (5).

Although PCC is advocated worldwide, its implementation has been hampered by the lack of clear and consistent conceptualization. The evidence suggests that there is variability in its implementation all over the world. For example Hwang et al. in a study used four fields to measure PCC including "respecting patients' perspectives," "promoting patient involvement in care processes," "providing for patient comfort," and "advocating for patients (6)." PCC is described as consisting of multiple components; however, not all of them are implemented at the bedside (1, 7). Clinicians select some of the related strategies to implement in bedside, mainly because PCC features have been reported differently in various perspectives, cultures, and circumstances (2). It can indicate anything from soothing room design, emotional support of patients, and customization of

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meals, to support of patient decision making. This inconsistency across the clinical and research literature makes the application of PCC difficult (1).

This variability is of concern and may be related to the confusion about the true meaning of PCC, implementation, and the misuse of this term (2). Patients and their family members mainly consider attending to their needs and respecting their preferences in clinical decisions as to the main component of PCC (7, 8). Organizations highlight the decreasing length of hospitalization and providing cost-effective care as key components of PCC (8). In this regard, the nurses' perspective, as the main caregiver, remains unclear.

Because nurses spend a long time with their patients, they act as key members of the professional staff of a health care organization in ensuring patient safety. However, high workloads and insufficient nurse staffing in the Iranian health care system contribute to an environment where makes it difficult to implement PCC (9). The pieces of evidence suggest that the first step in PCC implementation is to change the professionals' viewpoint, behavior, and understanding (10). Despite the importance of nurses in the care process, less attention has been paid to the experiences and expectations of nurses in defining PCC. Therefore, given that PCC is a contextual and multidimensional concept, nurses' views and opinions about PCC can be adapted to their work environment. Organizing care plans according to their understanding and expectations will lead to increased quality of care (11).

The results of some studies have shown that the Iranian health system faces some challenges in the accreditation process, including PCC (12, 13). To increase the quality of care, accreditation has been considered as a requirement by the Ministry of Health for the evaluation of hospitals since 2012 in Iran. Accreditation is a systematic non-organizational evaluation process that is performed to improve the quality and safety of care. By delivering standards, this process leads hospitals to

create a comprehensive, systematic management system and to promote a safe, quality, and patient-centric culture (14). Considering the importance of PCC and the role of nurses in providing it, as well as the reported variability in its implementation across countries, a question may arise concerning how nurses, working in Iranian hospitals, describe PCC, and how they provide it? Clarifying the definition within a setting-based approach will guide the implementation of PCC by nurses. The purpose of this study was to explore nurses' perceptions of the components of PCC and its delivery. The knowledge gleaned from this study might not only shed light on the feasibility of applying PCC but also help in the modification of existing handover methods to fit with the principles of PCC.

Methods

Design

The study was a qualitative descriptive study utilizing the conventional content analysis approach. Zhang and Wildemuth define content analysis as "any qualitative data reduction and the attempt to create sense, which requires a qualitative material and attempts to identify the main consistency and meaning." One approach is conventional qualitative content analysis in which direct and inductive coding categories are derived from raw data. While the purpose of this study was to investigate nurses' perception, it was necessary to reduce qualitative data through the direct and inductive coding process.

Setting and participants

The setting was teaching hospitals located in Tabriz, Iran. This city is a metropolis and its hospitals are regional centers to which patients from neighboring provinces are referred.

Nurses were eligible for this study if they were registered nurses working in the clinical wards of teaching hospitals. Based on nursing theory, nursing levels vary from novice to expert. A nurse engagement with

patients and family occurs at a professional level that needs about 2 to 3 years of work experience(15). Therefore to achieve richer information, participants with at least 3 years of work experience were selected. Exclusion criteria were participant withdrawal at any stage of the study.

