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The state of the art of person-centered healthcare: global perspectives

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The state of the art of person-centered healthcare: global perspectives

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Editorial: The state of the art of person-centered healthcare: global perspectives

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Editorial on the Research Topic
The state of the art of person-centered healthcare: global perspectives

Person-centred healthcare continues to gain momentum as a defining feature of quality care across the world. The global movement toward person-centredness transcends geographic and disciplinary boundaries. It calls for an authentic recognition of the personhood of all individuals engaged in health and care, whether as patients, families, professionals, or leaders. Despite decades of theoretical and empirical work, translating these principles into sustainable practice remains complex and challenging. This special issue, *The State of the Art of Person-Centred Healthcare: Global Perspectives*, brings together contemporary research from Europe, Australia, and beyond to present innovations, challenges, and innovations in advancing person-centred practice (PCP). The call for papers was framed around the Person-centred Practice Framework (PCPF, Figure 1), focusing on its five domains: prerequisites, practice environment, person-centred processes, outcomes, and macro-context. The twelve contributions in this issue collectively explore these dimensions through methodological diversity, ranging from meta-syntheses and scoping reviews to quantitative and mixed-methods research, practice development, and conceptual reflections. This collection of papers provides a comprehensive collection of new knowledge in person-centred practices, education, policy, leadership and measurement.

Several contributions demonstrate how organisational culture and leadership shape person-centredness. Teeling et al.'s paper on the Person-Centred Lean Six Sigma (PCLSS) model re-imagines quality improvement methodologies through a person-centred lens. Applied across multiple Irish healthcare settings, the model aligns operation with compassion, respect, and reflective practice – key characteristics of healthful cultures. Similarly, the work by Tuqiri et al. on *Co-Creating a Strategy for Transforming Person-Centred Cultures* showcases the power of facilitation and co-creation among nursing and midwifery leaders in designing a five-year roadmap for embedding person-centredness across a large local health district. Both exemplify how integrating person-centred principles into system-level improvement and workforce strategies can foster sustainable cultural transformation.

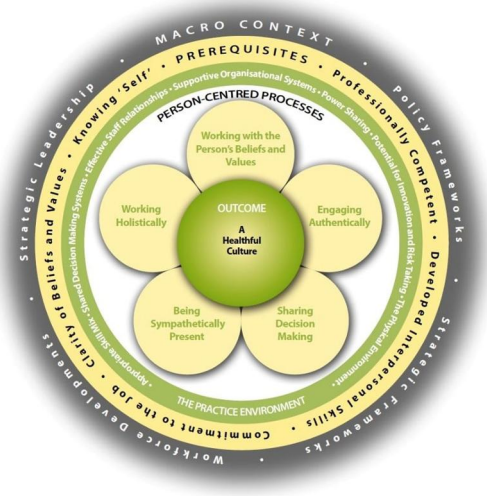

FIGURE 1
The Person-centred Practice Framework (Reproduced with permission from - McCormack and McCance).

Complementing these system-level insights, the qualitative research by Vareta et al. (*Person-Centred Workplace Culture in an Inpatient Department for Older Adults with Chronic Illnesses*) reveals the tensions between routine-driven care and holistic approaches in day-to-day hospital practice. Their findings highlight how reflective dialogue and interprofessional collaboration remain essential in translating values into action. Together, these studies demonstrate that cultivating healthful cultures requires leadership at all levels and that creates links between operational structures, professional values, and the lived experience of patients and staff.

Leadership and education emerge as recurring catalysts for advancing person-centred practice. Haraldsdottir et al.'s *Developing Person-centred Care in Hospices through the Voice and Leadership of Nursing,* documents an emancipatory practice development program focusing on leadership in shaping person-centred care. Education's transformative potential is further supported by Tyagi et al. in *Implementation of Learning into Person-Centred Practice*, which presents quantitative evidence from community nursing programs. Their study found that integrating person-centred learning fosters key "prerequisites" of person-centred practice, especially clarity of beliefs and values, self-awareness, and interpersonal competence. Leadership also features prominently in Anker-Hansen et al.'s Mixed-Methods Systematic Review on Leadership Dynamics in Nursing Homes. Their synthesis underscores the pivotal role of leaders who model person-centred values, create shared visions, and distribute leadership to sustain engagement and care quality. Collectively, these contributions reaffirm that cultivating person-centred practice requires deliberate attention to leadership development, reflective learning, and the empowerment of practitioners as agents for change.

Moving from concepts and principles and their implementation, Forsgren et al. provide a comprehensive analysis of strategies and complexities underpinning PCP implementation. Their synthesis reveals the interplay between top-down policy imperatives and bottom-up co-creative processes, reiterating the need for flexible, iterative strategies that are context specific. Similarly, Mabire et al. offer an exemplary case of adapting person-centred frameworks to local contexts. Using concept mapping and implementation science, the study demonstrates how leadership support, participatory design, and ongoing training can facilitate the translation of theory into practice. These studies collectively position implementation not as a linear process but as a dynamic negotiation between values, evidence, and context.

As person-centred practice becomes a global policy aspiration, evaluating its impact remains a challenge. Rosted et al.'s paper on *Danish Translation and Cultural Adaptation of the PCPI-S and PCPI-C* addresses this by extending validated measurement tools into new linguistic and cultural settings. By offering reliable ways to assess both staff and patient perceptions of person-centredness, the study contributes to the growing international effort to build shared metrics for quality improvement and benchmarking. In the accompanying *Perspective Piece on Patient-Reported Outcomes in Evaluating Person-Centred Care*, Rutherford et al. argue for a re-examination of how person-centred outcomes are conceptualised and measured. They distinguish between patient- and person-reported outcomes, urging the field to capture what truly matters to individuals rather than what is easily quantifiable. Together, these contributions advance methodologies for evaluating person-centred cultures and practices.

Person-centredness is inherently relational and inclusive, yet its expression varies across cultures and systems. Son et al.'s Narrative Review on *Person-Centred Care for Migrants* illuminates the intersections of cultural sensitivity, migration, and person-centredness. Their review identifies three key practices - enhancing migrant participation, building intercultural partnerships, and promoting provider education, reinforcing the need for equity and cultural humility in person-centred care. Expanding the global perspective, Forsgren et al.'s Scoping Review on *Person-Centred Care as an Evolving Field of Research* offers a macro-level analysis of over 1,300 studies across six continents. They reveal the continuing ambiguity in terminology and the dominance of "patient-centred" discourse, which complicates synthesis and policy translation. This work calls for conceptual clarity and cross-disciplinary collaboration to strengthen the global coherence of the person-centred movement.

Taken together, the papers in this Research Topic illustrate both the maturity and the evolving challenges of person-centred healthcare. We identified three cross-cutting themes from this collection of work:

1. Integration across levels: Sustainable person-centred systems require alignment of values, leadership, education, and policy.
2. Measurement with meaning: Evaluation must move beyond checklists toward tools and metrics that capture human experience, context, and cultural diversity.

3. Co-creation and inclusivity: True person-centredness flourishes when all stakeholders (patients, professionals, and policymakers) are partners in shaping care.

As healthcare systems are shaped by increasing complexity, person-centredness provides conceptual, theoretical and practical frameworks for achieving excellence in healthcare. This collection of papers reflects the dynamic, collaborative, and interdisciplinary focus of global developments in person-centred healthcare. This collection of evidence demonstrates progress in this field and highlights the potential that exists in systematically advancing knowledge for the benefits of all persons.

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Person-centered workplace culture: insights from an inpatient department for older adults with chronic illnesses

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Introduction: An aging population and the increasing prevalence of chronic conditions challenge healthcare systems in developed countries. In response, there is a growing emphasis on person-centered care, as advocated by the World Health Organization and integrated into national health strategies in countries such as the UK and Sweden. However, transitioning to person-centered care is a complex, long-term process shaped by organizational culture and care environments. These contextual factors play crucial roles in the development and sustainability of person-centered practice, significantly transforming the experiences of both older adults and staff.

Objective: To describe how workplace culture within an inpatient hospital department shapes person-centered care practices for older adults with chronic illnesses.

Methods: A qualitative, descriptive, exploratory-observational study was performed. Data were collected through participant observation guided by the Workplace Culture Critical Analysis Tool®. In a deductive thematic content analysis, data patterns of meaning were identified. The themes were generated underpinned by the Person-Centered Practice Framework dimensions of prerequisites, the practice environment, and person-centered processes and their respective constructs.

Results: Themes related to all person-centered practice dimensions were identified. Task demands during shifts create tension between routine-oriented work and the holistic, individualized approach required for person-centeredness. The absence of systematic multiprofessional team meetings further exacerbates this issue, limiting collaborative decision-making and personalized care planning. The contrasts in some subthemes may be related to discrepancies in the care provided by different professionals.

Conclusion: This study highlights the tension between routine-driven care and individualized approaches. Addressing identified challenges, such as formalizing multiprofessional meetings and enhancing reflective practices, is crucial for advancing person-centered care in this setting.

KEYWORDS

patient-centered care, workplace cultural critical assessment tool, workplace culture, aged, inpatient, non-communicable diseases

1 Introduction

The landscape of healthcare services in developed nations is undergoing significant transformation. The rise in chronic conditions among aging populations presents significant challenges to healthcare systems, particularly in ensuring accessible, equitable, and collaborative care (1). In response, Western health systems are increasingly transitioning from biomedical care models to person-centered clinical practices. A shift aimed at addressing these complex, evolving needs.

The World Health Organization (2) underscored the need to adopt person-centered care paradigms, which incorporate the perspectives of individuals, families, and communities. Older adults should be viewed as active participants in shaping services according to their expectations, preferences, and needs, compassionately and comprehensively (2, 3).

Following the lead of certain European nations such as the United Kingdom (4) and Sweden (5), Portugal's National Health Service acknowledges the imperative of addressing citizens' needs and expectations, recognizing their involvement in health management processes through initiatives such as the "SNS + Proximity" program (6). The program prioritizes a whole-system approach that puts older adults at the center where healthcare professionals and policymakers must be aligned with this vision. Despite the impetus for change, it is essential to view the transformation of health services toward person-centered practice (PCP) as a long-term process (7).

The Person-Centered Practice Framework (PCPF) (3) is a valuable guide for its implementation and development (8, 9). However, while the concept is understood theoretically, recognizing and embodying it in practice can be challenging (10, 11). Contextual factors such as organizational culture, the learning environment, and the care environment itself pose the most significant demands to the development of cultures that can sustain person-centeredness care due to its potential to restrict or support this practice (12–14).

Workplace culture in healthcare settings is not solely about individuals; rather, it revolves around the social contexts shaping behavior and the accepted norms. Behavior patterns mirror cultural aspects, highlighting the values, beliefs, and assumptions staff embrace. This culture impacts staff and user experiences, staff motivation and effectiveness, evidence implementation in practice, patient safety, innovation adoption, and productivity (15).

This study is part of a clinical study protocol (16) designed to provide recommendations for improving PCP in the daily care of hospitalized older adults with chronic illness at an internal medicine department. It corresponds to the qualitative string, which aims to characterize the workplace culture of an inpatient hospital department with a high prevalence of older adults with chronic illnesses. This study aims to describe how the workplace culture within an inpatient hospital department shapes person-centered care practices for older adults with chronic illnesses. It explores cultural factors influencing daily care experiences for older adults and staff, focusing on contextual challenges and adaptations in chronic care and considering all principles and domains presented in the PCPF.

2 Materials and methods

2.1 Design, population and study site

A qualitative, descriptive, exploratory-observational approach was followed. The design was informed by the ethnographic tradition, as it allows the investigation of social interactions and sheds light on the contextual factors influencing those interactions and activities. It offers a valuable approach to examining how the environment shapes the daily experiences of a specific population within a given social framework and cultural context. Ethnography, in its alignment with the PCP, delves into the influence of the environment on both older adults and staff, allowing the integration of diverse voices and experiences into a co-constructed research product (17).

The study was conducted at an internal medicine inpatient unit of a secondary hospital in an urban area of Portugal. The internal medicine department provides care for older adults with medical conditions, typically multiple chronic diseases. Accidental sampling methods were used to recruit professionals from the healthcare team working at the unit and older adults hospitalized who fulfilled the defined inclusion criteria during the data collection period.

The internal medicine unit comprises 46 inpatient beds. The physical area comprises nine patient rooms and offices for nurses and physicians along a lengthy corridor. A level 2 medical care unit with a distinct healthcare team is at the corridor end. It also has two single rooms designated for older adults with communicable diseases that meet isolation criteria. The other rooms accommodate three beds each, with a shared bathroom available. There is also a dining hall, the supplies room, and the dressing rooms. The workload distribution of nurses and health assistants prioritizes the level of dependency of the assigned older adults regarding the continuity of care by professionals. The medical staff consists of four different teams, and each team is designated a doctor who follows the patient throughout their hospitalization.

Regarding leadership, the clinical director, who has held the position for 6 years, oversees the coordination of medical teams, clinical decision-making, and overall unit organization. The head nurse, responsible for coordinating the nursing and health assistants' teams, had been informally managing the role for a year and was officially appointed a month before data collection began.

The team meeting occurs once a week and involves the clinical director, medical team members, the nurse manager, and one nurse specialist providing management support. No registered nurses or physiotherapists are involved. Clinical cases are presented, treatment plans are discussed, and discharges are prepared in these meetings.

Care activities within the ward followed structured routine schedules around three distinct periods: morning, evening, and night. Mornings were oriented to carry out tasks such as care planning, hygiene, treatments, and complementary diagnostic tests, whereas evening, night, and weekend shifts prioritized surveillance and monitoring. Most discharges and admissions take place in the afternoon.

Visiting hours are scheduled from 2 pm to 7 pm during half-hour periods. Visitors are not allowed to stay overnight, except if the patient is disabled or has a terminal illness and if one of the single rooms is available. There is no common space to spend time with family or to talk to other older adults.

The dining hall is used by health professionals but rarely by older adults. The meals are served by a kitchen assistant in each room, who receives the meal plan in advance.

The emergency car is in the corridor and is constantly available.

2.2 Inclusion criteria

Older adults were eligible to participate in the study if they were over 65 years old, had a chronic disease diagnosis, were hospitalized

at the inpatient internal medicine unit for more than 48 h, and could understand and communicate in Portuguese.

All healthcare professionals working full-time in the internal medicine unit were eligible to participate in the study.

2.3 Exclusion criteria

The 6-Item Cognitive Impairment Test (6-CIT) (18) assessed older adults' cognitive impairment and was the exclusion criterion. The cut-off point considers the level of education, namely a score of up to and including 2 years ≥12, a score of 3 to 6 years ≥10, and a score of more than 7 years ≥4.

2.4 Data collection

Data were collected between February and April 2024. A questionnaire including sociodemographic and health history characteristics was provided to the hospitalized older adults, and a questionnaire including sociodemographic and professional characteristics was provided to the healthcare professionals who met the defined criteria. Preparatory visits were made to discuss the study proposal and methodology with staff, familiarize the first researcher with the observation site's environment, and prepare the record data strategy during observation (notes, audio).

Participant observation was conducted systematically across all weekdays and shift patterns to capture diverse aspects of the department's culture. Guided by the Workplace Culture Critical Analysis Tool® (WCCAT), observations were performed. The WCCAT is an instrument for systematically generating evidence from observing the interactions between participants and the context, illuminating various aspects of practice (19). It was initially developed underpinned by the Person-Centered Nursing Framework (20) and was reviewed by the International Community of Practice members to ensure its alignment with the current PCPF and further tested for face validity (19). The WCCAT addresses the subjectivity inherent in qualitative data collection, as it combines ethnographic approaches with person-centered principles involving participatory, observational, and reflective elements (21).

For this study, WCCAT was translated into European Portuguese, supported by the translation and cultural adaptation of practice assessment instruments underpinned by the PCPF, such as the Person-centered Practice Inventory-Staff (22) and Person-centered Practice Inventory-Care (23), and back-translated to ensure that the fundamental principles were captured, as recommended by the authors (19). A protocol based on the authors' guidelines for each phase was previously defined to ensure rigor in using WCCAT (Supplementary material 1).

The observations were planned to include a mix of shorter intervals (5–15 min) for capturing routine daily interactions and longer intervals (up to 60 min) to examine more complex care dynamics. This design aims to ensure a comprehensive view of the department's cultural environment across different times of day and activity levels.

The first author positioned herself at different locations throughout the corridors, patient rooms, and physicians and nursing offices, strategic for observation while remaining unobtrusive to the situation. She relied on the essential senses: what was seen, heard, smelled or experienced.

After each observation session, an informal debriefing with the healthcare professional engaged in the interaction was conducted to address any issues that arose. This provided staff with an opportunity to discuss the observations and the implications for their practice individually and immediately following the observation period (19).

The saturation of findings was determined when a consistent perception of all the WCCAT domains in the context was obtained, which led to the closure of data collection.

Once the data had been collected, the preliminary results were analyzed, and two reflective sessions with the multiprofessional team were held. These sessions occurred several weeks after the observation phase and were a collaborative effort, where the multiprofessional team reflected on the data obtained and the meaning attributed to it, compared with their perception of the unit's working culture. The sessions were scheduled to last 1 h, at a time compatible with the unit's activities, announced 1 week earlier to the different professional groups, and conducted according to the script created for the purpose (Supplementary material 2).

2.5 Data analysis

After each observation, descriptions of what was observed were audio-recorded, transcribed, and supplemented with notes and comments. The first researcher begins a comprehensive familiarization of the data, reading it to gain an overall sense and ensure deep understanding. It was then reread, and descriptions and key words were highlighted. The qualitative data analysis software WebQda® (3.0 version, 2016, Aveiro, Portugal), combined with handwriting and mind-mapping methods to assist with developing themes, facilitated the analysis.

Deductive thematic content analysis was performed to identify data patterns of meaning or relations in an interpretive and iterative process data from a preexisting theoretical framework (24, 25). The themes were generated underpinned by the PCPF dimensions of prerequisites, the practice environment, and person-centered processes and their respective constructs. The subthemes arose in line with the data contribution to each theme, aiming to find evidence and examples that align with or challenge these theoretical concepts. During the definition of subthemes, it was ensured that each subtheme resonated with the predefined theoretical concepts (25). The first researcher carried out the data analysis, which was reviewed and refined by all the authors to produce the final set of themes and subthemes used to describe the work culture of the unit, ensuring internal coherence and alignment with the underlying theory.

Regarding the participants' characteristics, the numerical data was analyzed using the statistical package for social sciences software (IBM SPSS Statistics® for Windows, v.29.0. IBM Corp. Released 2023, Armonk, NY, United States). Normality tests for numeric variables, namely Kolmogorov–Smirnov and Shapiro–Wilk, were conducted to assess data distribution.

2.6 Ethical considerations

The study obtained ethical approval from the hospital's Ethics Committee (ref. nr. 36/2021). All procedures followed the principles outlined in the Declaration of Helsinki (26) and the General Data

Protection Regulation (27). Permission to use the WCCAT and 6-CIT was obtained from the respective authors.

Prospective participants received detailed oral and written information about the study, covering its purpose, relevance, data collection methods, expected participation, and data disclosure. Older adults had a minimum 24-h reflection period between receiving information and providing consent. Staff members participated in preparatory visits, and before observation, existing questions were clarified. Their voluntary attendance in reflective sessions implied consent. Participants who declined consent could be present circumstantially in the scene but were not included in the recordings during the observation sessions.

3 Results

Approximately 20 h of participant observation, divided into sets of 5 to 60 min (Table 1), were completed across 3 months, covering all weekdays and the two settings that compose the internal medicine unit. The observations occurred during the 24-h shift patterns, predominantly during the morning shift (67%) (Table 1). The most frequently observed situations were care interactions (50%), staff interactions (44%), the dynamics of the unit (33%), and shift handover (11%) (Table 1), with some of them overlapping. Among the participants, nurses were present in most observations (94%), followed by older adults (60%), health assistants (48%), physicians (33%), and physiotherapists (4%) (Table 1).

TABLE 1 Observations characteristics.

Characteristics	%
Time of observation	
Morning shift	67.4
Afternoon shift	30.4
Night shift	2.2
Duration (minutes)	
<15	44.5
[15–30]	30.4
>30	26.1
Participants	
Nurse	93.5
Health assistant	47.8
Physician	32.6
Physiotherapist	4.4
Older adults	60.1
Situation	
Shift handover	10.9
Care interaction	50
Staff interaction	43.5
Unit dynamic	32.6

3.1 Characteristics of the participants

A total of 67 participants were observed, including 41 healthcare professionals and 26 older adults. All professional groups were included, with nurses (49%) being the most representative group, followed by physicians (27%), health assistants (22%), and physiotherapists (2%) (Table 2). The participants were predominantly female (81%). Regarding the educational level, 70% of the health professionals are graduates, 10% postgraduate, and 20% undergraduate. In terms of professional experience, 39% of healthcare professionals had less than 5 years of experience, 17% had between 5 and 10 years, 32% had between 10 and 19 years, and 12% had more than 20 years of experience (Table 2).

TABLE 2 Sociodemographic characteristics of the staff.

Characteristics	*N* = 41
Gender	
Female	33 (80.5%)
Male	8 (19.5%)
Profession	
Nurse	20 (48.8%)
Physician	11 (26.8%)
Physiotherapist	1 (2.4%)
Health assistant	9 (22%)
Educational level	
Undergraduate	9 (20%)
Degree	28 (70%)
Postgraduate	4 (10%)
Professional experience (years)	
<5	16 (39%)
[5–9]	7 (17.1%)
[10–19]	13 (31.7%)
[20–40]	5 (12.2%)

All the older adults were Portuguese and were between 65 and 93 years old ($M = 77.4$; SD = 1.5). The sex distribution revealed a predominance of females (65%). Most participants lived primarily in urban areas (62%), in their own homes, or in relatives' homes (89%). Among the participants living at home, 74% had no domiciliary social or healthcare support, 13% had assistance from healthcare professionals, and 13% received care from informal carers (Table 2). Only 12% of the participants lived in a public or private residential facility that provides nursing care (Table 3).

The educational level ranged between no academic education (8%) and graduate (8%), with 46% of older adults with an elementary school education (Table 3). Previous hospitalization experience was referred to by 50% of the participants, who had between 1 and 3 distinct episodes of hospitalization. During the current hospitalization, the median length of hospital stay was 5 days (IQR = 4–7 days) (Table 4).

The most frequently identified diagnoses among the older adults were respiratory system diseases (35%), followed by metabolic, endocrine, and nutritional diseases (19%). The health history characteristics of the study sample were predominantly related to the circulatory system (58%), followed by oncological diseases (19%).

Regarding the level of dependence during hospitalization, the Barthel index revealed that half of the population had moderate

TABLE 3 Older adults' sociodemographic characteristics.

Characteristics	*N* = 26
Sex	
Female	17 (65.4%)
Male	9 (34.6%)
Age	
[65, 69]	3 (11.5%)
[70, 74]	7 (26.9%)
[75, 79]	8 (30.8%)
[80, 84]	4 (15.4%)
[85, 89]	0 (0%)
≥90	4 (15.4%)
Living environment	
Rural	10 (38.5%)
Urban	16 (61.5%)
Residence	
Home	23 (88.5%)
Nursing home	3 (11.5%)
Home care	
Health professional	3 (13%)
Informal carer	3 (13%)
None	17 (74%)
Educational level	
Graduate	2 (7.7%)
High school	4 (15.4%)
Middle school	6 (23.1%)
Elementary school	12 (46.1%)
Uneducated	2 (7.7%)

dependence (50%), followed by severe dependence (34.6%), complete independence (11.5%), and total dependence (3.9%) (Table 4).

3.2 Reflective sessions

The reflective sessions were attended by 15 participants (9 nurses, 2 physicians and 4 health assistants). During the sessions, the healthcare professionals commented and reflected on their personal experiences, adding information to the data already collected. The results of the reflective sessions were compared with the observational data to validate, complement, or challenge the findings. The collaborative nature of the meetings ensured that healthcare professionals' perspectives were a key element of the analysis and interpretation process. Globally, the participants supported the findings, considering they are aligned with the working culture experienced in the context.

3.3 Thematic analysis findings

In addition to the themes elicited in the PCPF constructs, the thematic analysis uncovered several subthemes that illustrate how the PCP is integrated within the internal medicine unit (Table 5). The findings are organized by themes to clearly present the subthemes within each domain. To enhance understanding, direct speech is italicized, participant roles are indicated (i.e., OA for older adults, HP for health professionals), and any unobservable details are noted within brackets [].

The subthemes identified in Prerequisites dimension disclosed different aspects of professional practice, revealing that while healthcare professionals displayed technical competency and effective interpersonal skills, the demands of routines often led to a task-oriented approach that limited holistic care. Professional experience enabled the anticipation of older adults' needs, yet opportunities for reflective practice and emotional competency were inconsistent. These findings suggest a need for enhanced support for less experienced staff and structured moments for team reflection, fostering both individual growth and the alignment of care with person-centered principles.

3.3.1 Professionally competent

3.3.1.1 Diverse depth of field specific knowledge

The healthcare team evidenced a technical-scientific domain relevant to their respective roles and the ability to share it with others to ensure better quality care.

> The lady had a recent fracture of the femoral neck, and the HP put a cushion between her limbs to do the mobilizations and explained to the colleague: "*We leave the cushion so as not to undo the hip angle and one leg is not in contact with the other.*" (Obs. 18)

Nonetheless, the tendency to follow a work routine weakened the importance of this knowledge,

> "*The patient was dyspneic, shivering, and feeling unwell; the paracetamol was brought forward from 3 pm due to a suspected temperature rise of 37° (…).*" The HP receiving the information asked how the temperature was after the medication administration, and the colleague said she had not assessed it as it was time for handover. (Obs. 10)

and a lack of knowledge in specific care areas was identified.

> A HP who has heard the persistent NIV alarm comes and says, "*Don't you need help?*" At the same time, she notices that the halter is on wrong (…) and immediately puts the mask on the woman's face, repositions the halter (…) and checks that the mask is big enough for the woman's features. The colleague says, "*I don't know anything about NIV.*" (Obs. 18)

3.3.1.2 Expertise in navigating complex situations

The team members' expertise in handling challenging situations, problem-solving, and teamwork was evident among experienced professionals.

> The nurse in charge comes to see the patient and immediately positions him in semi-fowler's [suspecting atelectasis], with improvement in the clinical condition. (Obs. 12)

TABLE 4 Older adults' health history.

	N = 26
Previous hospitalization	
No	13 (50%)
Yes	13 (50%)
Number of previous episodes	
1	5 (35.7%)
2	5 (35.7%)
3	3 (28.6%)
Health history	
Diseases of the circulatory system	15 (57.69%)
Oncological diseases	5 (19.23%)
Diseases of the nervous system	3 (11.54%)
Other diseases	3 (11.54%)
Actual diagnosis	
Diseases of the respiratory system	9 (34.62%)
Metabolic, endocrine, and nutritional diseases	5 (19.23%)
Diseases of the circulatory system	3 (11.53%)
Diseases of the genitourinary system	3 (11.53%)
Diseases of nervous system	3 (11.53%)
Other diseases	3 (11.53%)
Length of stay	
[2, 3]	2 (7.69%)
[4, 6]	16 (61.54%)
[7, 9]	7 (26.92%)
≥10	1 (3.85%)
Barthel index	
Complete independence	3 (11.53%)
Moderate dependence	13 (50.0%)
Severe dependence	9 (34.62%)
Total dependence	1 (3.85%)

3.3.1.3 Blending scientific rigor with informal nuances

In most staff interactions, the language used was clear, technical, and scientific.

> The HP transmitting the shift information used clear, scientific language with no value judgments. (Obs. 25)

However, colloquial language and some inappropriate expressions were used.

> "*was tied up to the neck*" (Obs. 10); "*doesn't look like a gypsy*" (Obs. 15)

3.3.1.4 Competence acknowledged by peers

Some team members were recognized by peers as references for their ability to facilitate knowledge transfer, skill development, and professional growth among other members.

> The younger HP comes to ask for support on the most appropriate treatment for a pressure ulcer. Her colleague says, "*you know who is really good at helping you with that is A.F., who knows a lot about wounds*". (Obs. 5)

3.3.2 Developed interpersonal skills

3.3.2.1 Effective communication with older adults and families

The staff demonstrated effective communication with older adults and their families, swoed the ability to listen to other perspectives and expressed respect through verbal and non-verbal language.

> HP: "*We can call your daughter and (…) ask her to bring some clothes*." OA: "*Yes, (…) but let her bring some proper clothes*." HP: "*What do you mean by proper clothes?*" OA: "*My gypsy clothes, with those pretty shirts and the skirt*." The HP smiles and says, "*Don't you prefer more comfortable clothes?*" (…) The lady says that she prefers to be well-dressed even when hospitalized. The HP agrees, saying, "I will call your daughter away and ask her to bring the clothes." (Obs. 16)

3.3.2.2 Seamless collaboration through professional communication

Communication between healthcare professionals was characterized by collaboration and effective exchange of information, which fostered a cohesive team dynamic and enhanced inpatient care outcomes. Using their knowledge, the staff generally gave voice to their assessments within the multiprofessional team.

> The colleagues listen in silence to the HP who is handing over the shift. There are occasional interruptions to question and validate or obtain more information that they consider pertinent. (Obs. 1)

3.3.2.3 Mutually supportive interpersonal relationship

Healthcare professionals showed open and respectful communication, fostered positive relationships with older adults, and provided reassurance and a sense of security.

> OA: "*I am very anxious… and I cannot see myself getting better; I always have a fever*." The HP says, "*I understand you are feeling anxious, but the bacteria is now identified, and you are taking the right antibiotic. Today, I will ask the doctor to come and talk to you*." (The HP holds her hand and smiles). (Obs. 2)

3.3.3 Commitment to the job

3.3.3.1 Commitment to ensuring quality of care despite disparities

The desire to improve care quality through evidence-based care and the creation of opportunities to share knowledge between professionals was evident in this context.

> When the health assistant leaves the room, the nurse calls her and reinforces the importance of people wearing slippers when walking around the room and toilets. (Obs. 4)

TABLE 5 Themes and subthemes.

Dimension	Theme	Subtheme
Prerequisites	Professionally competent	• Diverse depth of field-specific knowledge • Expertise in navigating complex situations • Blending scientific rigor with informal nuances • Competence acknowledged by peers
	Developed interpersonal skills	• Effective communication with older adults and families • Seamless collaboration through professional communication • Mutually supportive interpersonal relationship
	Commitment to the job	• Commitment to ensuring quality of care despite disparities • Fluctuation in dedication over time • Variability in punctuality
	Knowing self	• Lack of critical team reflection • Difficulty in managing emotional demands
	Clarity of beliefs and values	• Influence of personal convictions on professional practice
The practice environment	Appropriate skill mix	• Managing patient-to-staff ratio • Balancing specialization and experience in care
	Shared decision-making systems	• Lack of multiprofessional meetings • Opportunities for active involvement in decision-making
	Effective staff relationships	• Collaborative teamwork • Mutual support among staff
	Power sharing	• Equity among professionals within the same group • Impaired power sharing between professional groups
	The physical environment	• Influence of unit architecture on the care environment • Balancing ward dynamics with patient care • Challenges related to patient room design
	Supportive organization systems	• Promoting staff involvement in practice development • Ensuring access to training opportunities • Leadership that cultivates collaboration
	Potential for innovation and risk taking	• Divergent approaches to healthcare delivery
Person-centered processes	Working with the person's beliefs and values	• Efforts to know older adults • Tension between individualized and standardized care
	Sharing decision-making	• Exchange of information on care decisions • Collaborative decision-making in basic care needs • Routine-driven approaches to care transitions
	Engaging authentically	• Understanding person's perspective • Aligning care with patient's known wishes
	Being sympathetically present	• Demostrating understanding and support
	Working holistically	• Integrating all dimensions of the person in care • Recognition of biomedical tasks in practice

> The nurse in charge complements the information provided by the night shift nurse with data from her personal experience (…) and evidence to justify decision-making in relation to the patient (less frequent administration of cleansing enemas due to significant ionic alterations requiring correction with IV potassium). (Obs. 36)

On the other hand, in some situations in which self-will was overridden by compliance with rules regarding staff image and safety.

> Wearing artificial nails (Obs. 36), loose hair (Obs. 39), or an open gown (Obs. 39).

3.3.3.2 Fluctuation in dedication over time

The dedication was evident in the professionals' commitment to spending time with the older adults, getting to know them, and addressing more than just their basic needs.

> HP: (…) asks if the patient is comfortable. OA: yes. She seems bored. HP: "*Do you want to turn on the TV? Do you like reading?* She says she has no patience for such things. HP: "*Would you like to talk for a while?*" OA: "*Never mind, you've got a lot to do.*" HP: "*Let's agree on something, I'll give this lady a bath and when I've finished, I'll come back and talk to you*". (Obs. 6)

However, not all moments were used to improve relationships with older adults nor to enhance care provision.

> When they *determined that the shift's tasks had been completed*, the HP waited for their colleagues to arrive in the armchair. They stretch their legs and spend time on their cell phones. (Obs. 34)

3.3.3.3 Variability in punctuality

Different behaviors were observed among nursing teams; some arrived in uniform and on time for shifts, while others were late, which interrupted the shift handover and did not allow them to participate from the beginning.

> All the staff arrived on time, in uniform, and greeted their colleagues. (Obs. 1)

> At 8 a.m., three colleagues arrived in uniform, and the HP started the shift handover. (…) After 5 min, another colleague arrives, also in uniform, and after 15 min, the fifth member arrives discreetly, still not in uniform. (Obs. 36)

Identifying the medical team's compliance with arrival and departure times was challenging, as members arrived at different times and had overlapping duties in other hospital areas, such as the outpatient clinic and the emergency department. Health assistants were punctual.

3.3.4 Knowing self

3.3.4.1 Lack of critical team reflection

Moments of reflection on professional practice often occurred when actions do not align with personal expectations. However, this capacity for reflection was not observed within the team.

> "*I must organize my shift better; I don't have time to look at files. How come I didn't know that cardiology had come to see the patient? I ended up handing over the wrong information*". (Obs. 10)

> (…) the nurse and the health assistant at the entrance to the room, with gown and gloves on. The nurse asks: "*how long is he going to be there? This is clueless*". She pulls back the curtain and says, "*do you think this is the best time to listen to him? we're in the middle of the bath, he's undressed*". The doctor replies, "*you're right, I can come back later*" and leaves the unit without saying anything to the patient. (…) The nurse tells the health assistant that she may have been too harsh with the doctor "*I could have said it differently, don't you think? Sometimes it feels like I don't have a filter*." (Obs. 41)

3.3.4.2 Difficulty in managing emotional demands

Healthcare professionals struggled to recognize, understand, and manage the emotional demands of their profession, as well as their ability to handle stress in life-threatening situations.

> HP: "*I'm going to be looking after that patient again; it's getting to me (…) he is getting weaker and weaker, and always worried about his wife…*" (Obs. 15)

> The nurse always had a calm attitude and didn't transmit any anxiety to the patient, the health assistant or the doctor. (Obs. 12)

3.3.5 Clarity of beliefs and values

3.3.5.1 Influence of personal convictions on professional practice

Personal convictions shaped how staff approached their work at an individual level, interacted with older adults, and made decisions. The alignment or misalignment of these beliefs with person-centered care principles affected the way staff delivered care and engaged with patients.

> *Yesterday afternoon HP warned against leaving this patient sitting (…) they said it had been difficult to manage the work. (…) HP: "It's not my patient, but just so you know, I ignore this kind of information. I assess what's best for the patient, I'm not worried about what my colleagues in the afternoon say"*. (Obs. 15)

In relation to the practice environment dimension, the findings highlighted a collaborative team culture, yet there were significant barriers to shared decision-making across professional groups due to hierarchical structures. The spontaneous and informal discussions observed revealed concerns with vital signs, complications, or therapeutic issues. While valuable, these interactions did not always provide a platform for effective teamwork. The shortage of specialized nurses and the absence of formal multiprofessional meetings constrained collaborative and holistic care approaches. Additionally, the unit's physical layout, with limited shared spaces, reinforced professional silos. These findings underscore the importance of creating formal spaces for interprofessional communication and enhancing the skill mix to ensure consistent, person-centered care.

3.3.6 Appropriate skill mix

3.3.6.1 Managing patient-to-staff ratio

The staff distribution by shift aimed to balance the different functions and levels of experience, ensuring complete coverage of patient care and the health assistants kept track of the number of nurses per shift. However, staff are occasionally absent from the service for health or family reasons without being replaced, putting the ratio into question. Despite the higher workload, staff showed readiness to take on patients who were not initially assigned to them and adjusted their care planning according to the events arising during the shift.

> One of the HP (…) takes over the shift of the colleague coming in at 9 a.m. (…), while another HP advances some activities during the shift handover, bearing in mind that today, the patient ratio has changed, and, therefore, they will have more patients in their care. (Obs. 25)

> The night shift HP starts the shift handover and mentions that one of the morning colleagues will not attend (…). They must have more patients assigned, so the work distribution has changed. Everyone tries to find out who the new patients are without commenting or wasting time. (Obs. 25)

3.3.6.2 Balancing specialization and experience in care

There were different levels of professional experience among the staff, and an effort was made to maintain a balance between the teams, with the concern to guarantee the quality of the care provided. Concerning specialization, the gap in the nursing team stands out. Of the 50 nurses on the team, only one specialized in medical-surgical nursing and two in rehabilitation. Several shifts were observed without a rehabilitation nurse. Staff recognized the shortage of rehabilitation nurses and its impact on care provision.

> *The nurse manager reminds all nurses to be attentive when handing over shifts to newly arrived colleagues. "It is important not to change team members because it causes instability and insecurity. They should be placed in the teams of those who have accompanied their integration into working life and who know their difficulties."* (Obs. 25)
>
> *The doctor asked how the patient's tracheostomy closure training had been going. The nurse said there had not been much progress because there was only one rehabilitation nurse, and he did not come in on weekends.* (Obs. 31)

3.3.7 Shared decision-making systems

3.3.7.1 Lack of multiprofessional meetings

There was no formal time or place for healthcare professionals to meet with other professional groups. Information sharing occurred spontaneously in the medical and nursing rooms, bedrooms, or corridors. However, the need to create moments for sharing information and discussion between the various professionals was expressed.

> *Are four doctors outside a room discussing treatment options (…) One of the doctors starts sharing information about one of the patients (…) and approaches the nurse in the room to get more information about him.* (Obs. 39)
>
> *"How come we are putting off this referral to palliative care for so long?" (…) The HP said she was disappointed that there was no multidisciplinary meeting to discuss these situations as a team (…). "We end up feeling that we do not have a voice."* (Obs. 25)

3.3.7.2 Opportunities for active involvement in decision-making

In team meetings, there were opportunities to actively influence care decisions within the different professional groups through case discussion. However, challenges arose in find mutual solutions among professional groups, despite efforts to collaborate.

