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Implementation of patient-centered care into nursing practice

A Qualitative Literature Review

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Abstract

Patient-centered care (PCC) is an important concept which leads health professionals to deliver good quality care with positive outcomes for the patient. The aim of this study was to gain new knowledge and understandings that are based on new evidence from qualitative literature in order to enhance the implementation of PCC into nursing practice. Besides, the attention was to examine the possibility and limitation of PCC implementation into nursing care including some guidance and barriers.

This literature review was done by analyzing nine articles in an inductive approach by content analysis. This study intended to give comprehensive understanding of the possibilities and limitation and give new knowledge about the concept of PCC.

The results of the study are presented in three main categories, which illustrate care that nurses need to practice. Two main categories followed by three subcategories, and the third main category followed by two subcategories that describe in detail what specific actions each type of care consist of.

The results show that effectiveness of implementation of PCC needs to be measured. More studies should be conducted to find universal set of measurement tools.

Language: English Key words: person centered care, person -oriented, implementation, nurse, quality care.

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Introduction

An important topic to be investigated in the nursing field is the process of quality-care delivery. However, there is a misunderstanding regarding the concept of caring, there are gaps in the knowledge of the caring process, and the definition of caring is not clear. For example, the caring process often ends after the patient is discharged from the hospital. However, after returning to daily life, the person will require further health- and well-being examinations (Westphal, 2016, p.19). This is just one example of the misunderstanding between health professionals about the caring process.

These gaps of knowledge seem to be a common problem in nursing, which indicates a growing need for developing a new system of caring with decreased costs and improved quality of care. It is clear that the problem could be easily addressed by the implementing quality care that is focused on the patient rather than on statistical or diagnostic values (Miles & Mezzich, 2011, p. 3).

One solution to overcome the listed problems is by placing the patient at the centre of attention. The task of nurses is to provide care to meet the everyday needs of each patient rather than to view the patient from a disease perspective (Westphal, 2016, p.20). Nurses have to be competent and have the same care goal, which is the individualized care of each person. Nursing competence implies a good level of knowledge, the ability to think holistically, the desire to learn and the capacity for teamwork.

The level of education, information, health services, infrastructure, healthcare organization, and health providers is increasing and promotes the development of good care. Moreover, the healthcare system is changing and is adopting a holistic and humanistic approach to care in general and patient care in particular (World Health Organization (WHO), 2007).

The Institute Of Medicine stated (according to Millenson, 2014, 979) patient-centred care (PCC) as one of six goals for the health-care system. For this study, it was of interest to investigate the existing knowledge about the concept of PCC. A general hypothesis is that involving the patient in the process of their treatment is a goal, which is possible to reach by educating nurses to focus on the person and develop skills that can create a reliable and trusting relationship between a nurse and a patient (Khuan, 2017, p.216).

The overall aim of this work is to demonstrate the positive outcomes of PCC. The patient's well-being and state of health will improve by inviting them and their families to

participate in the process and by providing them with the necessary knowledge and guidelines (Cliff, 2012, p.86).

The main practical problem is that the importance of PCC was not recognized, and other factors such as safety and a healthy operating environment were believed to be more important (Hudon, 2011, p.155, Cliff, 2012, p.86). Today, the priority has changed and PCC is becoming widely integrated. New research is needed that provides information on how to implement PCC and how nurses can effectively integrate it into their practice in order to produce the best results for the patient and their family.

The main advantage of PCC is that the implementation of care, which places a patient at the centre of care, will simultaneously positively influence other fields. Firstly, it will help to meet patient needs and increase the level of care satisfaction, while giving patients the main role in their own care procedure (Sidani, 2015, p.11). According to Miles and Mezzich (2011, p.3),*"...patients are no longer prepared to be 'dealt with' or 'processed' by technicians in applied biosciences but rather to be attended by scientifically trained advocates who recognize their problems not only at an organic, but also at emotional, social and spiritual levels".*

One useful advantage of PCC is that it is a partnership between nurses, patients, and their families. The partnership allows the patient to understand their own desires and expectations from care, as well as to include shared decision making.

As a future nurse, I have a deep interest in the subject of PCC. I have a strong desire to do my best for the patient and to deliver good care. My goals for caring include good treatment, meaningful relationships, emotional and physical well-being, and respect for patients and their families. I have gained experience in different places and have met different types of patients, nurses, and other healthcare providers. I noted that the common problems in quality care provision were lack of time, lack of communication, absence of enthusiasm and motivation, increasing work-related stress and a lack of knowledge about caring concepts and process. This observation persuaded me to find an answer to the question of what quality care is and how to practice it.

This study sheds some light on the understanding of principles and the model of implementation of PCC in nurses' everyday practice. However, more research is needed to identify specific skills, training and communication approaches for implementing care, which nurses can use for functioning in the nurse-patient partnership.

2. Aim and problem definition

The study aims to gain new knowledge and understandings based on evidence from qualitative literature in order to shed new light on the implementation of PCC in nursing practice. To meet this goal, it is necessary to investigate insight from new research. This study intends to provide a comprehensive understanding of the possibilities and limitations of implementing PCC into nursing practice.

The following questions are addressed:

1. How do researches describe the implementation of PCC?
2. What barriers exist in implementing PCC into nursing care?

3. Background

Many concepts are used to explore the topic of PCC. These concepts can be divided into categories in order to more fully understand the type of care that is needed. This work explains the principle and related definitions of PCC. This background aims to offer a better understanding of PCC, especially its benefits. This study also discusses the difference between PCC and other types of care ideology. Knowledge from previous research on this topic is necessary in order to determine what progress has already been made and what goals should be pursued in the future.

3.1 What is PCC in relation to care?

The question that then naturally arises is what care means. Care is a complex definition that includes a specific action or activities aimed at improving the quality of life of a person. Quality of life depends on personal values and conditions (Tronto, 2001, p.61). According to Tronto (2001, p. 62), caring for someone indicates the need to recognize the demand for care and to ensure it.

Recently, the concept of care has improved and now takes into account the quality of provided care. The obligatoriness is to change care perception and move toward person recognition in the process, meeting individual demands, as well as creating a relationship

between nurse and person in the way of mutual trust and respect. Person-oriented care meets all of the listed requirements.

There is no standard definition of PCC. Different articles present different terms for PCC, such as family-centred, user-centred, client-centred, relationship-centred, and person-centred. In this study, the term "person-centred care" is used because it better describes the concepts of PCC and it demonstrates the critical idea of personal uniqueness rather than focusing on the clinical aspects of caring.

The term of PCC is widely discussed in the health system. In 1950, Carl R. Rogers was the first person to describe the central concept of patient-centred care. Later, Michael Balint improved on this concept and oriented it more to the medical field.

PCC is understandable at a basic level, but the problem is a lack of evidence concerning implementation into practice. The Britten explains (according to Birks, 2007, p. 368) that the integration of PCC is hindered due to a lack of understanding regarding the principles of PCC. A more systematic and theoretical analysis is required to understand the meaning of the term.

Birks (2007, p. 368) states that PCC includes the person at the centre of caring, where nurses view caring as holistic action with physiological, emotional, spiritual, social aspects. PCC is a type of high-quality care that could deliver a positive result for patients, healthcare workers and the healthcare system in general. Firstly, PCC will increase patient satisfaction regarding the care they receive, which will lead to better treatment and care and will reduce the severity of diseases. Secondly, PCC will give workers satisfaction in their work and enhance their desire to work. Thirdly, PCC can help the healthcare system to reduce expenses and improve services (Sidani et al., 2014, p.248).

On the other hand, the definition presented by McCormack and McCance (2011, p. 1) describes PCC as a term that includes all persons in the process of caring, which includes patients, clients, families, caregivers, nurses, doctors, and others who are involved in the process of care. PCC concepts include engaging in the caring process and understanding the need for care, feelings, specific values, worries and expectation (McCormack and McCance, 2011, p.1). An additional definition was proposed by Westphal (2016) who regards PCC as respect for personal values, goals for caring, and the person's freedom to choose.

Moreover, PCC includes communication between the nurse and other people based on the quality of personal, professional, and organizational relationships. Nurses must deeply respect patients, communicate, provide treatment, and care for people as unique individuals by involving them in the process of care (Epstein, 2011, p.100).

Lauver elucidates (according to Morgan and Yoder, 2012, p. 6) the popularity of and increasing interest in incorporating PCC into the process of education for healthcare providers. However, despite the popularity of the concept, there is still uncertainty. The variability depends on the care provision settings and appears to be a barrier to implementation, understanding the process, and there is still confusion among healthcare workers (Morgan and Yoder, 2012, p.6).