A purposive sampling strategy was used in identifying the participants to interview. Sampling continued until data saturation was reached. Data saturation means that by continuing data collection, no new information or category is obtained, and collected newer data will repeat previous data (16). In this study, data saturation was achieved after 17 interviews from the analysis, and 4 other interviews were conducted to ensure that no new data or results were obtained. A total of 21 interviews with 21 nurses were done to obtain a representative sample of nurses across age, gender, qualification, and hospital setting.

Data collection

The data were collected using semi-structured, face to face interviews, and field notes, which were used during data analysis. Interviews began with the following general questions: (1) Based on your experiences, what does PCC mean to you? (2) What criteria would you consider to describe care is patient-centered? Probing questions were asked if clarification or additional information was desired. Interviews lasted between 45 and 110 minutes. All interviews were conducted by the corresponding author in a private room within the hospital in which they were employed (for convenience). The interviews were immediately transcribed verbatim. Field notes were taken to document observations of the relationship between nurses and patients, and caring related tasks. Data collection took place between June and December 2017.

Data Analysis

Data analysis was carried out simultaneously with data collection. The conventional content analysis suggested by Zhang and Wildemuth was used to analyze data. According to this method, eight-step was followed as (1) preparation of data in which all transcripts were re-read several times to gain a full understanding of PCC (2) definition of the unit of analysis, in which data are divided into meaning units (paragraph, sentence, phrase, and word), making sure they maintain content and meaning, (3) development of categories and the coding scheme by using continuous comparison, evaluation, interpretation, and feedback, (4) testing the coding scheme in a text sample, (5) coding the whole text, (6) assessment of the coding's consistency, (7) drawing conclusions from the coded data, and (8) reporting the methods and findings (16).

Rigor

The criteria proposed by Guba and Lincoln were used to ensure rigor. These criteria included credibility, conformability, transferability, and dependability (17). Sufficient presence in the environment (interviewing with the appropriate length of time and sufficient engagement with the participants), increasing diversity in the participants' background, reviewing the text by the participants (number: 3, 5, 11), performing the steps of research under the supervision of qualified researchers, and reviewing the text by the experts was used to increase data credibility. To meet the conformability criterion, all research steps were documented; so that other researchers could examine the codes and categories. In order to increase the transferability, attempts to interview and collect data from appropriate participants, use of an external review procedure with 3 nurses who did not participate in the current study, and an accurate description of the research process were carried out, to allow others to follow the research pathway.

Ethical considerations

This study’s protocol was approved by the Ethics committee of Tabriz University of Medical Sciences (IR.TBZMED.REC.1394.816). The objectives and methods of the study were explained both verbally and in writing to the participants. Informed consent was obtained from individuals to participate in the study. They were assured of confidentiality, and the purpose of audio-recording was explained. The records of the nurses’ interviews were stored in a locked file and were transcript with removing all identifiers (by the corresponding author).

Voluntary participation in the study and the possibility of declining to discontinue at each stage of the study was explained. The interviews were conducted individually in a private room at the desired time and place of the participants.

Results

All 21 participants were recruited from two general and nine specialized (e.g. orthopedic regional center) hospitals. On average, participants were 35.40 years of age. Most participants were women who completed a bachelor’s degree (Table 1).

Table 1. Characteristics of participants

ID Number	Gender	Highest qualification	Work experiences (in years)	Hospital	Ward
1	Female	Bachelor	16	Cardiac	Echocardiography
2	Female	Bachelor	4	Cardiac	Coronary care unit
3	Female	Bachelor	12	General	Urology
4	Female	Bachelor	18	General	Infectious
5	Female	Bachelor	10	General	Internal
6	Female	Bachelor	3	Pediatric	Pediatric intensive care unit
7	Male	Master’s degree	17	Tertiary	Surgery
8	Female	Master’s degree	9	Gynecology	Post-partum
9	Female	Master’s degree	20	Pediatric	Intensive care unit
10	Female	Bachelor	11	General	Burns
11	Female	Bachelor	8	General	Gastroenterology
12	Male	Bachelor	6	Tertiary	Angiography
13	Male	PhD	22	Cardiac	Respiratory
14	Male	Bachelor	5	Psychiatric	Alcohol & drug rehabilitation
15	Female	Bachelor	21	Orthopedic	Surgery
16	Female	Bachelor	12	Ophthalmology	Emergency
17	Female	Bachelor	9	Ophthalmology	Internal
18	Male	Bachelor	7	Oncology	Hematology
19	Female	Bachelor	3	Gynecology	Surgery
20	Female	Bachelor	19	General	Neurology
21	Male	Bachelor	25	General	Otorhinolaryngology