> During the shift handover, the HP mentioned that one of the patients needed a central venous catheter to continue administering the therapy that had been prescribed (…). HP: "Although this has already been communicated to the physicians' team, they don't seem alert or willing to insert the catheter." (Obs. 25)
>
> After talking with the patient, the HP (…) discussed as a team what the treatment priorities would be, considering the motor deficit, the presence of easy fatigue and the need for respiratory rehabilitation to achieve the independence that was desired. They have thought of treatment options that they will consider with the family. (Obs. 9)

3.3.8 Effective staff relationships

3.3.8.1 Collaborative teamwork

Team members demonstrated adaptability, effective task management, and a commitment to collaboration toward common goals.

> The doctor approaches the nursing room (…) and says that a patient needs his central catheter "rotated". The nurse asks if she should prepare the material immediately and stops the computer records, she was making. She goes to the workroom, gathers the material, asks the health assistant to organize the space in the unit for the procedure. (Obs. 45)

3.3.8.2 Mutual support among staff

Team members communicated and supported each other respectfully and professionally, reflecting shared values of mutual trust, support, and respect in everyday situations and during clinical instability. The role of leadership in facilitating teamwork during challenging moments was also observed.

> During the shift, a HP had a personal problem (…) and ended up leaving the ward. The colleague who took over his tasks showed her support and reassured her, "Don't worry." (Obs. 8)
>
> The head nurse becomes aware of the inpatient decompensation (…) and comes to the room to check if she needs help. (Obs. 12)

3.3.9 Power sharing

3.3.9.1 Equity among professionals in the same group

A collaborative approach to resolving differing opinions was identified among professionals in the same group, who recognized that leveraging specialized knowledge could address uncertainties and enhanced the quality of care.

> Two physicians have different opinions. They all decide to call the gastroenterology specialist to explain their case and ask for advice. (Obs. 39)

3.3.9.2 Impaired power sharing between professional groups

In contrast, misalignments between different professional groups represented a missed opportunity for interprofessional dialog.

> The doctor (…) enters the room and says, "*I have seen the patient (…). I do not know what has happened but try removing the NIV and see if she can tolerate it*". The nurse (…) says she will remove the NIV without asking the doctor any questions or providing any more information, even though she knew that when she changed the mask in the morning, the patient had low oxygen saturation. (Obs. 21)

3.3.10 The physical environment

3.3.10.1 Unit architecture on the care environment

The unit's architecture consisted of a long corridor with nine patient rooms on one side and offices for nurses and physicians on the other. The walls were painted light yellow with informational posters for patients and visitors. All rooms had windows with natural light and views of the adjacent building and were equipped with televisions. No remote control was available for patients. The offices for nurses and physicians had windows facing the city, round meeting tables in the center of the room, and several computers were distributed on desks along the walls.

3.3.10.2 Balancing ward dynamics with patient care

Especially on weekdays, the ward environment experienced abrupt transitions, with unforeseen tasks arising simultaneously and professionals adjusting to the change of pace (e.g., discharges and admissions, complementary diagnostic tests, and patient physiological decompensation). During morning shifts, there was hustle and bustle in the corridor, which was full of equipment, and people moved around (blood analysts, physiotherapists, material delivery, food distribution, cleaning staff). During the shift handover, the silence was only interrupted by patient bells. Most of the day, older adults were sitting in armchairs or lying in bed. Still, during the visiting period, there was bustle again, with people coming and going and interacting with patients and staff.

3.3.10.3 Challenges related to patient room design

Almost all care activities took place in the patient unit. Each room could accommodate up to three patients, with a curtain in between for privacy, and a bathroom and shower inside. Although inside the room the atmosphere was calm, high noise levels were observed in the corridor, and the room's door was always open.

> "*The equipment has squeaky wheels*" (Obs. 31), "*people spoke loudly (…) shouting in the corridor to their colleague at the other end of the service*" (Obs. 32), and "*the phone rang and rang without being answered.*" (Obs. 31)

3.3.11 Supportive organization systems

3.3.11.1 Promoting staff involvement in practice development

Staff were encouraged to participate actively in working groups, such as practice improvement projects (e.g., prevention of falls and pressure ulcers), but work conditions still needed to be created (e.g., no time assigned in the schedule).

3.3.11.2 Ensuring access to training opportunities

Different training activities were provided for each professional group in the department, with few specifically aimed at health assistants. At the organizational level, training covered common areas such as infection control, life support, and risk management. To increase staff participation, training modules were mostly scheduled online.

3.3.11.3 Leadership that cultivates collaboration

The clinical director and the head nurse led the unit. They coordinated efforts to resolve tensions and ensured a collaborative environment. Both maintained an open line of communication with the team. However, none of the leaders were observed to express their support for the PCP clearly, consistently, or frequently.

3.3.12 Potential for innovation and risk taking

3.3.12.1 Divergent approaches to healthcare delivery

Distinct approaches to healthcare delivery were observed among different professionals. On the one hand, a creative ability to circumvent the rules and adapt care was identified. On the other hand, staff followed established routines and demonstrated a reliance on hierarchical authority, rather than personal judgment. The potential for collaborative problem-solving underscored a possible rigidity in rule enforcement that did not always fully consider the patient's specific circumstances.

> The relative asks for two visits to the family member (…). The HP says that (…) the rule is only one visit per day and returns to the nursing room to share what has happened with her colleague. The colleague replies, "Can't the patient go outside in her wheelchair? She is even sitting down and only has 2 liters of oxygen." (Obs. 44)
>
> Why did you restrain her? "He laughs embarrassedly and says," Because the colleague said so. "And you do things because you're told to, can't you decide?" (Obs. 10)

The analysis of Person-centered process dimension revealed a commitment to engaging older adults on an individual level, although care was often standardized to streamline routines, occasionally conflicting with personalized approaches. While staff made efforts to align care with patient values, this alignment was more apparent in basic care needs than in significant care transitions. These findings pointed to the need for strategies that balanced routines with flexibility, ensuring that protocols supported rather than hindered person-centered practices.

3.3.13 Working with the person's beliefs and values

3.3.13.1 Efforts to know older adults

Efforts were observed to get to know older adults, acknowledge discomfort, encourage them to discuss what is important to them, and act accordingly.

> The HP (…) says they will prepare for the shower and ask if the patient prefers to eat first. HP: "you must be hungry, it's getting late." She says no, "eating before bathing is harmful." HP: "Ok. Then we will move on to shower." (Obs. 18)
>
> At the same time as talking, the HP is preparing material to check the peripheral catheter (…). She sits down next to her and begins the procedure without alerting the person to the technique but always chatting amiably and with interest. She turns her head to the side and closes her eyes. HP: "I was trying to distract you with the conversation, I know you don't like it when I touch the catheter". She smiles. "You can rest assured that everything is fine with this one" (Obs. 3)

3.3.13.2 Tension between individualized and standardized care

Staff used established care practices to provide uniform care for older adults with similar conditions. In some cases, care interventions were imposed despite a person's disagreement.

> The nurse said that the patient is recovering, being more communicative than in previous days. (…) He did not want to get out of bed and clung to the mattress. However, I still got him up. HP: "*He tolerated it very well and is now lying down again*." (Obs. 10)

3.3.14 Sharing decision-making

3.3.14.1 Exchange of information on care decisions

Exchanging relevant information between staff and older adults ensured that well-informed care and treatment decisions were made collaboratively. The balance between respecting the patient's self-reporting and using external input to guide care decisions highlighted the importance of clear communication and active listening in delivering effective, individualized care.

> She also asked if the lady wandered around the house. The patient says no. The HP insists, "Not even with a walker? Your daughter told me that she could walk with a walker or support." (Obs. 19)

In this context, the focus was more on sharing information when the person or their family asked about their current health state and health plan, rather than collecting information about the person and their health history. The family was used as a resource to get more information about older adults.

> The HP says that he is going to check the IV line and administer the antibiotic. OA: "Am I taking more than one antibiotic? Until when?" The HP asks if she feels any pain and administers the medication while clarifying her questions. (Obs. 4)

3.3.14.2 Collaborative decision-making in basic care needs

Older adults were involved in decisions to meet their basic care needs, with care planes adjusted collaboratively to prioritize their comfort, satisfaction, and participation.

> OA: "*Today, let's try to go to the toilet with the walker. Do you feel like it?*" The patient says yes. HP: "*Do you want to eat first?*" She asks what the food is. HP: "*It's a porridge made of cornstarch*." The woman shows a look of displeasure. HP: "*You don't like it? Would you prefer something else? I can try to get some bread*." (Obs. 5)

3.3.14.3 Routine-driven approaches to care transitions

When it came to decisions on care transitions, such as discharge, unit transfer, or diagnostic exams, the routine of the unit prevailed. The lack of specific information or opportunity for the patient to ask questions reflected a hierarchical and task-centered approach, rather than a collaborative and person-centered one.

> The nurse calls the health assistant and asks her to pack up the patient's things as he is about to be transferred. She contacts the unit (…), arranges the equipment, medication, and documentation, and only then informs the patient. He asked why he was being transferred, now that he was used to being there, and expressed concern about a relative's visit, which was scheduled for later in the day. The nurse says that it was the doctor's decision. (Obs. 43)

> The HP (…) informs you that they are going to leave the service to carry out a test, she doesn't specify which one, nor the collaboration required. The patient doesn't ask any questions. (Obs. 32)

3.3.15 Engaging authentically

3.3.15.1 Understanding the person's perspective

Some staff members demonstrated that they valued, understood and were flexible to the person's perspective, acknowledged the role of familial support in improving the patient's well-being, and adapted care accordingly.

> In the afternoon nurses decide to facilitate a patient's family staying longer during the visit, as it is an extended hospital stay and the patient's condition has worsened. (Obs. 32)

3.3.15.2 Aligning care with patient's known wishes

Healthcare professionals' effort to align with patients' wishes and expectations while promoting active engagement in their treatment and recovery was observed. Balancing empathy with motivational support, contributed to a more satisfactory care experience with common goals.

> The patient was asked (…) if he has the energy to start doing some exercises. She says she keeps in pain. HP: "*We are going to try out some exercises; you tell me how much pain you have. Pain is normal, but we have to know when it increases and becomes difficult to bear. (…) It is important to do these exercises so that you do not lose any more muscle mass (…) and do not lose the mobility you had before*". OA: "*That is what I wanted most*." HP: "*So, let's work for it!*" (Obs. 23)

3.3.16 Being sympathetically present

3.3.16.1 Demonstrating understanding and support

Healthcare professionals demonstrated compassion when addressing older adults' expressions of sadness or concern. Their responses balanced reassurance, acknowledgment of emotions, and humor to alleviate distress and promote comfort.

> The patient (…) says that her husband was visiting her and thought she was more tired than yesterday. HP: "And what do you think?" OA: "I think I'm the same." HP: "But do you feel worse?" (…) OA: "I went in the shower today; it was my first time." HP: "And it went well, didn't it? It's natural to get tired in the shower the first few times. (…) Your husband wants you to go home" she laughs "If you've been in the shower, it's because you're better, a few days ago you couldn't even get out of bed. It's one step at a time." (Obs. 13)

> The doctor says, "I don't have good news. I had promised you that today would be your discharge day, and everything was planned for that, but we had the result of a test that we weren't expecting, so we will have to postpone your discharge. It's not going to be today anymore." The lady looked visibly sad. The doctor apologized for having created this expectation (…) and explained that she would have to take medication for a few days. She seemed to understand but kept her sad face. The doctor jokingly said: "It's not so bad; you're still here with this lady that you talk to a lot, and you need to be at 100% to get back home; the grandchildren give you a lot of work, don't they?" (…) The lady ended up breaking her sad face. (Obs. 7)

3.3.17 Working holistically

3.3.17.1 Integrating all dimensions of the person in care

Some healthcare professionals demonstrated their commitment to providing positive care experiences that integrated more than a physiological dimension. Despite resource limitations, they made effort to balance compassion, creativity, and effective communication, fostering the fulfillment of patient's needs.

> HP: "*Do you want to wash your hair? (…) I'll see if there's any shampoo*." Faced with the fact that she had no personal hygiene products, she asked, "*Do you ever receive visitors? Can they bring shampoo from home?*" She replies that she has no shampoo at home because she always goes to the hairdresser to wash. The HP said that she would use the unit's shampoo, which probably wasn't that good, but she would do her best to look as good as when she left the hairdresser. (Obs. 2)

3.3.17.2 Recognition of biomedical tasks in practice

The observations suggested that healthcare professionals prioritized task completion over immediate responsiveness to patient bells or visitors. Nurses and health assistants divided tasks, focusing on administering medication, hygiene, and comfort care to ensure efficiency in a high-demand environment. This approach might have led to feelings of neglect or dissatisfaction among patients, and visitors could have perceived staff as unavailable or inflexible.

> The nurses split up and carry out the tasks at the end of the shift. One of the nurses takes the medication trolley to one end of the service and starts administering oral and IV medication. The other begins hygiene and comfort care with the health assistant at the opposite end. Bells are rung constantly. The HPs follow the sequence of the rooms and only answer the bells when they get to the room. (Obs. 35)

> Visitors ring the doorbell (…). The HP in charge of the patient is busy preparing the therapy and tells the relative to wait outside for her to finish what she is doing. (Obs. 32)

4 Discussion

Observations conducted across all weekdays and shift patterns offered a balanced perspective of the unit's activity, aligning with the literature on capturing authentic healthcare interactions through varied timings (28), frequent, brief interactions typical of high-demand care environments, and consistent with findings by McLaney et al. (29) on staff's need to adapt to shifting demands. Nurses were central to observed interactions, which mirrors the Portuguese healthcare context, where nursing staff frequently lead inpatient care. This aligns with the Ministry of Health's data, reflecting nurses as primary caregivers in such settings (30). The observed profile of older adults, who are predominantly female and present with chronic conditions requiring high dependency, is characteristic of internal medicine units that manage complex, long-term care needs in aging populations (31). These demographic and interaction patterns provided the context for interpreting the unit's workplace culture and person-centered care practices.

The thematic analysis reflected how workplace culture shapes person-centered care in the internal medicine setting, according to the PCPF. The diversity of identified subthemes underscores the complexity of care delivery, reflecting both theoretical concepts and their practical manifestations. Reflective sessions with 15 healthcare professionals supported the validation of findings, adding depth to the interpretation.

The professionally competent theme highlighted the technical knowledge of healthcare professionals, often aligned with biomedical expertise but not always translating into holistic care. This contrasts with McCormack et al. (3) model of competence, which encompasses knowledge, skills, and attitudes for individualized care. While experienced staff effectively anticipate older adults' needs, routine practices often take precedence over personalized care, suggesting opportunities for reflective practice and mentoring for newer staff (32).

Effective communication, respect and compassion were evident among staff, particularly in interactions with older adults and families, which aligns with the cornerstones of the PCP (3). Collaborative communication within professional groups supported patient care, but the lack of formal interprofessional meetings limited broader information exchange and collective decision-making, indicating the potential benefits of structured communication forums.

The commitment to the job theme revealed dedication to high care standards, although non-compliance issues (e.g., wearing artificial nails) reinforced findings by Brooks et al. (33) on factors affecting healthcare professionals' compliance. Staff demonstrated strong patient engagement, through intentional involvement with older adults' and family to understand their needs and preferences despite the workload pressures that sometimes led to task-oriented disengagement once routine care was complete.

In the knowing-self theme, although moments of self-reflection were observed, professionals cited stress, routines, and limited structured reflection time as barriers to regular critical reflection. Formalized reflective practice could address this gap, supporting staff's personal and professional growth in line with PCPF principles (3). Staff also faced emotional challenges in life-threatening situations, underscoring the need for coping mechanisms to manage the emotional demands of care.

The clarity of beliefs and values theme showed that personal convictions significantly influence care delivery, sometimes aligned but other times diverging from person-centered principles. Cultivating awareness of these values could enhance consistency in person-centered approaches (34).

In the prerequisites construct, the strengths identified include the staff's strong technical expertise and biomedical knowledge, effectively

anticipating patient needs. Communication and compassionate interactions with patients and families align well with PCP principles, and staff commit to delivering high-quality care. Additionally, collaborative relationships and mutual support among team members foster a positive and supportive work culture. Areas where further development is needed guarantee professional standards, deepen knowledge in non-technical areas and enhance support for reflective practices individually and collectively. Emotional challenges in life-threatening situations reveal a need for stronger coping mechanisms and alignment of personal values with PCP principles to ensure consistency. Lastly, high workload pressures, stress, rigid routines, and insufficient time for reflection hinder professional growth and contribute to task-oriented practices, reducing opportunities for meaningful patient engagement.

Regarding the appropriate skill mix theme, the observed staff–patient ratios and skill composition are largely aligned with regulatory standards (30, 35), although unplanned absences disrupted ratios and increased workloads. Ensuring staff levels is essential for sustaining a high level of care and preventing burnout among staff (36, 37). Limited specialization, particularly in rehabilitation nursing (35), highlights a significant gap that targeted recruitment and skill development programs could address.

In the shared decision-making systems theme, the absence of formal multiprofessional meetings and structured interprofessional communication restrict opportunities for information sharing, inclusive decision-making, leading to hierarchical dynamics where physicians often dominated care plans despite nurses' relevant input (38). The example of a nurse following the physician's directive without question, despite having pertinent information, suggests a hierarchical culture that may stifle open communication and hinder person-centeredness (39). Encouraging more structured, inclusive decision-making processes would empower all team members to participate actively, promoting a balanced and person-centered workplace culture (40).

In the effective of staff relationships theme, collaborative relationships and mutual support create a harmonious work environment, fostering resilience and cohesion in patient care (41). The observed readiness to assist colleagues and seek advice reflected a supportive culture essential in high-pressure care settings, contributing to the unit's collective strength.

The power-sharing theme reveals a dichotomy between intra and inter-professional dynamics. Collaborative openness within professional groups and, conversely, a hierarchical culture that may stifle open communication and hinder person-centeredness was observed (39). Addressing these power imbalances is crucial for fostering an environment where all professionals feel valued and empowered to contribute to patient care (40). The physical environment, comprised of long corridors, contributed to isolation between staff and older adults, and noise from high activity levels detracted from patient privacy (42). Organizational adjustments, such as noise reduction and dedicated quiet areas, could improve patient comfort and privacy, enhancing the patient-centeredness of the environment.

The supportive organizational systems theme revealed the importance of practice development and training opportunities in sustaining a person-centered culture, as continuous learning reinforces person-centered principles (42). Although staff were encouraged to participate in quality improvement projects, there was limited emphasis on fostering reflective practice and team dialog. Providing dedicated time for such reflective activities could empower staff, fostering improvements in sustainable care. Expanding training to include diverse professions and specific skills would enhance team competence, supported by leadership that prioritizes individual and team growth (12, 43).

The potential for innovation and risk-taking theme highlighted a tension between adhering to protocols and exercising professional judgment. While some staff demonstrated creativity in adapting care to individual needs, others followed routines without question, underscoring the need to balance innovation with safety to advance the PCP (43). Establishing a culture that encourages both risk-taking and adherence to safe practices is essential for meaningful person-centered care. With respect to the practice environment construct, challenges related to staffing, specialization gaps, and hierarchical structures impacted collaborative care. Although the environment was largely supportive, power imbalances and ward layouts that physically isolated older adults presented obstacles to effective PCP. Additionally, a lack of formal meetings and practice development time constrained continuous improvement. Addressing these gaps, such as by introducing multiprofessional meetings, would promote collaborative decision-making and shared accountability (44).

In working with the person's beliefs and values theme, staff showed sensitivity to individual preferences, engaging personally with older adults. However, the necessity of standardized care sometimes conflicts with personal approaches, where established protocols could overshadow individual needs. Balancing flexibility with protocol adherence remains a core challenge for PCP (45, 46). The theme of sharing decision-making revealed variability in the involvement of older adults, with decision-making often limited to responses rather than proactive engagement. Encouraging a more collaborative approach could further align care with patient values (39). Older adults should be seen as active facilitators of decision-making (45, 46). Involving families as resources also enhanced PCP, recognizing the older adults' broader context. However, major care transitions often followed organizational routines, highlighting areas for improvement in shared decision-making practices (39). The behaviors of engaging authentically and being sympathetically present aligned with the PCPF's holistic care, illustrating staff efforts to connect genuinely with older adults (9). These actions fostered patient trust and a sense of security. However, a duality exists between holistic care and task-oriented approaches, where routine-based methods prioritize clinical efficiency over emotional and psychological needs (17). Strategies to integrate individualized approaches with standardized protocols are essential to reinforce PCP principles (47, 48).

In the person-centered processes construct, task demands frequently conflict with individualized care. High task orientation often undermined holistic approaches essential to the PCP, as staff judged competing priorities. Sharp et al. (49) reported similar tensions in acute settings, where task-oriented workflows diverted focus from direct patient care. Care fragmentation, time constraints, and goal-oriented organizations are reported as challenges in transitioning to PCP and factors delaying this change (12, 50). Aligning daily routines with person-centered principles, by training staff to merge standardized and personalized care could mitigate these conflicts, ensuring that protocols support, rather than constrain PCP (48). Additionally, older adults' involvement in decision-making was limited to basic care needs, remaining opportunities to expand collaboration to include a

broader scope of care decision. The study did not clearly address the willingness of older adults to participate in decision-making. However, previous studies in Portugal have shown a preference among older adults for healthcare-led decision-making in acute care, possibly due to dependence and loss of control in institutional settings (51, 52). Enhancing emotional relationships and personalizing information sharing could foster a collaborative environment, encouraging patient involvement and aligning care with individual values (48).

Variability across subthemes, such as working holistically, suggests inconsistency in how different professionals implement PCP. While some healthcare professionals make efforts to align care with the individual preferences of patients, routine practices often take precedence. This tension between adherence to established guidelines and the flexibility required to address personalized patient needs is a challenge throughout the unit. The inconsistent approach to care leads to older adults experiencing 'person-centered moments,' reinforcing the need for a more consistent workplace culture (47, 53).

The prioritization of task demands during shifts revealed a tension between essential aspects of PCP that span several themes across all dimensions of the PCPF, including professional competence, commitment to the job, knowing self, potential for innovation and risk-taking, sharing decision-making, and working holistically. This tension suggests that the task-oriented nature of work may conflict with the holistic, individualized approach that PCP requires. As a result, staff may struggle to integrate these core elements of PCP while meeting the demands of a busy clinical environment. Sharp et al. (49) identified this tension in acute settings, leading to missed aspects of care, especially non-technical ones. To enhance PCP it is crucial to emphasize strategies that support the alignment of daily routines with person-centered care principles (47), such as training staff to integrate standardized care with personalized approaches, ensuring that protocols serve as a foundation rather than a constraint.

The absence of systematic multiprofessional team meetings impacted several themes, including knowing self, shared decision-making systems, power sharing, supportive organization systems, and the potential for innovation and risk-taking. Regular meetings could facilitate professional growth and collaborative decision-making, promoting shared responsibility and comprehensive care planning (44). These structures are essential for creating an environment where each professional's contributions enhance person-centered outcomes. The hierarchical culture within the unit further complicates this issue. Physicians often dominate care planning, even when nurses have pertinent information that could contribute to decision-making. This power imbalance stifles open communication and limits the active participation of all team members in the care process. Addressing these hierarchical dynamics is crucial for fostering a more collaborative, patient-centered environment.

Professional development and reflective practice are also central issues. There is a significant gap in opportunities for continuous learning and structured reflection within the team. Healthcare professionals could benefit from formalized reflection periods to assess their practice and enhance their understanding of person-centered approaches. The lack of time and support for reflection and critical thinking restricts personal and team growth. Addressing these challenges through professional development, critical reflection, collaborative structures, and enhanced patient engagement practices remains essential for cultivating a sustainable person-centered culture. PCP just can thrive within an established care culture that prioritizes person-centered values and practices (53).

Overall, these transversal subjects underscore the importance of addressing organizational and structural challenges, such as communication improvement, collaborative culture fostering and, reflective practice support, to strengthen the PCP implementation and cultivate a sustainable person-centered culture (53).

As limitations of the study, the data collection was confined to one unit in a secondary public hospital, keen to understand the work culture, so the findings are not generalizable.

We identify potential biases in data collection based on observations and participant narratives, as they might omit critical aspects of interactions that were neither directly observed nor valued by the observer. Additionally, the recent appointment of the head nurse is a significant event that could introduce variations in data, depending on its impact on the work environment.

Owing to the study's methodological characteristics, the individual and organizational levels of intervention were considered in the interpretation of the findings. A deeper understanding of how the PCP is framed at the structural level and supported by health system policies could enhance the interpretation of the results.

As a strength, exploring person-centered concepts within a theoretical framework grounded in an established theory bolsters the existing knowledge of PCP in the field. Understanding the work culture of the unit based on PCPF offers added value in guiding the transformation of the PCP by defining areas for prioritization. To our knowledge, this is the first study to use an inductive approach based on this theoretical framework to describe the work culture in an acute healthcare setting. The established methodology, capturing behaviors in all shift patterns, including all professional groups and older adults, and validating the interpretation of the results in reflective sessions, lends credibility to the results.

5 Conclusion

This study contributes to a broader understanding of how work culture is experienced in an internal medicine unit through the PCPF lens and deepens how theoretical concepts can be identified in practice.

The diversity of subthemes identified reflects the complexity of care delivery and underscores the strengths and challenges of aligning it with person-centered principles. It offers guidance for targeted interventions to foster a person-centered work culture.

Key strengths include the healthcare professionals' technical competence, commitment to high-quality care, and compassionate communication with patients and families. Supportive staff relationships foster resilience and cohesion, contributing to a positive work environment. These elements align with the core principles of PCC and underscore the opportunities for further growth.

However, several challenges were identified. Task-oriented practices often take precedence over holistic care, and inconsistencies in PCC implementation result in fragmented patient experiences. Hierarchical dynamics constrain collaborative and inclusive care planning. The absence of structured multiprofessional meetings limits effective communication and shared accountability, while the lack of reflective practice opportunities hinders professional growth. Additionally, high workload pressures and routine-driven care reduce opportunities for meaningful patient engagement. Future efforts to address the identified challenges, such as implementing formal multiprofessional meetings, supporting collaborative decision-making, promoting staff engagement

in reflective practices, and patient involvement in decision-making, will be crucial in advancing the PCP in this context.

Data availability statement

The original contributions presented in the study are included in the article/Supplementary material, further inquiries can be directed to the corresponding authors.

Ethics statement

Written informed consent was obtained from the individual (s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

DV: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Supervision, Writing – original draft, Writing – review & editing. CO: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. FV: Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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Person-centred care as an evolving field of research: a scoping review

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Introduction: Changes in policy towards a healthcare approach viewing patients as persons provide calls for person-centred healthcare practices. The objective of this scoping review was to present an overview of the international literature on PCC.
Methods: Database-specific search string including index terms and free text words related to PCC were constructed to identify relevant literature indexed in PubMed, Scopus, PsychINFO, CINAHL and Web of Science. Two different methods of combined manual and computer-assisted screening were applied to identify citations to be included in the review.
Results: In total, 1,351 publications were included, whereof theoretical and empirical studies were most prevalent in the sample. For the latter, the most common setting was hospital care. The study population was most often health professionals or patients. The most frequently used term was patient-centred, followed by person-centred and family-centred. Research from six continents was included. An exploration of collaborations and research clusters has revealed several clusters.
Discussion: This review provides a snapshot of the literature on PCC. The lack of clarity in terminology presents barriers to comprehensively overviewing the vast amount of available research within the field, which in turn presents challenges for research-based policy and practice development.

KEYWORDS

systematic review, scoping review, patient-centered care, person-centred care, text mining, EPPI-Reviewer, literature review as topic, integrated care

1 Introduction

In recent decades there has been increasing demand for patients' perspectives to be taken into consideration when organising and carrying out healthcare. These demands have come from different stakeholders, including patient and family member organisations, healthcare professionals, researchers, and policymakers (1). A healthcare approach viewing the patient as a person, emphasizing co-creation and partnerships between patients and professionals, has become the gold standard of care within the healthcare sector. This approach, which we will henceforth refer to as person-centred

care (PCC), can be understood from the perspective of different frameworks (2–6). The implementation of PCC has been proposed as a way of improving quality of care and is included in European regional policy (7), as well as global healthcare policy (8). Research shows promising effects, such as increased effectiveness, patient satisfaction and cost reduction (9).

Due to the variety of people involved with similar but not identical starting points and goals, a plethora of different terms denoting this field of study have arisen—terms such as the aforementioned person-centred care, as well as patient-centred care, people-centred care, family-centred care etc. (10). Sometimes, different terms are used to label the same construct, while at other times, the same term is used to refer to different constructs. While some researchers assert that the conceptual differences between constructs are minor, others view the end goal of care as different, for example, when looking at patient and person-centred care (11, 12). The link between the term used and the basis of, for example, a PCC intervention is often not clear in research today (10).

Apart from the above inconsistencies in conceptualizations and terminology, the boundaries of this research field are blurry and there is an evident overlap with other fields, such as research solely focused on shared decision-making or research on patient and public involvement (PPI). In addition, only one medical subject heading (MeSH) currently exists, i.e., patient-centred care, further adding to problems with delimitation. This heading was introduced to PubMed in 1995 and is available in the MeSH tree syntax under primary care and narrative medicine (13). Patient-centred care is defined as: "Design of patient care wherein institutional resources and personnel are organized around patients rather than around specialized departments", hence not encompassing the conceptualization or delivery of care.

To stay within project constraints, the mentioned challenges may result in reviews choosing a limited scope, using only one or a few terms, having a short time frame or focusing on a specific population or healthcare context. While pragmatic, this approach risks providing an incomplete overview of the research field. For instance, two current reviews, a white paper and an edited volume, all on PCC (9, 14–16), have minimal overlap in the included studies, suggesting that different domains of PCC research are being presented. This example of different domains in the targeted field also raises the question of whether there are active collaborations between researcher groups or whether we are working in separate silos. If so, this could be an obstacle to building a shared knowledge base from which to generate research and evidence-based policy in the long run.

Thus, the objective of this scoping review is to present an overview of international literature on PCC and to answer the following research questions: (1) What populations, settings, research approaches, and designs are represented in PCC literature, (2) Which terms and keywords are used in PCC literature, and (3) Can research collaborations and clusters be observed in the research field of PCC?

2 Methods

2.1 Study design

A scoping review methodology combined with bibliometric analysis was identified as the best approach for describing the vast amount of literature on the topic of PCC, which has not been thoroughly examined or, is characterized by complexity and heterogeneity (17). The methodology outlined by Arksey and O'Malley (18) and Levac (19) involves five key phases: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data, and (5) collating, summarizing, and reporting. We followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis statement (PRISMA-P) (20) and PRISMA-Scr extension for scoping reviews (21). The review has been registered in PROSPERO ID [2020 CRD42020188804], and a PRISMA-Scr Checklist can be found in Supplemental data.

2.2 Identifying relevant studies

The team, encompassing experts in PCC, designed a comprehensive search strategy in close collaboration with two expert medical librarians. Literature searches were developed using index terms (e.g., MeSH) and free text words related to PCC, including terms such as person-centred, patient-centred, client-centred, woman-centred, women-centred, child-centred, family-centred, relationship-centred, and people-centred. All variations on term endings, for example, centric, centeredness as well as variations in accompanying terms such as care, practice, approach etc. were included. These terms were chosen based on collective knowledge and experience of the team at that point in time. No time restriction was applied but the language was restricted to English.

The databases PubMed, Scopus, PsychINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Web of Science were used to retrieve relevant literature. Search terms were adapted according to the different databases. The detailed search syntaxes used in PubMed can be found in Supplemental data. Database searches were conducted on three occasions, with the final search conducted in June 2023. Searches in Grey literature databases or manual searches of reference lists for the included citations were not conducted, and the quality of the literature was not assessed.

2.3 Study selection

To be included in the review, the citations needed be published in a scientific journal and (1) include PCC as a concept in the main aim or focus (independent of specific term used) and (2) include an elaborated discussion of the concept used either by: (a) including philosophical, ethical, and theoretical aspects of the concept, or (b) explicitly mentioning the elicitation of a patient narrative and patient-staff partnership.

In this study, the second criterion (2b) was guided by a definition of PCC in which the patient's will, needs and desires

are elicited and acknowledged and incorporated into a collaborative partnership involving patient, healthcare professionals and other people of importance in the patient's life. This general, and for our study, guiding definition is in line with the University of Gothenburg Centre for person-centred care (GPCC) framework, first presented by Ekman et al. (4, 5).

All reference types in scientific journals were eligible for inclusion, for example, original quantitative and qualitative studies, reviews, research in brief, editorial letters, study protocols, discussion papers and comments. Citations from all healthcare settings were eligible, for example, neonatal care, paediatric care, child and adolescent healthcare, school healthcare, primary care, hospital care, rehabilitation, residential care, medical home care, home care, hospice care, and education for healthcare professionals and students.

Exclusion criteria were citations not in English, not involving human subjects, citations not using PCC as a concept in the main aim or focus, citations focused solely on shared decision-making, narrative medicine, or person-centred psychotherapy, and citations using a PCC term without explicating and developing what is meant by the term/concept used. We also excluded books, book chapters, theses/dissertations, conference abstracts/proceedings/posters, erratums, and contexts that are not healthcare settings, such as criminal care, social services and general pedagogics/education.

We conducted a stepwise screening and selection process, including both manual screening and a computer software assisted methodology. A random sample of 5,455 citations from the first database searches was selected. The number of citations for the initial set selected was deemed to be a sufficiently large sample, using previous studies as a reference (22). This sample (screening set 1) was imported into Rayyan (23) and the title and abstract of each citation was screened manually by two reviewers independently against inclusion- and exclusion criteria. Citations were classified as "included", "maybe" or "excluded". All citations labelled as "maybe" were screened in full text (also by two reviewers), and then classified as included or excluded. This specific step was taken to safeguard that all citations labelled as "included" were relevant.

The classified citations from the manual screening were used to train a predictive classifier model, which was then applied to the remaining citations from the database searches. Having successfully used manually built classifier models in previous work, we tried this option first (22).

Developed by expert language technologists, the model was manually built on single-word frequencies. However, enhancing the precision of this manual model proved time-consuming, prompting us to explore the option of using ready-made screening software.

A bespoke classifier model was built in EPPI-Reviewer 6, which is a software developed and managed by the Evidence for Policy & Practice Information Centre based at University College London (24). Just like our manually built model, this model was built on word frequencies, but instead of single-word frequencies it uses a tri-gram "bag of words' approach, meaning word pairs and triplets are also recognised and counted for each record. In order to validate this methodological change, we conducted a comparison between the models (25). This comparison showed that, using the same set of citations for training, the classifier model built in EPPI-Reviewer could identify relevant citations earlier in the process than the manually built classifier.

All data from screening already conducted while building the manual model (Screening set 1–4) was imported into EPPI-Reviewer's bespoke classifier model, which ranked the remaining citations on their probability of being included in the review. To further strengthen the precision of the model, five additional rounds of screening (set 5–8) were then conducted in EPPI-Reviewer. These rounds also included the ranking of new literature published after the initial searches. After screening all citations ranked as most highly relevant by the classifier model (i.e., all records labelled 89–100), we decided to stop screening. This limitation will be acknowledged in the discussion.

All citations with titles and abstracts that seemed to meet the inclusion criteria were imported and read in full, apart from those which had already been read in full after first being labelled as "maybe" because these had already been marked as "included" or "excluded". The reviewers resolved any disagreements through discussion and, if needed, consulted with an additional person. Reasons for excluding citations were noted down.

2.4 Charting the data

Data relevant to answering the research questions was extracted in accordance with Arksey and O'Malley's (18) framework and entered into NVivo (26). A uniform charting approach was used for all studies included in the review, with data including title, authors, year of publication, country of first author, term used in full text publication, target group, healthcare area and reference type. For empirical studies, the research approach, setting, study design and study population were also extracted. A code-book can be found in Supplemental data. The data-extraction from NVivo was later exported into EPPI-Reviewer and can be found in EPPI-Visualiser (which is a feature in EPPI-reviewer).

A bibliometric analysis was conducted to explore potential research collaborations and clusters in the sample. The analysis was conducted on the citations available in the database Scopus: $n = 1{,}150$ of the 1,351 included citations. The software VOSviewer (27) and the R package Bibliometrix (28) was used to extract and visualize the co-occurrence of universities/research institutions and keywords in included publications. The keywords used in the publications citing the included publications where also extracted and visualized, this to explore how the field might evolve over time. A more detailed description of this methodology can be found in Supplemental data.

3 Results

In total 1,351 citations were included in this scoping review (Figure 1). The results are presented below in narrative summaries, as well as in figures and tables.