2.1. The principles of PCC

In order to implement PCC into nursing practice, the concepts must be understood by the whole organization. Therefore, PCC is a type of care that meets, observes and checks the individual needs of each person, provides support on an emotional and physical level, engages the person and those who are involved into the process of care in the disease-management process, provides information, demonstrates good knowledge, creates a natural caring environment, and offers different options.

The beginning of care planning is initiated by collecting information from the person. Nurses can become acquainted with a person in a significant way by creating a trusting nurse-person relationship. To understand the person means to be familiar with the specific needs, values, preferences, and goals of the person. This information and the assessment of personal health are needed in order to create a healthcare plan. The difference of PCC from other types of care is the meeting of patient needs as well as the use of specific patient needs for creating their individualized caring plan, which is modernized regarding need change (Westphal, 2016, p.20).

The Picker Institute (1993) explored the eight principles of PCC that will promote the high quality health care. The first is respect for personal values, preferences, and expressed needs. Furthermore, PCC comprises respect for people as individuals, their values, needs, and preferences. The second principle is the coordination and integration of the person into the process of care. The source describes the ability to face illness, to integrate the person and their family into the treatment process and to engage their participation in the process

of care. The third principle is the person's right to know, to be part of the caring, and to receive education from healthcare providers about their disease, symptoms, caring, and treatment options. In conclusion, the person has the right to know about the condition of their health, the diagnosis, and the prognosis to be able to make proper, comprehensive, and advance decisions.

Another principle for PCC implementation is experiencing physical and emotional comfort during caring that involves the person in the PCC process. This suggests that nurses support people and help them to alleviate any fear and anxiety they may experience. The ability to assist on an emotional level provides general well-being. Patients may be unsettled when they lack qualitative and comprehensive information about their need for care and their treatment prognosis.

For instance, suitable support is possible when family and friends are involved in the process. The circle then widens to more than a relationship between patient and nurse; it may include family and friends, which could help to provide emotional and psychological support and assistance with decision-making. Rogers suggests (according to Creasy, Lutz, Young, & Stacciarini, 2015, p. 351) that family involvement in the process *"... is not merely focused on increasing family presence and patient autonomy while decreasing medical paternalism"*. First, care is collaboration between the nurse, the person and their family with regard to collaborative planning of care, delivery, and evaluation of results. Families must be cognizant of treatment options, health status, rehabilitation and further care (Creasy et al., 2015, p. 351). For example, Ross, Tod, and Clarke (2015, p. 11) emphasize, *"...it [is] particularly important to get to know the family when the people themselves [are] unable to make their wishes known."* By becoming involved, the family can offer insight into the patient's needs and give advice about the preferences of the person, especially if the person is not able to do so themself.

The outcomes of PCC practice include the well-being of the person and quality of care. In order to meet PCC outcomes, there must be continuity of care. Continuity means that the person's care needs following their hospital discharge and the planning and providing of care after discharge from hospital are met. To achieve this, nurses need to understand the principles of multi-professional teamwork. In other words, the ability to communicate and deliver correct, complete, and quality information and data from one provider to another is needed for continuity of care. Moreover, patients need to have access to safe, quality, and appropriate supervision on all levels to receive the best help (Brownie, 2013).

2.3. Qualities of a nurse

It is clear that nurses are also people with different personalities and perspectives. Good quality caring includes communication – verbal and non-verbal. For example, during communication, a nurse sees the person's reaction to proposed caring options, advice, methods, and treatment goals. The person expresses these reactions through positive or negative emotions. Moreover, understanding the person's emotions allows the nurse to access the patient's reaction to treatment and caring. Birks (2007, p. 370) determined that the *"... ability to manage and read emotions would seem to be an important skill for any health professional and might potentially enhance patient-centred care..."*

Usually, people pick out nurses who are "good" and do not want those that are "bad" to take care of them. The good nurses are those who control body language during emotion expression, control voice tone and do not raise it due to personal life or working problems. Good nurses do not behave in a rude, angry, or irritable way that will affect caring, and they never connect their personal life with work.

One of the factors that affect creating a relationship between the nurse and the patient is a caring environment. As Ross, Tod and Clarke (2015, p. 11) explain, *"Being friendly and approachable [is] seen as crucial by participants to the initial stages of building trusting relationships".* For example, nurses who can find time to do something extra, to listen to the patient's concerns, to empathize with and support the patient, demonstrate job satisfaction and further lead to the well-being of the patient.

Additionally, the patient wants to be heard, to be valued as an individual, to be respected and understood. The ability to provide the patient and their immediate family and friends with information regarding the patient's condition, diagnosis and treatment plan will provide a better understanding of the process and reduce existing fears (Ross et al., 2015, p.11). It is important that the nurse pays attention to communication with the patient and their family. Ross, Tod and Clarke (2015, p. 13) illustrate the importance for the nurse to recognize the patient by *«listening to and recognizing the importance of [their] stories"* which is *"valuable in facilitating PCC".*

The communication between team members is one of the most important aspects for promoting PCC. The ability to communicate as a team is an important skill for each nurse. Slater, McCance, and McCormack (2017, p. 544) describe the positive effect of the interaction and describe it as "*The ability of the practitioner to communicate at a variety of*

levels with others, using effective verbal and non-verbal interactions that show personal concern for their situation and a commitment to finding mutual solutions".

The ability of health providers to understand each other, to make a mutual decision regarding care, and to learn from each other will increase work effectiveness and satisfaction. Communication needs to be professional and structural. Ross, Tod, and Clarke (2015, p. 12) suggest that this type of communication it will bring positive outcomes because will reduce stress among all who are involved. Friendly team relationships, where communication between members is present, have a positive impact and create a suitable environment for practicing PCC (Ross et al., 2015, p. 12).

Creating a relationship with other people depends on personal character. According to Ross, Tod, and Clarke (2015, p. 13), the nurse's personality affects the way in which the team promotes PCC. Thus, a basic understanding of PCC principles leads to its promotion at work.

Practicing PCC requires that nurses recognize their responsibilities. Nurses need to enjoy the work they are doing, to have the desire to work and learn new things. This is connected to professional reliance between team members on each other and the competence to practice good quality care, despite differences in work experience (Ross et al., 2015, p. 14).

2.4. Types of centred care for healthcare providers

This section explains the different approaches that reveal the concept of PCC as the new meaning for care. Centred care could be aimed at the person, patient, consumer, family, women, and relationships.

2.3.1. Centred care

It is possible to understand this concept by determining the difference between a person and a non-person, and what makes a person unique. People are able to think, have value and morals, they express emotions, and they have their own political and religious views.

"Person centeredness" is a term that is found in different areas beyond the scope of medicine or social care. Nevertheless, person centeredness is not always described correctly. The study of McCormack et al. (2011, p. 3) describes the term person

centeredness and proposes four key concepts in nursing. They explained it *"... as a position of one human upon by other in connection of relationship and social life"*.

"Being in relation", "being in a social world", "being with self", and *"being in place"* is the model of the main characteristics of four concepts regarding person centeredness (McCormack et al., 2011, p.3).*" Being in relation"* means that a relationship should be present. This is important for creating therapeutic benefits from care.

Another statement, *"being in a social world"* describes the importance of being within a social life that enables one to create and recreate meanings. The concept of *"being with self"* is similar to the previous term but is more related to the person and their own values of life, how they interpret it, and their ability to cope with everything that happens to them. The concept of *"being in place"* is a striking point that encourages people to look into their surroundings on the threshold of their care experience.

In nursing, it is important to see the patient as a collaborator, which helps to create a relationship between the nurse and the patient, as well with other healthcare providers to facilitate work that is therapeutic and conducive to providing a good work environment.

In view of the above, Morgan (2012) presents PCC as a holistic approach to deliver respectful and individualized care, allowing negotiation of care and offering choice through a therapeutic relationship in which persons are empowered to be involved in the decision-making process. This care consists of four characteristics: holistic, individualized, respectful, and empowering.

The first of these four characteristics is the holistic approach, which entails providing care and treatment to the whole person at a biological, social, psychological and spiritual level at the same time (Morgan, 2012, p.8). The second concept is that care must be individualized and not standardized for everybody. Rather, it must meet personal needs and help to create a care plan that understands the patient's beliefs, traditions, culture, habits, and preferences (Morgan, 2012, p.8). Respect is a driving approach in PCC, as the individual has the right and freedom to make a decision about their care and treatment, which are respected and supported (Morgan, 2012, p.9). Empowerment is important to allow individuals to participate in decision-making and confirm their autonomy and self-confidence (Morgan, 2012, p.9).