In the initial data analysis, 864 primary codes were extracted. The codes were classified into three themes and eleven subthemes. Each theme with its sub-themes is described next.

Theme 1: Effective communication

Effective communication was the most commonly mentioned component of PCC. A

nurse expressed the importance of communication as follows:

“Now, all over the world, everybody is talking about the importance of communication with the patient” (P 12).

The first subtheme of effective communication involves informing the patients about their condition and treatment. Active listening, asking open-ended questions, and developing functional goals

were strategies nurses used. They stated that unless the patient is educated in a simple and comprehensible language, the patient is not empowered and thus PCC does not occur.

“As much as I can, I explain all events before surgery, what he/she needs to do before anesthesia, when he/she will return to the ward, how to cough, as it's his/her right to know and be ready”(P 2).

This communication was viewed as essential for developing a relationship with patients, gaining the patients' confidence, and reducing the patients' stress. It is usually possible by communicating, being present for some time at their bedside, being available, paying attention to patients' concerns and using humor according to the patient's condition, as illustrated in this quote.

“Patients admitted here, usually have tachypnea and tachycardia. I stay with them and say to them, this is the most equipped CCU, we all are special nurses. The Doctors here are a faculty members. You are going to get well soon. Believe it or not, the patient's heart and respiratory rate will soon become stable” (P 4).

Theme 2: Careful care of distinctive needs

In the first subtheme as the uniqueness of a patient's need, the nurses considered patients as human beings with physical, religious, and social dimensions. To provide PCC, a nurse should not only provide care that addresses all those dimensions, but also consider that the patients' needs in these dimensions are unique, distinctive, and special. An ICU nurse, after emphasizing the uniqueness and, at the same time, the importance of all aspects of health, stated:

“You cannot view all the patients the same. Just as the two fingerprints are not equal, their wishes are different” (P 8).

In the second subtheme centrality of the physical dimension is focused. Despite acknowledging the importance of all dimensions of health, nurses commonly mentioned the physical dimension of health because patients are often admitted to the hospital to manage physical problems.

Nurses emphasized the centrality of providing high-quality care to improve the patient's illness and especially pain relief.

“The patient who comes to the hospital should no longer endure pain, this is the conclusion from my experiences” (P 21).

In the next subtheme, nurses noted that patients have religious needs. Unless meeting this need, PCC is not complete. Therefore, it was necessary to meet religious needs, such as facilitating prayer for patients, as exemplified in this quote.

“At times, only prayer and praise can make the patient calm” (P 18).

Social needs represent another dimension of health that only some of the nurses indicated they pay attention to provide PCC. Social needs are highlighted mainly as the importance to be with family members or significant others. Considering the family as a second patient, and facilitating their presence was identified as the main method to meet social needs.

“I witnessed that the patient needed her mother. She was really in stress when she was alone in bed” (P 3).

In the next subtheme, some nurses pointed to the role of PCC at the end of patients' life and said that it is the patients' right that their death should be “peaceful”, consistent with their physical and mental condition. These patients' needs should be met in the best possible way, such as having the family member present and read the holy Qur'an, as well as providing adequate pain relief, suitable respiratory ventilation and preventing hunger through tube feeding.

“I did not tell myself that he's going to die, his care is not important. And as far as I can, I helped him have a calm death” (P 19).