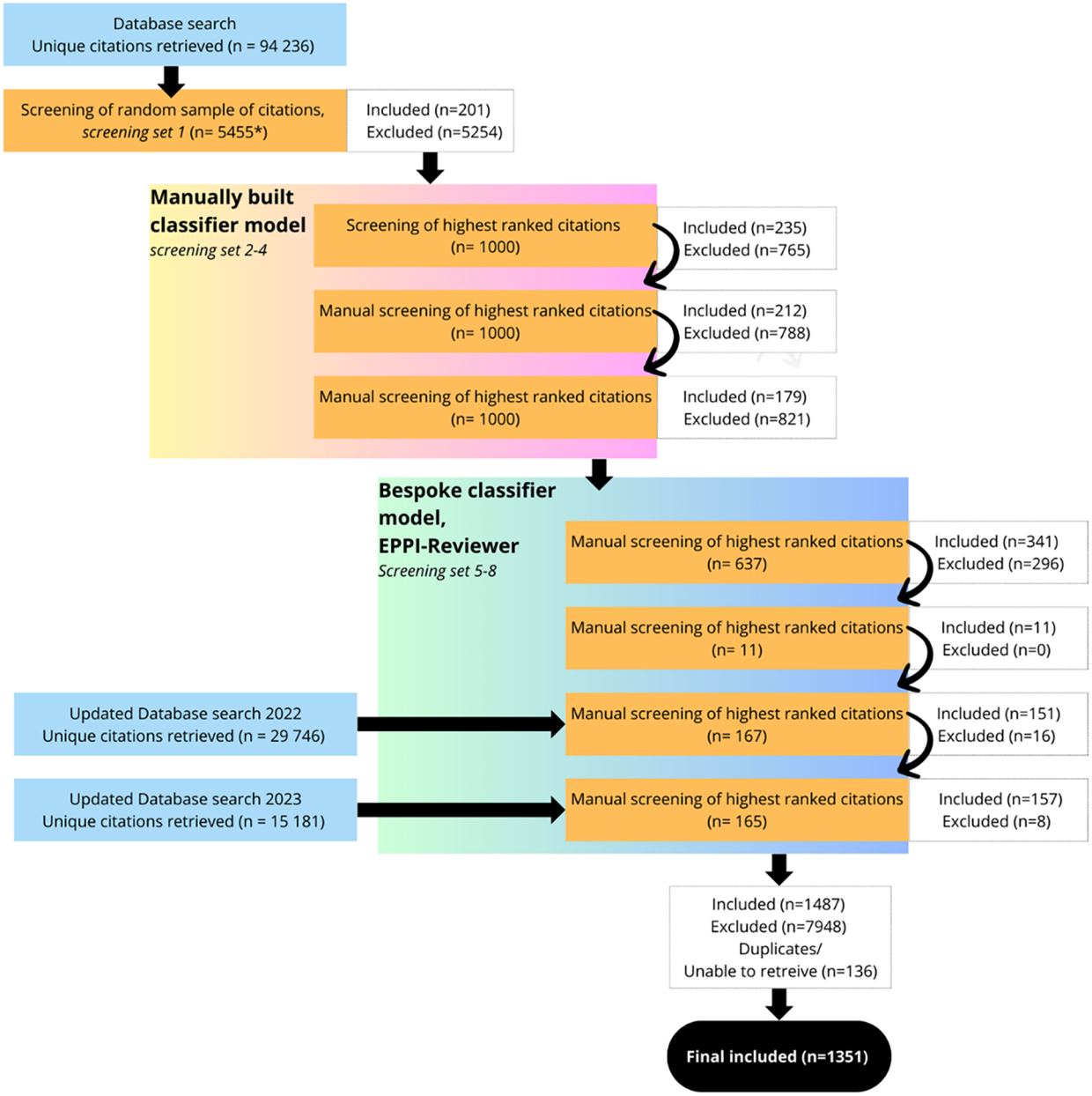


FIGURE 1
Flowchart of data screening and selection process. *The reason for the uneven number was that after the first 5,000 were selected, 455 were added after a complimentary search on people-centred care, which was not included in the initial search syntax; Full texts were excluded for the following reasons: wrong language, wrong publication type, wrong setting, PCC not the main focus, PCC not explicated or Unable to access.

3.1 Populations, settings, research approaches and designs

Most publications were focused on adults or did not specify any target group ($n = 925$). Children and the elderly were evenly distributed thereafter, representing $n = 217$ and $n = 218$ publications respectively (Table 1). General in-patient and out-patient care is the largest category of healthcare area within our data ($n = 836$). The next largest healthcare category is publications with an unspecified healthcare area i.e., literature for which no healthcare area or context is explicitly mentioned, for example, an explicitly theoretical article ($n = 257$).

Empirical studies made up the majority of the sample ($n = 658$), followed by theoretical studies ($n = 424$), literature reviews ($n = 163$) and editorials/letters/commentaries and anecdotal publications ($n = 90$). Study protocols were the smallest group ($n = 16$). Looking at development over time, theoretical and empirical studies have followed the same path, sharing the top spot for reference type until 2013 (Figure 2), followed thereafter by an upswing in empirical studies. In recent years,

10.3389/frhs.2025.1534178

TABLE 1 Characteristics of included publications 1972–2023 (June).

Included publications (n = 1,351)	Total n (%)	Empirical studies (n = 658)	Total n (%)
Target group[a]		Research approach of empirical studies	
Adults/unspecified	925	Qualitative	303 (46.0)
Children	218	Quantitative	281 (42.7)
Elderly	217	Mixed-methods	74 (11.2)
Healthcare area[a]		Setting of empirical studies[a]	
General in-patient and out-patient care[b]	836	Hospital care (specialist care)	329
Elderly, long term, residential, hospice	130	Residential home care	102
Psychiatric care	48	Primary care	96
Health promotion	36	Healthcare student education	42
Rehabilitation, habilitation, disability	16	Home care	31
Home care	13	Unspecified[e]	44
Dentistry	12	Other[f]	59
Unspecified[c]	257		
Other[d]	18	Study design of empirical studies[a]	
		Descriptive, exploratory, interpretive	427
Reference type		Quality improvement study	44
Editorials, letters, commentaries, anecdotes	90 (6.7)	Quasi experimental	34
Empirical studies	658 (48.7)	Participatory, action research	32
Literature reviews	163 (12.1)	Experimental (randomisation)	25
Study protocols	16 (11.8)	Case study	18
Theoretical studies	424 (31.4)	Other[g]	80
		Study population of empirical studies[a]	
		Patients	274
		Health professionals	370
		Family, parents, significant others	128
		Students	40
		Other[h]	76

[a]More than one category can be coded in citations.
[b]Includes a variety of in-patient and out-patient healthcare areas.
[c]Citations not stating specific area.
[d]Includes for example chiropractic care and pharmaceutical care.
[e]No specific setting stated.
[f]Includes for example. Rehabilitation and audiology.
[g]Includes for example development and validation of questionnaires.
[h]Includes for example hospital managers and members of the public. See additional details in Supplemental data.

empirical studies have become the predominant publication type, but the number of literature reviews has also increased.

The research approach of the empirical studies in our sample was most often either qualitative (n = 303, 46%) or quantitative (n = 281, 43%). The predominant setting was hospital care (n = 329) and has remained so over the years, followed by residential home care (n = 103). The study design was most often descriptive/exploratory/interpretive (n = 427), and the most common study population was health professionals (n = 370) or patients (n = 274), which is also the case looking at development over time. No clear increase in research focused on other groups can be seen in our data.

3.2 PCC terms and keywords

The most frequently used term within our data is patient-centred (n = 539, 40%), followed by person-centred (n = 425, 31%), family-centred (n = 240, 18%), and patient and family-centred care (n = 68, 5%) (Table 2). Other terms used are client-centred, woman-centred, people-centred and relationship centred. Multiple terms within one publication were also used.

Exploring development over time, patient-centred care was the dominant term used in our sample until 2018, when the term person-centred care took the lead (Figure 3). In our sample, the term family-centred care saw an increase in use during the 1990s, and has had a small, but steady growth over time. Other combined centredness terms have emerged, such as patient- and family-centred care.

We performed bibliometric analysis to explore keywords used within the included publications. Apart from PCC terms, the ten keywords most often used were nursing care, dementia, quality of care, long-term residential care, elderly, communication, primary care, qualitative research, family and nurses (Figure 4).

While exploring publications that cited the included publications (Figure 5), we saw that the most frequently used keywords (apart from PCC terms) were more or less the same, namely, qualitative research, nursing care, communication,

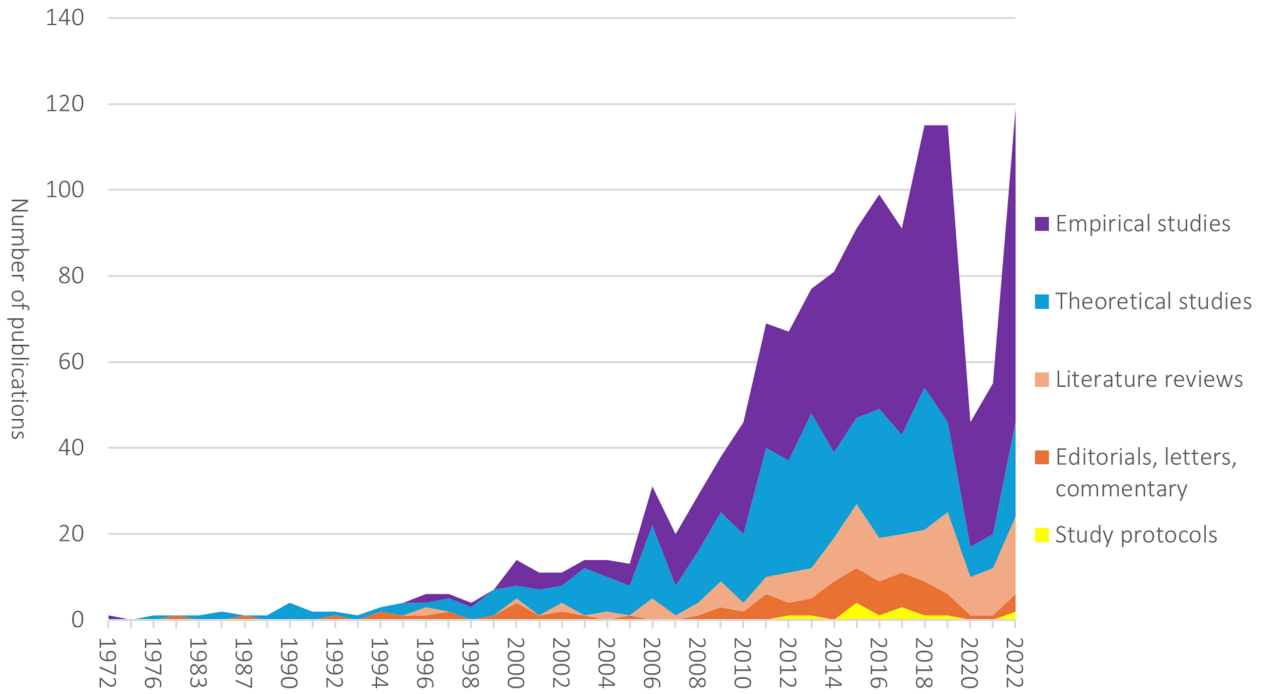


FIGURE 2
Development over time in number of publications in each reference type, 1972–2022.

dementia, primary care, shared decision-making, elderly, children, quality of care and family.

3.3 Research collaborations and clusters

Six continents were represented in our sample of research on PCC, with most publications from the United States ($n = 502$), United Kingdom ($n = 152$), Australia ($n = 131$), Canada ($n = 125$) and Sweden ($n = 108$), see Figure 6.

3.3.1 Universities/research institutions

Several clusters of universities/research institutions appear in the analysis (see colours in Figure 7).

TABLE 2 Term used.

Term used	Total *n* (%)
Patient-centred[a]	539 (39.9)
Person-centred	425 (31.5)
Family-centred	240 (17.8)
Patient and family-centred	68 (5.0)
Client-centred	15 (1.1)
Woman-centred	10 (0.7)
People-centred	10 (0.7)
Relationship-centred	10 (0.7)
Multiple terms[b]	21 (1.6)
Other[c]	13 (1.0)

[a]Includes citations using the term *patient centric*.
[b]Includes citations using multiple terms, such as patient-centred and person-centred.
[c]Includes child and family-centred, child-centred, community-centred, person and family-centred, person- and relationship-centred, resident-centred, student-centred, and soldier-centred.

4 Discussion

This scoping review provides an overview of the large and not easily delimited field of research on PCC. The terms patient-centred care, person-centred care and family-centred care were the most used within our whole sample. Person-centred care was the most used term after 2017. Combined terms, such as patient- and family-centred care have also come to the fore in recent years, and could potentially be traced to more groups taking on the PCC terminology. Some terms, e.g., woman-centred care, were exclusively used within a specific field—in this case, midwifery—which explains the limited number of publications represented in the sample.

PCC research is being conducted globally, with representation from researchers across six continents. It is nevertheless important to keep in mind that PCC is discussed as an approach that evolved in high-income countries, and therefore data across low-income and middle-income countries are limited (29). The top six countries represented in this review are the US, UK, Australia, Canada, Sweden, and the Netherlands. Comparing the top countries in this review to overall research output (30), the US, UK, Australia, and Canada all rank highly, while Sweden and the Netherlands are further down the list, potentially suggesting a specific interest or incentive for PCC research in the latter two countries.

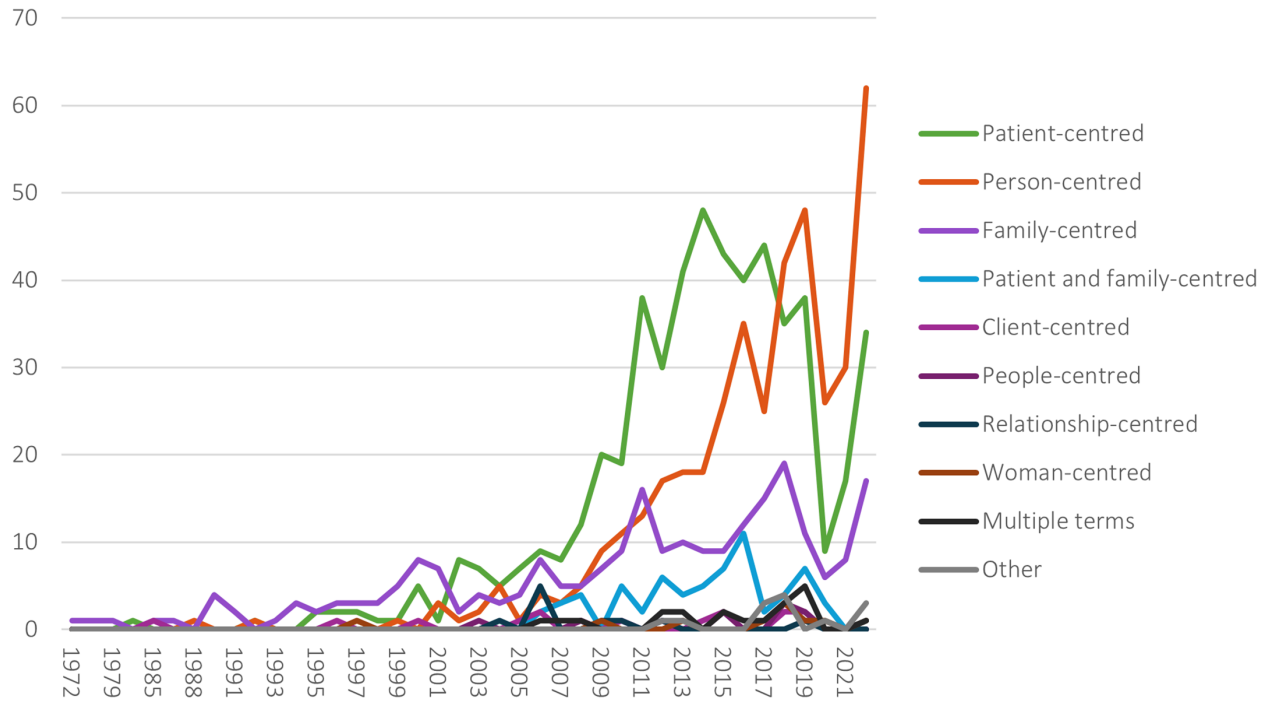


FIGURE 3
Development in use of terms over time, 1972–2022.

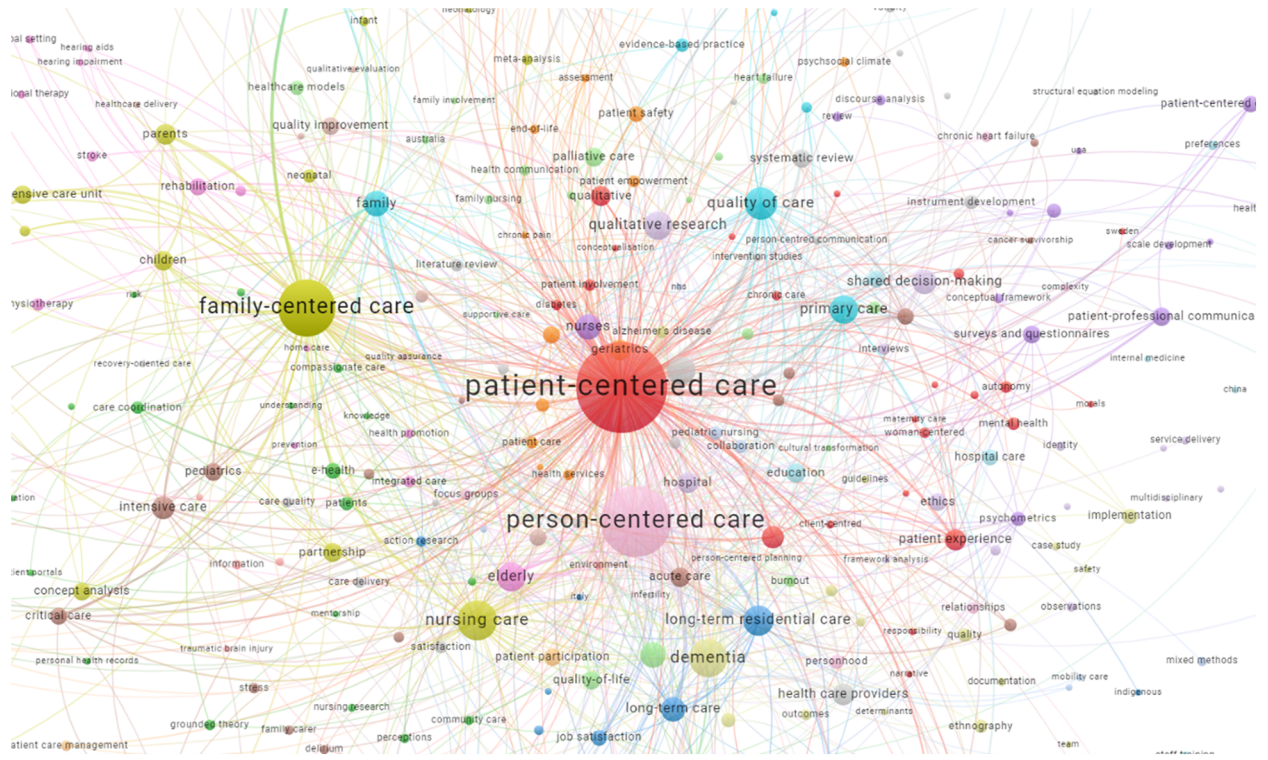


FIGURE 4
Keywords used in included publications. https://tinyurl.com/2n4daszo. The map is based on keywords with a minimum occurrence of 2 in the included publications.

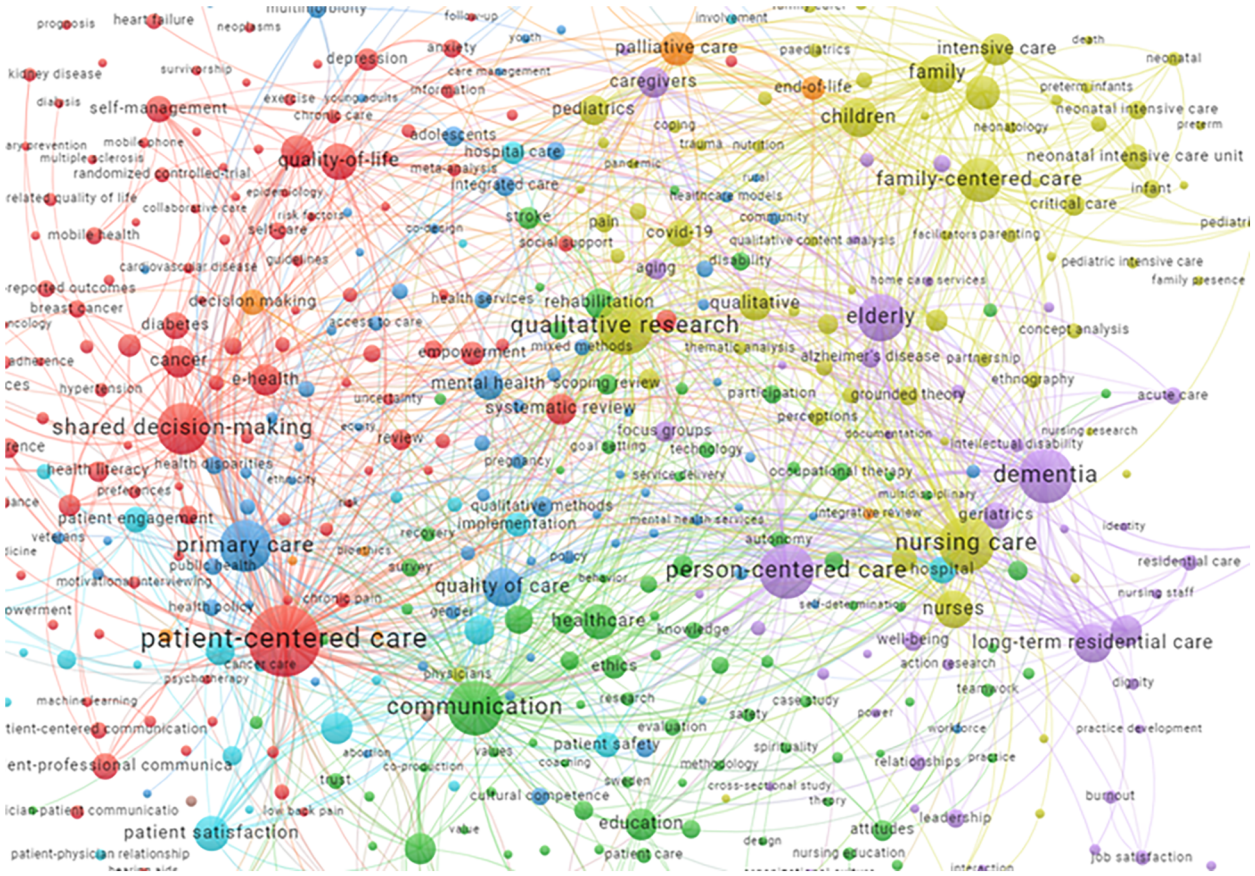


FIGURE 5
Keywords used in publications citing included publications (top 500). https://tinyurl.com/2z6t2bwm.

Our sample clearly shows an increasing focus on empirical studies, as well as reviews, indicating that the field is in some ways maturing. There are various ways of defining a mature research field, but Keathley-Herring et al. (31) propose that an important aspect is that the field is put into practice, which the increase in empirical studies may suggest.

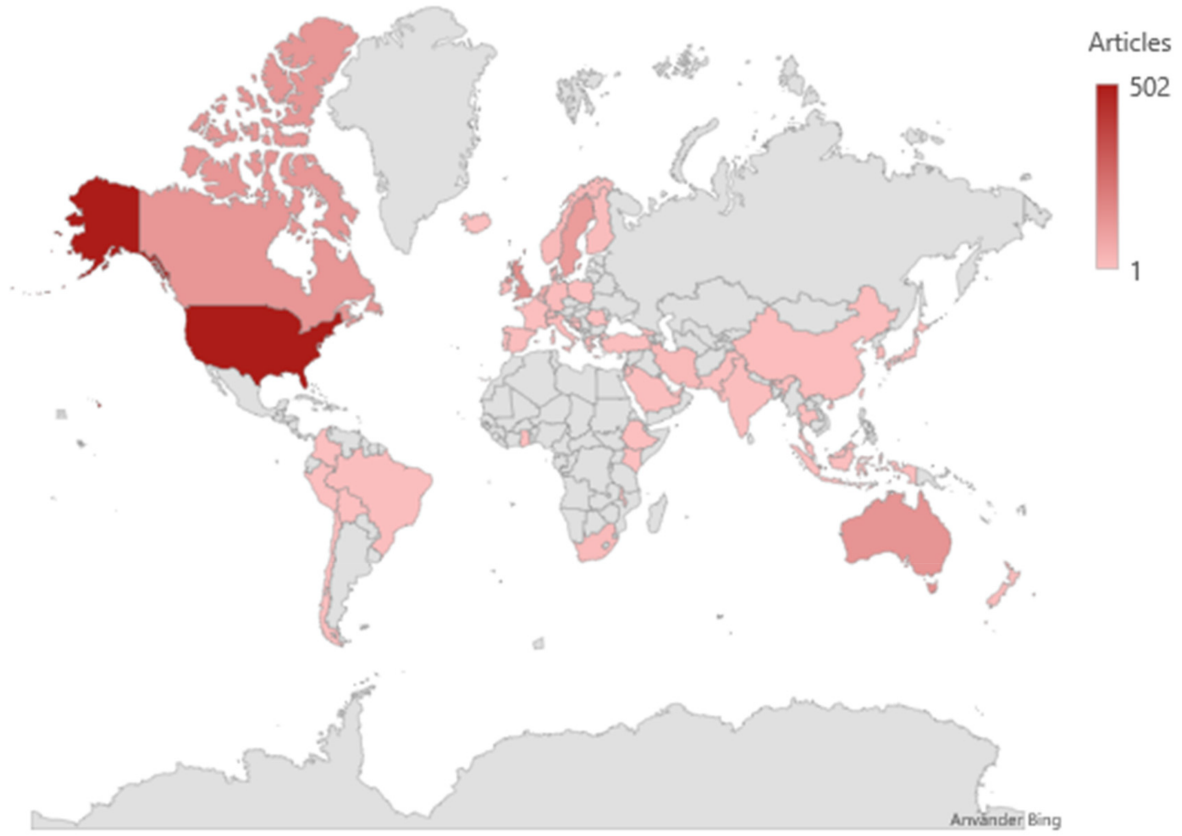
Nevertheless, the extent to which the number of empirical publications translates to actual implementation of PCC practices is unclear. Rosengren et al. (32, 33) suggest that PCC implementation in Europe depends on the healthcare system model. Countries with tax-funded public healthcare systems (Beveridge model), such as the UK and Scandinavian countries, may have been more successful in diffusing PCC than those with statutory health insurance-based systems (Bismarck model) like Germany, Austria, Switzerland and the Czech Republic.

Another factor pointing towards a mature research field, as discussed by Keathley-Herring and colleagues (31), is that the field is broadly accessible and agreed upon by a distinct research community. The bibliometric analysis in our study revealed collaborations between research groups and universities, which could suggest an emerging research community. However, there are also factors indicating that PCC is still only a moderately mature field, as there is no robust differentiation from other research areas. As previously discussed, there is a lack of consensus on the PCC concept, which suggests that the field is continuing to evolve (34). Even if this could be seen as positive, the lack of clarity in conceptualization and terminology presents barriers to a comprehensive and detailed overview of the field.

4.1 Method discussion and limitations

This project has been a challenge in many ways, and for us involved a methodological journey. Choosing to include a large variety of terms in our search syntax resulted in a large quantity of publications, meaning we had to make a number of decisions which could impact the overall results.

Firstly, due to the large number of publications, we did not include manual searches, which can be seen as a limitation. Secondly, we chose only to include citations explicitly focused on PCC in main aim and focus, as we did not want records which solely used a term without explicit discussion on the construct behind it. Thus, publications that were relevant but only used the term, without explaining its grounding according to our criteria, were excluded. Thirdly, we chose to use text mining features to assist the screening process and decided to end screening after



	Total n publications	Countries
Oceania	141	Australia (131), New Zealand (10)
Asia	94	Bahrain (1), Bhutan (2), China (9), Hong Kong (1), India (7), Indonesia (3), Iran (18), Israel (13), Japan (5), Jordan (1), Malaysia (3), Pakistan (1), Palestine (1), Saudi Arabia (8), Singapore (1), South Korea (14), Taiwan (3), Thailand (2), United Arab Emirates (1)
Europe	452	Belgium (6), Bosnia and Herzegovina (1), Croatia (1), Denmark (19), Finland (11), France (3), Georgia (1), Germany (13), Greece (5), Iceland (2), Ireland (14), Italy (10), Malta (3), The Netherlands (60),Bahra Norway (19), Poland (2), Portugal (2), Romania (1), Spain (8), Sweden (108), Switzerland (6), Turkey (5), United Kingdom (152)
North America	627	Canada (125), USA (502)
South America	13	Bolivia (1), Brazil (8), Chile (1), Colombia (2), Peru (1)
Africa	24	Ethiopia (1), Ghana (4), Kenya (1), Malawi (1), South Africa (17)

FIGURE 6
Geographical distribution.

we had gone through all records deemed most relevant by the classifier model (placed in the pile of a likelihood of 89–100 in EPPI-Reviewer). This could result in many potentially relevant citations being excluded from the complete sample.

Another factor which can be seen as a limitation is that our definition of PCC was general but nevertheless partly guided by the Gothenburg framework (4, 35), which can be seen as inherent bias in screening. There is a possibility that some citations related to, for example, people-centred care and family-centred care were excluded in our database queries and screening protocol. We chose to focus on the personal narrative and partnership as one part of our inclusion criteria, which could have excluded records more focused on the community or family perspectives, for example. The term

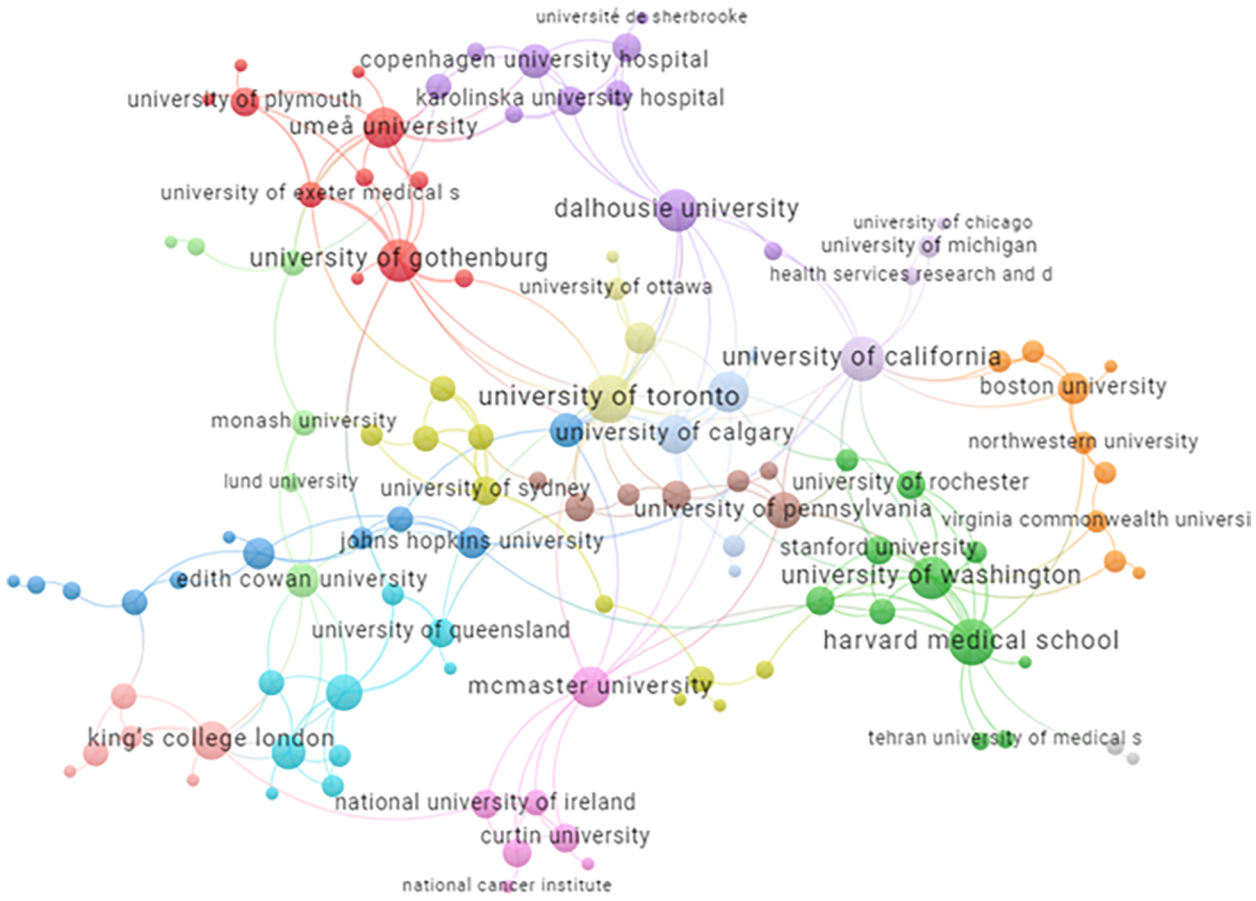


FIGURE 7
Universities/research institutions in included publications. https://tinyurl.com/2q9knonr. This map is based on institutions with at least five shared publications with another institution.

people-centred care focuses on the macro perspective of communities, which was not spotlighted in our criteria for inclusion. Possible additional specific terms, such as LGBTQ-centred, were not included in our search syntax, which in hindsight could also be seen as a limitation.

As for the bibliometric analysis based on Scopus data, covering 1,150 of the 1,351 publications included in the review, there is potential risk that relevant keywords and universities/research institutions occurring in the total data set might be missing in the figures presented.

Our approach made the project very time consuming, as well as labour intensive. This has implications, as the large number of people involved at various stages of the project could introduce rater bias in the screening process. The process of categorising areas of research literature also comes with limitations. We aimed to create categories of characteristics that would include most of the studies, but for some studies we had to create an "unspecified" category, as well as an "other" category. Another limitation is that the countries represented in our study have different systems of healthcare and care organization, meaning there is not necessarily a perfect fit with our categorization of healthcare area and settings.

4.2 Conclusion and implications

This review presents an overview of the literature showing that PCC research is being conducted worldwide in international collaborations. Most included publications use the terms *patient*, *person*, or *family centred care*. The term *person-centred care* is most frequently used in recent publications. Most publications are empirical studies of adult patients or professionals within a hospital care setting.

Our study demonstrates that using a broad conceptualization of PCC research results in the inclusion of a wide variety of terms. Such a variety of terms results in a large amount of citations, which subsequently affects how far one can present a comprehensive and detailed overview of the literature. While our study does not provide an answer as to how to manage these barriers, it does point to the necessity of making methodological choices clear, which will help prevent fragmentation of knowledge in future studies attempting towards PCC research synthesis.

This result, apart from working as a call for action for researchers in PCC to be more transparent in choice of methodology, could also be of interest for research in other fields encompassing substantial amounts of literature with more than one term applied, overlapping concepts, and that is not easily delimited.

Data availability statement

The included publications and their coding can be retrieved in EPPI-Reviewer Visualizer https://eppi.ioe.ac.uk/eppi-vis/login/open?webdbid=309.

Author contributions

EF: Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing. CF: Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing. SW: Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing. LT: Formal analysis, Writing – original draft, Writing – review & editing. LK: Formal analysis, Writing – original draft, Writing – review & editing. RS: Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing. JÖ: Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing.

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Patient and public involvement acknowledgement. The initial project idea was anchored in the GPCC steering committee in which a senior patient partner was a member. Two patient representatives/partners were included in the project group and their involvement within this specific scoping review is reported according to the ACTIVE framework (36).

The first patient partner, Inger Ros, was recruited by closed invitation as a patient representative, initially for the Person Council for Patients and Relatives/Carers at GPCC. IR was invited to review stage 4, and her mode of involvement has been a couple of single sessions, with direct interaction, and closest to the levels of receiving and contributing. The second patient partner, Jakob Wenzer, was openly recruited in a flexible position at stage 6 of the review process. JW has been continuously involved in the group, with direct interaction, contributing to discussions on data analysis and visualisations (stage 6–9). JW was also involved in discussion on the final results.

Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Generative AI statement

The author(s) declare that no Generative AI was used in the creation of this manuscript.

Publisher's note

Supplementary material

The Supplementary Material for this article can be found online at: https://www.frontiersin.org/articles/10.3389/frhs.2025.1534178/full#supplementary-material

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Co-creating a strategy for transforming person centred cultures

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Introduction: Transforming healthcare systems to support person-centred practice reflects environments where individual values and beliefs are respected and where healthful cultures can flourish. However, there are significant challenges within healthcare systems that impact on the development of healthful workplace cultures. The nursing and midwifery professions need to play an influential role in formulating health policy and decision-making to contribute to health and social care systems that are underpinned by person-centredness. This paper reports the use of a practice development approach underpinned by the Person-Centred Practice Framework to co-create a strategy for nurses and midwives that will enable the development of person-centred healthcare practices. The key objectives are to demonstrate the processes that support co-creation to build consensus on what is strategically important to nurses and midwives; to gain an understanding of the value of external facilitation throughout the process and exploring the challenges encountered during the development of the strategy.
Methods: Practice Development methodology was the approach used with skilled facilitation adopted to enable the working with values and beliefs, defining purpose and vision and establishing agreed working principles and behaviours. Consensus building methods were used to co-create draft strategy priorities further defined by wider stakeholder engagement.
Results: A 5-year strategy was co-created with senior nursing and midwifery leaders, inclusive of key strategic priority areas and strategic actions. The seven priority areas align to the Person-Centred Practice Framework with underpinning shared purpose and values. (1) Developing Person-Centred Cultures, (2) Creating a Supportive Practice Environment, (3) Building Research Capacity, (4) Building a Dynamic Workforce, (5) Fostering Leadership at all Levels, (6) Enhancing Digital Informatics and New Technologies, (7) Delivering High Quality, (8) Safe Person-Centred Care. Together they provide a roadmap for implementation across the many nursing and midwifery contexts providing a solid foundation for leading and supporting person-centred practice across a large local health district with a focus on what matters most while continuing to be innovative in approaches to practice. The development of a clear shared purpose of person-centred practice and the exploration of values were critical first steps in the development of the strategy and provided a clear foundation from which the nursing and midwifery leaders could utilise for the ongoing strategic priorities and action discussions.

Implications for practice: The development of nursing and midwifery strategy using Practice Development Methodology and the Person-centred Practice Framework enables critical dialogue that supports nursing and midwifery leaders identify key influences over nursing and midwifery practice. This approach not only fosters a sense of ownership and engagement among nurses and midwives but also ensures that their values, beliefs, and professional insights are integral to the strategic direction of healthcare practices. By aligning the strategy with the Person-Centred Practice Framework, nurses and midwives are better able to develop a shared understanding of person-centred practice where the individual needs and preferences of patients, families and staff are acknowledged. Overall, this strategy represents a significant step forward in supporting the professional development of nurses and midwives, enhancing the quality of patient care, and fostering a healthful culture where continuous improvement and innovation are at the forefront of the healthcare system.

KEYWORDS

person-centred practice, nursing, midwifery strategy, co-creation, culture, leadership

Introduction

Person-centredness is a global movement in healthcare simply because it reflects the importance of keeping people at the centre of healthcare systems (1, 2). It prioritises the human experience and places compassion, dignity and humanistic caring principles at the centre of planning and decision making and is translated through relationships that are built on effective interpersonal processes. We advocate the importance of the underpinning values of person-centredness, where the core value of "respect for the person" is paramount (3).

Transforming healthcare systems to support person-centred practice reflects environments where individual values and beliefs are respected and where healthful cultures can flourish. Healthful cultures are viewed as "contexts that are energy-giving for the benefit of health and wellbeing" (4). For healthful cultures to be achieved all persons need to be energised by the context in which they work and for that energy to connect with the personhood of all persons. This perspective on wellbeing ensures that person-centredness is not a uni-directional activity focusing on ensuring that service users have a good care experience at the expense of staff wellbeing.

Despite widespread acknowledgment that person-centredness is the appropriate underpinning philosophy for health and social care, person-centredness in practice is still misunderstood and difficult to operationalise and implement in practice. Whilst person-centredness permeates healthcare strategy and policy, the reality is that often stakeholders aren't actually talking about the same thing. We also see this dilemma in the published literature with interchangeable use of terms such as patient-centred and person-centred, leading to arguments that person-centredness is too difficult to define (5). Furthermore, in a recent editorial, McCormack (6) highlights the rhetoric of person-centred care often espoused in healthcare strategy and policy, but for many clinicians their lived experience of providing care and treatment on a daily basis can be very different.