Leplege (2007, pp. 1555-1556) frames the concept of PCC with four statements. First, PCC includes a specific, individualistic, and holistic approach where methods of care,

treatment, and diagnosis must be individual because outcomes will also be different. Second, PCC has to include everyday life problems because disease may lead to vulnerability, and it affects daily activity and life in general. This means that PCC has a broader approach and regards environmental factors. The third concept focuses on respect: Respect for the patient, his values and point of view, creating a dialogue and finding the best ways to solve problems from the perspective of the healthcare provider and the patient. The last idea is important and formulates a statement that everyone must receive the same care, regardless of their condition.

Patient- and person-centred cares are synonymous, but there are subtle differences and it is important to distinguish one from another. The most significant difference is the object of care. In patient-centred care, the object is the patient – a person under medical treatment. This type of care is focused directly on recipients of care, and in the process of treatment and caring, it includes the patient and family and friends (Zhao, 2016, p. 400). On the other hand, if care is person oriented, the object of care is a person – a human being –who is central and has freedom in the decision-making process. This implies a wider scope and involves all relationships in the environment (Zhao, 2016, p. 400).Both types of care emphasize conditions that include the individual's health and their disease treatment. Furthermore, the patient-centred concept is oriented at the disease-treatment process, its management, and the progress of disease, while the person-centred concept refers to health promotion (Zhao, 2016, p. 400).

It seems that both concepts of care consider the same values, preferences, and needs, but differences exist in their views and practices. In patient-centred care, delivery of care focuses on the receiver of care who suffers from the disease, and it does not address the whole person. In this case, workers in hospitals, long-term clinics, and policlinics are involved in care (Zhao, 2016, p. 400). On the other hand, person-centred care involves individual needs in conjunction with the surrounding environment and the care plan is based on the whole health condition of the patient by involving interdisciplinary experts (Zhao, 2016, p. 400).The phenomenon of patient-centred care provides visit-based care by healthcare professionals, but this interaction is restricted to the stay in hospital during disease treatment, while person-centred care is ongoing and accessible because the keys to care are prevention and management (Zhao, 2016, p. 401).

Therefore, this discussion relates to the person as the centre of care, the importance of which can be emphasized by providing additional information about PCC. Mccormack (2010) summarizes PCC as a way to treat individuals, to respect them and create a trustful

relationship with them as people, not merely as patients, because after their short stay, they will leave the hospital and become a person again. Moreover, the nurse's task is to provide care and it does not depend on the title or whether it is in a hospital setting or outside the hospital. In order to investigate PCC, it is important to be committed to becoming person-centred.

Another term that is often used is "family-centred care". It is frequently replaced with the term "patient- and family-centred care". The difference is that the objects are different, and in family-centred care, the emphasis is on the importance of including the family in the process. Family plays an important role in the patient's life. Involvement of families in the process helps to promote health and well-being because the family can provide the best social, emotional, and developmental support.

This care approach is integrated into the pediatric field more often than into other fields. The advantage of this type of care is that the centre of care is the family and they are constant part of the patient's life. Usually the family knows the patient far better than health providers do, which is why they take part in decision-making. Creasy (2015, p. 352) states that*"...family is meant to acknowledge consideration for patients supportive networks".*

McCormack et al. (2011, p. 3) have proposed terms such as "women-centred", "relationship-centred", and "client-centred". However, Leplege and Slater et al. explain (according to McCormack et al, 2011, 3) that all these terms describe the same aim of person-centeredness in provided care.

Women-centred care aims to meet the needs of the women rather than the needs of healthcare workers (McCormack et al., 2011, p. 2). The term relationship-centred care refers to the involvement of the person, healthcare workers, and families in the caring process (McCormack et al., 2011, p. 2).

Additionally, all of the previously listed definitions aim to care for the person. McCormack et al. (2011, p. 4) state that person in nursing work 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."*

2.4. The main barriers of PCC

The challenging barrier to PCC implementation is the difference between theory and practice. McCormack et al (2011, p. 4) state that while *"... the idea of person-centeredness is well understood at a basic level, the challenge is often recognizing it in practice".* Therefore, in order to implement PCC, the first task is to measure how nurses perform it. It is clear that each healthcare provider is sure that they practice PCC, but the reality is that they do not (McCormack et al, 2011, p. 4).

PCC could be implemented in practice if more research and a greater understanding were made available. Many studies show that even though PCC is not a new concept, it is not implemented by healthcare providers. The phenomenon is still on being integrated into the health system. The main problem is that PCC concepts are not fully comprehended and understood. Entwistle (2013) mentions that PCC is a widely known term among healthcare providers but it is not understood correctly.

Generally, PCC is discussed as a method that helps to improve health-status outcomes. The problem is that it is impossible to determine whether care is more or less patient-centred and often the patient becomes aware of treatment alternatives but does not participate in making a decision, which automatically undermines their autonomy (Entwistle, 2013, p.31).

The old-fashioned way of thinking creates difficulties to regard care as person-centred. Three barriers have been detected. The first concerns traditional practices and structures in healthcare systems. Often it is more convenient and easy for professionals to work according to an established standard and they usually do not want to be more flexible in their approach or use different strategies in their work.

Healthcare workers focus on objective data and theoretical care plans that they follow for everyone with this disease. The problem is that communication with the person does not take place as it should; they converse in monologs, where they keep talking and the person just listens without being integrated in the decision-making process. It is possible to overcome barriers but nurses have to understand their role in caring and treatment. Nurses have individual tasks, treatment goals, individual methods to cooperate with patients, families, and other health providers to reach the desired outcomes (Moore, 2017, p.668).

Time constraints is another challenge, because professionals need to learn new techniques, communication methods, to participate in new training; these processes take time (Moore,

2017, p.668). Healthcare providers do not always want to change their way of thinking. It may be difficult for them to accept the patient's culture, tradition, and needs and to create an individual care plan for each patient.

PCC promotion requires special work in the environment and the culture. This includes coping with work stress, time constraints, and language. The work environment also includes person-nurse relationships based on dignity and mutual respect and the nurse's desire to update knowledge.

Professionals' attitudes are a significant barrier to PCC, because the patient is not accepted as an individual. Care providers behave as though they know everything and as though the patient's participation is not needed. This may be due to lack of interest, knowledge, or commitment (Moore, 2017, p.668). According to Westphal (2016, p. 21), *"People want their choices to be heard and respected…",* however, people have to understand and have a desire to participate in their care.

Other barriers include method of intervention, lack of knowledge among population about new approaches, language barriers, difficulty in creating a trustful relationship, and existing documentation systems (Moore, 2017, p.669). Documentation serves as communication between staff where goals are stated and all information about patient health status should be noted. However, because information is recorded in a brief manner, important information could be missing; everyone works independently and not as a team.

Overall, the barriers involve a biomedical approach, because traditional professional attitudes are difficult to change due to lack of motivation and desire. Many professionals strongly believe that the standard system is well developed.

2.5 Popularity of PPC in research

In order to present the new data and suggest recommendations for effective implementation of the new knowledge and understanding regarding PCC into nursing practice, a few studies are examined.

A list of good articles was accessed to help meet the aim of study. In the article titled "A Description of Nurse Practitioners' Self-Report Implementation of Patient-centred Care", the study aimed to explore how nurses implement PCC and what factors influence this implementation (Sidani, 2015, p.1).

With this in mind, in order to discover the methods used to create communication between nurse and patient and to create a trustful and patient-centred relationship, another study was found. It aimed to assess how staff accepts new approaches and how communication care plans are implemented into practice. In addition, it aimed to evaluate whether the level of knowledge about PCC has increased among nurses; whether the method is used during communication with patients; and it explored changes from the patient's perspective and whether they are more aware of their care plan and are satisfied with their psychosocial functioning (Mcgilton, 2011, p.1).

Because the concepts of PCC are complex, it is difficult to put them into practice. Another study sheds some light on the implementation approach of PCC in nursing. The aim was to identify the concepts of PCC and to implement them into nursing education by involving different paths of the healthcare system (Natan, 2017, p.596).

3. The theoretical framework

Caring is a foundation of nursing and central to nursing practice. Nursing care embodies awareness of professional responsibilities, which is important, because patient-centred care, firstly, focuses on meeting individual needs. Clearly, this is the task of healthcare professionals, especially nurses who are responsible for developing good communication skills and for functioning as a patient advocate who can address patient needs effectively and safely.

Swanson (1993, p.354) describes nursing care as a deep relationship between nurse and patient. In this care, nurses use their knowledge to help patients recover. The most important aspect is that the provided care acknowledges the patient's dignity, respects the patient, and facilitates empowerment of the patient.