For nurses, PCC also involves providing care according to the patient's preference and promoting their comfort. Choosing a room, bed, site of angiocatheter, time to implement care procedures, and therefore caring according to the patient's preferences and benefits can help maintain the patient in comfort.

“The patient was not comfortable in that room. He asked me to change his room. I

did so and the new room had a good view from the window. He was thanking me frequently and saying I was caring for him well” (P 3).

Theme 3: Valuing the patients and their rights

Nurses believed that they should respect all patients as human beings, and as a host must try to provide the best care for these valuable guest. This is possible by respecting patients’ dignity, advocating them, and helping others increase quality care.

Observing their privacy, “not looking at the patient from above” that is, with arrogance, not speaking in an unfriendly tone, and not discriminating between patients were strategies nurses implemented to maintain the patient’s dignity. The researcher asked a nurse, who emphasized preserving the patient's dignity, “what do you do to keep their respect the dignity?” She answered:

“For example, I do not care if the patient is a convict or addict. I only care, that he is a human anyway.” (P 9).

In the second subtheme, nurses also considered themselves as patient advocates and believed that they could not provide PCC without an advocating role. Particularly nurses pointed to the materialist view that some physicians have and to some nurses’ fear of reporting errors; for these reasons, the patient's right may get ignored. Defending the patient's rights were carried out by informing the patient and helping the patient receive the best care. A Nurse staff in orthopedic surgery wards described supporting the patient's rights before implant placement as follows:

“Although there is not a good implant in the operating room, some surgeons do the surgery. They say that it does not matter. But I inform the patient that “they want to put that brand down; be aware that there are better alternatives” (P 24).

Another subtheme was related to strategies nurses used to help each other implement PCC. Nurses indicated that in

some instances such as a crowded ward, novice staffing, unknowing staff, or lack of staff, the patients’ welfare and value are ignored by the nurse. Volunteering to help colleagues in these situations prevents the patient from getting lost in the system and promotes the delivery of care that benefits the patient. It means that the patient is a higher priority for nurses. An experienced nurse depicts this situation as follows:

“When I see a novice nurse filling a tray filled with angiocatheters, and is going toward an edematous patient, I know that the patient will be pricked many times with needles, so. I go help her soon enough in such a way that does not upset her” (P 17).

Discussion

This study aimed to examine nurses' perceptions of the components of PCC and its delivery. The study revealed that the PCC has three areas of “Effective Communication”, “Careful Care of Distinctive Needs”, and “Valuing the Patients and Their Rights”. In a study from the nursing students' point of view, the key area of patient-centered care is the complexity of care that must inevitably be provided through the nursing process. This comprehensive care includes three important components of education, good patient communication, and patient autonomy (14). The finding of a concept analysis shows that patient-centered care is humanitarian care, which includes many aspects including the relationship with the patient and his / her family, having an anthropological perspective on the patient, providing scientific care based on patient needs and conditions and maintaining patient safety (1). Other studies also suggest that patient-centered care is a core ethical value for nurses, which relates to patient satisfaction, higher quality of care, and more effective care delivery (2, 3, 10, 18). Edvardsson provides a general framework for patient-centered care from the perspective of patients, including appropriate clinical communication with the patient, giving information to the patient, recognizing and

responding to patient emotions, managing uncertainty, decision making, and activating presentation (3). The results of this study are consistent with other research, with nurses believing that patient-centered care can be implemented in the clinical setting. From Watson's point of view, care has four essential components, including respect for one's identity and value, recognizing one's unique response to illness, upholding one's independence, and helping one achieve his / her maximum potential (19). This is consistent with the findings of the present study.

The first theme is about communication with the patient. As participants acknowledged, communication is a vital element in nursing care (20). In patient-centered articles, communication is typically described in terms of information exchange, leading to a common ground of understanding and effective collaboration between the caregiver and the patient. For example, Eklund et al. emphasized the importance of patient-centered care of "sharing information in a complete, accurate and timely manner to facilitate effective patient participation in decision making." (2).