Major healthcare external reviews internationally have identified that the contributions of key stakeholders are critical to improving the provision of quality health care and that the effectiveness of workplace culture is influenced by leadership (7–9). An important recommendation of the State of the World's Nursing report (10) is to strengthen nursing leadership to ensure that nurses play an influential role in formulating health policy and decision-making to contribute to effective health and social care systems. There is currently limited evidence identifying collaborative processes utilised by health care leaders in developing strategy (11). The Person-centred Practice Framework (3) identifies the need for strategic leadership within the macro level which informs the bringing together of nursing and midwifery leaders to explore current healthcare context and co-create strategy to influence practice and culture. Compassionate and person-centred leaders who embody a leadership approach that is considerate of each individual contribution, foster healthful relationships, invite, and encourage full engagement with the processes of decision-making and consensus making experience increased engagement, commitment, and trust across all levels of the organisation (12–14).

Within the Australian context, there is evidence of the impact of developing strategies that reflect innovation, creativity, and compassion in the way care is provided, and how supportive teams focus on individuals reaching their full potential (15, 16). This paper reports on an initiative that involved a senior group of nurse and midwifery leaders within a healthcare system within Australia who were committed and passionate about creating a strategic direction that would be enabling and supportive of the development of person-centred healthcare practices. It describes their engagement in collaborative processes to re-imagine a nursing and midwifery strategy through the lens of the Person-centred Practice Framework (3), ensuring a focus on what matters most to people across the system.

Abbreviations

DoNMS, directors of nursing and midwifery; CIP, collaboration, inclusiveness and participation; LHD, local health district.

Aims and objectives

Aim

To explore the collaborative and inclusive process undertaken to co-create a strategy for Nursing and Midwifery that will support the development of person-centred healthcare practices.

Objectives

- Demonstrate the processes that support co-creation to build consensus on what is strategically important to nurses and midwives
- To develop a strategy for transforming person-centered cultures in Nursing and Midwifery

Methodology

The theoretical underpinnings for this initiative was the Person-centred Practice Framework developed by McCance et al. (3). This is a theoretical model developed from practice, for use in practice, which offers a unique perspective of person-centredness. The Framework has evolved over two decades of research and development activity and has made a significant contribution to the landscape of person-centredness globally. Not only does it enable the articulation of the dynamic nature of person-centredness, recognising complexity at different levels within healthcare systems, but it offers a common language and a shared understanding of person-centred practice. The Person-centred Practice Framework is underpinned by the following definition of person-centredness:

> [A]n approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development (17).

The Person-centred Practice Framework comprises five domains: *prerequisites*, which focus on the attributes of staff; the *practice environment*, which focuses on the context in which healthcare is experienced; the *person-centred processes*, which focus on ways of engaging that are necessary to create connections between persons; and the *outcome*, which is the result of effective person-centred practice, that is a healthful; culture. Finally, these domains sit within the broader *macro context* (the fifth domain), reflecting the factors that are strategic and political in nature that influence the development of person-centred cultures. The relationships between the five constructs of the Person-centred Practice Framework are represented pictorially, that being, to reach the centre of the framework, one must first take account of the macro context, followed by consideration of the attributes of staff, as a prerequisite to managing the practice environment, in order to engage effectively through the person-centred processes, to bring about the outcome. The Person-centred Practice Framework is presented in Figure 1.

Practice development was the approach used and is a recognised methodology for enabling person-centred cultures (18, 19) which focus on supportive person-centred relationships and practice across individuals, teams, and systems to stimulate effective change and that are good places to work (20, 21). Practice Development (PD) includes the principles of collaboration, inclusiveness, and participation (CIP), active learning, skilled facilitation and is underpinned by shared values and purpose for person-centredness (19). A person-centred approach to facilitation was essential to engage the Directors of Nursing and Midwifery (DoNM) group across 12 sessions, this involved the approach of working with people rather than working on (22) and the skill of "being fluid", agile in practice when necessary (23). Skilled facilitation is at the heart of PD as an enabler to developing an understanding of person-centredness, with facilitating the building of relationships within the DoNM group instrumental in them engaging individually and as a group (19, 22, 24). External skilled facilitators enabled the essential principles of CIP to be maintained throughout the strategy development process and the co-creation of a safe space to have critical discussion.

Co-creating working principles and behaviours enabled the DoNM group to openly share what a safe and supportive group space would look and feel like to them individually and then further develop as a collective group. This was facilitated virtually gaining consensus on how the group wanted to work collaboratively together in a respectful manner, these became the agreed "working principles and behaviours" and were also an important aspect of the group's relationship building (see Figure 1).

Setting and sample

Located in New South Wales, Australia, the LHD is inclusive of nine hospitals, mental health and population and community health services, with approximately 5,000 nurses and midwives delivering health care to 930,000 residents. The LHD strategies align to the New South Wales Future Health Strategic Framework (2022–2032) vision and values, "A sustainable health system that delivers outcomes that matter most to patients and the community, is personalised, invests in wellness and is digitally enabled", underpinned by the values of collaboration, openness, respect, and empowerment (25). Cultivating caring cultures that place people at the centre has been well established recognising the importance of treating each other as individuals, respecting personal beliefs, hopes and preferences, with the emphasis on kindness and what really matters to the person. The development of safe person-centred compassionate care has been embraced through engaging with the Heart of Caring Framework (26) that has guided the promotion of human-to-human

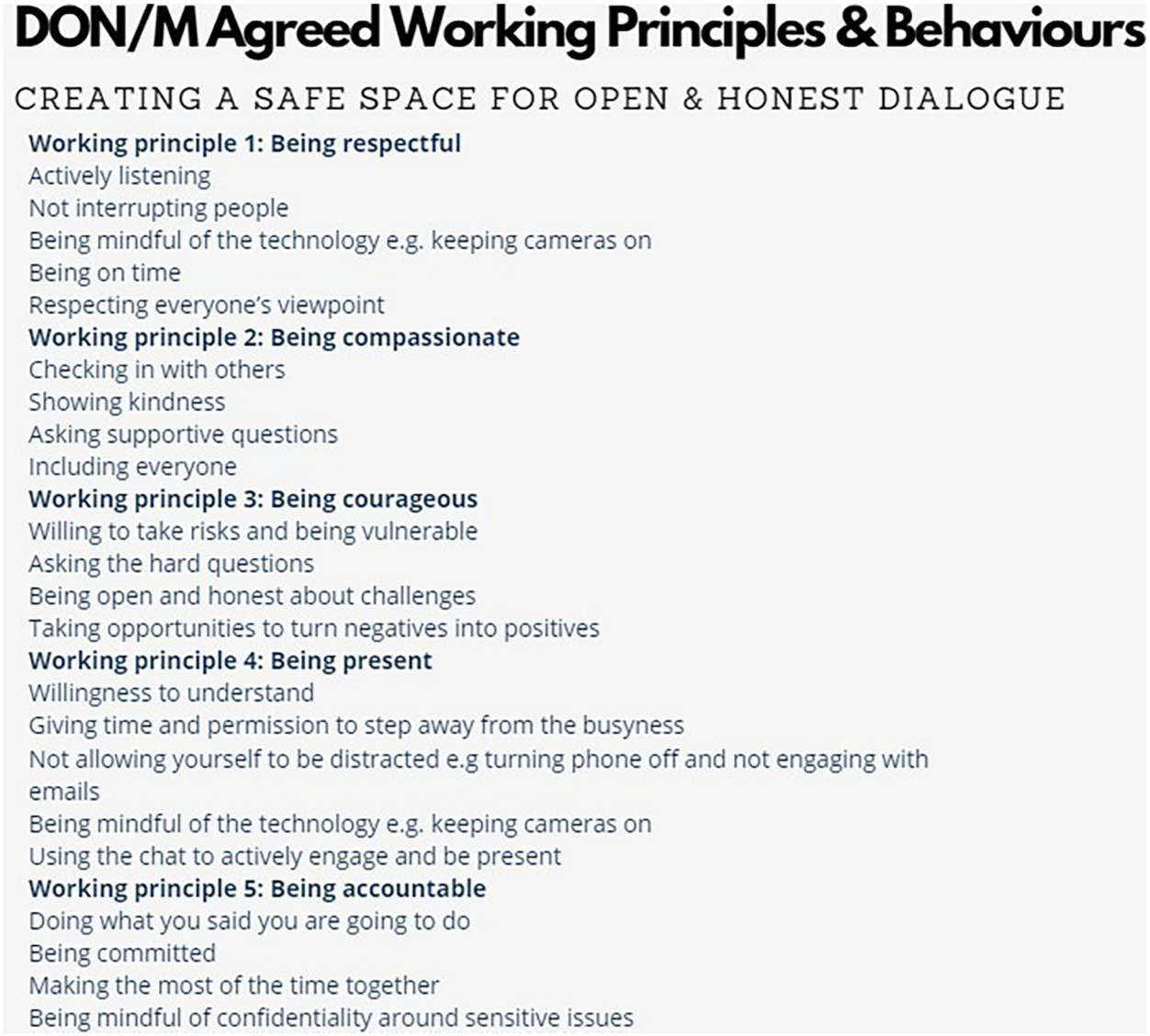

FIGURE 1
DON/M agreed working principles & behaviours.

connections, engaging effectively as teams, promoting self-care and wellbeing, and creating positive workplace cultures. Despite this focus the need for a co-created strategy inclusive of the nursing and midwifery workforce adopting a collaborative approach was identified. The LHD recognises skilled facilitation is at the core of enabling the development of person-centred cultures, continual investment in facilitation growth and development has been a LHD priority for over two decades.

Eleven Directors of Nursing and/or Midwifery co-created and led the strategy along with five members of the SESLHD Nursing and Midwifery Practice and Workforce Unit across over fifteen workshop sessions. For the engagement opportunities, the target population was Nurses and Midwives, working across the 8 public hospital including Population and Community Health and Mental Health Services within the LHD, with all role designations represented. Consumer participation was also included and considered important as a stakeholder group. Convenience sampling was used, with Nurses & Midwives invited to participate in the engagement opportunities. Thirteen Town Hall events were held with 390 Nurses and Midwives attending, with 2,127 items of feedback collected. Four Focus Groups were held with 65 attendees in total. All facilities and services from across the LHD were represented by their Director of Nursing and Midwifery and senior leaders. This led to a wider stakeholder engagement, which was critical to the strategy development to ensure collective ownership.

Data collection & analysis

Data was collected throughout a range of approaches across the strategy development including values clarification and

development of a shared purpose; identifying priorities areas through consensus; and wide stakeholder engagement.

Values clarification and shared purpose statement

Working with values and beliefs and defining purpose and vision, are key to person-centred practice. These processes have been identified as important for transforming workplace cultures and developing positive and effective working relationships with colleagues (17, 18, 27). Having a voice and being involved in decision making was fundamental, leading to on-going engagement, commitment and contribution of the DoNM group (21). The DoNM group first worked at an individual level and then collectively to co-create an agreed shared purpose and values statement. An exploration of purpose, values, and beliefs of "person centred practice" was undertaken, the external co-facilitation model enabled each DoNM to be actively involved in every aspect of the process. Individual reflection and responses were captured using a values clarification exercise (28), these were shared, collated, and themed in two smaller groups following critical dialogue, resulting in the co-creation of two draft purpose statements for "person centred practice". Voting resulted in a preferred statement with further review of the second statement for any elements that needed to be integrated. Further facilitated dialogue enabled consensus on an agreed final purpose statement. Underpinning values were also considered, shared, and critically discussed. The DoNM group agreed that the previous LHD nursing and midwifery strategy "Journey to Care 2015–2020" six values should remain as they continue to be the values underpinning their shared purpose. An additional value "courage" as proposed and added with an accompanying value "in action" statement.

Identifying priorities by building consensus

Consensus building, also known as collaborative problem-solving or collaboration (29), is a process used to generate ideas, understand problems and to settle complex, multiparty issues. Building consensus was an intentional part of the facilitation to enable CIP principles and ensure each DoNM was part of the co-creation of the 5-year strategic plan, with a consensus of priority areas. Each DoNM prepared and had thoughtful consideration of their context and identified individual facility priorities, breaking into three groups to share, discuss further and collectively identify duplication and need for any rewording. Final priorities from each group were captured through an online visual work platform for collaboration. Facilitation enabled further consolidation and consensus building with seven key priorities being identified. The priorities were further refined and then mapped onto the Person-centred Practice Framework (3).

Engaging in stakeholder events

Feedback sessions in the form of online and face to face townhall events were agreed as a forum to engage Nurses and Midwives from across the LHD. These were opportunities for the facilitation team to engage in conversation with stakeholders, gaining their feedback on the purpose statement and strategic actions to achieve each of the seven priorities. We asked, "*what words speak to you/what do you connect with*" and "*what would be needed for this priority to be achieved?*". A facilitator guide was developed to ensure consistency across events which included an opportunity to feedback on the draft purpose statement and values and the seven priority areas. The raw data obtained from stakeholder townhall events was reviewed. The data was analysed to answer the proposed question with each reviewer reading comments and organising into thematic categories for their allocated priority. Robust dialogue enabled the feedback data to be collated further and themed with draft strategic actions emerging for all seven priority areas along with priority descriptors of the focus and important.

The final part of the strategy development process involved virtual focus groups seeking feedback on the final draft strategy through the lens of nursing and midwifery leaders. Participants were asked "*What are the key messages you get from the strategy?*" "*How does the strategy resonate with you?*" and "*In reading the strategy, can you see yourself as a Nurse/Midwife within the strategy?*"

Ethical considerations

The Human Research Ethics Committee (HREC), at the Low Negligible Risk review, approved the project. Participation in every aspect of the strategy development was voluntary with no coercion. All invites to participate at townhall events and focus groups followed ethical processes, ensuring and declaring anonymity throughout.

Results

The following section presents results from the large data set collected across the development of the strategy. Table 1 summarises key data captured during the development of the strategy.

The first outcome from this work was the co-creation of a shared purpose statement and values with person-centred practice at its core, which is presented in Figure 2. When asked in the peak Townhall event to review the purpose statement and share what words they connect with, our Nurses and Midwives identified that they connected most with "Authentic behaviours, co-creating, compassionate care, enhance the human experience, innovation, person-centred and positive workplace cultures" (Peak Townhall event).

TABLE 1 Summary of engagement sessions.

Directors of nursing and midwifery group	15 facilitated sessions	
Townhall events	13 events and 390 attendees	2,127 items of feedback received
Focus Groups	4 focus groups and 65 attendees	

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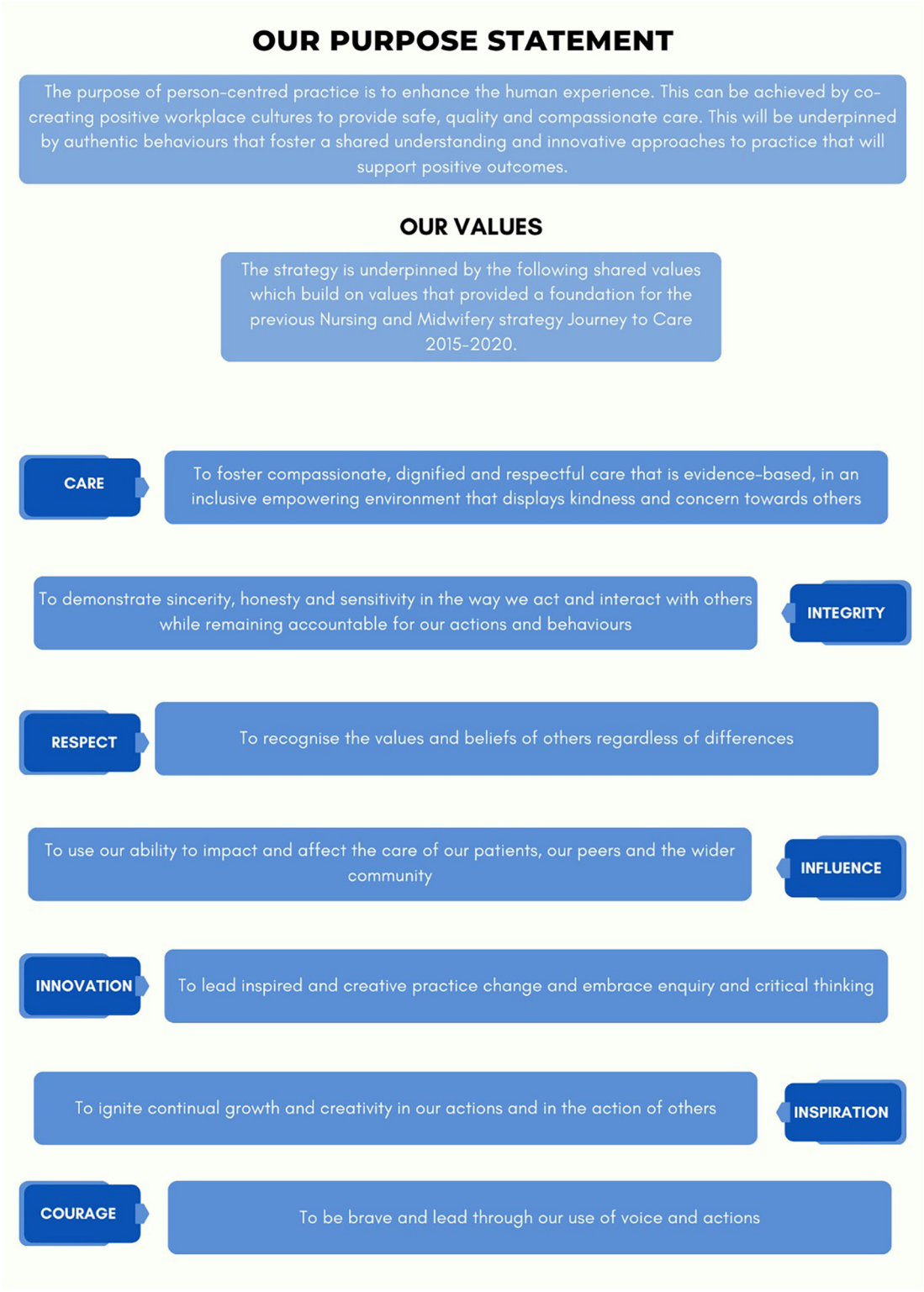

FIGURE 2
Our purpose statement and values.

One participant shared: "*I feel it (the purpose statement and values) aligns well with my own values, the purpose I feel is clear*" (Focus Group 4, Nurse Unit Managers and Midwifery Unit Managers). Another participant stated: "*I love the inclusion of courage as a value*", "*It is values based and values people*". (Focus Group 1, Nurse and Midwifery Managers).

A total of 17 priority areas were generated and then themed resulting in 6 key strategic priorities. This collaborative process

TABLE 2 Priority area consensus building.

Initial priority areas						
Flexible Approaches to Education, Patient Experience, Developing a Strong Nursing & Midwifery Voice, Staff Wellbeing, Professional Pathways, Recruitment and Retention, Meeting The Needs of Vulnerable Populations, Shared Understanding of Person-Centred Care, Preceptorship & Clinical Supervision, Effective Use of Resources, Communication for Positive Collaboration, Building/Developing Leadership, Digital and Informatics, Developing Person-Centred Culture, Building Capacity and Capability for Research, Capable Workforce, Flexible Approach to Education						
Secondary Priority Areas (Grouped)						
– Developing Person-Centred Culture – Shared Understanding of Person-Centred Care – Staff Wellbeing – Communication for Positive Collaboration – Meeting the Needs of Vulnerable Populations	– Quality & Safety – Patient Experience	– Building/Developing Leadership – Developing a Strong Nursing & Midwifery Voice	– Digital & Informatics	– Capable Workforce – Professional Pathways – Preceptorship & Clinical Supervision – Flexible Approaches to Education – Recruitment & Retention	– Building Capacity & Capability for Research	
Final Priority Areas						
Developing Person-Centred Cultures	Creating a Supportive Practice Environment	Building Research Capacity	Building a Dynamic Workforce	Fostering Leadership at all Levels	Enhancing Digital Informatics and New Technologies	Delivering High Quality, Safe Person-Centred Care

was highly valued by the DoNMs: "*Using a shared online platform for collaboration enabled us as a group to bring along our own priorities and in a transparent and open forum, have a robust dialogue and work through a process of grouping, theming and coming to a consensus on our final priority areas*". (Director of Nursing & Midwifery, Facilitated Session—Strategic Priority Consensus Building). A seventh priority area, Creating a Supportive Practice Environment, was identified through this process as it was noted in the facilitated session that the Practice Environment element of the PCPF was missing. The final Strategic Priority Areas are outlined in Table 2.

During the Facilitated Session—Strategic Priority Consensus Building, it was identified that the seven final Strategic Priority Areas aligned with the Person-Centred Practice Framework. The seven final Strategic Priorities were then mapped to the Person-Centred Practice Framework to ensure there was a comprehensive approach to creating healthful workplace cultures as demonstrated in Figure 3.

The Strategic Priorities, shared with staff via the Town Hall events, garnered 1,406 suggestions for action areas. *Enhancing Digital Informatics and New Technologies* received the highest volume of feedback with 245 responses. The importance of nursing and midwifery having an active role in this rapidly evolving space was emphasised:

> "Fair representation from all nursing and midwifery roles within the clinical councils that make big decisions on allocated resources to technology and recourses", (Town Hall Event 3)

> "Having a clear pathway for nurses and midwives to approach and follow for development of technologies in their clinical areas", (Town Hall Event 2)

> "Inclusion of nursing and midwifery in development of technology systems including during testing and planning for implementation" (Town Hall Event 6).

Developing Person-Centred Cultures received the least responses at 172. The sense that this was already happening in the organisation was evidenced form the data:

> "Our weekly Multidisciplinary meeting structure and the way we work as a team with our patients, demonstrated through our daily interactions, shows that we are doing it" (Town Hall event 12).

However, there was also a sense that a consistent approach to developing person-centred practice would be valuable:

> "Unpacking person-centred care will look different for each team, so a personalised and meaningful approach to doing so will be most effective" (Town Hall Event 9).

Strategic themes from the Townhall events are outlined in Table 3. Clear themes emerged from the collated dataset for each of the seven Priority Areas as presented in Table 3. These themes formed the basis for development of the strategic actions.

Following the Town Hall events, the collated data was shared with key focus groups. When asked what their key messages were, Nursing & Midwifery Unit Managers shared "*The key messages I take-away relate to supporting nurses and midwives to deliver person centred care. Importantly, the context of care delivery has been explicitly acknowledged with the concept of healthful cultures and healthful relationships*". In addition, they shared with us that the strategy resonated with them because, "*It has purpose, and the strategic actions are helpful to allow transfer to practice*".

An early career Nurse shared with us that, "*This strategy clearly resonates with me as an Acting Clinical Nurse Educator. I believe that nursing workforce requires more support and environment where they can thrive and give their fullest*".

Throughout all four focus groups, the question, "*In reading the strategy, can you see yourself as a Nurse and/or Midwife within the strategy*", was posed. This was an important way to

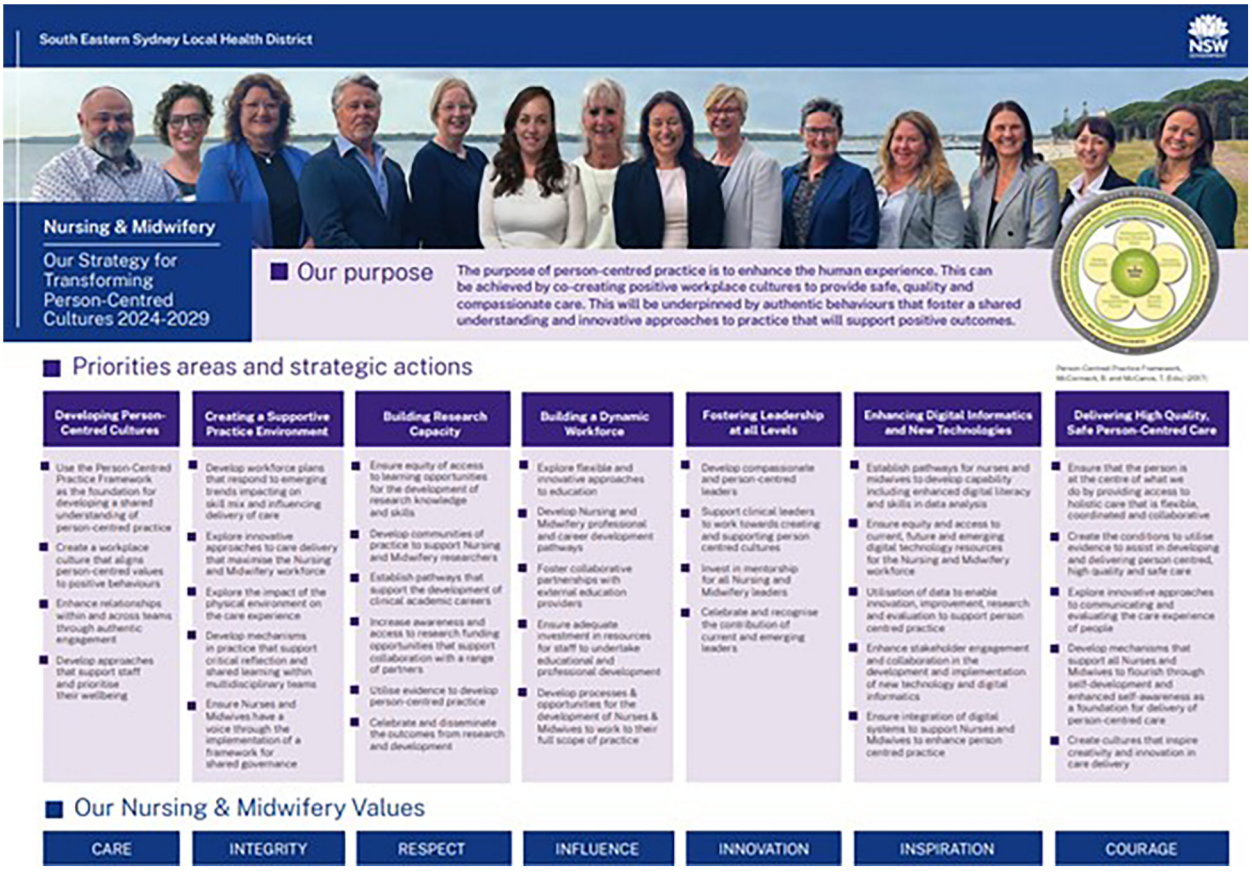

FIGURE 3
Alignment of strategic priorities to the person-centred practice framework.

identify if the strategy truly represented the current workforce as well as providing a gauge for future engagement of Nurses and Midwives in delivering the strategy. A CNC highlighted for us that they, "*Can see myself as a nurse but also in my role, this framework will bring a consistent way for all Nurses and Midwives to align their practice and encourage increased collaboration*".

Furthermore, our Nursing Unit Managers indicated that, "*The strategy encompasses all levels of health, can see myself from an RN to NUM across all of the priorities*", "*Person centred care is widely used term and practice that is followed in patient care. The strategy provided will provide the support to nurses and midwives by supporting and developing skills in them, which help in practicing and achieving the person-centred care goals*". Feedback from the focus groups on the priority areas and descriptors is outlined below in Table 4.

There was an identified need to ensure the strategy was captured both in a comprehensive strategy document as well as in summary on a page to enhance usability and engagement. The final Priority Areas and Actions are outlined in Figure 4 below.

A key finding from the strategy development process was that using a mixture of both face to face and virtual skilled facilitation enabled the development of strong relationships, enhanced engagement between DoNMs, creating a high challenge and high support learning journey. Our DoNMs shared that, "it has been a fun and challenging journey to get to this point, external skilled facilitation had the role of taming us all and our thoughts and ideas whilst blending their [the facilitators] expertise and experience in person-centredness and challenging our thinking" and that "the facilitators encouraged us to just take a step back and think about what we wanted to do and where we wanted to take nursing and midwifery, the journey that we went on with our facilitators guided us in looking at how we can incorporate person-centred care into our practice here in our health district".

The use of virtual skilled facilitation was effective for multiple aspects of the strategy development, with the exception of undertaking a Values Clarification Exercise (VCE) where the use of the virtual space challenged the ability to engage in the level of critical dialogue required. This was evident within the DoNMs shared experience where they stated that, "we had several sessions, I think there were twelve or so sessions in total as we went through, we tried to do some of the exercises with facilitation online, which definitely does not always work". Switching to face-to-face skilled facilitation was essential to ensure that the VCE was undertaken effectively aligning to the CIP principles.

Relationship building between the DoNMs and their engagement throughout the strategy development was highlighted, they shared

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TABLE 3 Identified strategic themes from town Hall events.

Strategic priority	Responses	Themes	Agreed strategic actions
Developing Person-Centred Cultures	172	– Shared values and purpose – Staff having a voice – Team engagement – Wellbeing and positivity – Diversity	Use the Person-centred Practice Framework as the foundation for developing a shared understanding of person-centred practice. Create a workplace culture that aligns person-centred values to positive behaviours. Enhance relationships within and across teams through authentic engagement. Develop approaches that support staff and prioritise their wellbeing.
Creating a Supportive Environment	187	– Skill mix and staffing – Physical/clinical environment – Support, engagement and education – Staff and consumer experience – Models of care	Develop workforce plans that respond to emerging trends impacting skill mix and influencing delivery of care. Explore innovative approaches to care delivery that optimise the Nursing and Midwifery workforce. Explore the impact of the physical environment on the care experience. Develop mechanisms in practice that support critical reflection and shared learning within multidisciplinary teams. Ensure Nurses and Midwives have a voice through the implementation of a framework for shared governance.
Building Research Capacity	183	– Accessibility and resources – Education and support – Partnerships & collaboration – Governance – Professional development investment	Ensure equity of access to learning opportunities for the development of research knowledge and skills. Develop communities of practice to support Nursing and Midwifery researchers. Establish pathways that support the development of clinical academic careers. Increase awareness and access to research funding opportunities that support collaboration with a range of partners. Utilise evidence to develop person-centred practice. Celebrate and disseminate the outcomes from research and development.
Building a Dynamic Workforce	226	– Career development and pathways – Engagement and flexibility of workforce – Innovation – Partnerships – Recruitment processes – Resourcing – Mentoring & supervision – Succession planning	Explore flexible and innovative approaches to education Develop Nursing and Midwifery professional & career development pathways Foster collaborative partnerships with external education providers Ensure adequate investment in resources for staff to undertake educational and professional development Develop processes and opportunities for the development of Nurses and Midwives to work to their full scope of practice
Fostering Leadership at all levels	191	– Acknowledgement and appreciation – Leading culture – Leadership development – Empowerment – Mentoring – Pathways and programs – Reward and recognition – Succession planning	Develop compassionate & person-centred leaders Support clinical leaders to work towards creating & supporting person centred cultures Invest in mentorship for all nursing & midwifery leaders Celebrate and recognise the contribution of current & emerging leaders
Enhancing Digital Informatics and New Technologies	245	– Access to digital and technology resources – Digital and technology support and training – Using data – Stakeholder engagement and collaboration – Digital & Virtual Innovation and Research – Integrated systems	Establish pathways for Nurses and Midwives to develop capability including enhanced digital literacy and skills in data analysis Ensure equity and access to current, future and emerging digital technology resources for the Nursing and Midwifery workforce Utilisation of data to enable innovation, improvement, research and evaluation to support person centred practice Enhance stakeholder engagement and collaboration in the development and implementation of new technology and digital informatics Ensure integration of digital systems to support Nurses and Midwives to enhance person centred practice
Delivering high-quality safe person-centred care	202	– Consumer focus – Data access, evaluation and utilisation – Evidence Based Practice – Quality and safety – Resources – Training and education – Understanding self	Ensure that the person is at the centre of what we do by providing access to holistic care that is flexible, coordinated and collaborative Create the conditions to utilise evidence that assists in developing and delivering person-centred, high quality and safe care Explore innovative approaches to communicating and evaluating the care experience of people Develop mechanisms that support all Nurses and Midwives to flourish through self-development and enhanced self-awareness as a foundation for delivery of person-centred care Create cultures that inspire creativity and innovation in care delivery

TABLE 4 Fous group feedback on priority areas and descriptors.

Priority Area	Descriptor	Feedback
Developing Person-Centred Cultures	Nurses and Midwives will develop a culture that evidences person-centred practice, is inclusive of all people, and is built on a shared understanding of their unique goals, expectations, wellbeing, and context. People and teams can personalise their experience and prioritise what really matters to them through relationships that are based on respect, integrity and trust.	*"A key message was the emphasis on the person-centred framework" & "What resonated with me was the strategic actions are helpful to allow transfer to practice"* (Focus Group 1 Nurse Managers). '*I liked the whole body of the strategic plan being based on the "Person-centred Practice Framework". It makes a lot of sense to have that as the compass to drive all the actions that need to follow before we can achieve the goal of building "healthful cultures" across the district*' (Focus Group 2, Early Career Nurses & Midwives).
Creating a Supportive Environment	Nurses and Midwives will work collaboratively to create the conditions that support person-centred practice. This requires a focus on the development of shared decision-making processes that support effective staff relationships. It also requires an understanding of the impact of both skill mix and the physical environment on how Nurses and Midwives organise and deliver care.	*"This ensures that all staff have the tools and framework to work with persons in their treatment and recovery" & "This strategy clearly resonates with me as an Acting Clinical Nurse educator. I believe that nursing workforce requires more support and environment where they can thrive and give their fullest".* (Focus Group 2, Early Career Nurses & Midwives)
Building Research Capacity	Nurses and Midwives will develop collective expertise in contributing to a sustainable research culture, enabling the generation and translation of knowledge that can support exceptional care. There is a need to continue to develop Nurses and Midwives to lead and support research initiatives that will shape clinical practice and workforce development. This will include participating in all types of research, often in collaboration with key partners.	*"This priority also is inclusive of enhancing staff skills, allow staff to be innovative in practice and quality initiatives and providing a culture that assists patients to be the centre of their care".* (Focus Group 2, Early Career Nurses & Midwives)
Building a Dynamic Workforce	Nurses and Midwives will remain responsive, connected and engaged through focusing on innovative approaches required to develop Nursing and Midwifery careers and providing opportunities for staff to excel. This requires Nurses and Midwives to have learning resources that are easily accessible and appropriate, integrating both theory and practice. This will be enabled by working environments that are conducive to growth and development, supportive of the individual and team experience.	*"Recruitment and retention of nurses is dependent on positive culture environments. If this framework can be applied, it will have positive impacts on the patient care" (Focus Group 2, Early Career Nurses & Midwives).* *"It focuses more on nursing and midwifery growth and development which is good"* (Focus Group 3, CNC/CMC). *"Building strong nursing workforce for future with capability and capacity"* (Focus Group 4, NUMs & MUMs).
Fostering Leadership at all Levels	Nurses and Midwives will lead, inspire and influence, regardless of the role and setting they work, in to create healthful cultures. This will be achieved by investing in more creative and effective ways of developing and supporting leaders. Nurses and Midwives will feel valued and respected and will have permission to lead and transform person-centred practice. This will be achieved by investing in a culture of recognition, developing a strong Nursing and Midwifery voice and acknowledging the achievement of our leaders.	*"The importance of strong leadership in facilities, the ongoing training and professional development opportunities to inspire staff to meet all of the priority areas"* (Focus Group 3, CNC/CMC). *"What resonates for me is that there is a focus on Leadership at all levels"* (Focus Group 4, NUMs & MUMs).
Enhancing Digital Informatics & New Technologies	Nurses and Midwives will embrace digital health, informatics and innovative technologies and incorporate these into clinical practice, whilst maintaining a focus on person-centred therapeutic relationships. This ensures Nurses and Midwives have the data and resources to continue to provide evidence-based, safe, quality, cost-effective and outcome-focused care for people into the future.	*"What resonates with me is the need to move with the times and the use technology by all staff"* (Focus Group 4, NUMs & MUMs).
Delivering High Quality, Safe Person-Centred Care	Nurses and Midwives will utilise the available evidence to evaluate their person-centred practice that is inclusive of all people and ensure there is a shared understanding of their unique goals, expectations, wellbeing, and context. People and teams can personalise their experience and prioritise what really matters to them, ensuring safe practice for all.	*"The strategy incorporates all aspects of care from the perspective of the patients" needs, but also provides a framework to assist staff in safe delivery of care in a positive health culture setting'* (Focus Group 2, Early Career Nurses & Midwives). *"Creates a positive shift to increase awareness of the patient experience"* (Focus Group 4, NUMs & MUMs).

how "I found it a really good time to get to know our DoNM group at a closer level and also for us to get to know each other just a bit better, and that it was actually quite nice to be able to spend some time together in person". Another DoNM stated how "it has been, from my perspective, really great working with the other DoNMs so closely and through this working with a DoNM who works in a very different environment (aged care) to where we work (maternity) further enhanced my experience".