Swanson (1993, p.354) finds five caring processes such as philosophical attitudes, informed understanding, the message conveyed, therapeutic actions, and intended outcome-patient well-being that is related to each other and creates a model of caring. The concept of caring delivery is central and logically arranged to provide an effective caring process and to enhance patient well-being. Nurses should become aware of the caring process and incorporate it in their practice. While they need to understand how difficult it is, they must also be cognizant of how pleasure they can receive from taking care of others, and of how their patients can rehabilitate and recover because of their help.

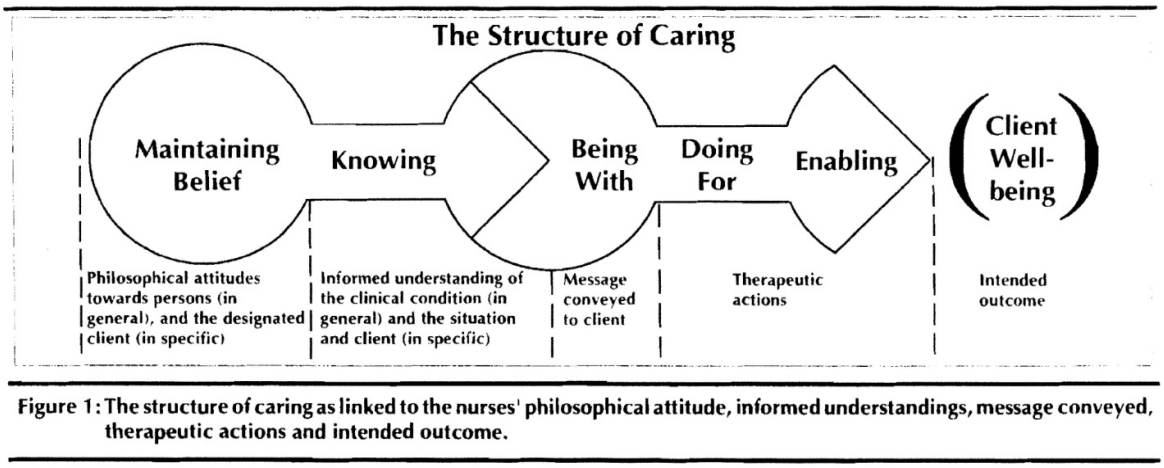

Figure 1: The structure of caring as linked to the nurses' philosophical attitude, informed understandings, message conveyed, therapeutic actions and intended outcome.

Figure 1 Structure of caring according to Swanson (1993, p.355)

Swanson (1993) illustrates the structure of care. In her theory, Swanson (1993) presents five main concepts that ensure the provision of effective care. *"Maintaining belief"* is a philosophical attitude to the patient, *"knowing*" is informed understanding, *"being with"* is a communication with the patient, *"doing for"* and "*enabling"* are therapeutic actions, and all these actions provide the desired result – the patient's well-being (Swanson, 1993, pp. 354-357). *Maintaining belief* is the base of caring, where nurses determine what care is needed and where to address this care (Swanson, 1993, p. 354). It is important to keep belief for overcoming all troubles and to be ready to face them in the future, while still maintaining hope and optimism.

The base of nursing care is *knowing* (Swanson, 1993, p.355). If the nurses know, they will be able to understand, see reality, and maintain the belief into the realism of the human condition. Nurses have special knowledge with practical, ethical, and visual aspects to be able to solve actual and potential health problems.

Emotional presence makes solving problems possible because it establishes a link of respect between the nurse and the patient where in all needs and sufferings are shown. *Being with* is more about emotional presence than a physical presence, and it is shown in personal attentiveness to the people you are taking care of (Swanson, 1993, p. 355) *To be* with and *to do for* are relevant terms that explain the ability of the nurse to be present for the patients by meeting their individual needs (Swanson, 1993, pp. 355-356) This links to the last concept of *enabling,* which aims to create long-term and effective well-being. It includes an internal and external focus on needs, guidance, and finding alternative solutions to the problem (Swanson, 1993, p. 356)

Swanson (1993, pp. 353-354) defines four main phenomena of consumption: "*environment", "nursing", "health", and "person/client"*. According to Swanson (1993), caring is grounded in maintenance of a basic belief in human beings, supported by knowing the client's reality, conveyed by being emotionally and physically present, and enacted by doing for and enabling the client. This study addresses the *person*. The person is unique, because he or she has a soul and a brain, can express emotions, and is able to feel. Swanson proposes that the life experiences of each individual are influenced by a complex interplay of *"a genetic heritage, spiritual endowment and the capacity to exercise free will"* (Swanson, 1993, p. 352). The relationship between the nurse and the patient also involves families, friends, society, other nurses and staff, but it is first caring about themselves. The nurse is responsible for the mandate to take on leadership roles in fighting for human rights, equal access to health care, and other humanitarian needs that will provide patient well-being.

5. Research Method

This study aims to detect existing knowledge on PCC investigation into nursing and evaluate the implementation level, and to determine which barriers hinder the implementation process into the daily routine. To achieve this, a qualitative literature review of previous studies and research in this area was conducted to continue future development by referring to previous knowledge. The overall goal is to provide knowledge about implementing PCC into nursing practice and to present the importance of care that is oriented to individuals, which will highlight the benefits of a nurse-person relationship in caring, treatment, and rehabilitation.

This chapter explains the ethical consideration that arises, the qualitative literature review, a content analysis, and it demonstrates how data was collected and analyzed in this study. Data collection took place through comprehensive research and examined studies on implementation of care where the person play centred role.

5.1. Data collection

A strong literature review has to be universal, organized, reproducible, and must not have a foregone conclusion. A qualitative literature review is more flexible and is the best approach for finding data (Polit& Beck, 2012, pp. 96-97).

A search strategy is needed to explore the data for review. One of the methods is to search for relevant data in a bibliographic database. In addition, there is the ascendancy method, descendancy approach, and grey literature. This study uses the first two methods. Firstly, a search was made of a database. Once a relevant article was found, the second method was used to check the citation and to search for earlier studies on the. Using a database is helpful and is often used in literature reviews because it contains substantial amounts of information that is coded according to language, year, author, subject, type of data, and many other codes. In order to find answers to study questions, it is important to have inclusion and exclusion criteria (Polit & Beck, 2012, p. 98).

The data for the study was collected by selecting studies from different database. Through the Novia University of Applied Sciences, access was gained to the Academic Search Elite Database (EBSCO) host bibliographic database, which has access to the Pub Med database, Cinahl (nursing).

The initial search for articles included studies from around the world and English language was an important criterion because this study is in English. Any article written in a language other than English, or which had only the abstract in English, was excluded. Many articles were found about PCC in nursing homes and the implementation of PCC for patients with dementia, and these were collected to see the overall picture. Articles that were specific about implementation of PCC depending on the country's culture were excluded because this study focuses on finding general principles that can be applied universally.

To ensure the search was clear and structured, keywords were identified that relate to the topic of this study, which include "patient-centred care", "person-centred care", "centred care", "person centred", "care", "new researches", "implementation", and "nursing" in order to find relevant data. Through the database, access was gained to different journals, which were then analysed in this study. However, it then became apparent that some articles were available as full texts online through the journal's website, without being accessible as full text following the EBSCO search.

In order to provide relevant information for the study, the search also selected articles according to a search was conducted for articles from 2010-2018 and all article titles and abstracts that followed key words and years were considered in order to find articles that create a wide and effective guideline. In order to check whether the articles were related to the topic and could help provide answers to the questions, the abstract, aim, conclusion, and discussion were read. Nevertheless, it was difficult to find relevant data by using all limitations (year, full text, English language, peer-reviewed) and the period was changed from 2010-2018 to 2005-2018 (older articles were excluded), after which the article "Development of a framework for person-centred nursing" was found, which was published in 2006. A reading of the article showed that the research answers this study's question: "How does research describe implementation of PCC?" This led to the inclusion of the name of the author "McCormack" as an inclusion criteria and that led to the discovery of more of his articles: "Developing a tool to assess person-centred continence care" and "Developing person-centred care: addressing contextual challenges through practice development".

Thereafter, it became clear these limitations and keywords did not lead to finding articles concerning the second question: "What barriers exist in implementing PCC into nursing care?" Therefore, the inclusions criteria was amended, and the period was changed to 2010 to 2018 and new keywords were added, such as " barriers of PCC", "barriers of implementation PCC" and, as a result, more articles were discovered: "Developing person-centred care: addressing contextual challenges through practice development" and a few others that offered answers to the second study question.

5.2. Systematic literature review

The study uses a qualitative literature review, and this research provides an understanding of the human condition in different contexts and of a perceived situation. The review is used to find current information about the topic of the study.

The aim of qualitative approach is to find answers to the questions by viewing them from different perspectives. The process of analyzing and collecting previous data proposes to find new perspectives of knowledge (Gerrish, 2015, pp.165-166).