The finding of this study highlighted the centrality of nurses' communication in defining and informing their patient-centered approach to care. Nurses felt responsible for gaining patients' confidence, reducing stress, and educating them; however, the patients' participation in this relationship was not clearly delineated. According to McCormack and McKenzie, in patient-centered communication processes, caregivers obtain a "clear picture of what the patient values in his or her life" (2). Accordingly, practice guidelines could be developed to inform and instruct nursing students and nurses in principles of two-way communication and patient involvement in bilateral communication.

In the second theme, the nurse's pointed to the importance of attending to patients' physical, psychological, and religious dimensions of health, which is consistent with holistic practice as described by

Watson (19). Therefore, sensitivity to all those patient needs is another important criterion for PCC. In this study, nurses identified comprehensive care, including meeting the patients' social needs (e.g. need for the presence of family members), as the hallmark of PCC. Given that a patient has entered a new, serious stage of life, he/she will need support from close relatives and family members. Nurses should facilitate this source of support and comfort for patients (20, 21).

The family is the most important social resource that affects the health of the individual (10). Nguyen et al. in a related systematic review in the intensive care unit state that disagreement with family members hampered the PCC's decision on end-of-life care (22). In this study, the patient and family involvement in care was not explicitly mentioned. While Barzegar et al. emphasize the role of the family member on the patient's recovery (23). However, failure to describe the contribution of patients and families in planning and carrying out care cannot be a definite reason for not implementing it in the clinic. In Iran, as an Asian country, the family bond is strong. Although the family members' continuous presence interferes with the hospital rules and the privacy required for care procedures, families cannot accept to leave their patients alone in the hospital. The corresponding author as a nurse of a similar setting, concludes that participants have considered the presence of the family and their involvement in the process of treatment and care as a usual phenomenon, and therefore have not mentioned it in their experiences. This probability suggests that since the non-participation of the patient and family in self-care is a threat to patient dignity (18), PCC should be included in curricula so that nurses get to know PCC standards precisely.

According to the third theme participants believed in respect for patients and their innate value. Maintaining patient dignity is a moral value in care and ignoring it can reduce patient satisfaction (7, 24). The patient's expectations of PCC were rudimentary and involved just "accepting the

patient as a human” (18, 20). Similarly in this study, nurses’ perspectives were even more fundamental, and included respecting the basic humanness of person in care.

In this study, the nurses supported patients by preventing the loss of their rights. Shahbazi et al. in a study about Iranian Nurse Preceptors emphasize that nurses are expected to provide safe services to patients and must be accountable for their interventions without direct supervision (25). Another new finding that this study added to nursing knowledge, is to help colleagues for the benefit of the patient. Although the evidence suggests that teamwork is required for PCC (21, 24), in this study, the purpose and focus of the volunteer help is highly addressed, which is “patient”. In addition, participants provided practical reasons and strategies and highlighted some changes to adequately address PCC. Future studies need to assess the degree to which such a valuing the patients and their rights improves PCC.

Study limitations

This study has limitations. The participants were from a different ward and reported not having enough time to spend on direct care. Therefore, for data transferability, the context and setting must be considered. Another limitation was mainly about data triangulation. Although, in this study, rich interviews were used, in further studies, observation of the nurse and interviews with the patient and other colleagues is also recommended to determine the extent of self-report bias (due to social acceptability) and to gain a more accurate depiction of nurses’ actual PCC practices.

Conclusion

The findings of this study showed that nurses implemented some components of PCC in the studied hospitals. According to the findings, PCC is considered as an approach to care, in which attention to the patient is taken into account. Also, this study covers most of the known dimensions of

PCC, but the evaluation of the involvement of the patient and the family as part of care requires further studies. In addition, this study suggests the need for an educational initiative to help nurses and nursing students learn about PCC principles and strategies to implement PCC components in practice.

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Conflict of Interests

The authors declare that there is no conflict of interest.

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