Discussion

The development of nursing and midwifery strategy that acknowledged the multiple challenges of working within a large complex healthcare system including the social and political influences was important to ensure relevance, effectiveness and connection with our nurses and midwives. This program of work utilised the PCPF (3) as its foundation in which person-centredness and our current context could be explored. This enabled the DoNMs and other senior nursing and midwifery leaders to engage in critical discussion about their individual and collective understanding of what person-centredness meant in practice. Through exploring each domain of the PCPF and the current healthcare landscape in which we worked, a shared understanding of person-centred practice was achieved. This was an important first step in the strategy development as a shared understanding of what we were aiming to achieve through this strategy was essential. This is supported in the literature with the

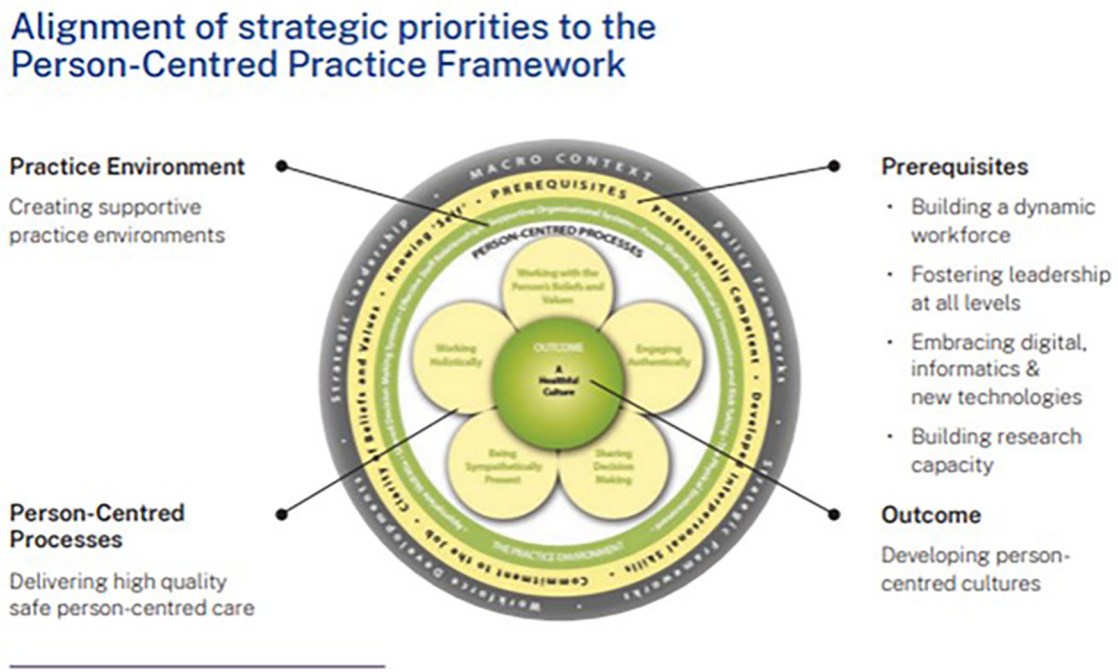

FIGURE 4
Priority and actions on a page. Reproduced with permission from "The Person-Centered Practice Framework" by Ailsa McMillan, Brendan McCormack, Cathy Bulley, Donna Brown, Suzanne Martin and Tanya McCance, licensed under CC BY 4.0.

value placed on person-centredness increasingly being recognised in research and healthcare policy for its positive impact on outcomes for patients, staff and workplace cultures (21, 30, 33). Internationally, the World Health Organisation (WHO) (1) has identified the need for a shift in healthcare delivery which places the person at the centre of care, through the promotion of a comprehensive framework of people-centred health services. This exploration enabled the identification of key factors we would need to address to ensure we were able to develop and implement a strategy that supported person-centred practice and the transformation of culture. This is supported by McCance et al. (3) who highlights that whilst the knowledge base that underpins person-centredness has continued to expand an increased understanding of the multiple key elements that are required for effective implementation of person-centred healthcare practices is essential (3).

It is necessary that during the development of nursing and midwifery strategy, that aims to support person-centred practice and the development of healthful cultures, leaders identify and work with the influences on the diverse healthcare contexts in which nurses and midwives practice. This program of work aimed to develop a strategy that all nurses and midwives of all classifications could connect with. Following significant facilitated discussion and debate the priority areas of the leaders were explored and tested to fully understand their depth and content. The opportunity for nursing and midwifery leaders to explore and contextualise all influences on health care enabled the generation of strategic priority areas and actions that would support person-centred practice and were relevant and relatable to nurses and midwives across all levels of the broader organisation. The strategic priority areas identified can influence at the micro, meso and macro levels of healthcare organisations. The need to more fully understand and recognise the macro influences is captured within the PCPF and is identified as an essential component for the development of healthful cultures (3). Specifically, the important 5th domain of the PCPF—the macro context, acknowledges the need to understand the factors that are strategic and political in nature that will influence the development of person-centred cultures which include health and social care policy, strategic frameworks, workforce developments and strategic leadership (3).

This program of work recognised the importance of creating a shared vision and purpose statement of person-centred practice that would clearly articulate the direction and future within our organisation and could be utilised to connect with all nurses and midwives at all levels (31). The completion of a values clarification exercise to support the development of a shared purpose statement and the underlying values and behaviours provided a foundation for developing the strategy aimed at providing person-centred practice and transforming workplace culture. This is supported by Cardiff et al. (21) who identifies the need for strategic leadership to adopt a values-based approach and the development of a shared purpose where leaders can respectfully and constructively challenge each other while sharing the vision of what person-centred cultures look and feel like. The development of a clear shared purpose of person-centred practice and the exploration of values that underpin this purpose were critical first steps in the development of the strategy (32).

The creation of this shared understanding and values provided a clear foundation from which the nursing and midwifery leaders could utilise for the ongoing strategic priority and action discussions with all nurses and midwives. It is acknowledged that whilst nurses and midwives play a pivotal role in delivering person-centred practice at a microsystem level, the need for strategic leadership is a key factor in enabling person-centred cultures (3). The willingness of the DoNMs to be at times vulnerable, discuss what matters most to them professionally and identify with value-based behaviours that support person-centred practice was a significant component of the strategy development and represents authentic strategic leadership (38). It is necessary that this level of communication is supported to enable the development of trust and relationships within senior leadership groups. It is well documented that leaders who can adopt a value-based approach, are considerate of individual contributions, foster shared- decision-making whilst maintaining healthful relationships experience positive outcomes such as increased engagement with staff, commitment and trust across all levels of the organisation and improved staff outcomes (9, 12, 34). These outcomes are all are important considerations of successful strategy implementation.

The DoNMs recognised that person-centred cultures cannot be achieved by individuals alone and involvement of all key stakeholders was necessary throughout the process. To support the engagement of all stakeholders skilled facilitation using a collaborative, inclusive, and participative process (using CIP principles) was adopted. The use of CIP is a core foundation of practice development which offers a framework for implementing, monitoring and enhancing effective, evidence-based strategies that aim to achieve systems-wide sustainable change (20, 22). The co-creation of the shared purpose and values encouraged engagement and ownership from the DoNM group of the strategy, and the building of person-centred relationships. The commitment to a collaborative and inclusive way of working ensuring all nursing and midwifery staff had an opportunity to contribute further demonstrated a willingness to embrace a co-production model. The use of co-production models within healthcare research, policy development and education have been well established (27, 35). Co-production models have a range of advantages such as enabling stakeholders to have a voice as well as equalising power among users, clinicians and leaders (36). Oye et al. (37) broadly outline how the use of practice development principles utilised to support person-centred practice and the transformation of workplace cultures which have people at their centre.

Skilled facilitation, supported by a knowledge of co-production and use of person-centred approaches were essential aspects of engaging the DoNMs and staff who attended the stakeholder forums. Staff perceptions toward the organisation's commitment to its values, priority areas and direction were enhanced using skilled facilitation to elicit critical discussion with stakeholders on the strategy for nursing and midwifery into the future. This critical discussion enabled critique, alternative options and the development of a shared language that would connect with nurses and midwives at all levels within the organisation. This is reaffirmed by Oye et al. (37) who highlights the importance of using facilitation as critical to enabling reflection and practical consideration of how elements of the strategy impact on nurses and midwives as well as those receiving care at the individual, team, organisation and system levels.

Conclusion

Developing strategy through the lens of the Person-Centred Practice Framework, skilled facilitation and the use of CIP principles for co-creation has resulted in the establishment of our 5-year strategy. This strategy provides a solid foundation for leading and supporting nurses and midwives to reach their potential, focus on what matters most and continue to be innovative in approaches to practice. The strategy provides a clear direction for enabling the development of healthful cultures that enable human flourishing for those who give care and those who receive care.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Author contributions

KT: Writing – original draft, Writing – review & editing. SM: Writing – original draft, Writing – review & editing. DS: Data curation, Supervision, Formal analysis, Project administration, Investigation, Visualization, Writing – original draft, Writing – review & editing. KH: Writing – original draft, Writing – review & editing. TM: Writing – original draft, Writing – review & editing.

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Time is now to consider how we evaluate person-centred care—the role of patient-reported outcomes

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Person-centred care refers to health care that is respectful of and responsive to personal experiences, preferences, needs, goals and values of service users. Despite the growing recognition of the value of patient-reported outcome measures, they are rarely used as evaluation endpoints in person-centred care research and care practices. This paper contributes to knowledge by examining the opportunities and challenges of using patient-reported outcome measures to measure person-centred care. Our focus is not the collection and feedback of patient-reported outcomes to enact person-centred care. We discuss differences between patient- and person-reported outcomes and their role in assessing person-centred care. We also challenge some existing measurement practices and usage of existing patient-reported outcome measures. We critically discuss some potential consequences of current practices, and present possible solutions. We do not have all the answers, and we urge those working in the field of patient-reported measurement to collectively come together to find solutions. With this perspective article, we aim to start the conversation to think differently about how we evaluate person-centred care and propose areas of enquiry that incorporate patient-reported outcomes into the evaluation of person-centred care.

KEYWORDS

person-centred care (PCC), patient-reported outcomes, evaluation, measurement framework, research

Introduction

This paper aims to further our understanding of patient-reported measurement practices and improve *how* we evaluate person-centred care. *What* should be measured in this space has been previously reported (1). This paper is structured in four parts. First, we provide definitions for the key concepts covered in this paper: person-centred care, person-centred practice, and patient-reported outcomes. Second, we consider the role of patient-reported outcomes as evaluation endpoints in person-centred care research and care practices. Our focus is on patient-reported outcomes measuring the outcomes of person-centred care, not the collection and feedback of patient-reported outcomes to enact person-centred care, on which much has been published (2–4).

Third, we critically reflect on measurement practices and usage of patient-reported outcome measures in person-centred care research. Finally, we end with a discussion of some potential consequences of current measurement practices and possible solutions for how the field might consider the inclusion of patient-reported outcomes in evaluative models of person-centred care. Our paper contributes to knowledge by setting out the opportunities and challenges of using patient-reported outcome measures to measure person-centred care.

Key concepts and the need for clarity

Healthcare and healthcare practice is dominated by complex language and person-centred healthcare and assessing its outcomes is no different. Like Alice in Wonderland, sometimes it seems that a word "can mean just what we choose it to mean", rather than there being an explicit and consistent use of words in this field. With that challenge in focus, we offer our perspective on essential key terms.

Treating a patient as a whole person

The concept of treating a patient as a whole person and standards for person-centred caring were proposed back in 1981, with the development of a measure that enabled evaluation of the concept of treating a patient as a whole person, the Standards for Person-Centred Caring (SPCC) (5). The SPCC focused on assessing person-centred, rather than disease-centred issues through measurable structure, process and outcome criteria. Since then, several frameworks and standards of person-centred care (6, 7) and person-centred practice, as well as measures (or questionnaires) to assess them, have been developed and used (8). We have seen exponential growth of research assessing both patient and healthcare provider, particularly nurses, perceptions of person-centred caring and practices (9). More recently, the concept of *person-centredness* has emerged in healthcare guidance and policy, stressing approaches that focus on healthcare relationships and interactions that consider the whole life of a/the person.

Person-centred care and person-centred practice

Person-centred care refers to healthcare that is respectful of, and responsive to, the preferences, needs, goals and values of service users. It is "*a way of practising or engaging with service users that is focused on their beliefs and values…their wants, needs, hopes and dreams—in deciding on care, and deciding on how best to deliver care. It's a relationship-based, partnership model where the person is at the centre of the decision-making, and the elements of the system fit around that, rather than the other way around,*" (10). It therefore requires a whole-systems understanding of, and commitment to, person-centredness as a philosophy for how care is organised, provided, and subsequently evaluated.

An increasing body of research has found person-centred care associated with many positive outcomes. For example, patients reported improved physical function, emotional state and quality of life; staff reported improvements in satisfaction and consultation time (11, 12); and supporting integrated care at the service level (13).

Person-centred practice on the other hand, embraces the core philosophy of person-centred care, but contends that providing such care is unsustainable without applying the same values and principles to care providers. One framework that makes person-centred practice explicit and operationalises it as a whole-systems philosophy for the purpose of application and subsequent evaluation is the Person-Centred Practice Framework (7). Figure 1 depicts the relationship between the five domains of the Person-centred Practice Framework. The first domain, *prerequisites*, focuses on the attributes of staff. The second, the *practice environment*, focuses on the context in which healthcare is experienced. The third, the *person-centred processes*, focuses on ways of engaging that are necessary to create connections between persons. The fourth, the *outcome*, which is the result of effective person-centred practice. These four domains are set within the fifth domain, *the macro context* which reflects factors (regionally within country, nationally, internationally and globally) that are strategic and political in nature that influence the development of person-centred practices (7). To reach the centre of the framework, the attributes of staff must first be considered, as a prerequisite to managing the practice environment, to engage effectively through person-centred processes. This ordering ultimately leads to the achievement of the *outcome*, the central component of the framework, described as a healthful workplace culture, and with all of this influenced and shaped by the macro context. This ordering and layering is important as it highlights the impact of context (workplace culture) on the ability of individual clinicians to operationalise their qualities as person-centred practitioners, i.e., without a conducive context, sustaining effective person-centred practice cannot be realised. It is also important to recognise that there are relationships and overlap between the constructs within each domain, again showing the need for a whole-systems understanding of person-centred healthcare that ensures an organisation-wide responsibility for quality of care and not just individual clinician responsibility.

The Person-Centred Practice Framework has evolved over two decades of research and development activity and offers a common language and shared understanding of person-centred practice (14). In a broader sense, the Framework provides a quality assessment/assurance evaluation framework consisting of structure, process and outcome quality indicators. Use and adoption of this framework in research, practice, education and policy is widespread and the past two decades have seen a growth in research that focuses on evaluating the processes and outcomes arising from the implementation of person-centred care (14). Person-centred care is a dynamic multidisciplinary field in its own right, with an international community dedicated

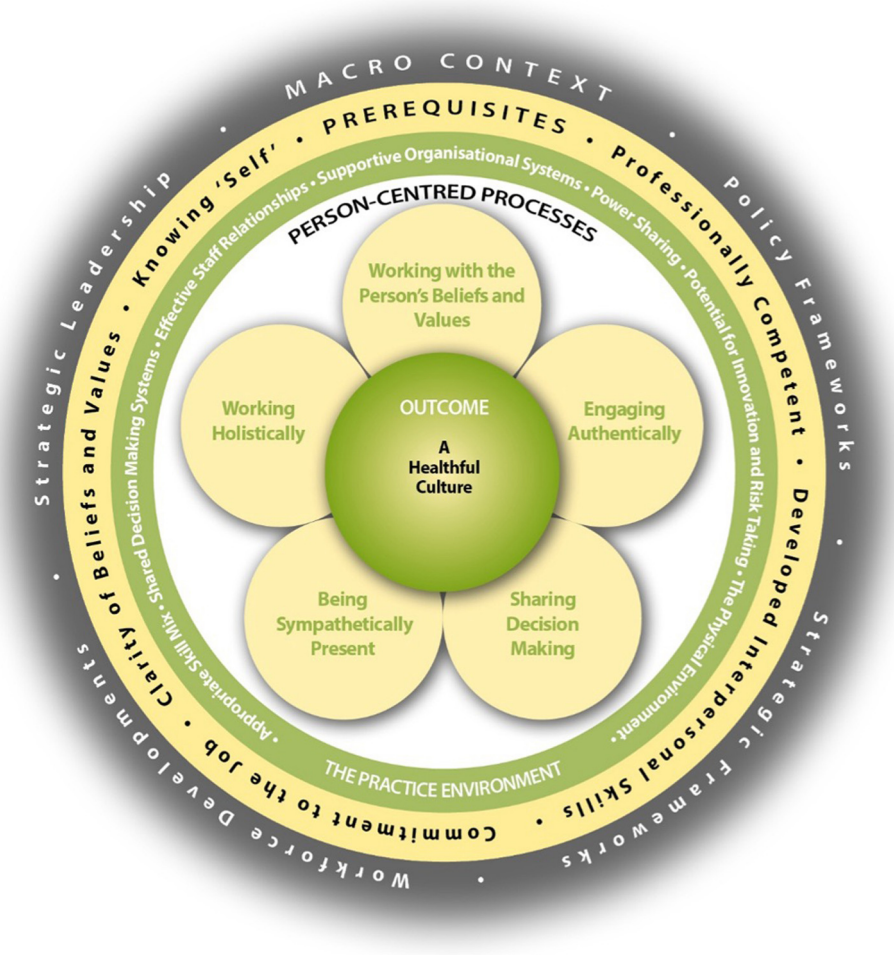

FIGURE 1
The person-centred practice framework (7).

to innovating and improving healthcare (15). In this paper, we consider whether patient-reported outcomes fit within the fourth domain and central component of the Person-Centred Practice Framework and examine the extent to which they have been applied in a way that captures the process and impacts of a person-centred philosophy.

Patient-reported outcomes

A patient-reported outcome (PRO) is "*a measurement based on a report that comes directly from the patient (i.e., study subject) about the status of a patient's health condition without amendment or interpretation of the patient's response by a clinician or anyone else.*" (16) They encompass a variety of measurable outcomes of care from the patient's perspective, including disease symptoms, side-effects of treatment, functioning, and health-related quality of life (HRQL) (17, 18). Over the past two decades, the added value of PRO data has been recognised and increasingly included as important endpoints in clinical research and to support labelling claims in drug development (16), and there is growing support from governments and professional organisations for using patient-reported outcome measures (PROMs) in healthcare to support person-centred care (19–22). They have also been used to judge the degree to which a hospital provides good quality care or improvements in patient-clinician communication—assessed through both PROMs and patient-reported experience measures (PREMs) that assess the impact of the process of care on the patient's experience. For example, patients' perceptions of the structure and processes of care delivery (e.g., patient satisfaction), experience with healthcare services and care providers (e.g., patient-provider communication, care coordination), and patient activation (e.g., shared decision-making, self-efficacy/autonomy) (23). PREMs are classified as functional or relational. Functional PREMs examine practical issues (e.g., availability of facilities) while relational PREMs examine the patients' experience of their relationships during treatment (e.g., did they feel listened to) (23). Several PREMs are available to assess person-centred care (8). Healthcare

providers use both PROMs and PREMs in various ways to improve different aspects of patient care (24).

The role of patient-reported outcomes as evaluation endpoints in person-centred care

Many of the outcomes (measured by PROMs) and *experiences* are useful measures for assessing person-centred care and can be linked to constructs included in the Person-Centred Practice Framework. However, we question, as McClimans does so eloquently, "how can measurement, which relies on standardisation, represent patients perspectives, which, if not idiosyncratic, are at least variable and changeable?" (25) And how do we factor into our measurement individual health-related preferences, needs, goals and values when in research we require rigorous standardised measurement tools to enable between-group and within-group comparisons; that is, assessing with the same questions, response options and scoring methods in all participants at each assessment time-point?

HRQL and symptom burden are PROs commonly used in comparative effectiveness research and health service evaluation as they are outcomes considered important to patients and useful for clinical decision-making. However, they are often aggregated without accounting for differences between individual beliefs, values, wants, needs and goals for healthcare, which are fundamental to person-centred care. Aggregating data is useful in healthcare if we want to evaluate the effectiveness of a particular treatment or our overall health service or practices. However, this aggregation is less important for individual patient care, and on its own, arguably not conducive to person-centred care. Two people with the same disease and treatment could have the same improvement in, for example, HRQL outcomes, but what we don't know, or rarely assess, is whether those improvements were meaningful to, or desired by, the individual person (26–28). Further, existing PROMs are often developed to allow for between-individual comparisons (nomothetic approach) and therefore include a standard set of pre-selected items which are presented to all participants. Albeit selected through a rigorous process and retained as the best set of items representing the outcomes selected as important to patients to measure, their completion does not allow for individual preferences, needs, goals and values for those PROs to be captured. This raises the question about whether PROs provide a mechanism for capturing and evaluating person-centred care?

Within healthcare, the term *outcome* refers to end-results or consequences of treatment, interventions, or healthcare (29). The PROMs used reflect indicators within healthcare that are based on *quality* of outcomes and impacts of health conditions and interventions from the perspective of the person experiencing them. Here, quality has to do with a person's perceived state and value of something, particularly their life or part of that life (in the form of outcomes of a healthcare procedure). However, the aspects of life that a person *values* are limited to the aspects represented in the PROM(s) used. This standardised measurement through use of existing PROMs implies that everyone values the same aspects represented and only captures what is represented. If a key element of person-centred care is the tailoring of care to address individual beliefs, values, wants, needs and goals for healthcare, then how can we reflect that potential heterogeneity of these when PROMs are standardised? Perhaps what is at the heart of the problem is the tension between the need to demonstrate effectiveness via standardised measurement with the principles of person-centred care, which is inherently individualised and tailored.

The concept of personhood lies at the heart of person-centredness in all its guises. Whilst a review of concepts and philosophies of personhood is beyond the scope of this paper, we draw on previous work to articulate personhood through modes of "being" (being in place, in relationship, with self, in social context and in time) (30, 31). In actively being, we draw on all kinds of knowledge and life experience to shape the way we exist in these modes. We are also in a constant process of change that is neither static nor fixed. A PRO is a static or fixed outcome whereas personhood is constantly changing and transforming so that the outcome measured is only a moment in time. Outcomes are of value, but only in any given time and in the specific context in which they were assessed. A shift in approaches to measurement in this context represents a shift in focus from "what is the matter with you" to "what matters to you" (32). This is something that has been embraced as a healthcare movement, but to which little systematic outcome measurement has been applied (33, 34). We need person-reported measurement that considers an individual persons' preferences, needs, goals and values, and then a way of standardising that evaluation for the purpose of rigorous measurement.

Critical reflection on measurement challenges and use of patient-reported outcome measures in person-centred care research

Complexity of person-centred care

Despite the recognised value of person-centred care and of the persons' perspectives on healthcare, measuring whether person-centred care has occurred, and if it has occurred, its impact on patient outcomes presents ongoing challenges to researchers, clinicians, and patients (35). Whilst the complexity of person-centred healthcare as a whole-systems approach to practice presents one set of unique evaluation challenges, another part of the measurement problem is how we define, operationalise, and evaluate person-centred care. Whilst a definition of person-centred practice is offered in the Person-Centred Practice Framework, within that there is no clear articulation of what *person*-related outcomes should be evaluated to assess whether person-centred care has actually been provided and led to improved patient outcomes.

Lack of consistency in the person-centred care discourse

Another problem is the interchangeable use of person- and patient-centred care despite published differences (36) and no published distinction between patient- vs. person-reported outcomes (measures) or between patient- vs. person-centred outcomes (measures). Whilst we have agreement about what constitutes a PRO, to the best of our knowledge, we lack a published or internationally accepted definition of person-reported outcomes for the purpose of measurement. Person-reported outcome has been used in published literature, however, the articles reported on what we know as *PRO*s, using these terms interchangeably (e.g., person-reported outcomes of health status but no definitions; others provided the same definition for person-reported outcomes as the FDA definition for PROs) (37, 38). One group described the term *person* being relevant when referring to proxy-reports given by relatives, caregivers or other health professionals when the patient was unable to report on their health, or when outcomes related to general populations, for example, when developing preference-based measures (39). Interchangeable use makes it difficult to tease out distinct differences between the concepts and how people are working within them. Further, it precludes agreement about models that operationalise person-centred care and person-reported outcomes for the purpose of measurement.

Limitations of existing evaluation practices

Despite the lack of clarity, established programs of work aim to measure person-centred care. However, evaluation outcomes have included a narrow range such as the quality of the care given, assessed using different patient-reported measures that collect varying information, rather than broader processes and practices within a whole system approach (8). A 2014 review of commonly used approaches and tools to measure person-centred care found a large number of tools available, without agreement about which to use to measure person-centred care, with no one questionnaire covering all aspects of person-centred care (8). Further, no single valid and reliable measurement tool has been recommended for general use (40). Poorly described definitions of constructs measured and lack of conceptual frameworks that underpinned the measurement models may be a large part of the problem. Capturing the complexity of person-centred care and the influencing individual, contextual and cultural factors should be considered in measurement frameworks.

Since the 2014 review, important contributions to developing evaluation models of person-centred care and practices of measuring and improving person-centred care are being made. A new instrument underpinned by the Person-Centred Practice Framework has been developed—the Person-Centred Practice Inventory (PCPI). This is available in both staff and patient versions and enables assessment of how person-centred practice is perceived (41). The PCPI evaluates the process and experience of person-centred practice and care, but not outcomes in this context; perhaps a gap that PROs could somewhat fill. Additional work by McCance et al. has developed and tested eight person-centred key performance indicators for evaluating and improving person-centred nursing practice (42, 43). However, how these process measures align with outcome measures remains a challenge. Santana et al. (2018) developed a conceptual model of person-centred care consisting of structure, process and outcome components that includes PROs as one of two outcome domains (44). Importantly, the value of PROs is recognised and recommended as an evaluative outcome of the impact of person-centred care. This model has informed several quality improvement initiatives. For example, work from Canada developed a core group of person-centred quality indicators applicable across healthcare sectors and contexts that provides standardised metrics to measure person-centred care to help drive the changes needed to improve the quality of healthcare that is person-centred. These quality indicators can be used by healthcare systems to monitor and evaluate the delivery of person-centred care, identify the gaps, and make the changes needed to improve the quality of care (45). However, only one PRO, general health, is an included quality indicator.

Uncertainty about what to measure in person-centred care

As highlighted earlier, a key measurement problem is lack of agreement about what should be measured—is it the enactment of person-centred care (i.e., as a process) or the anticipated outcomes of person-centred care—but what are these and how do we decide? Without answering these questions we cannot determine whether we have adequate PRO(M)s for the purpose of evaluating person-centred care and it may in part be the reason for the lack of practical examples of how PROs can be useful in person-centred care. The challenge we face is often construed as us needing to develop methods to measure a PRO at the individual level that considers individual preferences, needs, goals and values for treatment and outcomes, but which can still be aggregated despite such variability to demonstrate effective person-centred care based on between-individual measurements. Nevertheless, it is well-understood that measures of PROs are always only validated for specific purposes (46–48), that they depend on the epistemic goals and positions of developers and users (25, 49, 50), and finally, international initiatives such as the development of core outcome sets and similar assessment frameworks recognise that usually more than one outcome is required (51). Describing the goal of the process as finding a single measure to represent the multidimensional concept of person-centred care may be posing the wrong question and setting the endeavour up for failure.

Potential consequences of current measurement practices and possible solutions

PROs such as symptom control and maintaining or improving HRQL are important outcomes of person-centred care but only tell

us part of the person-centred story. Constraining measurement to disease burden, as is with the HRQL approach to measuring function and health status, moves us away from considering how a person perceives and reacts to their health status. But we know that one's HRQL perception is influenced by an interaction of personal and environmental influences that determine quality of life (52). Using only standardised measures of HRQL or health status would not enable consideration of individual goals, needs, and preferences for the quality of individual life and would fail to comprehensively assess the different components of person-centred care practices. Both aspects are needed to collectively reflect evidence of successful person-centred care. This is where PREMs may be beneficial to capture certain aspects such as whether a personalized care plan was developed or whether patients felt involved in decision-making. These experiences are shared across individuals, even if the care plans themselves differ. Such questions operate on a meta-level: the content of the care plan may vary, but the existence and co-creation of that plan are measurable and comparable.

Pairing PREMs with PROMs allows for meaningful analysis of patient experiences of care and services. This notion is reflected in several international initiatives. The Organisation for Economic Co-operation and Development (OECD) set a new international standard for patient-reported outcomes and experiences through its Patient-Reported Indicator Surveys (PaRIS) initiative, where countries worked together to develop, standardise and implement a new generation of indicators that measure the outcomes and experiences of healthcare that matter most to people (53). The International Consortium for Health Outcomes Measurement (ICHOM) developed several standard sets of outcomes based on patient priorities (54). The sets of outcomes mostly focus on patient-centred outcomes, but some do include experience of care measures (55). The World Health Organization (WHO) also recognizes the importance of PROs and experiences, emphasizing their role in patient safety and quality of care (56), and promoting their use to improve healthcare quality and outcomes (57). These initiatives emphasize people-centredness, a concept that underpins frameworks like the WHO's People-Centred Health Care Framework (58) and the OECD's People-Centred Health Systems framework (59).

However, we contend that this only tells part of the story of person-centred care and its outcomes. The term *patient* does not encompass the whole person in the context of healthcare (60) and reduces an individual person to their disease and treatment. Person-centredness is fundamentally about individual goals, considering the social context and the kind of life that a person wants to live. So, to capture these dynamic caring practices we need to move beyond measurement of patient-reported indicators of clinical effectiveness towards more holistic measures that evaluate PROs in the context of the whole person including individual goals and preferences for treatment, personal values, and social and cultural contexts. But if we advocate for respecting the whole person then we need to operate within a social model of health. Social models of health recognize that our health is influenced by a wide range of individual, interpersonal, organizational, social, environmental, political and economic factors (61).

Our measurement frameworks should be reconsidered in light of how person-reported outcomes/experiences fits within the context of person-centredness. But the challenge is how to capture these subtleties in our patient-reported measures. "*No two people are the same*" is at the core of person-centredness so one might argue that we cannot aggregate outcomes data for everyone. One might further argue that we cannot standardise these outcomes because everyone is different so then what do we measure to capture the essence of person-centred care? Improved person-centredness is an implied driver of quality of life assessments in clinical practice (62). However, this approach does not address the challenge of how to capture person-centred care within a much broader understanding of a person's life experiences, values, beliefs and preferences, before, during and after care giving, the environmental context, the interactions between care providers and service users, and the perceptions of the care providers. Aggregate data allows us to evaluate whether we are doing/achieving person-centred care and whether that care is improving patient outcomes, whatever they might be for the individual. But to achieve this we need to individualise our care and therefore our assessments. So, then how do we evaluate person-centred care and marry aggregate and individual data? This is the real challenge.

Perhaps as a first step, our person-centred care measurement models and measures should factor in PROs and working with the person's beliefs and values within broader life domains and social contexts. Additionally, we need agreement about what we believe the outcomes of person-centred care will be. In person-centred care evaluation, perhaps we should be asking patients what they hope to achieve with their treatment, rather than confining evaluation of person-centred care to preselected standardised outcomes.

Several approaches may provide some solutions for our measurement conundrum. In the needs-based approach, rather than asking directly about a function, it is possible to inquire about the needs that could be satisfied by that function (63). The Needs-Based approach to quality of life is based on the individual's possibility of fulfilling their expectations and needs in life (64). Similarly, the underlying propositions of the Schedule for the Evaluation of Individual Quality of Life are that quality of life is individual in nature and that an individual's judgment of their overall quality of life is constructed from their assessment of their level of functioning/satisfaction in discrete domains of life which they consider to be important (65). Goal Attainment Scaling is a measurement tool that allows patients to set individual goals, together with their treating healthcare professional (66, 67); and individual-generated indices allow patients to develop their own assessment content (e.g., most concerning or impacting symptoms) (68–70). Despite being developed over 30 years ago, these approaches have not been widely adopted. Reasons for this are unclear but may be in part due to the contradiction we highlight in this paper, i.e., the acknowledgement of the uniqueness of individual experience of healthcare matched by the need for universality for resource planning and decision-making. Most PROMs have been developed to offer an option for between-individual comparisons. This leads to instruments where the same set of symptoms, health or quality

of life impacts are presented to all individuals. And while these are at least today usually the result of a robust multi-round, mixed methods, and stakeholder-informed process, there is no guarantee that the content represents the needs, goals, values and preferences for treatment for every individual. Individualised measures might allow for individual goals/needs for treatment to be captured. But given that the content of such measures is then individualised and heterogeneous, it is unclear whether patient-responses to such assessments can be aggregated for between-individual comparisons, and what such aggregates would mean.

Finally, predictive models or computerized adaptive testing (CAT) may offer increases in efficiency identifying relevant subsets of questions selected from the full patient-reported questionnaires, triggered by and optimising measurement precision for what patients say is important to them based on their preferences, needs, goals and values. CATs are a method between fully standardised (such as questionnaires) and fully individualised assessments (such as individual-generated indices or goal attainment scaling). A computer program is used to select questions from a larger pool to tailor the assessment to the individual without loss of scale precision or content validity if items being selected measure the same construct (71). They have been used in this way to assess PROs in health-related research for the past two decades (72).

We would argue that while healthcare cultures are shifting their focus to improvement, approaches to measurement continue to privilege standardised, quantifiable data and information that can be used for standardisation (73). Despite over 30 years of developments in patient-centred and then person-centred care, quantitative measurement continues to dominate, despite doing little to inform stakeholders about the person-centredness of a health system. So, understanding whether a person recovers is of course a good and important thing, and we do not want to move away from assessing whether a patient improved, recovered, lived well and so on. However, understanding the extent of the healthcare experience and recovery in terms of what it means to an individual and one's ability to engage in the five modes of being is what is needed to shift from measuring outcomes of health status to measuring person-centred care. Further, we need a shift in perception that addressing a patients HRQL is not within the remit of healthcare providers or that they lack time to do it (74).

When we talk about PROs, we are essentially talking about an outcome that we want to assess or measure. In person-centred care, we need common agreement and understanding about what the *outcome(s)* is that we are interested in. We also need theoretical models that operationalise these *outcomes* of interest and how we can measure and assess whether we are truly delivering person-centred care and working within person-centred caring practices. The literature often reverts to proxy measures in terms of outcomes for person-centred care; a reflection of difficulty in trying to define what we mean in this space. But in order to demonstrate the value of person-centred cultures to healthcare organisations and the significance of person-centred outcomes for patients, families, carers and staff, we need greater clarity in our definitions, concepts and models, and to embrace theory-driven evaluation designs that fully embrace mixed-methodologies and capture the diversity of experiences among all stakeholders, as well as demonstrating effectiveness (73). Needing standardised aggregated assessment for evaluative research designs should not be an excuse for assessing the *wrong* things or omitting other important aspects that are perhaps more challenging to measure and interpret.

Data availability statement

The original contributions presented in the study are included in the article/Supplementary Material, further inquiries can be directed to the corresponding authors.

Author contributions

CR: Conceptualization, Writing – original draft, Writing – review & editing. JB: Conceptualization, Writing – review & editing. JG: Conceptualization, Writing – review & editing. VT: Conceptualization, Writing – review & editing. TM: Conceptualization, Writing – review & editing. BM: Conceptualization, Writing – review & editing.

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Development and contextual analysis of a person-centered professional practice model in a home care service in French-speaking Switzerland

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Background: The Swiss healthcare system faces increasing challenges with an aging population and rising prevalence of chronic conditions, necessitating better-coordinated care delivery, particularly in home care settings.
Objectives: This study aimed to develop (objective 1) and conduct a contextual analysis for implementation (objective 2) of a person-centered professional practice model for home care services in French-speaking Switzerland.
Methods: A multi-method approach was used. For objective 1, concept mapping with 157 healthcare professionals (86% response rate) was conducted to develop the model. For objective 2, a contextual analysis was guided by the Intervention Mapping framework, involving focus groups with stakeholders (n = 14) and field validation with frontline staff (n = 6). Data analysis included both quantitative and qualitative methods.
Results: The concept mapping process identified 13 core values rated on importance (scale 1–5), with health promotion scoring highest (4.4) and interprofessionalism lowest (3.7). Implementation analysis revealed key facilitators including leadership support (83% agreement) and barriers such as linguistic/cultural differences. Eight implementation strategies were identified and validated through a Delphi process, including continuous training (67% strong agreement) and safety culture promotion (83% strong agreement).
Conclusions: The study demonstrates that developing and implementing a person-centered professional practice model is feasible in home care settings when supported by strong leadership commitment and structured implementation strategies. The model's alignment with the Person-centred Practice Framework of McCance and McCormack provides theoretical validation while offering practical guidance for implementation.

KEYWORDS

professional practice model, person-centered practice, home care services, implementation science, Switzerland

Introduction

The Swiss healthcare system faces significant challenges due changing patterns of illness and functional limitations rather than demographic aging alone. While, by 2050, the number of people aged 60 and above is projected to double to 2.1 billion (1), research by Reinhardt (2) demonstrates that aging itself is not the primary driver of healthcare utilization. Instead, it is the increased prevalence of functional limitations and chronic conditions that directly drives home care demand (3). Switzerland mirrors this trend, experiencing a concurrent rise in non-communicable diseases (NCDs) and associated functional limitations. While these conditions are more prevalent in the growing older population segment (projected to reach 30% aged 65+ by 2050 (4), multimorbidity affects all age groups and is increasingly common, with estimates suggesting over 60% of those aged 65+ have multiple chronic conditions (5). This complex health profile, primarily driven by the burden of functional limitations and multimorbidity rather than age alone, underscores the limitations of a healthcare system historically geared towards acute care, leading to fragmentation and poor coordination (6). This fragmentation contributes to adverse health outcomes, increased healthcare expenditure, and a reduced quality of life, particularly for older adults with complex care needs (3).

In response, integrated care networks have been developing in Switzerland since the 1990s, evolving from primarily physician-centric models to encompass a broader spectrum of healthcare providers, including essential home care services (6). These networks strive to deliver comprehensive somatic and psychiatric care through multidisciplinary collaboration (7), addressing the intricate needs of individuals with multiple health conditions. However, the rapid expansion of these networks has often proceeded without clearly defined objectives and standardized implementation strategies, potentially creating a misalignment between system-level objectives and the professional values of healthcare practitioners (8). This ambiguity can foster confusion, resistance to change, and ultimately impede the successful implementation of integrated care initiatives (9). Professionals may perceive standardized protocols as a constraint on their professional autonomy and their capacity to deliver personalized care (10).

In Switzerland, home care services operate within a complex system of governance and financing (11). These services are regulated at the cantonal level (i.e., Swiss state or provincial), creating significant regional variations in organization and delivery. The canton plays a crucial role in this system by providing partial funding, establishing regulatory frameworks for service standards, approving organizational structures, conducting quality assessments, and bridging national policies with local implementation. Home care is primarily funded through a mixed system: mandatory health insurance covers nursing care prescribed by physicians, while the cantons, municipalities, and patients finance additional services themselves. The prescription process typically begins with a physician's order, followed by a needs assessment that determines the scope and intensity of services. The Sarine Health Network, where this study was conducted, operates within the canton of Fribourg and serves approximately twenty-eight municipalities with a population of 95,000 residents. Its distinctive feature is a decentralized organizational structure with six geographical branches plus a coordination center, all operating under a unified management but with significant operational autonomy. This district-level governance structure directly influences our operational capabilities, resource allocation, and strategic priorities, shaping which services we must provide and establishing quality standards we must meet. This structure, while allowing for local adaptation, has contributed to the fragmentation challenges that our research aims to address through a unified professional practice model.

Implementing integrated care within Switzerland's federalist structure necessitates a well-defined framework that promotes a shared vision and clear role distribution across the cantons. This is especially pertinent given the variations in resources and development across different cantons (12). Professional Practice Models (PPMs) have demonstrated their value in clarifying organizational values and missions, while simultaneously enhancing employee satisfaction and, importantly, improving patient outcomes (13). PPMs can bridge the gap between national-level strategies and local implementation, ensuring that the principles of integrated care are effectively translated into practice at the organizational level (14). Within this context, person-centered practice emerges as a critical approach to address these challenges, particularly within home care settings. Person-centered practice prioritizes individual needs, preferences, and goals, aligning with the core values of many healthcare professionals and cultivating a sense of partnership between patients and providers (15). Within home care, this approach is particularly valuable, as it enables care delivery within the patient's familiar environment, promoting autonomy and dignity (16). Furthermore, the integration of technology within home care, such as telehealth and remote monitoring, can further enhance Person-centered practice by facilitating continuous communication, support, and proactive care management (17).