A literature review helps identify relevant information on the topic; frameworks, appropriate research methods, and summarize the final findings about the topic of the

study. Using this approach in the study determines what has already been done concerning the topic, provides a deeper understanding of the topic, emphasizes the need for the research, and assists in the formulation of a hypothesis. The method aims to summarize relevant literature and present what was already described, as well as to clarify the significance of the new study (Polit, 1989, pp.65-66).

Data was collected through databases and manual searches. All relevant articles are included and checked for quality beforehand. Articles are excluded when they demonstrate different ideas (Polit& Beck, 2012, pp. 653-654).

The first step in a literature review is to find the topic of the review, the type of literature, and to formulate the research questions. Thereafter, it is important to determine a search method that facilitates the collection of good quality data, abstract, criticisms, and then to analyze it in order to formulate a conclusion. It is necessary to use determinate data from the primary source. It is possible to offer good quality research by basing it on current and complete data that explains the importance of well-researched materials. Moreover, the review has a clear structure and well-formulated inclusion and exclusion criteria (Polit& Beck, 2012, pp. 94-97).

5.3. Content analysis

Content analysis is used for processing information and aims to find objectives and to systemize information. This method can be applied to oral and written data. Analysis of information should have inclusion and exclusion criteria of materials that will provide unique information and conclusions that another person analyzing the same material might not get. Key words, themes, and items are used to find needed information for analysis. The next step in content analysis is categorization and classification of content. This step is important in order to produce good analysis. A systematic or random sampling plan in selecting materials for analyzing is used in content analysis. This study uses a systematic sampling plan for analyzing information (Polit, 1989, pp.325-326)

Content analysis is used in this research and is the best method to analyze existing knowledge about PCC and to discover what the main barriers are that prevent integrating this approach into practice. Content analysis is a research method that is characterized by creating new information conclusions from the data context (Elo and Kyngäs, 2008, p 108). The method finds categories that are then combined to create an implementation

model. A researcher could choose which of the two terms to use –*category* or *concept*; however, the term *concept* is known to be used if the study aims to develop theory. In this study, the term *category* is used, which is found more often in literature (Elo and Kyngäs, 2008, p 108).

Standard instructions for the qualitative analysis do not exist, which means the researcher must see similarities and link them in order to break a large part into smaller components. These smaller units then need to be labeled with codes. Then smaller units with these codes according to the connection between them are grouped in main categories. Generic categories are created from two to six categories. Lastly, a few generic categories create the main categories (Polit& Back, 2004, p.572-576, Elo & Kyngäs, 2008, pp 108-112).

Initially, the researcher must select what to read and analyze in terms of whether the material has latent or manifest content. The latent content analysis means that the examiner is able to see beyond the words and see information that is hidden. In the case of manifest content, the answers are already in the analysed paper. Content analysis can be used in an inductive or deductive way; the first way is used when categories are created from the data, where the researcher creates a statement from concrete examples. On the other hand, in the deductive method, the researcher uses previous information in order to test the theory (Elo & Kyngäs, 2008, pp 109).

This study used inductive content analysis because the aim of the study was to gain new knowledge and understanding based on new evidence from qualitative literature. The decision was made to analyze manifest content. First, all articles were printed for analysis and were carefully read to find answers for and gain a deeper understanding of the two study questions. All information that appeared to be an answer to the first question was marked in one color, and possible answers to the second question were marked in another color. The article was then reread to ensure that relevant information had not been overlooked. Thereafter, the second copy was printed with the results and coded so indicate which page was from which article. It was reread twice to ensure that the quotations were relevant to the theme, and the text was colored on the copy. Thereafter, all the quotations that were relevant in the smaller parts were cut out and sorted into groups that that appeared to constitute applicable sets. This was continued until the exact group for each quotation had been determined. Sub-categories were then formulated, and from them main categories were created. In order to make the structure clear, a table was drawn up that shows three main categories with underlined sub-categories to each of them.

5.4. Ethical consideration

Ethical issues must be discussed in any research where human beings are involved, especially in nursing research. The lack of clarity in ethical standards encourages nurses to be aware of these issues and is an effective framework to deal with problems involving human rights.

In qualitative literature reviews, the researchers interact with participants by collecting, analyzing, and using information. The main principle is beneficence for the participants and society in general. In qualitative studies, informed consent must be provided to protect participants and to ensure their safety. Confidentiality, anonymity, privacy, impact on researcher or participant are further important components, which must be considered from the step of collecting data until analyzing. It is important to consider all psychological and social implications to provide confidentiality in the study. It is vital to remember that nurses are advocates for the patients. The information must be true and reliable in order to be used in interpretation and evaluation of information .In order to use the previous studies in an ethical way, raw data should be analysed and interpreted with accuracy and fairness (Polit& Beck, 2012, pp. 151-170).

This study does not use interviews or similar data. Therefore, the participant's rights did not need to be considered, in other words, their right to anonymity, autonomy, their right to freedom from harm and discomfort, the right to leave the study any time without giving a reason, and the right to be fully informed about the study before deciding whether to participate or not (Polit & Beck, 2012, pp. 152-163).

Plagiarism is forbidden in a literature review and will be not be present in this study. Plagiarism destroys ethical issues and disrespects the author's dignity. The information should be paraphrased into the author's own words; and all information must reference the original sources. This study attempts to endeavors to create a clear, structured work and to be honest in order to avoid misconduct (Polit & Beck, 2012, pp. 94-95).

6. Result presentation

This chapter presents the findings and answers to the questions listed in chapter 4. During the content analysis, three main categories were determined. The first is **holistic care**, the second one is **collaborative care**, and the third one is **active care.** Under the category

holistic care, three sub-categories were identified, such as ***meeting needs, culture change, and communication.*** *Collaborative care* also includes three sub-categories: ***teamwork, leadership, and learning***. In the category *Active care,* two sub-categories were found: ***measurement of care*** and ***continuity of care.***

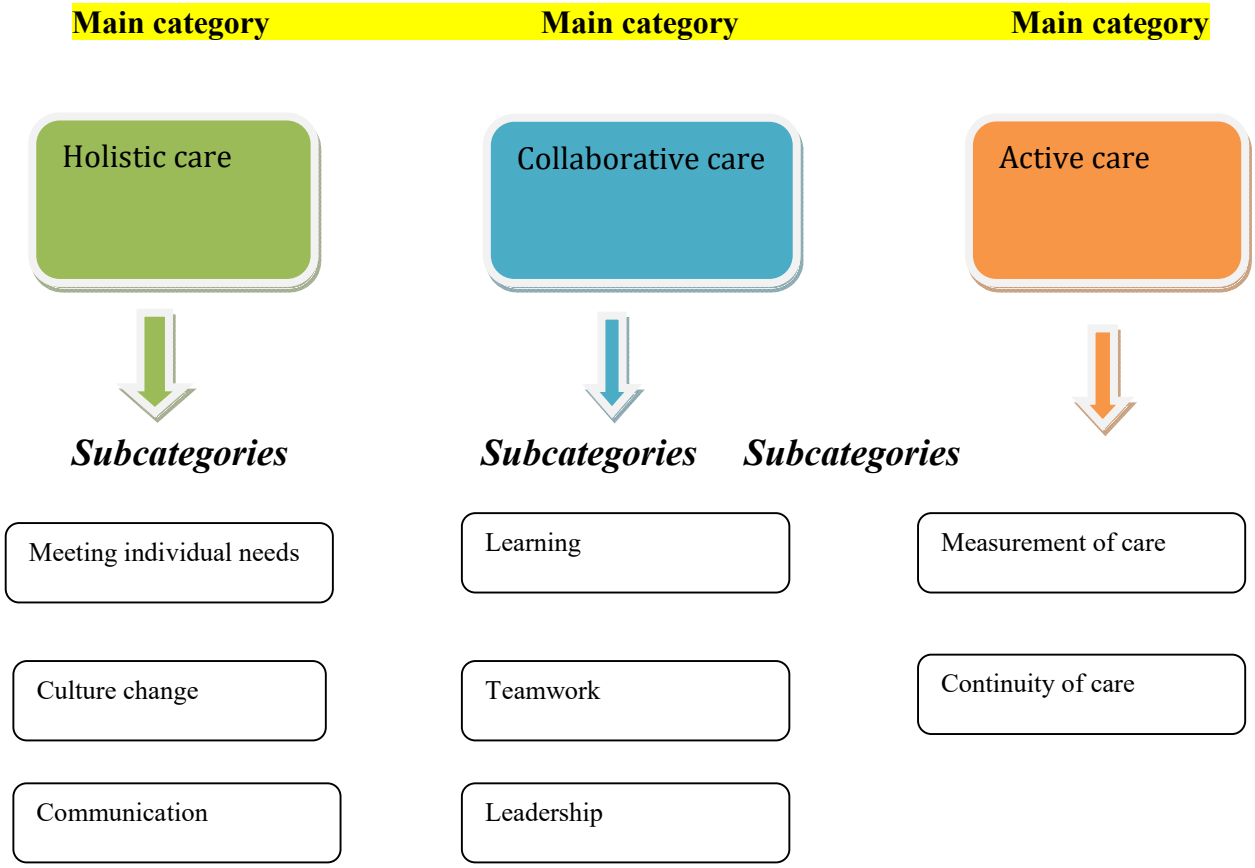

Figure 2. Data analysis process

6.1. Holistic care

Holistic care includes the biological, social, psychological, and spiritual needs of the person that demonstrate valuing the person as an individual, as well as those who take care of them (Sidani et al., 2014, p. 249, McCormack, 2011, p. 1). Nowadays, the caring process is depersonalized, which undermines a person's autonomy. However, people are different; and everyone cannot have the same type of care. But in order to practice PCC, care has to be focused on the person and not just on the condition or disease; the person's care needs have to be individualized because that will demonstrate the uniqueness and