Person-centered practice, as described by McCormack et al. (18), emphasizes treating individuals with dignity, compassion, and respect, while considering their personal experiences, values, and preferences in healthcare decision-making. This approach offers several benefits, including restoring meaning and coherence in the work environment (19), enhancing care consistency among health professionals, improving patient outcomes (20), bridging the gap between organizational goals and professional values, and adapting to the complex needs of home care patients (21, 22).

The integration of person-centered practice principles into a PPM for home care services offers a multifaceted solution to the challenges posed by Switzerland's evolving healthcare landscape (23). This approach has the potential to address several critical aspects simultaneously: it can enhance the quality of patient care, improve the work experience and job satisfaction of healthcare professionals, and clarify the values and mission of home care services within broader integrated care networks. By focusing on

person-centered practice, this PPM can foster better coordination and continuity of care for patients with complex needs (24), while also strengthening the professional identity of home care staff (23). Moreover, it provides a framework for promoting consistency in care delivery across different providers, ultimately contributing to the broader implementation of person-centered practice principles throughout the Swiss healthcare system. This holistic approach not only aims to improve patient outcomes but also to restore meaning and coherence in the healthcare professionals' work environment, potentially leading to better staff retention and a more resilient healthcare workforce.

Within our specific home care network in Switzerland, these challenges manifest as fragmentation of care delivery across geographically dispersed teams. With multiple branches operating across different locations, inconsistent approaches to care have emerged, leading to discontinuities in service provision and potential variations in care quality. The absence of a unified professional practice framework has contributed to siloed operations, where teams develop branch-specific practices rather than implementing a cohesive, network-wide approach to person-centered practice. This geographical and operational dispersion presents unique challenges for maintaining consistent values and approaches across all network components.

This study objectives are (1) to identify and structure the core professional values perceived by healthcare staff as fundamental to guiding the development of a person-centered PPM for home care services in French-speaking Switzerland, and (2) to understand and analyze the perceived determinants (barriers and facilitators) influencing the potential implementation of a person-centered practice model within home care services in French-speaking Switzerland. Specifically, our research targeted the fragmentation of care delivery across geographically dispersed teams in our home care network, by creating a unified professional framework that would establish consistent person-centered values and approaches across all network branches, providing a cohesive foundation for care delivery despite geographical dispersion.

Methods

Setting

The Sarine Health Network (RSS) was established on January 1st, 2016, in the Sarine district of Fribourg canton, Switzerland. Its primary mission is to facilitate care for vulnerable individuals while improving healthcare efficiency, cohesion, and cost-effectiveness. The RSS integrates seven distinct services: the Coordination Center, the nursing home commission, the commission for flat-rate allowances, the ambulance service, the Sarine Nursing Home, the Sarine Home Care Service (SASDS), and, since January 2023, the Sarine fire service. The organization's activities are guided by three core values: responsibility, professionalism, and respect.

This study specifically focused on two components of the RSS: the SASDS and the Coordination Center, both operating under a unified Nursing Care Management. These two services play a crucial role in coordinating and delivering home care within the district.

The Coordination Center, composed of a manager and nurses, is responsible for processing new healthcare requests from the Sarine district population, managing family caregiver allowances, and overseeing administrative staff who maintain direct patient contact.

The SASDS provides home care services through seven geographical branches, each led by a manager who oversees an interprofessional team of nurses, healthcare assistants, and nursing aids. The service is further supported by an occupational therapist, dieticians, and a specialized wound care nurse. Together, these two services employ 183 staff members, providing care to approximately 2,300 clients annually.

Objective 1: development of the professional practice model

Design: For the development phase, the study employed a cross-sectional multi-method design following the concept mapping process described by Kane and Trochim (25).

Sample: The target population consisted of all employees from both the SASDS and the Coordination Center ($N = 183$) who met the inclusion criteria of current employment and French language proficiency. Following Kane and Trochim's concept mapping methodology, we selected a purposive subsample of 17 professionals from both the SASDS and the Coordination Center to participate in the detailed mapping activities. The selection ensured representation across all service roles, including clinical staff (seven nurses with one mental health specialist, four healthcare assistants, and two nursing aids), support services (one administrative staff member), specialized professionals (one occupational therapist and one dietician), and management (one branch manager). We determined this sample size based on previous concept mapping studies suggesting that 10–20 participants provide sufficient variety in perspectives while maintaining feasible group dynamics.

Data collection: The concept mapping process unfolded through six sequential steps (25). The preparation steps involved clarifying project objectives, defining the sample, and establishing a detailed schedule through a Gantt chart. Eight information meetings were conducted with stakeholders to ensure comprehensive understanding and engagement. The Concept Systems Incorporated software was utilized to develop demographic questions and the primary focus question (26).

During the generation steps (May 8–June 2, 2023), participants responded anonymously to the focus question: "Based on your role within SASDS, could you define what is important to you in providing services that meet patient/beneficiary needs?" Responses were collected through The Concept Systems Incorporated software, with participants having access to view previously recorded responses to avoid duplication. The project team subsequently refined the response set by removing duplicate and unclear statements.

The structuring steps involved the 17-member subsample participating in two-hour sessions in July 2023. During these sessions, participants individually sorted and categorized

statements based on perceived similarities and rated each statement's importance on a 5-point Likert scale (1 = not important, 5 = extremely important). The representation stage utilized the Concept Systems Incorporated software to perform multidimensional scaling and hierarchical cluster analysis, generating concept maps that visualized the relationships between statements.

In the interpretation steps, the project team examined the concept maps and identified 15 core values. These findings were presented to SASDS management and branch managers for validation and refinement. An in-person focus group with 8 participants (managers) was conducted to validate the visual design, ensuring data triangulation through diverse stakeholder feedback. The utilization steps involved applying these results to guide subsequent implementation phases.

Data analysis: Data analysis was conducted using Concept Systems software (26), which is specifically designed for concept mapping methodology. The analysis process followed the standard steps of this approach. After data collection, the software was used to perform multidimensional scaling of the sorts completed by participants, generating a similarity matrix (27). This matrix was then subjected to hierarchical cluster analysis to group statements into broader concepts (25).

The software generated visual representations of the relationships between statements in the form of concept maps. These maps were collaboratively interpreted with participants to name clusters and identify structuring axes, ensuring a collective understanding of the studied issue (27). The software facilitated the creation of interactive concept maps and pattern matches.

Participants' ratings on predefined criteria were analyzed to provide complementary information on the relative importance of different identified concepts. The Concept Systems software allowed for the input of card sort piles and ratings from participants, which were then analyzed to produce visual representations of the data (27).

This analysis approach enabled the organization of disparate ideas, linking of similar thoughts, and equal consideration of contributions from numerous participants. The resulting concept maps illustrated group ideas and concerns, how ideas were related to one another in a multidimensional concept space, how ideas were organized into general concepts, and how concepts were rated in terms of criteria relevant to stakeholders (27).

Connection between concept mapping and intervention mapping

The two methodological approaches were directly connected, with concept mapping providing the foundation for intervention mapping. The concept mapping process from Objective 1 produced the core values and structural framework of our Professional Practice Model. These values then directly informed the intervention mapping in several ways: they provided the foundation for the needs assessment, helped define implementation objectives, guided the selection of theory-based methods, and served as evaluation criteria for implementation strategies. The 15 core values identified became the central content that needed to be implemented, with particular attention to the highest-rated values (health promotion and patient-centered approach). The visualization created during concept mapping was used as a communication tool during intervention mapping focus groups to maintain conceptual consistency. Additionally, areas that received lower ratings in concept mapping (particularly interprofessionalism) were prioritized for targeted implementation strategies during intervention mapping.

Objective 2: contextual analysis for the implementation of person-centered PPM

Design: The contextual analysis for the implementation phase employed the Intervention Mapping (IM) framework (28). While this framework was originally developed for health promotion programs, we adapted it for our professional practice model development because of its structured, stepwise approach that emphasizes stakeholder involvement and theoretical grounding. We found its systematic approach to development, implementation planning, and evaluation particularly valuable for structuring our work in the complex home care environment, despite this representing an adaptation from its original purpose. The framework was utilized with a participatory research approach to ensure alignment with population needs and contextual factors (29).

Sample: The contextual analysis process involved two groups strategically formed to ensure continuity from the development phase. The resource group ($n = 3$) consisted of the Nursing Care Director, the same Clinical Nurse Specialist (CNS) who had led the concept mapping phase, and a newly appointed SASDS head nurse. The stakeholder group ($n = 6$) was expanded from the initial concept mapping participants to include the Coordination Center manager, all six branch managers (including the branch manager who participated in the concept mapping), and the same occupational therapist (MScHS) from the development phase. This composition maintained key participants from the first phase while broadening representation across the organization's leadership structure to facilitate implementation.

Data collection: Implementation followed four key stages of the IM framework (28). The needs assessment stage consisted of three two-hour focus groups with the stakeholder group over a two-month period. During these sessions, semi-structured focus groups based on the Consolidated Framework for Implementation Research (CFIR) identified implementation barriers and facilitators (30). Focus group discussions were guided by a pre-defined interview guide developed from the CFIR domains.

The objectives definition stage involved two additional focus groups where executive nurses shared their understanding and vision of person-centered practice, and stakeholders identified existing facilitators that could support the implementation of the professional practice model developed in phase 1. The theory-based methods selection stage examined current care delivery practices and implementation strategies already established within the organization that aligned with person-centered practice principles.

The intervention design stage utilized a modified Delphi method to achieve consensus on implementation strategies. This

process involved two rounds: first, a focus group to discuss and refine the strategies, followed by stakeholders rating identified implementation strategies using a 5-point Likert scale questionnaire. For validation purposes, we conducted one additional focus groups with 6 field staff members (nurses, healthcare assistants, and nursing aids) who had not participated in previous stages. These sessions included both structured discussions and individual questionnaires with Likert scale ratings (0–5) and open-ended comments sections. The sequential nature of data collection allowed for continuous refinement of implementation strategies based on stakeholder feedback and field validation.

Data analysis: The qualitative analysis employed a rapid analysis approach based on Nevedal's method, incorporating both deductive coding using the CFIR Codebook and inductive coding for emerging themes (31). Codes were weighted on a scale from −2 to +2, and data triangulation was performed with the CNS and research team. Quantitative analysis of questionnaire responses utilized Excel-based analysis, including response distribution and percentage calculations.

Ethical considerations

The requirement for ethical approval for the studies involving humans was waived by the Reseau Sante Sarine (RSS) Board Direction. This decision was made in accordance with the RSS's specific local institutional guidelines. These internal guidelines stipulate that service development projects and professional practice evaluations—which primarily involve an institution's own staff perspectives and do not directly impinge on patient interventions, nor make use of sensitive, identifiable patient health data requiring review by an external cantonal committee under Swiss human research legislation—fall under the ethical oversight of the RSS Board of Directors. This study, aimed at developing a professional practice model through the input of healthcare professionals regarding their work and service organisation, was classified as such a project.

Despite this specific authorisation pathway, the study was conducted in strict adherence to all applicable organisational ethical guidelines and fundamental international ethical principles, including those outlined in the Declaration of Helsinki. Voluntary participation and the right to withdraw from the study at any time were ensured for all participants. Information meetings were conducted to ensure that all potential participants clearly understood the study objectives, procedures, and their rights before written informed consent was obtained for all data collection activities. Anonymity was maintained during the concept mapping phase. Focus group recordings were used solely for the purpose of analysis, with explicit consent obtained from participants for their use; confidentiality was prioritised throughout all stages of data collection and analysis. To minimize potential fatigue and ensure minimal interference with professional responsibilities, sessions involving participants, such as focus groups and structuring activities, were limited to a maximum of two hours, with breaks provided as needed during longer activities.

Results

Objective 1: development of the professional practice model

The concept mapping process achieved a high participation rate of 86%. During the idea generation phase, participants responded to the focal question about defining important elements for meeting patient needs in their service delivery. This process yielded 325 initial statements, which the research team systematically refined through consensus. After eliminating duplicates, synonyms, and unclear statements, 111 unique statements remained for further analysis. These statements underwent sorting and rating during structured sessions.

The subsequent analysis initially identified 15 distinct values, which were later refined to 14 core values through an iterative stakeholder validation process. This refinement process revealed ten key attributes that crossed multiple values: training, staff autonomy, patient autonomy, professional positioning, equity, quality of care, empathy, holistic approach, communication, and collaboration. These attributes served to clarify and enhance the definition of the core values of the professional practice model (Figure 1). Figure 2 presents the cluster concept map generated directly from the multidimensional scaling and hierarchical cluster analysis of participant sorting data. It visually represents the statistical proximity and relationships between the identified value clusters as perceived by the study participants, forming the empirical basis for the final model.

The concept mapping process identified 14 core values that form the foundation of our Professional Practice Model. Below, we present these values in descending order based on their importance ratings (1–5 scale), from highest to lowest rated.

Health promotion and prevention emerged as the highest-rated value at 4.4, emphasizing the importance of maintaining a healthy work environment while supporting staff autonomy in healthcare delivery. Participants described this value as encompassing approaches to both staff and patient well-being. Importantly, participants viewed health promotion as foundational to effective care coordination across our geographically dispersed network. When different branches consistently prioritize health promotion, they create a shared starting point for care planning that helps overcome fragmentation. As one participant noted, 'A unified approach to supporting patient self-care creates natural coordination points between different providers and services.

The patient-centered approach emerged as the second highest-rated value (4.3), incorporating holistic care, empathy, and patient autonomy as key attributes. This value emphasized the active consideration of patient needs and preferences in care planning and delivery, positioning patients as central decision-makers in their care journey.

Job satisfaction scored 4.2, demonstrating its significance in the organizational context. This value encompassed various elements contributing to employee contentment, including occupational health and safety measures, recognition of staff contributions, and active listening from management. A particular emphasis

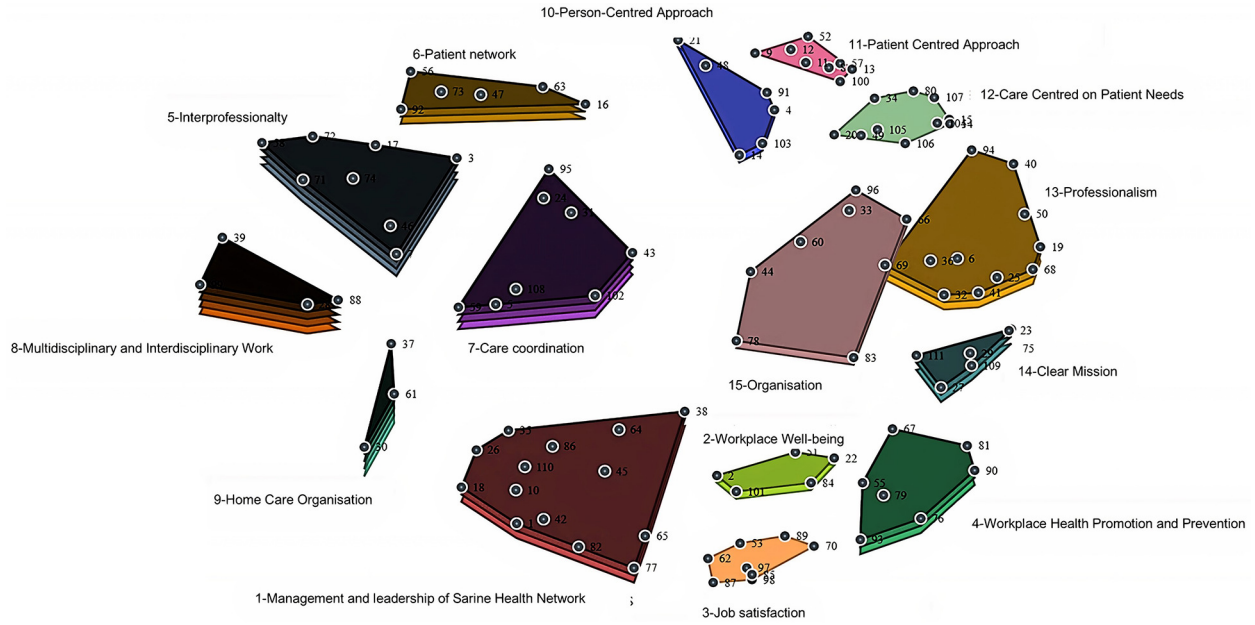

FIGURE 1
Flow chart.

was placed on aligning institutional objectives with staff aspirations to create a harmonious work environment.

Professionalism (rated 4.1) integrated several crucial elements, including care quality, equity, and professional positioning. This value emphasized the importance of maintaining high standards while ensuring equitable care delivery across all patient populations.

Workplace well-being received a rating of 4.1, reflecting its critical role in maintaining organizational health. This value incorporated multiple dimensions, including service flexibility to adapt to changing needs, clear job descriptions to establish role boundaries, and adequate time allocation for patient care. The emphasis on professional qualifications within this value highlighted the organization's commitment to maintaining high standards of care delivery.

The SASDS organization value (rated 4.0) encompassed the structural and operational aspects necessary for effective home care delivery. This value focused on ensuring that organizational mechanisms and practices consistently support high-quality healthcare service provision.

The patient network value (rated 3.9) focused on developing and maintaining strong partnerships with patients, their families, and caregivers. This value recognized that effective care extends beyond direct patient interaction to include the broader support network essential for optimal health outcomes.

The management and leadership value, rated 3.8 out of 5 on the importance scale, emerged as a fundamental component focused on coordinating human and material resources. This value particularly emphasized the importance of training and development, highlighting the organization's commitment to continuous professional growth. It encompassed leadership abilities essential for motivating and guiding team members effectively.

Care coordination received a rating of 3.7, emphasizing the importance of integrated care management. This value particularly highlighted communication and collaboration as essential attributes for ensuring seamless care delivery across different providers and settings.

Although receiving the lowest rating (3.7), interprofessionalism was recognized as crucial for comprehensive care delivery. This value emphasized the importance of collaborative approaches across different health professionals and services, acknowledging that effective patient care requires integrated expertise from multiple disciplines.

Four additional values were incorporated to align with broader organizational principles. Respect was added as a transversal value at management's request, emphasizing fundamental human dignity and acceptance of others' rights and opinions. Similarly, responsibility was included to reflect professional commitment and reliability. Relational ethics was incorporated as a transversal value emphasizing the importance of interpersonal relationships, compassion, trust, and effective communication in healthcare delivery.

The Professional Practice Model was constructed by organizing the 14 identified values into a coherent framework that reflects their interrelationships and relative importance. As shown in Figure 2, health promotion and patient-centered approach form the central core of the model as the highest-rated values (4.4 and 4.3 respectively). These are surrounded by supporting values arranged according to their importance ratings. The three transversal values (respect, responsibility, and relational ethics) permeate all levels of the model.

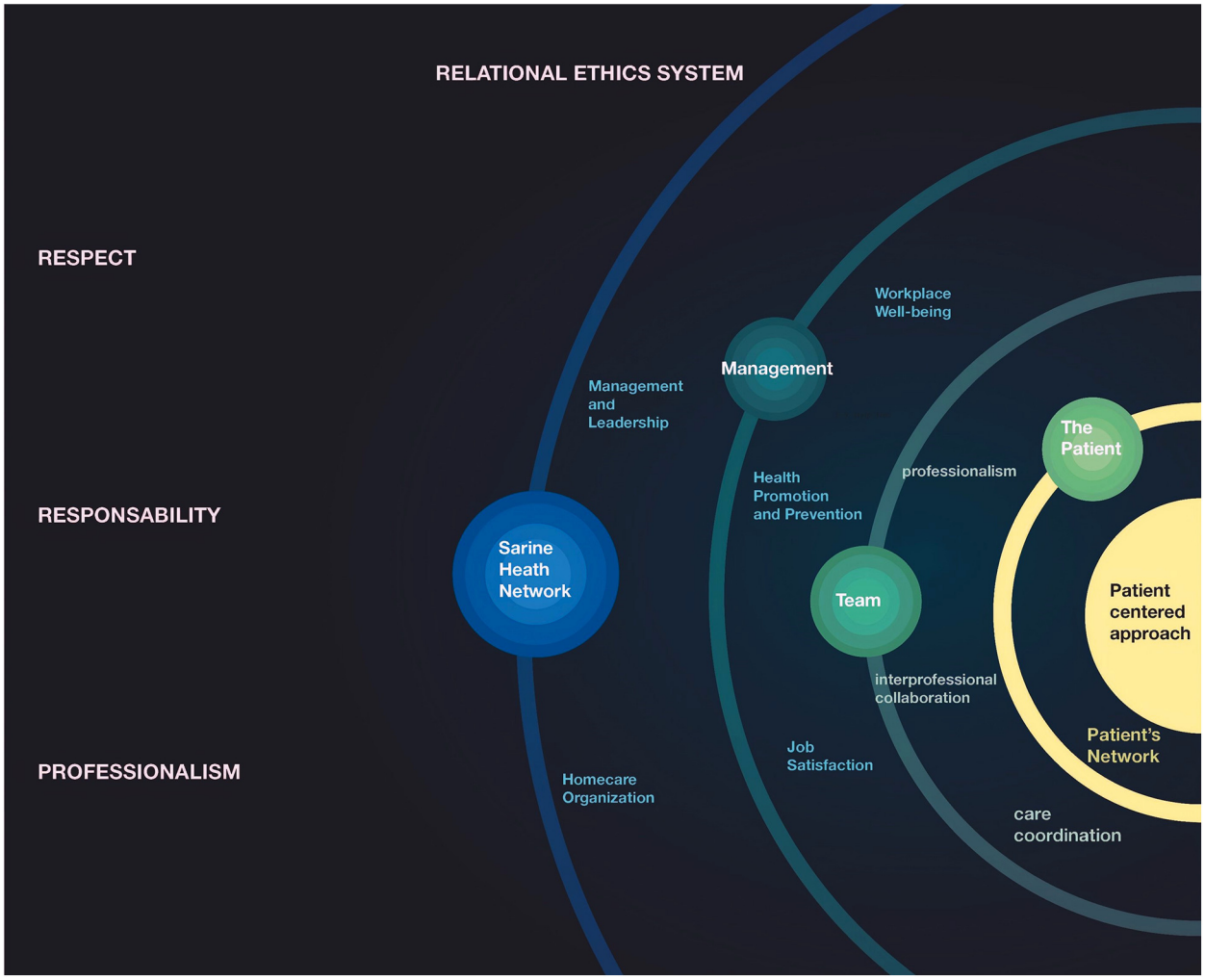

FIGURE 2
Cluster concept Map generated from participant data analysis, showing relationships between potential components of a professional practice model at SASDS.

Based on the conceptual relationships identified in Figure 2 and incorporating the importance ratings assigned by participants, the final Professional Practice Model (PPM) was constructed and synthesized into a visual framework presented in Figure 3. Through focus group consultation, stakeholders selected the solar system design shown in Figure 3 as it effectively conveys the hierarchical organization and interconnected nature of the 14 core values within the final PPM framework. The design illustrates how these values interact and support each other in practice, creating a cohesive approach that can be implemented across all network branches.

The validation process not only confirmed the relevance and comprehensiveness of the identified values but also ensured their alignment with organizational objectives and RSS core values. Notably, the resulting model showed significant alignment with established theoretical frameworks, particularly the Person-centred Practice Framework of McCance and McCormack, providing additional validation of its theoretical underpinning (18).

Objective 2: contextual analysis for the implementation of person-centered professional practice model

Analysis of the focus groups revealed several key determinants influencing the implementation process. The successful implementation of person-centered practice fundamentally depended on individualizing care approaches and engaging in active listening. A branch manager articulated this essential approach: "We identify their habits regarding care…there's also the notion of including the patient in their project. We identify objectives, a care plan. We accompany them in their goal, whether it's recovering autonomy, maintaining it, or promoting whatever is needed." This perspective resonated consistently across both management and front-line staff perspectives.

Beyond individualized care, a holistic approach proved fundamental to implementation success, with branch managers particularly emphasizing the importance of considering social,

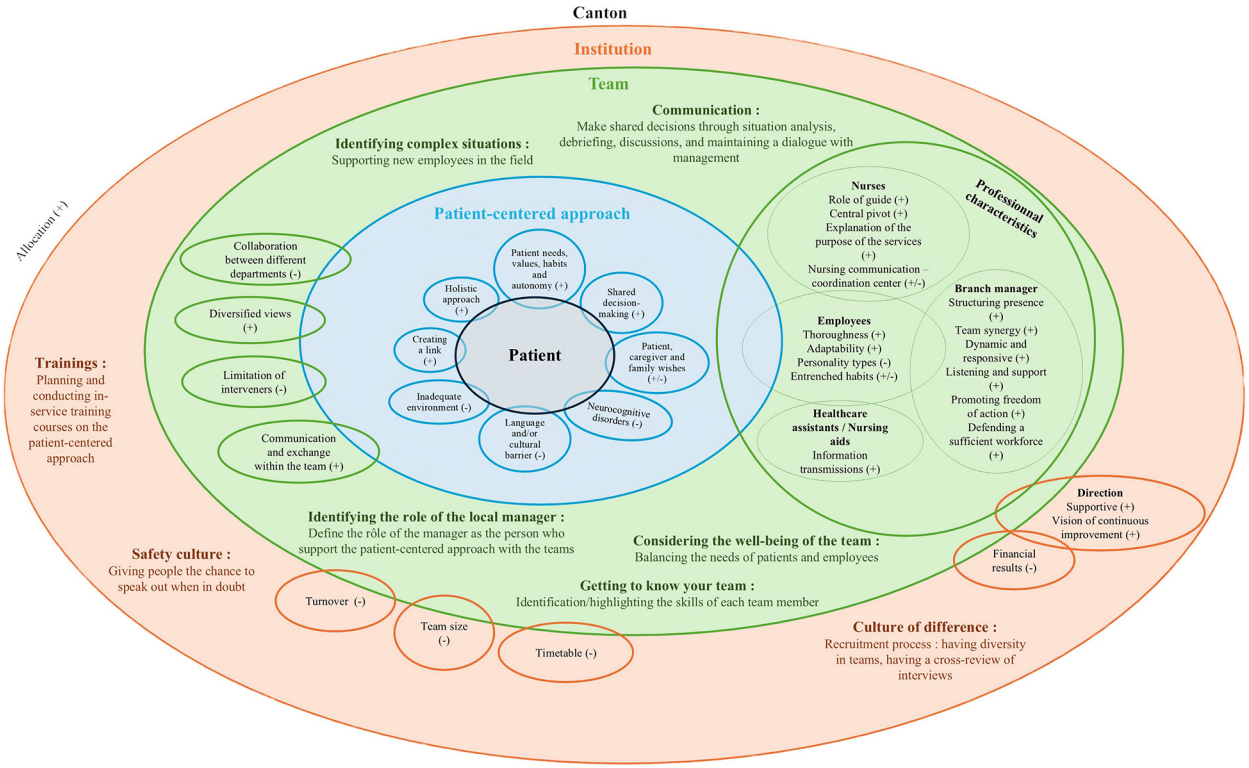

FIGURE 3
Synthesized visual representation of the SASDS professional practice model, showing the hierarchical organization of core values (based on importance ratings) and their interrelationships.

familial, psychological, and economic dimensions in care delivery. However, the implementation process faced significant challenges, particularly regarding linguistic and cultural differences. While healthcare providers consistently strived to meet patient expectations, resource limitations often necessitated extended discussions to properly align values and expectations.

The implementation of person-centered practice proved particularly challenging for patients with cognitive impairments. Care teams frequently encountered complex situations where patients' expressed wishes conflicted with safety requirements. Both management and front-line staff consistently emphasized the critical nature of building therapeutic relationships, observing that trust development varied significantly among patients, with some forming connections quickly while others required extended time and regular visits to establish meaningful relationships.

Within this implementation context, patient support networks emerged as both facilitators and potential barriers to success. Family involvement proved especially crucial in decision-making processes, particularly for patients with cognitive impairments. One participant eloquently described this dynamic: "The idea is to have a therapeutic relationship with both the patient and their entire environment, and to co-create this relationship with all stakeholders—home care, physician, really all participants. We talk a lot about partnership…It's a co-construction of all objectives and interventions we're going to do together."

The success of implementation relied heavily on team dynamics and professional relationships. Branch managers consistently emphasized the importance of thorough preparation for daily rounds, acknowledging the unique challenges each day presented. This perspective was captured by one manager who reflected: "We're in a constantly evolving world, we must always adapt for many things. It's also an adaptation that we must make, and all collaborators must constantly adapt, and I think it's important to keep this in mind. But everything revolves around the patient, keeping them at the center of our concerns."

Within the team structure, reference nurses emerged as critical facilitators of implementation. These professionals served as essential information hubs, developing intervention plans aligned with patient wishes while coordinating information flow between healthcare assistants and nursing aids. Their effective communication with the coordination center proved particularly crucial in preventing unnecessary hospitalizations.

The role of leadership proved fundamental to implementation success, with branch managers positioning themselves as essential supporters of the person-centered approach. They provided structural presence and maintained team cohesion throughout the implementation process. The importance of responsive leadership was emphasized by one manager who noted: "It's important for me to hear team feedback. What do you need to have a patient-centered approach? What are your needs? Express them, and then we'll look at what we can implement."

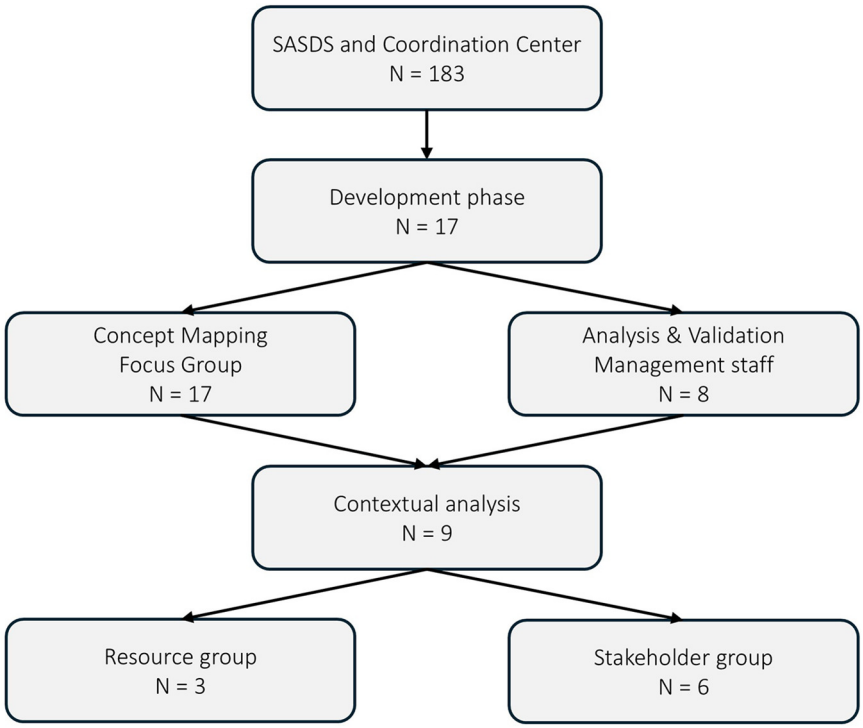

FIGURE 4
Determinants and implementation strategies of the SASDS professional practice model.

The broader organizational structure significantly influenced implementation in multiple ways. While management demonstrated strong support for continuous improvement, the implementation process revealed tensions between meeting patient needs and maintaining financial sustainability, particularly regarding billable hours. This dynamic was captured by one focus group participant who observed: "We have a management team right now that is supportive and encouraging," while acknowledging the practical challenges of balancing care quality with operational constraints.

Throughout the implementation process, several key strategies emerged, already embedded within the organization's practices. The foundation of these strategies rested heavily on continuous professional development, which proved essential in strengthening multiple aspects of person-centered practice implementation. Training activities focused on enhancing understanding of patient needs, facilitating shared decision-making, and promoting holistic care approaches. Participants described the organization's approach to professional development, with one staff member noting, "Things are being done and developed, we provide training. Training is offered. Management is open to training." This commitment was further validated through quantitative data, with 67% of stakeholders strongly agreeing they received adequate training, while the remaining 33% somewhat agreed.

Building on this foundation of professional development, the organization implemented a strategic approach to recruitment that emphasized diversity in professional backgrounds and expertise (Figure 4). This approach represented a significant shift in hiring practices, as explained by one manager: "The recruitment approach is completely different now. Management's message is to hire based on the specific skills needed in our branch…When we post a position, we ask for experience because that's what we'll be missing. For healthcare assistants, we might request specific training…For nurses, we might look for cardiovascular expertise or other specialties we need." This recruitment approach aimed to create teams with diverse professional skills.

The organization further supported implementation through robust shared decision-making processes. Communication strategies centered on systematic situation analysis, regular debriefing sessions, and continuous dialogue with management. These processes were designed to be inclusive and collaborative, as one participant described: "Situations are presented and everyone brings up the problems they encounter, everyone has a voice. Then there are exchanges about the situation. It can be brainstorming, the care plan evolves. Reference nurses take action or not." However, this approach faced practical challenges, particularly regarding time constraints. Front-line staff expressed concerns about the limited time available for in-depth analysis, with one participant noting: "Time is limited, there's a lot at the start and then only 20–30 min remain for situation analysis, and that's short. And I feel that's what we need."

To maximize the effectiveness of their diverse workforce, the organization developed a comprehensive team competency mapping approach. This mapping approach connected available

skills with specific patient needs. The approach not only enhanced patient care delivery but also supported professional development and improved care coordination across teams.

Branch managers were involved in the implementation process as facilitators of the person-centered approach. While this strategy received mixed responses in the Delphi validation, quantitative data showed strong support from front-line staff, with 83% strongly agreeing that branch managers supported the person-centered approach, and 67% strongly agreeing about overall management support. However, some participants noted gaps between expectations and practical implementation realities.

The organization developed specific approaches for managing complex cases and supporting new staff members, recognizing the challenges these situations presented. A manager detailed this approach: "There's identification of situations requiring supervision regarding patient knowledge from referents…these patients are systematically paired multiple times until the person feels comfortable. It's not just once…We also make staff vigilant, so they don't find themselves failing. There's preventive work around this." This strategy received strong validation, with 83% of stakeholders strongly agreeing that adequate support was provided for challenging cases.

Recognizing the interconnected nature of staff and patient well-being, the organization placed significant emphasis on maintaining a balance between these two aspects. This approach was reflected in one participant's observation: "We spend as much time and energy on work centered on staff as on patients…We're more focused on team well-being than patient well-being. While it should primarily be the reverse. Although one doesn't go without the other."

The organization's commitment to safety and open communication was evident in its promotion of a culture where staff felt comfortable expressing doubts or concerns. A manager described this approach: "We asked if they thought they could tell us when they're not sure about what they're doing…They see there's always a positive reception from us…There's always a yes, I'll stop what I'm doing, and we'll discuss. And having this benevolence in the team means that nobody ever disturbs the other and we always manage to build together." This emphasis on psychological safety received strong validation, with 83% of stakeholders strongly agreeing they could freely express concerns to both colleagues and managers.

Despite these comprehensive strategies, implementation faced several persistent challenges. The size of teams significantly impacted communication effectiveness, with larger teams experiencing more difficulties in information exchange. Staff turnover posed ongoing challenges to maintaining stable patient-provider relationships, while visit scheduling constraints and financial pressures created continuous tensions between meeting patient preferences and maintaining organizational efficiency.

Interprofessional collaboration emerged as a particularly significant challenge. As one participant observed: "The barriers include the network which can be extremely important with different services. Collaboration is sometimes difficult between services. Everyone works a little bit in their domain. There is little communication, I would say a lack of partnership between services."

The implementation process benefited significantly from a favorable political context, including recent increases in staffing allocations. This external support was highlighted by a participant who noted: "Home care has been enjoying an absolutely incredible cantonal political context for 3–4 years. There has been an increase in allocated positions." This positive political environment strengthened the organization's capacity to implement and sustain person-centered practice practices effectively.

Discussion

This study of a home care network has yielded significant insights into both the development and context analysis for a Professional Practice Model (PPM). Through engagement with stakeholders across multiple care branches, our findings illuminate important considerations when developing a theoretical framework for potential application in home care settings.

When interpreting our results in the context of existing literature, in the decentralized context of home healthcare, where teams often operate in geographical and professional isolation, stakeholders identified that a unified Professional Practice Model could potentially serve as stabilizing force (7). Our contextual analysis suggests that such a model, if successfully implemented, might help bridge diverse practices across the network's branches. This potential unifying function would be particularly valuable in the home care context, where physical separation of teams can lead to divergent practices and approaches.

The model's potential for fostering cohesive care practices aligns with Slatyer et al.'s (32) findings in hospital settings, while suggesting its possible application to enhance integration within home care networks. Supporting this extension, Imhof et al.'s (33) research on Advanced Practice Nurses (APNs) in home care demonstrates how structured professional frameworks can enhance quality of life and health outcomes for community-dwelling older adults. While our study identified distinctive challenges within the home care environment, it also revealed opportunities for improving care coordination and practice standardization through the model's implementation.

The involvement of all stakeholders in the model's development, from frontline staff to management, proved crucial in establishing its legitimacy and applicability. The high response rate (86%) in the concept mapping phase suggests the strong engagement of staff across all levels, indicating a collective recognition of the need for a unifying framework. This broad participation helped ensure that the resulting model reflected the real-world experiences and needs of those delivering care, rather than merely representing a top-down theoretical construct. Including intended end-users in guideline development is a moral imperative and critical for addressing the right issues (34). Furthermore, as emphasized by Wiig et al. (35), involving diverse stakeholders, including patients, healthcare professionals, and managers, is crucial for creating resilient healthcare systems, which aligns with our observation of broad participation across all levels.

Critical analysis of our results reveals that a particularly noteworthy finding was the striking alignment between our developed PPM and the Person-centred Practice Framework of McCance and McCormack (18). This congruence emerged organically through the development process, rather than being deliberately engineered, lending additional credibility to both our model and the Person-centred Practice Framework of McCance and McCormack. The natural alignment suggests that the fundamental principles of person-centered practice resonate deeply with home care practitioners, regardless of their role or level within the organization.

This alignment manifested across multiple dimensions. The values identified through our concept mapping process, particularly those emphasizing patient autonomy, holistic care approaches, and professional competence, mirror the core components of McCance and McCormack's model (18). As Kitson et al. (36) highlight, these elements are crucial in creating a truly person-centered practice environment. Participants noted this connection in relation to the home care context and the direct nature of care delivery.

The congruence between our PPM and McCance and McCormack's model provided more than theoretical validation; it offered a robust framework for practical application across the network. By establishing a shared language and common vision for clinical outcomes that transcended individual branches, the model facilitated more coherent care delivery in our decentralized setting.