personality of the person. The studies illustrated that satisfaction regarding caring depends on receiving humane care (Edwardsson et al., 2010, p.835, Wrightet al., 2006, p.25, Entwistle et al., 2013, p. 32, McCormack & McCance, 2006, p.479).

Entwistle et al. (2013) demonstrate that the important aspect in practicing PCC is *"...taking each patient's subjective experiences seriously, being attentive and responsive to patients' unique biographies, social contexts, and the relationships that matter to them, and being careful to avoid damaging personal identities that they value."*

Wright et al. (2006) describe that *"...a strong culture that reflects person-centred care is one that reflects the person as a unique individual."*

Also, Scholl et al. (2014) explain that PCC requires *"...providing care that is tailored to each specific patient."*

Effective holistic care implies the person's involvement in the process. This is possible by understanding caring needs, acknowledging, and seeing alternative complementary options. Patient involvement and caring together with the person is possible by providing information that will help the patient to make a decision about their own process of treatment and care (Santana et al., 2018, p.43).

According to Santana et al. (2018) it *"... is a need to ensure that care is also patient-directed, whereby patients are provided with sufficient and appropriate information to make decisions about their care and level of engagement."*

As well, Santana et al. (2018) demonstrate *"... a key guiding principle in implementing PCC is to incorporate the patient perspective...."*

6.1.1. Meeting individual needs

The sub-category ***meeting individual needs*** describes that practicing PCC requires satisfying the needs of each person. Holistic care is possible when the nurse meets specific needs of the patient in specific situations (Entwistle et al., 2013, p. 33). Staff members need to consider the patient's age, gender, race, culture, and economic and social status to be able understand and apply specific patient needs into the process of care where dignity and autonomy are respected. To be able to see the person as a whole person, the workers need to understand and value needs that are required to assess the person's condition,

health problems, and goals of treatment, and to find solutions concerning health together with the person and the others who are involved in the process (Sidani et al., 2014, p. 251).

As, Scholl et al. (2014) explain that *"This includes eliciting each patient's individual needs, preferences, values, feelings, beliefs, concerns, ideas, and expectations as well as exploring both the patient's disease and illness experience, the impact on functions (e.g. the patient's idea of how the illness affects his or her daily life; effects of the illness on the patient and his or her family), and his or her individual explanatory model.*"

Also, Cingel et al. (2016) offer that *„...next to information about who someone is as a person, the category 'appearance and characteristics' also releases information on what a person believes to be important at a certain moment or in general."*

Nurses have to respect each individual's values, needs, background, life situation, relationship, emotions, and difficulties that will demonstrate how the person accepts and makes sense of the situation. Some people have a range of limitations due to a disability or mental disorder, which means they have more needs that nurses must fulfill in order to provide the person with effective care. Therefore, care needs to be individualized specifically for each person in a way that will demonstrate respect and support dignity (Entwistle et al., 2013, p.36, p.542, McCormack & McCance, 2006, p.476, Santana et al., 2018, p.433).

McCormack & McCance (2006) report that *"Working with patients' beliefs and values reinforces one of the fundamental principles of person-centred nursing, which places importance on developing a clear picture of what the patient values about their life and how they make sense of what is happening."*

Santana et al. (2018) add that "A "rights- approach" to PCC is aligned with the promotion of human dignity for both patients and health- care providers and allows both parties to be aware of their rights and responsibilities."

6.1.2. Culture change

Culture change is widely described in literature and plays an important role for patients, healthcare providers, organizations, and healthcare systems as a component of implementing PCC into practice.PCC culture is a constant process that includes change of perception of care. This can be achieved by providing the person with a choice, involving

them in the process of decision-making, and supporting their desire to participate in their health management in a way that shows patients respect, autonomy, increased satisfaction with care, and which promotes humanity (Entwistle et al., 2013, p. 31, McCormack & McCance, 2006, McCormack et al., 2011).

McCormack et al. (2011) state that *"The development of person-centred cultures is not a 'one-off' or 'one-time' event but instead is an ongoing and continuous process."*

Also, Entwistle et al. (2013) suggest to *"...do not allocate patients responsibilities that are misaligned with their supported capabilities for self-management, that health promotion efforts do not undermine or preclude the exercise of patients' self-trust, self-respect, or (other) capabilities for autonomy, and that patients' own views of what is good for them are not neglected."*

Care perception and organizational culture must be taken into account. Each ward has a different culture; it includes uniform, language, care environment, caring location, surroundings, work stress, time pressure, and emotions. Organizational culture plays role in the process of implementation. Different working cultures explain that implementation of PCC into organization could be possible by understanding each specific work place culture (McCormack et al., 2011,p. 2, Wright et al., 2006, Slater et al., 2017, McCormack & McCance, 2006, Santana et al., 2018).

Cingel et al. (2016) report that *"...work cultures do have a significant influence as a primary condition for person-cantered care."*

McCormack & McCance (2006) declare that *"... the care environment has a major impact on the operationalization of person-centred nursing, and has the greatest potential to limit or enhance the facilitation of person-centred processes."*

As well, Cingel et al. (2016) assert that "The context in which care takes place influences the working culture."

Culture change also means definition change, so that each worker understands the concept of what they are doing and how to provide PCC. Thus, the definition has to be changed, because practicing PCC means to place the person atthe centre of care and to involve important people for the person in the process and to create a caring plan together.

Santana et al. (2018) explain that *"...PCC promotes the value of co- design where health-care providers do things with people, rather than "to" or "for" them."*

Entwistleet et al. (2013) argue that *"Current definitions and interpretations of person-cantered care cannot always differentiate more from less appropriate forms of involvement: they cannot recognize these health professionals' approaches as less person-centred than the approaches of health professionals who are more responsive to individual patients as persons."*

6.1.3. Communication

Communication was found to be a vital aspect of effective implementation of PCC. Communication includes active listening and acting between health professionals and the person, which helps to create a friendly, respectful, and trustful relationship. Communication between the person and the nurse, between healthcare providers and a leader needs to be done in a professional and ethical way that will provide support and will be oriented on the health questions that involve verbal and non-verbal contact (Entwistle et al., 2013, p. 32, Scholl et al., 2014, p. 3).The relationship between the nurse and the person is vital and allows the nurse to see a whole person, to understand a specific person's situation and difficulties, and to know what a specific person needs in the caring process that will give positive caring outcomes. Nurses have to be able to see a whole person rather than the disease, which will help them practice self-control, honesty, tolerance, and understanding of their role (Scholl et al., 2014, p. 3, McCormack et al., 2011).

McCormack et al. (2011) state the importance of the *"... evidence of staff 'knowing the person' in a more meaningful way."*

Entwistle et al. (2013) describe that the *"... interactions between healthcare staff and patients reflect relationships of equality–mutuality in terms of entitlement to ethical consideration within and as part of a social group."*

Moreover, Cingel et al. (2016) describe the significance of caring relationship in PCC implementation and point that *"A good caring relation is an important prerequisite for good care, in which compassion, respect; personal and professional involvement and closeness can flourish."*

6.2. Collaborative care

Collaboration between the person and the nurse plays one of the main roles in the care delivery process. Satisfaction with care and effectiveness proportionally depend on good leadership, teamwork, and work satisfaction among personnel. Collaboration is vital and gives the possibility for active learning and observation of caring needs (McCormack et al., 2011, McCormack & McCance, 2006). Good collaboration increases the desire to work and thus effectiveness, because it helps to create teamwork with engagement of the person, the health providers, and families in addition to providing the person with more information about their treatment. Moreover, it helps create the same image of PCC and ways of implementation among all who are involved in the process of care. Collaboration is the base for ease of access to care, availability of staff, time and cost savings, as well as effectiveness of care (Santana et al., 2017, p. 435).

Santana et al. (2017) explain that *"...when people are better informed, they may choose different treatments – often those that are less invasive and less expensive when people are supported to manage their own care more effectively care."*

Scholl et al. (2014) clarifies that *"...the clinician-patient relationship is described as central for patient-centred care, by building a partnership with the patient through collaboration."*

6.2.1. Learning

Nurses are required to learn all the time, to progress and to update knowledge, as well as advance PCC in their practice (McCormack & McCance, 2006).Active learning could be possible if they desire to grow on a professional and personal level and are open to learn new things. Active learning affects work effectiveness and general personal satisfaction of provided care.

McCormack et al. (2011) explain that *"A learning culture is a culture in which nurses view their work as exciting and revitalizing, offering them the prospect for both personal and professional growth"*

Learning means to understand mistakes and create conclusions, bring new things to work, share experiences with colleagues, underline outcomes, and to use them in practice.

"Practice development emphasizes the central place of learning through everyday practice, what we have come to describe as 'active learning'" (McCormack et al., 2011).

Moreover, learning also means to see what is important for the person and take it into account during the caring process for nursing interventions, diagnosis, and evaluation. This requires experience that could be gained at work as well as own experience.

"Providing good care depends on up-to-date professional knowledge and skills" (Cingel et al., 2016).

6.2.2Teamwork

The team includes a range of professionals from organizational level of the healthcare system to healthcare providers who practice PCC. Implementation of PCC is the work of the whole team and requires improving work effectiveness, time management, and relationships (McCormack et al., 2011, p. 7-8). Nurses are always working in multi-professional teams. To work in a team means to train new skills and study all the time. This is important in order to have the same point of view between the team members on how to practice PCC. The team members have to be able to communicate, to respect, to trust, to have the same values, point of view, goals of care, and to value each other if the members want to deliver these values to the other person (Scholl et al., 2014, p.4, McCormack et al., 2011, Wright, 2006, p. 28). The way in which staffs treat the patient depends on how they treat each other, which means they value, respect, see perspectives and concerns, and promotion of self-development (Entwistle et al., 2013, p.35).

Scholl et al. (2014) confirm that *"Patient-centred teams are characterized by their ability to communicate, respect and trust among team members, mutually shared values, goals and visions, information sharing, constructive feedback, more equal distribution of responsibility, accountability, and power and awareness of one's own abilities and priorities."*

"The list of activities may be helpful in training members of the interprofessional healthcare team in developing a common understanding of PCC and hence in following comparable strategies in providing this approach to care, which promotes a consistent implementation of PCC across professions"(Sidani et al., 2014).

6.2.3. Leadership

A nursing leader is a person who encourages workers to develop professional skills, knowledge, and become patient supports (Wright, 2006, p.25). Quality of care depends on the quality of nursing leadership. Firstly, good leadership encourages staff to grow professionally, to develop PCC qualities, and to use them in practice.

McCormack & McCance (2006) clarify that *"...the quality of nursing leadership and the commitment of the organization to the use of multiple sources of evidence to evaluate the quality of care delivery."*

A leader is required to bring more information and knowledge to workers, encourage them, bring enthusiasm, and implement new activities into the work routine.

"Without transformational leadership team members were unable to optimize their skills, abilities and knowledge" (McCormack et al., 2006).

6.3. Active care

Active care means evaluation of PCC implementation and obtains positive outcomes of care for nurses and persons they take care of. These positive outcomes include patient satisfaction of care and well-being on all levels.

"The categories 'physical well-being', 'psychological well-being' and 'social well-being' all show either a measure of those aspects known to be important to a person from earlier assessment or an evaluation of something in the moment itself"(Cingel et al., 2016).

The care for the patients has to be implemented in each unit from the nurses until the healthcare organization, in general. To make it really is possible by creating special curricula and educational programs for personnel.

Santana et al. (2018) describe that *"...governments and organizations play a key role in the development of clear and comprehensive polices, processes and structures necessary for health- care systems and health- care providers to deliver PCC"*

As well, Santana et al. (2018) explain that *"...current education tends to focus on the biomedical model, is not standardized across health- care sectors and professionals, and is not co- developed with patients and health- care providers…"*

6.3.1. Measurement of care

The ability to practice PCC is possible by measuring its implementation, for which a specific tool of measurement needs to be found. Measurement of care has to be performed by everyone who is involved in caring in order to practice activities that evaluate quality of care, involvement of family, the person's needs, values and desires, condition of the person, and effectiveness of care.

"Having healthcare providers report on their performance of the PCC components is a means for assessing fidelity of implementation" (Sidani et al., 2014).

"The measure may be useful in assessing the fidelity with which professionals implement PCC in different practice settings" (Sidani et al., 2014).

The person's experience of care and satisfaction are also a measurement for PCC implementation. The response to obtained care could help to improve, identify, and remove existing problems.

Santana et al. (2018) supports that *"...patients, health- care providers and policy makers should co- develop structures to measure and monitor PCC performance based on feedback from patients, to promote PCC practice."*

However, there is a list of available tools for PCC measurement but they are not convenient for all wards and were not used in practice, which creates a barrier to implementation.

"We have demonstrated a growing number of innovative, useable, psychometrically robust tools; however, a limitation of this body of research is that most of the tools (with the exception of DCM, PCQ, measures of individualized care, and PCIS) have not been used in actual research since the development period" (Edvardsson et al., 2010).

6.3.2. Continuity of care

Continuity is one of the main aspects for caring that needs to be understood by nurses and applied at work. Discharge from the care centre is not the end of care; it needs continuity of services. Because nurses are responsible for providing care after discharge by using data they know about the person, it includes support services, home services, transition from one place to another, and booking of follow-up appointments.

Scholl et al., (2014) illustrate that *"…the literature review showed the importance of coordination and continuity of care to be patient-centred"*

"The data illustrate the value of understanding the context within which care is provided in person-centred continence care and management" (Wright et al., 2006)

Possible intervention that allows for continuing care can be achieved through special electronic medical records that can link the person's data, communication, and support, and involve family in treatment (Santana et al., 2018).

"E- health technologies should provide secure and private platforms and its integration involves both building and updating existing health- care facilities, and effectively connecting patients and caregivers with practitioners throughout the continuum of care" (Santana et al., 2018).

7. Results presentation

This chapter includes two sections: the first discusses the results and the second discusses the methods. The first section describes links between the study results with the background and theoretical framework. The second section presents the study method.

7.1. Results discussion

This section presents three main categories that will help to implement PCC into nursing practice, where care is a key component. Swanson (1993, p.355) illustrates that care is structured in three parts: attitude, action, and outcome. The first main category is *Holistic care,* which underlines attitudes toward the person and informed understanding of condition and the person according to Swanson's (1993, p. 355) structure of care. The second is *Collaborative care,* which addresses the action the nurse has to provide to the people she takes care of, and it includes the ability to understand, to explain, to support, and do for cared people things that they would do themselves if it were possible (Swanson, 1993, p. 355). The last main category is *Active care,* which describes the desired outcome of PCC: well-being of the person that can be measured and evaluated (Swanson, 1993, p. 355). The background demonstrates the main concepts of PCC and describes understanding the difference between patient and person, human and non-human.

Holistic care explains that in order to implement PCC, nurses are required to see the uniqueness of persons rather than the disease and symptoms, and to involve the person in the process of care in a way that makes this care humanistic and follows Swanson's (1993, p. 352) definition about the person as an unique being with their own thoughts, beliefs, behaviors, free will, and choice to decide, and it includes caring for other people involved in patient care. The barrier that exists in practicing holistic care arises from gender, race, age, skin color, religion, care access differences, and according to Swanson (1993, p. 352), limits the vision of the person, their free will, and their choices.

Meeting individual needs is a component that facilitates getting to know the person, seeing the whole person, and providing care that is individualized according to their needs and preferences. Swanson (1993, p.355) describes that knowing is a prerequisite for this, because knowing helps to observe specific person's situation, to see the person and meet the needs that are required in each specific case without guessing.

The sub category ***culture change*** contains three key terms – working culture, person involvement, and terminology change. In order to get to know the person, the special working culture has to be present, where the person is involved in decision making, as well as others who are important to that person. Moreover, the definition of PCC needs to be standardized and describe what PCC is, the components that will allow nurses to understand how to practice PCC and will help to remove the barrier of misunderstanding for future successful implementation of PCC in practice.