The hierarchical structure of our PPM, with clearly defined core values arranged by importance, provides a clear blueprint for implementing person-centered practice and directly addresses our primary aim of reducing care fragmentation across geographically dispersed teams by establishing value priorities while showing their interconnections. By providing a unified framework of professional values, the model creates a common language and shared priorities that transcend branch-specific practices. When all branches align their operations around the same core values—particularly the highest-rated health promotion and patient-centered approach—they naturally develop more consistent care approaches. This consistency helps bridge the geographical and operational gaps that previously led to fragmented care. The visual representation as a cohesive system further reinforces the interconnected nature of these values, encouraging practitioners to view their work as part of an integrated whole rather than isolated branch-specific activities. The four transversal values that permeate all levels ensure ethical and professional continuity across the entire network. This structured approach to professional practice provides the foundation for standardized yet flexible care delivery that maintains consistency while accommodating local context—essential for reducing fragmentation in a decentralized home care system. It is crucial to emphasize that this PPM is intended as a high-level conceptual framework designed to guide strategic direction, decision-making, and practice development by establishing shared values and priorities. It is not an operational blueprint dictating specific day-to-day procedures or protocols, which would need to be developed subsequently in alignment with this guiding framework.

Despite this alignment, our model does present distinct characteristics when compared to McCormack's model. Our approach contextualizes person-centered practice principles specifically within a decentralized home care network structure, addressing organizational challenges unique to this setting. The concept mapping methodology revealed specific value prioritization patterns in our context, particularly the relatively lower rating of interprofessionalism despite its recognized importance. Additionally, our framework integrates organizational values (responsibility, professionalism, respect) with person-centered principles, reflecting the specific cultural context of our Swiss home care network. These differences represent contextual adaptations to our specific operational environment rather than fundamental conceptual departures from McCance and McCormack's comprehensive model.

The contextual analysis phase of our study revealed further significant insights, particularly in how emerging strategies naturally aligned with McCance and McCormack's key dimensions of "The practice environment" and "Prerequisites". This natural alignment between theoretical constructs and practical application strategies suggests that McCance and McCormack's model provides a particularly suitable framework for home care settings.

In examining the practice environment, our findings revealed that strategies of open communication and collaborative decision-making aligned closely with McCance and McCormack's framework of shared power and effective staff relationships. This alignment is further supported by Narayan et al.'s (37). research on patient-centered care in home healthcare settings, which emphasizes the fundamental importance of relationship-building and comprehensive assessment skills. Their findings reinforce our observations about the critical role of open communication and collaborative approaches in creating an effective practice environment that supports person-centered practice delivery. The "Prerequisites" dimension of McCance and McCormack's model was strongly reflected in our implementation strategies. Our emphasis on continuous training and interprofessional relationships aligned with McCance and McCormack's focus on professional competence and interpersonal skills development. Quantitative data supported this alignment, with 67% of stakeholders strongly agreeing and 33% somewhat agreeing that they received adequate training, demonstrating robust commitment to professional development. These findings echo Watson's (23) research highlighting the critical importance of prerequisite interprofessional team skills in delivering person-centered practice.

Examining the organizational context more deeply reveals the critical role of macro-level context factors in enabling person-centered practices. Recent research by Roberts et al. (38) emphasizes the necessity of moving beyond theoretical PCC frameworks toward integrated care models for older adults, a perspective particularly relevant to our implementation context. The network demonstrated organizational readiness through three key elements: leadership commitment, organizational alignment, and resource allocation.

Leadership support emerged as a pivotal factor in implementing consistent person-centered values across

geographically dispersed teams. Quantitative data underscored this support, with 83% of front-line staff strongly agreeing that branch managers supported the person-centered approach, and 67% strongly agreeing about overall management support. Branch managers and senior leadership played crucial roles in translating abstract person-centered principles into consistent operational practices, including unified approaches to documentation, care planning, and interdisciplinary collaboration. Without this leadership engagement, each branch would likely maintain its own distinct approach, perpetuating the coordination challenges the PPM sought to address. As one participant noted: "We have a management team right now that is supportive and encouraging." This support extended beyond mere verbal endorsement to include practical implementation initiatives. Critically, the alignment between organizational mission and person-centered values proved crucial for implementation success. By incorporating the network's core values—responsibility, professionalism, and respect—into the PPM, the organization ensured cultural continuity and prevented common pitfall of implementing changes that conflict with existing organizational values.

Our in-depth examination of the data suggests that the combination of supportive leadership, aligned organizational values, and adequate resource allocation indicated a system well-prepared for the implementation of person-centered practices. Interestingly, our findings revealed that interprofessionalism received the lowest rating (3.7) among the identified values, despite being recognized as crucial for comprehensive care delivery. This apparent contradiction merits further examination. While care coordination and interprofessionalism are closely interconnected concepts, they were differentiated in our study—interprofessionalism focuses on collaborative practices among diverse professionals (knowledge sharing, mutual respect), while care coordination emphasizes the operational mechanisms that integrate these collaborative efforts into seamless service delivery. The lower rating of interprofessionalism may reflect the practical challenges in its implementation. This suggests that while stakeholders recognize the theoretical importance of interprofessional collaboration, they experience significant barriers to its practical application in daily operations. This finding aligns with research by Ashcroft et al. (39) highlighting the persistent challenges of establishing effective interprofessional practices in decentralized care systems, where geographical and organizational boundaries can impede collaborative relationships.

To address these interprofessional collaboration challenges, several strategies could be implemented in this decentralized home care context. First, establishing structured communication protocols specifically designed for geographically dispersed teams could facilitate more consistent information exchange. Regular interdisciplinary case conferences, both virtual and in-person, would create opportunities for meaningful collaboration despite physical separation. Additionally, implementing shared documentation systems accessible to all professionals involved in a patient's care would support timely information sharing. Finally, joint training initiatives focusing on collaborative competencies could help build the interprofessional relationships necessary for truly integrated care delivery. These approaches could help bridge the gap between the recognized importance of interprofessionalism and its practical implementation (40).

However, our findings also revealed certain implementation challenges that required attention. Team size affected communication effectiveness, with larger teams experiencing more difficulties in information exchange. Staff turnover complicated the maintenance of stable patient-provider relationships, whilst scheduling constraints and financial pressures created ongoing tensions between meeting patient preferences and maintaining organizational efficiency. These challenges highlighted the importance of maintaining focus on person-centered principles even in the face of operational pressures.

Study limitations

Some limitations warrant consideration when interpreting our findings. The relatively small sample size of front-line staff in the implementation phase, whilst providing valuable insights, may not fully represent the diversity of perspectives within the organization. Additionally, our analysis lacks comprehensive demographic data about participants, including age, ethnicity, professional background, and years of experience—factors that could significantly influence perspectives on person-centered practice and serve as important cultural influences on the data collected.

Time constraints created periods of latency between study phases, potentially affecting participant engagement. Although these periods were managed through regular communication updates, they may have influenced the continuity of the development process. The potential for social desirability bias, particularly in focus groups and questionnaire responses, cannot be discounted despite efforts to ensure anonymity.

The study's single-organization focus, whilst allowing for depth of understanding, may limit the generalizability of findings to other home care contexts. Additionally, the study's timeframe did not permit long-term evaluation of implementation outcomes.

Recommendations for home care management

By synthesizing our findings and translating them into practical implications, we propose several key recommendations for home care management. First, our findings highlight the crucial importance of leadership development in supporting person-centered practice implementation. Managers should receive specific training in person-centered leadership approaches, with particular focus on creating supportive practice environments. This training should encompass developing skills in facilitating open communication, managing diverse teams, and effectively balancing operational demands with person-centered principles. The establishment of regular leadership forums can help

maintain consistency across branches whilst allowing for necessary local adaptation to specific contexts and needs.

Our research also emphasizes the need for robust structural support systems within organizations implementing person-centered practice. Healthcare organizations should establish clear mechanisms that support person-centered practice in daily operations. This includes ensuring dedicated time for team reflection and case discussions, which our findings showed were crucial for successful implementation. Organizations should develop flexible scheduling systems that can better accommodate patient preferences whilst maintaining operational efficiency (41). Additionally, implementing appropriate technology solutions can significantly enhance communication across geographically dispersed teams, addressing one of the key challenges identified in our study. Regular review mechanisms for person-centered practices ensure continuous alignment with organizational goals and patient needs.

Professional development emerged as a critical factor in successful implementation. Organizations should implement a comprehensive professional development framework that supports person-centered practice delivery. This framework should incorporate regular training in person-centered practice principles, ensuring all staff maintain current knowledge and skills. Mentorship programs for new staff have proved particularly valuable in transmitting person-centered values and practices. Creating opportunities for interprofessional learning can enhance collaboration and understanding across different professional groups, whilst recognition systems for person-centered practice excellence help reinforce desired behaviors and approaches (42).

Finally, our findings underscore the importance of robust evaluation and monitoring systems. Organizations should implement regular evaluation processes that assess the effectiveness of person-centered practice implementation. These evaluations should encompass patient experience measures to ensure care delivery aligns with patient needs and preferences. Regular staff satisfaction surveys can help identify areas requiring additional support or modification. Quality indicators aligned with person-centered principles provide objective measures of progress, whilst impact assessments of person-centered initiatives help demonstrate value and guide future developments. Together, these evaluation components create a comprehensive framework for monitoring and improving person-centered practice delivery in home care settings (43).

Conclusion and future directions

This study makes a significant contribution to understanding how person-centered practice principles can be conceptualized and potentially applied in home care settings. Our findings demonstrate that a Professional Practice Model, when developed through collaborative engagement and aligned with established theoretical frameworks like McCance and McCormack's model, can provide a foundation for bridging the gap between theory and practice in home care delivery.

The alignment between our empirically developed model and McCance and McCormack's theoretical framework provides both validation and practical guidance for home care organizations seeking to implement person-centered approaches. This convergence suggests that person-centered practice principles are not just theoretically sound but could be practically achievable in-home care settings, given appropriate organizational support and implementation strategies.

Our findings illustrate a home care network with promising readiness for transformation. The PPM, informed by McCance and McCormack's model, provides a potential roadmap for transitioning person-centered practice from an aspirational ideal to an operational reality in home care settings. The model's potential to unify diverse practices across geographically dispersed teams suggests its possible value for other decentralized healthcare organizations.

Several areas warrant further investigation to build upon these findings. Longitudinal studies examining the implementation process and measuring outcomes if the PPM were to be fully implemented would provide valuable insights into the model's applicability and sustainability. Research exploring the development of person-centered practices in different cultural and organizational contexts could help identify universal principles and context-specific adaptations.

Additionally, investigation into the role of technology in supporting person-centered practice delivery in home settings could help address some of the communication and coordination challenges identified in our study. Research examining the economic implications of person-centered practice implementation would also be valuable for healthcare organizations considering similar transformations.

The journey toward truly person-centered home care continues to evolve. This study provides both theoretical insights and contextual analysis for organizations considering this transformation. As healthcare systems globally grapple with increasing demands and resource constraints, the importance of effective, person-centered approaches to home care delivery becomes ever more critical. Our findings suggest that with appropriate theoretical grounding, careful contextual analysis, and organizational support, such transformation may be possible and could potentially enhance both care delivery and professional practice in home care settings.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The requirement of ethical approval was waived by Reseau Sante Sarine Board Direction for the studies involving humans because Reseau Sante Sarine Board Direction. The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

CM: Conceptualization, Methodology, Project administration, Software, Supervision, Validation, Writing – original draft, Writing – review & editing. SP: Formal analysis, Investigation, Methodology, Software, Visualization, Writing – original draft, Writing – review & editing. JWe: Formal analysis, Investigation, Methodology, Visualization, Writing – original draft, Writing – review & editing. JWi: Conceptualization, Supervision, Validation, Writing – original draft, Writing – review & editing.

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Learning from the implementation of person-centred care: a meta-synthesis of research related to the Gothenburg framework

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Introduction: While research has shown promising effects of person-centred care (PCC) in a variety of settings, it remains to be systematically implemented in practice. Publications exist on conceptual frameworks for PCC implementation, as well as identified barriers and enablers, but a comprehensive overview of lessons learned from PCC implementation efforts is lacking. The aim of this study therefore is to synthesize research-based empirical knowledge on implementation of PCC using the theoretical foundation of the Gothenburg framework.
Method: Interpretive meta-synthesis, using the theoretical framing of the Gothenburg framework for PCC, and implementation science in the context of healthcare services in Sweden.
Results: The results illuminate that PCC implementation includes three interrelated categories of strategies, more precisely: strategies connected towards creating and safeguarding a person-centred work and care culture, strategies in connection to leaders and change agents, and strategies focused on learning activities and adaption to setting. An ideal of co-creation in partnership is prominent, and both top-down approaches (such as policy) as well as bottom-up approaches (activities/methodologies/tactics) created within services are at play. Implementation strategies are both deliberate and emergent during the implementation process.
Discussion: The synthesis connects to available implementation research in that it highlights the importance of care culture, connected leadership at different levels, and learning activities. While patients and family carers are included as partners in intervention research, their role as leaders and actors for change in implementation efforts is not explicitly described.
Conclusion: The combination of deliberate and emergent strategies, movements from top-down and bottom-up in combination with the ideal of co-creation at all levels demonstrates the complexities and iterative nature of PCC implementation. By illustrating this complexity and providing examples of handling practical issues, this study contributes to deeper insights on PCC implementation.

KEYWORDS

person-centred care, implementation, patient-centered care, meta-synthesis, healthcare services, literature review, patient participation, clinical practice

Introduction

Care, which includes patients as partners and is based on their needs and preferences, is advocated by government agencies, professional organizations and patient groups and aims to increase patient engagement (1–3). The conceptualization and terminology depicting such an approach to care varies but is often denoted as Person-centred care (PCC) (3–6). Person-centredness can be understood as an ethical stance that recognizes every individual as capable, resourceful, and able to contribute. It emphasizes the human drive for collaboration and partnership. When this ethical approach is applied in healthcare practice, it is referred to as person-centred care. Person-centred ethics encompass individual autonomy, solicitude with and for others, and justice for all people, and thus, it can be implemented at micro, meso as well as macro levels of health care. This includes implementation and integration of person-centred practices in healthcare organizations. While the effects of PCC shown in clinical trials are promising (7), the introduction of PCC within clinical practice has met challenges. The person-centred practice development places the care environment at the forefront, emphasizing that a setting supportive of PCC fosters a work culture of participation and mutual respect, encourages continuous learning and reflection among staff, and ensures that the environment is both safe and accessible (4).

The complexity of implementing new approaches in health care has been increasingly in the spotlight, which is exemplified by the development of frameworks for complex interventions, such as the one developed by the Medical Research Council (MRC) (8). The first version of this framework presented in the year 2000 provided a step-by-step linear process of development and evaluation of complex interventions, while the latest version presented in 2021 presents a non-linear, iterative and systems-oriented approach. The scope of the context and co-creation that encompasses those affected by the intervention (e.g., patients, practitioners) is ever increasing, highlighting the complexity of implementing sustainable change.

A number of frameworks for implementation in health care exist, such as the Normalization Process Theory (NPT) (9), and the iterative Knowledge-to-Action cycle (10). Organizational change frameworks of a more general nature are also used within healthcare implementation, such as John Kotter's 8-Step Framework for Change Management (11). The overlap between these frameworks is the emphasis on engagement of all those affected by the implementation, as well as the use of adaptive, context-aware strategies aimed at sustainable, long-term change. The choice of framework depends on the intervention and focus of study, as well as the specific assumptions about how to go about implementation. A combination of frameworks is also possible.

Regarding the implementation of PCC in health care, several efforts have been made to describe the process, as well as identify facilitators and barriers. For example, Santana et al. (5) present a conceptual framework for PCC implementation related to structure, process and outcomes. Further, in a European collaboration, the COST CARES project, enablers and barriers to implementing PCC and health promotion in Europe were identified (12, 13). Identified barriers included a lack of accuracy and appeal of program theories, low legitimacy of those advocating for change, and lack of engagement of authoritative local leaders. Key enablers included incentives beyond financial rewards, such as increased external recognition and legitimacy. Notably, such influences on PCC implementation could be regarded as meso level factors that raise questions about how to practically facilitate PCC implementation.

To our knowledge, no comprehensive synthesis of knowledge on practical strategies and approaches for PCC implementation is available. To guide future PCC implementation and practice change, the aim of this study is to synthesize research-based knowledge for the implementation of PCC using the theoretical foundation of the Gothenburg framework.

Research question: Which implementation strategies have been used in order to facilitate PCC practices?

Methods

The design of this study was an interpretive meta synthesis informed by Thorne et al. (14). The design was chosen because of its suitability to synthesize findings from varied data sources and types of study results. The Gothenburg framework for PCC (15, 16) and implementation science in the context of healthcare services (9–11) was used as a theoretical foundation in the analysis to facilitate knowledge development. Methodological considerations were anchored in the aim of integrating and synthesizing research results from a variety of publications that related to PCC implementation with similar assumptions in ways that expand on individual study results and conceptualize the findings.

Theoretical foundation

The Gothenburg framework, which was used as a theoretical foundation for PCC, has its underpinning in Paul Ricœur's action ethics, spanning from self-esteem in a first-person perspective and practical wisdom in a second person perspective to principles of justice in a third person-perspective, which has been operationalized into practically applicable healthcare actions (3, 15, 17). The notion of partnership is seen as essential. On a micro level, the initiation of partnership entails eliciting the patient's narrative through actively listening to the patient, engaging in one or multiple discussions regarding their experience of the condition and prior treatments, and evaluating available resources within their personal and social environment. A relevant health plan with one or more realistic goals is then collaboratively formulated, the inclusion of the patient's perspective being fundamental to this process. Finally, the health plan is documented in the patient's medical record or other accessible format for the patient and their significant others or family carers, ensuring that the plan is transparent, continuously

updated and contains useful guidance for the patient's self-care and family carers' informal care.

The core idea of partnership extends beyond individual care interactions and can also be applied at the meso and macro levels of healthcare, including within teams, organizational management, and system-wide governance. At the meso level, person-centredness relates to how healthcare organizations—such as hospitals, health centres, departments, or regions—are structured and managed to support collaborative and respectful care. At the macro level, person-centredness informs the development and implementation of national healthcare policies, legislation, budgeting decisions, and public health strategies, ensuring they reflect and promote the values of partnership and individual agency in care.

Focusing on studies using the Gothenburg framework for PCC enabled a synthesis of studies with a similar approach and assumptions, and which are in the same national healthcare governance context, thus adding to existing international knowledge on PCC implementation.

Study selection

Studies relevant to the aim were identified through a publication database maintained by the Centre for Person-Centred Care at the University of Gothenburg (GPCC), accessible via the EPPI-Reviewer Visualizer platform (https://eppi.ioe.ac.uk/eppi-vis/login/open?webdbid=521). The database currently includes 570 peer-reviewed publications from 2010 to 2024, all affiliated with GPCC and directly relevant to PCC. Publications lacking a clear connection to PCC, despite a GPCC affiliation, are excluded.

The purpose of the database is to facilitate an overview of research conducted at GPCC and to support targeted searches for specific studies, benefiting both internal and external researchers as well as the general public. Each publication is categorized as *Empirical*, *Theoretical*, or *Review*. Empirical studies are further coded by healthcare area, research setting, population, and study design. Users can also perform keyword searches to tailor the results to specific research needs.

For this study, the terms "implementation strategies" and "process evaluation" were used to search the database. In addition, relevant publications not included in the database were identified via manual searches. These included studies related to the implementation of person-centred care using the Gothenburg framework, but which lacked a formal GPCC affiliation in the publication.

In addition to implementation studies and process evaluations, other studies with primary aims that included results on strategies and considerations as related to implementation of PCC were included, even if they had not necessarily been designed to investigate implementation of PCC practice. Eldh et al. (18) point out that it is difficult to distinguish between clinical interventions and implementation studies and that many studies are in fact hybrids. Therefore, a variety of publication types were considered eligible for inclusion, such as implementation studies, process evaluations, clinical intervention studies, as well as theoretical papers.

All the included studies were based on fieldwork in Swedish regional healthcare services. In Sweden, the healthcare system is tax-financed (Beveridge oriented) with national governance and patient autonomy primary by law (19, 20). However, at the same time, the healthcare system is highly decentralized, with regions and municipalities being responsible for allocating resources. No assessment of the methodological quality of the selected studies was made.

Analysis

The synthesising thematic analysis of the included studies was informed by Thomas and Harden (21). First, the included studies were scrutinised to identify study results related to strategies and practice for how to practically implement PCC. Parts relevant to the aim of our study was then coded and by means of contrasting differences and similarities in data descriptive themes of strategies and practices were formulated. Finally, we related these identified strategies and practices to each other and integrated and synthesized the results to develop interpretive higher-order structures, considerations and insights. In this way, we aimed to theorize and make sense of the results in the included studies. To illuminate practice considerations, quotes from the original studies are included (although the interpretation and synthesis is based on the reported results).

Results

The results of this study are based on 26 publications all published between 2012 and 2024, see Table 1 in Supplementary file 1. These include 3 implementation studies (22–24), 4 observation studies from real world settings (25–28), 5 explorative or qualitative studies of experiences of implementation (29–33), 7 process/feasibility/intervention evaluations (34–40), 3 studies of developing intervention and education programs (41–43), and 4 theoretical studies (17, 44–46).

The synthesis reflected an overall iterative process of PCC implementation and revealed three interrelated categories of strategies for the same, see Figure 1. The categories were 1. Strategies that targeted prerequisites for implementation by creating and safeguarding a person-centred work and care culture, 2. Strategies focusing on engagement of driving forces for implementation, such as leaders and change agents, and 3. Strategies of actions for implementation, meaning learning activities and adaptation to setting. In the publications, co-creation in partnership was continuously emphasised as the core for activities within the implementation process but also problematized. Implementation processes were described as guided by both top-down approaches initiated by governing structures (those responsible for the implementation initiative), and bottom-up approaches, created within services during the implementation. Implementation strategies were both deliberately

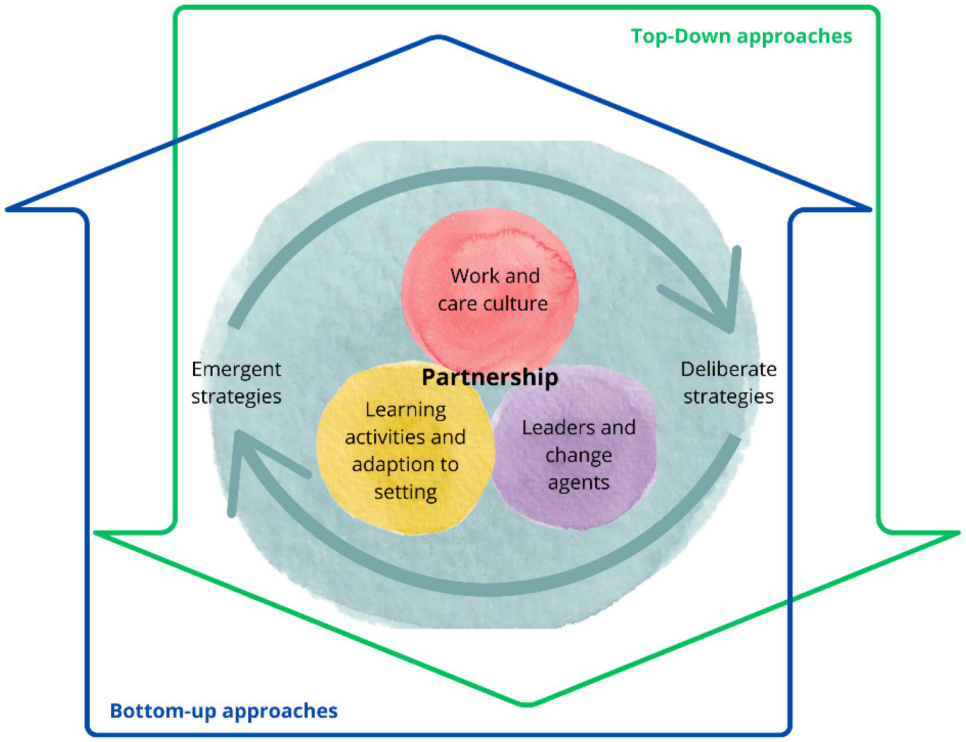

FIGURE 1
Implementation of PCC as an interrelation between person-centred work and care culture, learning and adaptation to the setting, and leaders and change agents. Implementation is further guided by a combination of top-down and bottom-up approaches, as well as deliberate and emergent strategies.

pre-defined and emergent and processual, meaning situationally based strategies that emerge from experiences of practising PCC (17, 32).

> "Acknowledging PCC as a complex intervention that requires emergent strategies from within to normalize the change process" [Naldemirci et al. (32), p.8].

The three categories of implementation strategies, including examples of top-down and bottom-up approaches and deliberate and emergent strategies will be further elaborated on below.

Creating and safeguarding a person-centred work and care culture (prerequisites)

Implementing PCC entails a shift in power and a change in mindset that creates the space, time and opportunity to focus on patient narrative and partnership (31). The implementation of PCC cannot be isolated from the setting in which it is practised, which in turn is influenced by organizational and cultural complexities. Creating a mutual understanding of what a systematized PCC approach entails in a particular setting (including barriers, resources, goals and responsibilities for all included in the team and the organisation) is therefore a prerequisite (17, 27, 37).

> "Increased knowledge of PCC and its philosophical principles and values, contextual factors, structural elements and core practices, is necessary to build a common understanding of the PCC-concept. Such knowledge is essential when PCC is operationalised as part of implementation efforts in health care" [Fridberg et al. (27), p. 13].

Emphasis is on the need to be aware of one's own care and work culture (22) and this can be achieved with the deliberate strategy of using assessment instruments suited to the task (26, 30).

> "It is essential for health managers to be aware of what characterizes their organizational culture before attempting to implement any sort of new healthcare model" [Alharbi et al. (22), p. 300].

It has been shown that change towards PCC is more easily facilitated in a flexible organizational culture (characterized by cohesion and trust) as the resistance to change is low, as compared to a stable and controlled environment (22, 30). Nevertheless, sustainability is more easily achieved in a stable and controlled culture (22). The ideal is a balanced culture, i.e., a culture which can balance opposing cultural characteristics, as

implementation in such a setting would be supported, as well as sustained. A development from a dominance of flexibility and cultural diversity towards increased stability and cultural balance has been seen when implementing PCC within a hospital setting (40). Nevertheless, in a study where a stable and balanced culture was seen after implementing a person-centred intervention, a discrepancy between the current and preferred culture was also reported (23). This result was discussed in terms of the implementation potentially not being systematically applied, and as such, reaching a structurally based change and not a relational change.

Conflicting or divergent views and expectations of PCC are apparent in teams and between professions, thus affecting the implementation of PCC (25, 32, 37, 43). Such divergent views can be seen in the different approaches to person-centred care, i.e., how it is applied among professionals, and may be due to inter-professional hierarchies (32) and differences in logic between the professional groups involved e.g., knowledge-oriented vs. administratively oriented professional logic (37).

A study by Dellenborg (25) revealed that physicians in a medical emergency ward setting lacked involvement in the implementation process and lacked confidence in management leaders. Resistance was also observed in a project for co-designing new patient-education material which employed a participatory design (37, 41). The project involved patients, clinicians, researchers and a designer and involved negotiation of power related to, for example, areas of knowledge and mandate to decide. The process was described as challenging and time-consuming, even if the end result of the project was perceived as beneficial. In addition, associated challenges, such as fatigue from previous implementations, time constraints, rotation of staff and the physical environment, have also been put forward as organizational barriers to implementation of PCC (31, 32).

Deliberate strategies to overcome the aforementioned barriers include initiating teamwork and using research-based evidence to increase motivation for change (32). Related emergent strategies include interprofessional dialogues and reflection on professional boundaries, power structures and hierarchies of knowledge (25). Other examples are the use of leading personalities or 'ambassadors' from the staff group and strengthening teamwork by engaging all expertise in the team (including patients) (32). In addition, strategies for empowering health professionals with less mandate (e.g., nurses in the setting explored) have been trialled to contribute to decision making and developing new practices to safeguard continuity, for example, new staff introduction.

Leaders and change agents (driving force/motor)

Research has emphasised that a stable and committed leadership is important for the implementation of PCC (24, 31, 37). However, for successful implementation, more must be done than simply having the leadership on board in the initial stages of change (37). Efforts must be made to harmonise the endeavour through all structural levels. An example can be taken from one Swedish region, where researchers followed their work towards PCC implementation (26, 27, 29). At the policy level, the region's support strategy involved gaining legitimacy for implementing PCC using a political strategic plan and steering documents and supporting middle managers (29). However, coupling (or connection) between levels of management (politicians, senior management, middle- and frontline managers) was found difficult, which affected the implementation process.

> "Full coupling, i.e., the idealistic outcome of management control, was difficult to achieve because of the fuzziness of definitions, the challenge to achieve a common view of the actual level of person-centredness and consequently the need for further implementation efforts" [Tistad et al. (29), p. 12].

Soft management control to encourage rather than to push for the change was seen in the regional project, meaning, for example, that it was not mandatory for services to participate (26).

Frontline managers have been involved in providing vision and goals for clinical implementation programs (17). This level of leadership was also closely connected to the care and work culture, as expressed by Dellenborg and colleagues (25):

> "Dialogue about priorities is an important feature of good leadership in order to connect implementation and learning to the cultural norms of the clinic's everyday practices" [Dellenborg et al. (25), p. 376].

A common, deliberate implementation strategy connected to leadership was the use of specifically appointed health professionals (change agents) whose role was to support the transition to increased levels of PCC, and to act as role-models (24–27, 36, 37). The selection of these agents was generally described as a task for management teams (which includes people with mandates within the service, such as frontline managers and chief physicians) to strategically select participants representing different layers and roles in the organization or setting (17, 26).

In regard to change agents, one top-down strategy has been to provide incentives for implementation work. For example, in the regional project, funding was assessed to recruit two change agents to lead the change within the complete region, while local leaders in health care units were to be accommodated within the regular budget (26). Participating change agents were offered learning seminars free of charge that included lunch, which could be seen as a form of incentive. Clinical implementation programs have also used incentives in the form of funding extra staff, such as research nurses (32).

Learning activities and adaption to setting (action)

For an implementation program to work, the translation of abstract principles into concrete practices in a specific setting is crucial (31, 32). For the healthcare professionals involved, this

presupposes flexibility and degrees of freedom to influence the design of the working method so that they perceive it as meaningful (17, 26).

Educational implementation strategies that aim at individual and collective learning in teams or entire services are commonly described in PCC implementation (24–27, 34, 36). Deliberate strategies regarding education included the provision of lectures and workshops on PCC ethics and philosophy of the person by researchers and clinicians (17, 26, 32, 37). An example of a top-down approach is that all health care services in a region were invited to participate in a series of learning seminars on PCC. The participating services had to enlist several healthcare professional members, preferably from different professional groups to support the team (26).

Bottom-up and emerging learning approaches are also described and consist of adapted learning activities performed at unit level within a service and involving all healthcare professionals. This can entail lectures and workshops on specific topics relevant to the setting, such as communication disorders (24) or motivational interviewing (26). Learning seminars could include a variety of actors, such as politicians, experts in PCC, patient representatives and health professionals representing other healthcare settings. Continuous informal meetings and small group discussions were also held at the respective services (32).

Further, co-created pedagogical resources adapted to context have been used for training health professionals and health- and social care leaders (35, 42), or for both patients (their family members) and health professionals (37). These resources rest on a person-centred learning approach in which a didactic mix of theory, discussion, reflections, and exercises are used to promote the healthcare providers' learning, training, and implementation of PCC in their respective settings.

> "Educational initiatives on the application of person-centred ethics is an ongoing and collaborative process, characterised by an exchange of ideas and collective efforts" [Lood et al. (42), p. 2].

Challenges arising in the educational strategies and the fact that completion of PCC education is not equal to PCC practice are further related to communicative differences in PCC practice, as exemplified by two PCC intervention studies on patient narratives. In a study by Cederberg et al. (45), audio recorded phone calls disclosed three interactive communication patterns: narrative sequences driven by the patient pushing the health professional to listen and affirm, question-directed sequences guided by health professionals pushing the patient to respond, and narrative sequences collaboratively driven by the patient and the health professional, with communicative space for the patient contributing to the dialogue. This points to the patient's narrative unfolding in the two latter patterns and necessitates taking into account the patient's integrity and respect for what the patient is willing to share. In a study of communicative space, Pettersson et al. (38) disclosed two overarching strategies enacted by nurses: *talking together* with the patient and securing the patient's space to tell, ask and share their assumptions of disease, treatment and care, and *talking to the patient*, implying a type of one-way communication in which dialoguing in a person-centred manner becomes obstructed. Thus, communicative competence characterised by preparedness for the dialogue unfolded in combination with problematising what eliciting the patient's narrative entails. This can be related to PCC as based on capability and partnership. Educational challenges exist in relation to negotiating and sustaining a partnership in PCC implementation. To illustrate, the partnership between patients and health care professionals can be seen as both formal and informal (44). The formal aspect of partnership is grounded in principles of participation, with collaboratively formulated goals and care planning. However, the informal aspect of partnership involves listening and being open to the patient's ways of communicating, their preferences and what matters to them most. Hence, the informal partnership is about closeness and respect from health professionals with clear attention to the patient's ability to recognize their own opportunities and resources in relation to their health and illness. The partnership at work may also entail the negotiation of opposing views between patient and health professionals, requiring a flexible approach to communication and adapting the interaction to each situation and person (46). Another challenge in establishing partnerships is highlighted in an ethnographic study examining PCC in practice on a medical in-patient ward (28). The study observed a tension between educational ideals and the realities of clinical work. Specifically, PCC was often perceived by staff as a series of routines or procedural steps—such as completing a health plan. However, even this seemingly straightforward task proved difficult in practice. For instance, staff struggled with the requirement to document health a plan using the patient's own words, knowing that those words might be misinterpreted by colleagues. This created a professional dilemma, reflecting the complexity of translating person-centred principles into everyday clinical routines. Consequently, partnership requires training in specific skills and can develop independently from explicit governance from policy and guidelines. Importantly and convincingly, partnership is not dependent on physical meetings but can be created and maintained through distance communication (online or over phone) (33, 39). These examples point to the significance of educational PCC implementation strategies, emphasising a foundation in ethics of action.

The specific action to be performed by change agents can vary with the setting and be both deliberate and emerging. The literature describes actions such as interchanging and co-creating the content of implementation programs and capturing patient journeys to understand patient views of care through the system (17). Further, change agents are engaged in developing specific tools for the setting, such as clear protocols, which can help to support and reinforce the adoption of new working practices. Other tasks include developing structured interview guides and patient health plans, as well as handling questions and knowledge from the rest of the staff. The space and mandate to be able to conduct small tests of change is also described as part of the implementation process (17, 26). One concrete example in several projects was for change agents to have lunch with staff members

(preferably outside their profession) and who had not participated in seminars. This enabled knowledge translation and exchange (17, 36).

> "Knowledge translation activities included ward meetings for all staff, group sessions for staff supervised by PCC experts, as well as lunch dates. The latter were working lunches during which a staff member who had taken the PCC course met with two colleagues who had not, in order to facilitate knowledge exchange" [Allerby et al. (36), p. 3].

However, implementing PCC comes with challenges. Documenting the patient narrative has been described as problematic when faced with established systems (28, 31) and an initial increased workload from documentation can also have negative effects (32). Moreover, an increase in person-centred practice, which facilitates a reduction in the length of hospital stay for patients, could mean a burden in terms of increased workload (17). One deliberate strategy discussed is that managers may need to change the patient flow from the emergency room to manage these changed workloads. A different inequity, which also needs to be addressed, arises when services which have adopted person-centred care become more attractive for health professionals to work in. This highlights the importance of change at all levels of a setting, as change in one unit will have effects on the complete service and beyond.

Discussion

This synthesis of PCC research sheds light on the complexity of successfully implementing PCC, which relies on the integration and normalization of person-centred ethics across all levels of healthcare. It requires a commitment to partnership, while actively breaking down barriers such as resistance to change, rigid work cultures, fragmented communication and time constraints. Effective implementation depends on three interrelated areas: establishing sufficient prerequisites for implementation (creating and safeguarding a person-centred work and care culture), engagement of driving forces for implementation (leaders and change agents) and actions for implementation (learning and adaption to setting). Implementation of PCC can be seen as a dynamic process that involves an interplay between top-down and bottom-up approaches, as well as deliberate strategies and emergent practices that evolve through experience.

The included publications used the Gothenburg framework for implementation of PCC which has operationalized Paul Ricœur's action ethics into practically applicable healthcare actions focusing on partnership. Within this framework, the most detailed account is given regarding the micro-level of care, even if the ethical claim encompasses a second- (meso) and third person (macro) perspective as well. This fact could have informed our results which provided the most detailed accounts of strategies within the third category focusing on action for implementation (learning activities and adaptation to setting).

In regard to available implementation frameworks, our results do have parallels with Kotter's (11) eight steps for change management in acknowledging the need for organizational and cultural change in order to implement PCC, as well as the need to mobilize leaders and health professionals to work towards change. However, in contrast to Kotter, our results do not portray PCC implementation as linear in a step-by-step model but represent a dynamic and iterative process in line with current views on the complexity of healthcare implementation (10, 47). The ways in which PCC might entail a paradigm shift to a narrative, in-action engaged care might also be considered a transformative learning process (48) that involves a change from primarily talking *to* the patient, to talking *with* the patient in collaboratively driven narrative sequences (38, 45). Santana et al. (5) assert that creating a PCC culture is key to successful implementation and that this can be achieved through governmental and organisational policies (top down) and shared core values (bottom up), as supported by our results, which also highlight the role of leaders and managers in this process. Supportive care environment and work culture has also been argued as essential to person-centred practice (4). Thus, the use of an organizational values tool to reach an understanding of what characterizes the organizational culture according to those involved might be useful (22, 30, 49).

Other known factors for successful implementation are relative advantage and compatibility with practices and values (50). If involved actors feel that practising PCC "makes sense" and is in line with their values, they support implementation. However, actors within a certain healthcare setting, such as an inter-disciplinary team, may not share practices and values and thus have different understandings of the relative advantage of PCC over practice as usual, as highlighted by the included publications in our synthesis. Some actors might favour economic factors and workload while others are influenced by patient perceptions (47). The logics of healthcare practice might also differ between the groups involved (37). Health professionals need adequate resources to practise PCC (5) and to find relative advantage (50). This actualizes the importance of actors co-creating and agreeing on *shared* goals and values. To arrive at shared goals and understandings, a number of activities can be utilized, e.g., interdisciplinary lunches, as described in the synthesis. Achieving a shared view may be considered a normalisation of person-centred practice. When a practice is normalised, it is so natural and self-evident, it is taken for granted. A practice is normalised when there is coherence, it makes sense, when there is participation and engagement, when there is collective action and reflexive monitoring (51).