Practicing holistic care is possible via ***Communication*** by creating friendly and trustful relationships with the person, which helps to know what the person needs and how to provide care in each unique case, which Swanson (1993, p.355) mentions in her theory as a definition of "*being with*", which means being open to the person and present in the moment.

The second main category *Collaborative care* demonstrates actions that are needed to implement PCC. Collaboration increases active learning, the desire to work, effectiveness of work, brings new knowledge, creates strong teamwork, and leaders are able to function, which follows Swanson's (1993, p.356) theory regarding doing for and enabling.

Through ***Learning,*** nurses update knowledge; they discover from experience and mistakes. This knowledge is the component of "*enabling*" described by Swanson (1993, p.356) for use in order to treat and take care of the person, as well as educate and support the person to go through this specific situation.

Good ***Teamwork*** increases effectiveness of care delivery, brings care satisfaction, creates meaningful, and respectful relationships between workers, which directly affects the people they take care of. Good teamwork can provide care that meets patient needs, and includes activities that this person would like to do for themselves, as explained by Swanson's (1993, p.356) theory definition of *"doing for"*.

To meet this need, another sub-category ***Leadership*** was found. The leader is responsible for bringing new knowledge and common understanding about principles and concepts of PCC. However, a barrier exists if the team does not want to accept this information or do what is recommended by the leader.

The main category *Active Care* means evaluation of outcomes and continuity of care. In her theory, Swanson (1993, p.354) describes it as the concept of maintaining belief, which means transferring optimism through the process of care.

Measurement of care is evaluation of PCC implementation into nursing practices by estimation of the person's satisfaction with the care and their general well-being. The use of measurement tools is needed but, as literature demonstrates, the main barrier is that all available tools are not convenient to all organizations and, moreover, not all of them are tested in practice.

The sub category ***Continuity of care*** illustrates the importance of care continuity being person-centred and according to Swanson (1993, p. 354), "*maintaining belief"* in the treatment and health, and expressing realistic future and staying optimistic.

7.2. Method discussion

A qualitative literature review was used in this study because the author wanted to gain deep knowledge from literature in order to find the answers to the research questions. According to Polit and Back (2004, p. 591), the results of qualitative study are oriented to have use from findings, as well as to demonstrate the way of use. The presented results have to be reliable, trustful, and high quality.

The framework of Lincoln and Guba, demonstrate that the data in a qualitative study must be trustworthy, and includes four domains: credibility, transferability, confirmability, and dependability, described by Polit and Back (2004, p.36). Dependability means that facts used in the study are not contradictory; confirmability means that the study is reliable in

the context and that information collected from the study participants was not the author's guess; credibility describes that data information and the author's interpretation of data is true; and transferability is the ability to transfer data from a qualitative study to other circumstances (Polit & Back, 2004, p. 36, p. 41).

Credibility demands that the study is properly structured and explains the way in which the author conducted the study. In this study, the author endeavored to write in a structured manner and to explain how information was processed in the data collection and data analyzing stages. The author attempted to communicate clearly throughout the process, but sometimes it was difficult to explain certain definitions. Another difficulty was to find articles that suited this study – good articles that were done in a qualitative method because of time limitations.

Transferability and dependability demonstrate that the study can be recreated and it has connection to a specific time or situation. However in this study the situation will probably not change but due to changes that occur over time, information will be updated and the number of conducted studies will increase (Polit & Back, 2004, p. 36, p. 41).

The Swanson (1993) theory of caring was vital because the result of the study has links with caring. Caring is fundamental for nurses and the PCC implementation model includes three types of care described in the results.

However, more studies are needed in this area, and education of nurses, as well as curricula, must be amended so that the way of practicing care focuses on the person. Nurses need to see the individuality of the person and provide care that meets the specific needs of each person in order to reach the desired outcome, which is the person's well-being as described in Swanson's theory.

This study will be useful to all who work in the healthcare system, especially nurses who take care of people every day. The importance of the study is to highlight the importance of changing the way for caring is administered, demonstrate the positive outcomes of PCC care implementation, and to encourage nurses to use PCC in their practice.

8. Conclusion

This study found three main categories with subcategories that could be used to implement PCC. The implementation process requires that nurses see the person holistically, that they

involve all important persons into the caring process, and that they encourage people to practice and make good decisions regarding their health. Nurses need to educate people and provide information about disease, symptoms, treatment, caring, and alternatives, which will enable the person to make good decisions concerning their health. Furthermore, nurses need to have good communication skills to be able to create a good relationship with others, based on truth, respect, and dignity. However, this is a complex process that includes professionals from different levels, from the highest level in the healthcare organization to those whom care is delivered to. In order for that to be implemented, changes need to be made on all levels, and collaboration is vital. This process can begin with the nurse's attitude and develop into a caring relationship.

The traditional method is too old to be in use, and the leader of the ward needs to encourage nurses to use PCC by setting a good example, nurses must have more time for learning and updating their knowledge, they should possibly spend more time with people without stressing, and they must create a favorable work climate for nurses that will support PCC. Moreover, the significant impact of team relationships exists in the implementation model, and good communication between team members increases PCC practice developments. Good teamwork increases work effectiveness, the desire to work, to learn, and improve performance of delivered care.

Caring is not completed after the person is discharged from the ward; it is a continual process either at home or in another place. Nurses have to demonstrate realistic future help to the person in the rehabilitation process and in the continuity of life after discharge.

Ultimately, evaluation of effective implementation is the basis of good PCC practice. Measurement of performed care demonstrates the success of implementation. Evaluation could be conducted from surveys, questionnaires, and feedback at the end of the caring process. Nevertheless, study data shows that universal instruments that are suited to all wards are not available. Therefore, more studies are needed to find suitable tools. I would like more studies to be conducted. I hope that proper instruments for the measurement of effective implementation will be found and nurses will change their perception of care and embrace the PCC practice.

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Appendix 1

Author	Name	Year	Method	Result
Brendan McCormack, Tanya V. McCance	Development of a framework for person-centred nursing	2006	Combination of two existing conceptual frameworks derived from empirical studies.	The framework tested in a development and research project in an acute hospital setting, but it is not enough of research to determine its outcomes for patients and nurses.
Brendan McCormack Jan Dewing Tanya Mccance	Developing person-centred care: addressing contextual challenges through practice development	2011	Emancipatory practice development underpinned by a specific, person-centred, practice framework.	The main challenge for implementation PCC into organizations is the movement from individual, 'person centred moments' to 'personcentred cultures.'
Souraya Sidani, Laura Collins, Patti Harbman, Kathleen MacMillan, Scott Reeves, Christina Hurlock-Chorostecki, Faith Donald, Patti Staples, Mary van Soeren	Development of a Measure to Assess Healthcare Providers' Implementation of Patientcentered Care	2014	Content validity	The study detects three main elements of PCC: holistic, collaborative, and responsive cares, which describes contents and construct validity.
JayneWright,BrendanMcCormack,AliceCoffey, GeraldineMcCarthy	Developing a tool to asses person centred continence care	2006	In-depth case study design set within PARIHS framework (1998) and developing the tool.	The understanding the concept of three elements of context, which care is provided in person-centred continuety care and management is important in order to provide it.

Margreet van der Cingel*, Lobke Brandsma, Mirjam van Dam, Marcella van Dorst, Claudia Verkaart and Cilleke van der Velde	Concepts of person-centred care: a framework analysis of five studies in daily care practices	2016	Framework analyze of five empirical studies.	It summirizes the concepts that nurses can understand and apply into practice: -Knowing of specific person characteristic -Using trust, involvement and humour in nursing practice. -Acknowledgement of emotions and compassion create mutuality in the caring relationship
Vikki A. Entwistle & Ian S. Watt	Treating Patients as Persons: A CapabilitiesApproach to Support Delivery of Personcentered Care	2013	Capabilities approach	The article suggests to explore the capability of focusingon the recognition and cultivation of personal capabilitiesin person-supportive care.
David Edvardsson, Anthea Innes	Measuring Personcentered Care: A Critical Comparative Review of Published Tools	2010	Literature review	The study found out twelve tools which can be used to measure PCC in different settings and different perspectives. Continuety of testing instruments is still needed.
Isabelle Scholl,Jördis M. Zill, Martin Härter, Jörg Dirmaier	An Integrative Model of Patientcenteredness – ASystematic Review and Concept Analysis	2014	Systematic literature review	The model of PCC could be foundation that will help to create better measurements and interventions, used for informing development of clinical guidelines and help the shift towards PCC.

Maria J. Santana, Kimberly Manalili, Rachel J. Jolley, Sandra Zelinsky, Hude Quan, Mingshan Lu	How to practice person- centred care: A conceptual framework	2018	Literature review	It is a guidline for health care systems in providing PCC across different settings