One aspect pointed out in the synthesis is the gap between and within practice, governance and management levels within the health care system (Cf. 29), which indicates a need for awareness of and bridging between levels. To achieve this, Martin and colleagues (52) suggest organisations combine an adaptation of practices to policy with contributing practice needs to policy development, therefore labelling this a dual challenge for organisational learning. As seen from our results, practising PCC entails communication and so does the implementation process. For example, there may be preconceived ideas about PCC that hinder implementation, such as that it is too demanding, does

not fit our setting or that our patients do not want it. Thus, communicating and problematising different understandings about PCC can enable reflections and learning within the organisation (53). Further, in an attempt to facilitate the implementation of PCC at all levels within the system, a European standard has been introduced (54). The standard guides the establishment of a minimum level of patient involvement at point-of care, organizational and policy levels, fostering the shift towards PCC. It also includes illustrative case examples from different healthcare settings.

Patients, family carers and public involvement (PPI) align with PCC ethics, as it reinforces the principle that healthcare should be co-created with those it serves (54, 55). PPI ensures that healthcare services are not only clinically effective (56–59) but also align with patients' values, preferences and goals (60, 61). Many examples of emergent bottom-up movements exist e.g., *Nothing about us without us* (62) and *Act up* (63), as well as of proactive engagement in education and training in order to increase credibility and knowledge (64). There are also top-down initiatives, such as patient councils at different governance and management levels (65).

Many PCC intervention studies have involved patients as partners (7). A fact not explicitly described in our synthesis is that patient and family carer representatives can also be seen as change agents. There are real-life examples of change agents being patients working in collaboration (change team) with health care professionals. Patients and family carers could also act as knowledge brokers in the context of PCC implementation, bringing in perspectives and lived experiences that have been missing in traditionally paternalistic health systems. The co-creation between healthcare professionals and patients is also highlighted in major PCC frameworks (6).

The main barriers to PPI appear to be related to practicalities, such as time constraints, specifying roles and expectations, and missing structural mechanisms, e.g., for financial compensation in both research (66) and healthcare (67, 68). To implement PPI, the suggestion is to start easy (for example, invite people to coffee meetings, ask open questions). A shared understanding includes a shared definition and language of PCC, which includes the patient perspective (5). However, this does not mean there needs to be complete agreement within an organisation since the "open-endedness" of person-centred care points towards its richness and is a strength (69). Preserving flexibility in the understanding of PCC serves to accommodate different people, whether they are professionals, patients or informal carers, as well as unique settings.

Methodological discussion and limitations

A strength of this study is the congruence in assumptions, which comes from the inclusion of studies informed by a specific PCC framework and using the same framework in the synthesis process. In this way, similarities in ontological, epistemological and methodological assumptions as related to PCC were achieved, and as highlighted by the discussion above, we argue the results are transferable and applicable to other contexts. However, extensive literature searches, assessment of the methodological quality of the selected studies and linking to additional PCC frameworks would likely refine and further develop the results. Although no structured quality assessment of the included studies was performed, we did critical considerations to identify that foundational research ethics standards were met. Additional publications related to the GPCC framework may be available which were not included. Hence, further research into implementation and knowledge translation of PCC is needed.

Conclusion

This synthesis connects to available implementation research in that it highlights the necessity of knowing and working with care culture, connected leadership at different levels, as well as learning-enabling activities and contextual adaptation to the setting. The need to combine deliberate and emergent strategies, and top-down and bottom-up approaches with co-creation at all levels demonstrates the complexities and iterative and participatory nature of PCC implementation. By illustrating this complexity, as well as providing examples of handling practical issues, this study contributes to deeper insights on PCC implementation.

Author contributions

EF: Writing – original draft, Writing – review & editing. CF: Writing – original draft, Writing – review & editing. SW: Writing – original draft, Writing – review & editing. IB: Writing – original draft, Writing – review & editing. JB: Writing – original draft, Writing – review & editing. FF: Writing – original draft, Writing – review & editing. JÖ: Writing – original draft, Writing – review & editing.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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The author(s) declare that no Generative AI was used in the creation of this manuscript.

Publisher's note

Supplementary material

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Danish translation and cultural adaption of the Person-Centred Practice Inventory-Staff and Person-Centred Practice Inventory-Care questionnaires

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Background: Internationally, person-centred practice is a recognized standard of quality care influencing the experience of care for healthcare professionals, service users, families and care partners. To measure the experience from the perspectives of both caregivers and patients, the instruments Person-Centred Practice Inventory-Staff (PCPI-S) and the Person-Centred Practice Inventory-Care (PCPI-C) have been developed, which are both theoretically aligned with McCormack and McCance's person-centred framework. In this paper, we present translation and cultural adaption of the questionnaires into Danish.
Methods: A model including translation and cultural adaption of both the PCPI-S and the PCPI-C questionnaires was used. The translation and cultural adaption took place from September 2021 to March 2022 and was conducted within the context of a Danish University Hospital.
Results: Six steps were included in the translation and cultural adaption. Discrepancies were addressed and revised by the expert committee until a consensus was reached on a reconciled version.
Conclusion: As person-centred practice is a recognized standard of quality influencing the experience of care for healthcare professionals, service users, families and care partners, it has been important to translate the questionnaires PCPI-S, a measure of staff's perception of person-centred practice, and PCPI-C, a measure of patients' perception of person-centred practice into Danish. Based on this, we now have a Danish instrument that may give the patients a voice by examining to what extent they experience person-centred care in our hospital. This will hopefully support learning and further development of a person-centred culture.

KEYWORDS

translation, person-centred practice, cross-cultural adaptation, person-centred, measurement

Background

The development of person-centred cultures has become a global movement in healthcare that underpins many Western healthcare policy positions and strategic developments (1). Person-centred cultures prioritize the human experience and place compassion, dignity and humanistic caring principles at the centre of planning and decision-making and are translated through relationships that are built on effective interpersonal processes and where the core value of 'respect for the person' is paramount. The concept of person-centredness extends beyond mere individual treatment; it embodies a holistic understanding of individuals within their social contexts. In healthcare, person-centred care prioritizes patients' preferences, needs and values, ensuring that they are active participants in their own care decisions. This approach has been linked to improved health outcomes, patient satisfaction and overall quality of care. Person-centredness is not a unidirectional activity focusing on ensuring that patients have a good care experience at the expense of staff wellbeing. So, whilst many organizations might focus on providing person-centred care, McCormack and McCance (2) articulate the importance of the broader idea of 'person-centred practice' where the focus is on creating cultures that enhance the wellbeing of all persons (including staff). Over the years, numerous frameworks and models have been developed to operationalize person-centred practices across various disciplines, reinforcing its significance as a guiding principle for effective and compassionate service delivery. As the landscape of care continues to evolve, the principles of person-centredness remain integral to fostering respectful and responsive care environments. McCormack and McCance define person-centred practice in healthcare as:

> ….an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development. (2)

Internationally, person-centred practice is a recognized standard of quality care influencing the experience of care for healthcare professionals, service users, families and care partners. One challenge regarding developing person-centred cultures is that there is no universally accepted definition. According to de Salvi (2014), person-centred care is a philosophy that sees patients as equal partners in planning, developing and accessing care to make sure it is most appropriate for their needs (33). Different terms such as 'person-centred', 'patient-centred', 'family-centred', individualized and personalized have been used as subcomponents to unfold person-centred care but often without being defined precisely [33; p. 8]. A systematic review of 60 articles explored the core elements of person-centred care in the health policy, medical and nursing literature, and three core elements were identified: patient participation and involvement, the relationship between the patient and the healthcare professionals and the context where care is delivered [33; p. 9].

In a newly established university hospital in Denmark, the overall vision in the area of nursing (valid from 2020 to 2025) is to place the beliefs and values of service users/patients at the centre of decision-making and thus recommends a person-centred approach to the development of evidence-based practice cultures (4). Thus, several departments decided to implement a person-centred approach guided by 'The Person-Centred Practice Framework' (PCPF) developed by McCormack and McCance (5).

The internationally recognized theoretical framework for person-centeredness provides a detailed exposition of its dimensions and offers guidance on how to implement these dimensions effectively in practice. At its core, the framework emphasizes the importance of establishing a therapeutic relationship between healthcare professionals and individuals, which includes families and care partners. It also emphasizes the importance of staff wellbeing. These relationships are built upon fundamental values such as respect for the individual, the right to self-determination and mutual respect and understanding (5).

The framework is structured around four key domains, including prerequisites, the care environment, person-centred processes and person-centred outcomes, as shown in Figure 1. These domains are positioned within the broader macro context of the healthcare setting, the fifth dimension. The framework asserts that understanding and developing the attributes of healthcare staff are critical prerequisites for effectively managing the care environment. This management, in turn, enables the delivery of effective care through person-centred processes. Ultimately, this sequence is designed to lead to the achievement

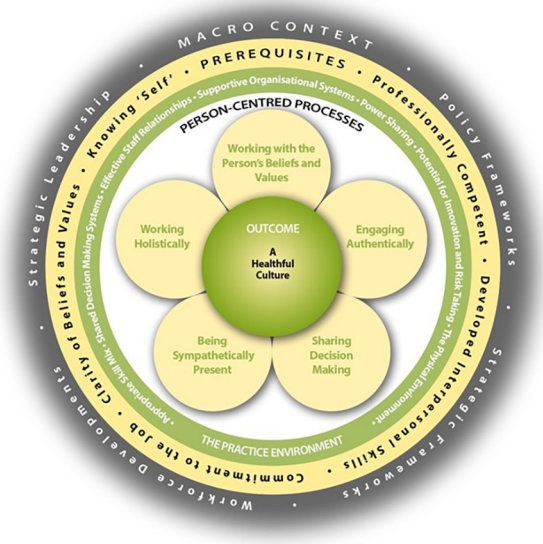

FIGURE 1
Person-Centred Practice Framework (5).

of person-centred outcomes, with the overarching goal being the creation and maintenance of a healthful culture.

The framework has been described as a practical approach to operationalizing person-centredness, acknowledging that whilst the concept is well understood in principle, its application in everyday practice remains challenging. Within the network dedicated to the consolidation of the PCPF, there is an increasing recognition of the complexities involved in implementing person-centred practices (6). These challenges are particularly pronounced for teams working within intricate and multifaceted organizational systems, where adapting the framework to suit specific contexts can be difficult (7). Thus, the framework not only serves as a guide but also highlights the need for continuous adaptation and reflection to effectively integrate person-centred practices into the fabric of healthcare delivery. Such challenges may influence how healthcare professionals can implement the framework into their practice and thereby live out the values of person-centred care.

The use of a framework such as that of the PCPF offers a systematic approach to decision-making in the development of person-centred cultures, and capturing the perspectives of the implementation process and experiences from both professionals and patients is important (8). The instruments Person-Centred Practice Inventory-Staff (PCPI-S) and Person-Centred Practice Inventory-Care (PCPI-C) questionnaires conceptually align with the four key domains and constructs in the Person-Centred Practice Framework (8, 9). Others, such as Vareta et al. (10), have used the PCPI instruments to provide evidence that would inform a starting point for defining strategies to move practice towards person-centredness and for monitoring changes (10). Tiainen et al. (11) showed that newly graduated or less experienced nursing professionals need support to explore person-centredness in their work, thus correlating the length of experience with the ability to provide person-centred care.

A research group at the newly established university hospital in Demark translated the Person-Centred Practice Framework (PCPF) into Danish (4), as well as the two associated instruments PCPI-S and PCPI-C used to measure outcomes, as a first step to implementing the PCPF at the hospital. In this paper, we report the process of translation and face validation of the instruments. Cross-cultural research can be conducted to explore the same questions in several cultures or measure differences across cultures (12).

The Person-Centred Practice Inventory questionnaires

To measure the experience of person-centred practice from the perspectives of both caregivers and patients, two instruments were developed for all healthcare settings. Both instruments align with the theoretical domains of McCormack and McCance's Person-Centred Practice Framework and enable the measurement of the contextual and cultural issues that reflect the development of a healthful workplace culture (5, 13). The constructs within the Person-Centred Practice Framework are illustrated in Table 1.

TABLE 1 The questionnaires PCPI-S and PCPI-C domains and constructs in the Person-Centred Practice Framework.

Domains and constructs of the Person-Centred Practice Framework	PCPI-S questions	PCPI-C questions
The prerequisites of the Person-Centred Practice Framework		
Professionally competent	Q1–Q4	
Developed interpersonal skills	Q5–Q7	
Being committed to job	Q8–Q12	
Knowing self	Q13–Q15	
Clarity of beliefs and values	Q16–Q18	
The care environment of the Person-Centred Practice Framework		
Skill mix	Q19–Q21	
Shared decision-making systems	Q22–QQ25	
Effective staff relationships	Q26–Q28	
Power sharing	Q29–Q32	
Potential for innovation and risk-taking	Q33–Q35	
The physical environment	Q36–Q38	
Supportive organizational systems	Q39–Q43	
The care processes of the Person-Centred Practice Framework		
Working with patients' beliefs and values	Q44–Q47	Q1–Q12–Q7–Q6
Shared decision-making	Q48–Q50	Q3–Q15–Q18–Q10
Engagement	Q51–Q53	Q11–Q16–Q9
Having sympathetic presence	Q54–Q56	Q14–Q5–Q2
Providing holistic care	Q57–Q59	Q13–Q8–Q4–Q17

The instruments are developed in English, and both have been translated and structurally validated to French (14) whilst the PCPI-S also has been translated and culturally adapted to Norwegian, German, Spanish, Portuguese and Malaysian (15–20). The many culturally adapted instruments make it possible to compare the experiences of person-centred practices around the world. A Danish translation will complement the collection of validated questionnaires that document the development of person-centred practice.

Person-Centred Practice Inventory-Staff

The PCPI-S was developed to measure the experience of person-centred practice from the perspective of caregivers, and items were derived from a consensus-based process with experts on person-centredness described by Slater et al. (8). It consists of 59 items covering all constructs in the five domains of the Person-Centred Practice Framework. Each item is presented as a statement and scored on a 5-point-Likert scale ranging from strongly disagree, disagree, neutral, agree to strongly agree. The instrument has been tested for face validity and is psychometrically valid (8).

Person-Centred Practice Inventory-Care

The PCPI-C measures the experience of person-centred care from the perspective of care receivers/patients (9). The PCPI-C consists of 18 items designed as statements covering the construct of the 'care processes' domain of the Person-Centred Practice Framework. Each item is presented as a statement and scored on a 5-point-Likert scale ranging from strongly disagree, disagree, neutral, agree to strongly agree. It has been tested for face validity, and it is a psychometrically valid instrument (9).

Aim

This paper aims to describe the translation into Danish and cultural adaption of the questionnaires PCPI-S, a measure of staff's perception of person-centred practice, and PCPI-C, a measure of patients' perception of person-centred practice.

Method

To translate the PCPI-S and PCPI-C, back translation and cultural adaption methods were used (21, 22). The research group found that only using a forward–backward translation would not be sufficient to capture the complexity of the questions related to the theory of person-centred practice as developed by McCance and McCormack (23, 24). A more profound approach was needed, including a focus on implicit content and cultural adaption. The process was inspired by the principles of classic practice methods in translation and cultural adaption, as laid out by Ortiz-Gutiérrez and Cruz-Avelar (21, 25). At each step of the cultural adaption process, we collected evidence to support the equivalence between the original and the translated version. According to the recommendations, the following roles took part in the process: project manager, two bilingual translators educated as English-language correspondents (one translator had an in-depth understanding of the concept of person-centred practice), three Danish senior researchers, one professor and two English-speaking professors who were part of the development of the instruments. The translation and cultural adaption took place from September 2021 to March 2023 and was conducted within the context of a Danish University Hospital. Six steps were included in the translation process as illustrated in Figure 2. The study was approved by the Danish Data Protection Agency (REG-001-2023). According to Danish law, ethical approval is not required for non-invasive studies, including interview studies.

The steps of the translation process included the following:

- Translation
  - Preparation—initial work carried out before the translation work begins.
  - Forward translation—translation of the source versions of the questionnaires to Danish by two native-speaking translators.
- Synthesis
  - Synthesis—comparing and merging two forward translations into a single forward translation.
- Back translation
  - Back translation—translation of the new Danish language version back into two English versions by two independent translators.

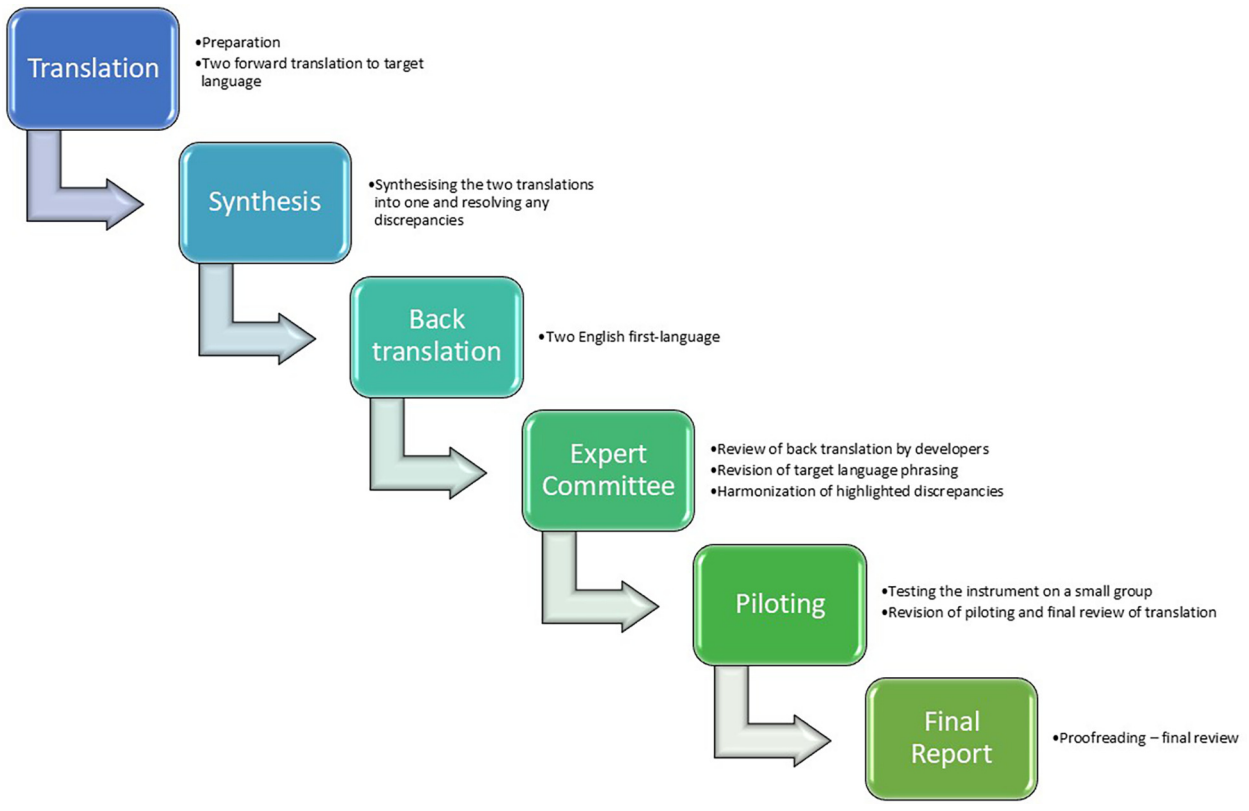

FIGURE 2
The steps of the translation process in a six-stage model.

- Expert committee
  - Review of back translations—comparison of the back-translated English versions of the instrument with the original version. Discussions with developers of the original tool to highlight and investigate discrepancies, which are then revised in the process of resolving the issues.
  - Revision of the target language phrasing.
  - Harmonization—to achieve a consistent approach to translation problems.
- Piloting
  - Piloting—testing the instrument on a small group of relevant patients and healthcare professionals to test alternative wording and to check the understandability, interpretation and cultural relevance of the translation.
  - Review of piloting and completion by the expert committee (26)—comparison of the patients' and healthcare professionals' interpretation of the translation to Danish with the original English version to highlight and amend discrepancies.
- Final report
  - Proofreading—final review of the translation to Danish to highlight and correct any typographic, grammatical or other errors carried out by one of the researchers. Report written at the end of the process documenting the development of each translation.

Results

The translation and cultural adaption were performed according to the recommendations presented by Ortiz-Gutiérrez and Cruz-Avelar (25). The work carried out throughout the recommended steps is now described in detail.

Translation

Preparation

Initial contact with the developers of the PCPI-S and PCPI-C was made, and permission for translation from English into Danish language was obtained. The measurement properties of the original tools were evaluated, and it was assessed that it was reasonable to use a five-step scale to measure person-centredness in a Danish clinical setting. The three Danish senior researchers and the professor agreed that the construct of the PCSI-S and PCSI-C measured culturally similar populations in the development and the target populations in which the adapted version was to be used. The developers confirmed that there were no ambiguities between the two populations and equivalence of concepts. The group assessed the feasibility of the process and agreed on a plan. The instrument developers agreed to be involved in the process.

Forward translation

Two bilingual and native speakers of the target language (Danish) independently translated the tools from English to Danish, thus creating two versions of both the PCSI-S and PCSI-C in the target language.

Synthesis

Synthesis focused on comparing and merging two forward translations into a single forward translation. The three Danish senior researchers, the professor and the two forward translators compared the translations of both the PCSI-S and PCSI-C, discussed them against the English versions and agreed on a reconciled first version of both the PCSI-S and PCSI-C in the target language (Danish).

Back translation

Two native English speakers who also had adequate knowledge of Danish back-translated the first drafts of the Danish version of PCSI-S and PCSI-C into English. The translators were uninformed about the final use of the translations, and new versions of the tools were created in the original language (English). To maintain the concepts of the PCSI-S and PCSI-C, the translations focused on a conceptual translation rather than a more literal back translation. The three Danish senior researchers and the professor discussed and agreed on discrepancies and then merged the two versions into a new English version that was sent to the developers.

Expert committee review

To achieve cross-cultural equivalence, an expert committee was established consisting of the project manager, bilingual translators, three Danish senior researchers, one professor and two English-speaking professors who were part of the development of the instruments. According to Cruchinho et al. (26), this approach is also referred to as *harmonization* (see Figure 2).

Review of back translation

To ensure that the same meaning can be deduced from the new English versions and the original versions of PCSI-S and PCSI-C after the translation is converted to the original language, both versions were assessed by the developers. They pointed to three ambiguities between the original and back-translated English versions. One was simple spelling as they found typos in five questions (PCSI-S questions 36 and 59; PCPI-C questions 7, 9 and 20); one was in relation to the English wording or meaning in the back translation that differed from the original versions (PCSI-S questions 28, 33 and 57) and one was in relation to the conceptual equivalence of the translation. In the PCSI-S question 28, we changed the phrase 'effective relations' to 'good relations' as 'effective relations' has a different meaning in Danish. The typos and the wording were corrected and approved by the developers through e-mail correspondence. The differences in the translations were addressed and discussed first by e-mail with

both developers and secondly by the expert group and one of the developers in person. The main conceptual ambiguity was in relation to the concept 'patient'. The developers avoided the term 'patient' as it is not a person-centred phrase, and not all service users are patients. One developer commented on the use of the term 'user':

> I have a comment on the PCPI-S and the "user/service user" issue. I completely understand the challenges you faced with this and indeed the term "service user" is also challenged here in the UK now and we have also discussed our own challenges with the term as language evolves in our health systems. I struggle with the term "user" as that term has such negative connotations in the English language. I also note that in a couple of items/questions you have used the term "patient". So, I am wondering if the best thing at this point is to use the term "patient" throughout?.

In response to this, the other developer commented:

> I agree that this is very challenging in terms of language. I realise there can be limitations in the wider context with using the term "patient", but it would be my preference over "user".

Taking the developers' comments into account, the review group agreed that the terms 'care recipient', 'service user' or simply 'user' would not be understood appropriately in a Danish setting, and thus the term 'patient' was retained.

Revision of the target language phrasing

Based on the back translation review and the comments from the developers, discrepancies in the Danish version were discussed in the expert committee until a consensus was reached. Based on this version, a revised English version was created by the translator and sent to the developers. The developers accepted this version.

Piloting

Piloting—testing the instrument

The final stage of the adaption was the pretest where the instrument was tested on a small group of relevant patients and healthcare professionals in order to test alternative wording and to check the understandability, interpretation and cultural relevance of the translation. The PCPI-S was tested among 10 nurses from a target setting, who completed the questionnaire followed by an interview to uncover what they thought was meant by each question and the chosen response. In question 28, the wording was adjusted, and the revised question was assessed by all 10 nurses to make sure the meaning was the intention. The PCPI-C was tested among 30 patients also from a target setting. They completed the questionnaire and were interviewed afterwards. This revealed that questions 4, 7 and 17 needed revisions to make sure they were understood as intended in the English version. The questions were revised and tested again among 30 patients.

Review of piloting and completion

The review group went through the corrected wording to check the understanding, interpretation and cultural relevance of the translation. Only a few grammatical revisions were made.

Final report

Proofreading

To correct typographic, grammatical or other errors, the final versions of the instrument were proofread by the project manager.

A detailed report describing the translation process of actions taken in each step was written. We highlighted how the tasks were approached and how possible discrepancies were detected. We explained changes made and how quality was monitored to produce the cultural adaption.

Discussion

This paper aims to describe the Danish translation and cultural adaption of the PCPI-S, a measure of the perception of staff's person-centred practice, and PCPI-C, a measure of patients' perceptions of person-centred practice. Translating an instrument into a second language is not a linear process of merely finding the exact, corresponding word. There are inherent risks with translation, because it may mean that parts of the original instrument are subtly altered, resulting in a version which measures something else than the original (27). Moreover, cross-cultural validation of an instrument is a complex and time-consuming process. Nevertheless, it is important to systematically document the method used to clarify specific risks of bias that could affect the research process and results (16, 26).

Many guidelines exist for translating and culturally adapting instruments (21, 26). However, as the goal of the study has been to achieve equivalence between two languages, we have chosen a model that is well described and builds on the classic method of translation, back translation and using an expert committee as key points to discuss the potential identified discrepancies in translations (25). The chosen approach ensures that a translated measurement tool uses language in the way it is understood culturally that is different from the original setting, yet does not lose its measurement properties (25–27). The benefit of traditional back translation is the possibility of holding the original language as a desired standard and as part of the translation process compared with the translated text with the objective of ensuring the interpretation is as close to the original language as possible (28). Back translation alone, however, may introduce false discrepancies and hence lead to inefficient use of time and effort due to the risk of mainly focusing on semantic equivalence—e.g., ensuring that the translation of items semantically matches the items in the 'original version' and not conceptual equivalence (29).

Herdman et al. (29) describe conceptual equivalence as the type of equivalence that verifies which domains, and their inter-relations, are important in the 'target culture' (e.g., the language being translated into) for the concept of interest evaluated by the instrument. In this study, the core concept of interest is 'person-centred practice' (PCP), as it is the concept that is measured using respectively PCPI-S and PCPI-C instruments. The PCP concept is well described in English (1) as well as in a Danish article (4). However, there may still exist a lack of clarity on how to use and understand the concept, especially in the target culture. For instance, the current study pinpoints how the English word *person*—as it is used in person-centred practice—during the translation process turned out to be difficult to translate into a Danish culture, as the Danish word *person* is unusual to be used in a health-related connection. The terms *patient* and *user* are more often used, but the review committee was unsure if the two words sufficiently covered the perception of the chosen English word *person*. An expert committee was used as part of the cultural validation, in which two developers of the original English version of the measurement took part. This opened a unique opportunity to discuss the conceptual unclarity of the choice of the most appropriate Danish terms. According to the translation and cultural adaption group (22), the inclusion of the instrument developers is one of the most important components of the cross-cultural adaption process, but one that most of the existing guidelines have not specifically addressed. The statement underscores, why we in the current study have placed great emphasis on this part of the cross-cultural adaption process.

After obtaining consensus among all experts, including two bilingual linguistics who ensured idiomatic and semantic equivalence, a pilot testing—similar to pretesting—was conducted. This involved the testing of the two measurements as recommended on a small number of healthcare professionals (PCPI-S) and patients (PCPI-C) (25, 30) (see Figure 1). Carrying out a pretest provides the identification of problems that may affect the reliability and validity of the translated version of the measurements, namely, related to the clarity and relevance of the core items, which in this context is the PCP concept. Furthermore, the pretesting gives the researchers the opportunity to consult the documentation of the previous steps and, if needed, to exclude semantic equivalence problems to replace or eliminate items from the measurements (26). Regarding the current study, only minor semantic equivalence problems were identified and subsequently revised by the expert committee. The Danish translations of the PCPI-S and the PCPI-C have been used to evaluate an action research study focusing on the development of a person-centred culture in a university hospital (31). The questionnaires were well received by both patients and nurses and results show that both patients and nurses experience care as person-centred (31).

Limitations

Based on 42 guidelines on translation, adaption or cross-cultural validation of measurement instruments, Crunchinho et al. (26) suggest that the data obtained during the pretest can be submitted to a statistical analysis regarding the consistency and accuracy of the degree of agreement between reviewers. One opportunity is using a content validity index (CVI) to identify the content validity of the adapted version of the measurement. CVI is suitable for dichotomous answers but can also be used for Likert-type multiple-choice response formats by recoding the answers. Polit et al. (32) describe how using CVI instead of alternative indexes has advantages with regard to ease of computation, understandability, focus on agreement of relevance rather than consistency, and provision of both item and scale information. At the same time, it is from more sources underscored that using CVI may cause failure to adjust for chance agreement (32)—e.g., an issue of concern in evaluating indexes of inter-rater agreement, why the researchers should ensure that such procedures do not compromise the construct coverage of the original instrument. Based on that criticism, the researchers decided not to apply the use of CVI in the current study and instead highlight the use of the expert committee—including the two developers of the original version of the instruments (26). This ensured that the Danish translations were semantically consistent with the original questionnaires. In addition, the Norwegian language is closely related to Danish and a Norwegian study by Bing-Jonsson et al. (16) performed a psychometric evaluation comparing the Norwegian version with the original version of PCPI-S and found that the psychometric properties were acceptable (16).

Conclusion

As person-centred practice is a recognized standard of quality influencing the experience of care for healthcare professionals, service users, families and care partners, it has been important to conduct the translation into Danish and cultural adapt the questionnaires PCPI-S, a measure of staff's perception of person-centred practice, and PCPI-C, a measure of patients' perception of person-centred practice. Using an internationally accepted approach to translation and cultural adaption, and between the original and back-translated English versions, several ambiguities were found. The main conceptual ambiguity was related to the concept 'patient'. An Expert Committee consisting of the researchers and two developers of the original English version discussed the discrepancies and conducted a harmonization process, followed by a pilot testing of the translated instrument. The pilot testing highlighted other ambiguities, which were discussed and revised by the expert committee. The revised Danish version was retested. Only a few grammatical revisions were made, and a detailed report describing the translation process of actions taken in each step completed the translation and cultural adaption process. Based on this, we now have a Danish instrument that gives the patients a voice by examining to what extent they experience person-centred care in our hospital. This will hopefully support learning and further development of a person-centred culture.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Author contributions

ER: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Validation, Writing – original draft, Writing – review & editing. MK: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing – review & editing. BH-H: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing – review & editing. TM: Formal analysis, Supervision, Validation, Writing – review & editing. BM: Formal analysis, Supervision, Validation, Writing – review & editing. TT: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Validation, Writing – original draft, Writing – review & editing.

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The interplay of leadership dynamics and person-centred practice in nursing homes: a mixed methods systematic review

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Background: Implementing a person-centered approach in nursing homes can significantly improve patient satisfaction and care quality while also enhancing job satisfaction among healthcare staff. Leaders play a pivotal role in establishing and nurturing a culture that supports person-centered practices. While there is some empirical evidence, a more comprehensive understanding of how leaders effectively foster and sustain person-centered practices in nursing homes is needed.
Aim: To investigate the role of leaders in fostering person-centeredness within nursing homes.
Methods: The study is based on the PRISMA reporting guidelines. Comprehensive searches were performed in CINAHL and PubMed, with article screening and selection facilitated by Rayyan software. A convergent integrated approach from the Joanna Briggs Institute (JBI) was used to synthesize findings from both qualitative and quantitative studies.
Results: The review included ten studies, comprising six qualitative and four quantitative studies. The results indicate that leadership in nursing homes that fosters person-centeredness involves creating and communicating a shared vision, empowering staff, and ensuring systematic and consistent approaches. Additionally, leaders must embody person-centered values through role modeling.
Conclusions: This systematic review highlights the critical role of leadership in fostering and sustaining person-centered practices in nursing homes. Leaders carry a substantial burden of responsibility. The results suggest that a shift towards a more integrated leadership approach, incorporating both distributed and person-centered leadership models, could promote a more sustainable and supportive environment for both leaders and staff, ultimately enhancing the quality of care. These insights provide valuable guidance for nursing home leaders and policymakers aiming to strengthen person-centered practice.

KEYWORDS

attitudes, empowerment, leadership, management, nursing homes, older people, person-centered, role modeling

1 Introduction

In nursing homes, a significant majority of residents are frail and vulnerable and cope with multiple health conditions (1). For this study, the term "nursing home" refers to residential care facilities that provide long-term care for individuals who are unable to live independently due to physical or cognitive limitations. These facilities offer a range of services, including assistance with activities of daily living, medical care, and rehabilitation. In some countries, such facilities may be referred to by other terms, such as "care homes," "residential care facilities," or "assisted living," depending on the context and specific services provided.

Despite continuous efforts to improve care quality in nursing homes, a concerning number of residents still face poor care experiences (2). Rosemond et al. (3) suggest that adopting a person-centered approach, which emphasizes residents' relationships, life histories, abilities, and preferences, can be a transformative step in nursing home care. Person-centeredness is often hailed as the "gold standard" of care (4) and has become a cornerstone of healthcare, aiming for high-quality service (5, 6). Person-centeredness can be defined as follows:

> "An approach to practice established through the formation and fostering of healthful relationships between all care providers, care receivers, and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual right to self-determination, mutual respect, and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development." (5, p. 3)

We have chosen to adopt McCormack and McCance's (5) definition of person-centeredness, as it is recognized as a well-established mid-range theory with a solid empirical foundation (5). This definition is widely applied in academic research and practical implementations of person-centered practice (7–9), making it particularly relevant to our study.

The emphasis on person-centeredness represents a shift towards inclusivity and equality in the professional-patient relationship, aiming to address each person's unique needs. McCormack and Skatvedt (10) outlined four fundamental principles of person-centered practice: treating each person as a unique individual, respecting their rights, establishing mutual trust and understanding, and nurturing collaborative relationships. Person-centered practice encompasses the intricate nature of nursing and the broader healthcare context, emphasizing the significance of all individuals within the healthcare environment. Person-centered practice shifts from the dominant practice focus on "doing" to one of "being", emphasizing the role of individuals working in healthcare and the significance of relationships with others (11). Person-centered care (PCC) is widely acknowledged as essential for ensuring both the quality of care and quality of life in long-term care settings (12). Research indicates that PCC leads to improved patient outcomes, more efficient resource utilization, reduced costs, and heightened satisfaction among both patients and staff (13). However, person-centered interactions can be challenging as nursing home routines sometimes take precedence over individual needs (8).

Leadership in nursing homes plays a crucial role in shaping staff interactions, the work environment, and the quality of resident care (14–16). Nursing home leaders also play a vital role in ensuring residents receive PCC (15). Over time, various leadership styles have emerged, including distributed, transactional, laissez-faire, transformational, and situational (16). While relational and transformative leadership styles have been identified as the most effective in nursing homes (14), research indicates that passive-avoidant leadership remains the most prevalent (17). Often considered a subtype of laissez-faire leadership, passive-avoidant leadership is marked by disengagement from both tasks and personnel, neglect of staff needs, and inaction in the face of emerging issues. It is frequently described as an absence of active or effective leadership (18) and has been linked to reduced satisfaction with leadership, increased incidence of workplace bullying, and higher levels of absenteeism (19). This leadership style may contribute to a disengaged work culture in which staff feel unsupported, ultimately compromising the delivery of PCC and negatively affecting the well-being of both residents and employees. Given the complex and relational demands of nursing home environments, these outcomes underscore the urgent need to adopt leadership models that are proactive, engaged, and aligned with person-centered values.

In recent years, there has been a growing interest in leadership approaches grounded in person-centered values (20, 21). One such approach is person-centered leadership, described by Eide and Cardiff (22) as "leadership supporting, creating, and securing person-centered values and practices" (p. 96). While closely aligned with the values underpinning the Person-Centered Practice Framework (5), person-centered leadership is not formally included in the framework but offers a complementary perspective on how leadership can foster a person-centered culture in healthcare organizations.

Much of the existing research has focused on associations between specific leadership styles and care outcomes. However, recent studies have underscored the need to consider both leadership behaviors and styles when evaluating the quality of care in nursing homes (23, 24), highlighting the importance of leadership approaches that are collaborative, value-driven, and relational in nature.

One such approach is distributed leadership, which has gained increasing relevance in healthcare settings, particularly where complex care processes require shared and relational leadership practices. Unlike traditional models centered on a single leader, distributed leadership involves the collective enactment of leadership tasks across multiple actors. Leadership is understood not as the responsibility of one person, but as a set of behaviors and interactions embedded within everyday relationships (25, 26). By enabling joint responsibility and shared decision-making, distributed leadership supports core person-centered principles such as empowerment, cooperation, and mutual respect. Evidence from a systematic review indicates that distributed

leadership can enhance organizational performance (27), suggesting that this model may also contribute to the development of person-centered cultures in nursing homes.

The management of nursing homes requires systems and processes for planning, implementing, evaluating, and adjusting healthcare delivery in line with national laws and guidelines (28, 29). While these systems demand efficiency and compliance, leaders must also foster principles of compassion, individual attention, and relationship-building. Leadership, particularly when supported through facilitation, plays a vital role in strengthening team collaboration and refining person-centered strategies (20). More broadly, leaders carry both the opportunity and responsibility to shape, nurture, and sustain the cultural ethos of their organizations (30, 31).

However, transitioning to a person-centered approach in nursing homes represents a complex and far-reaching organizational shift (3). Despite growing interest in leadership approaches aligned with person-centered values, there remains limited guidance on how to educate and support leaders in this transformation (21). To date, no systematic review has examined the nuanced leadership dynamics that underpin the facilitation of person-centered practice in nursing homes.

2 Methods

This systematic review was conducted to investigate the role of leaders in fostering person-centeredness in nursing homes. The review specifically addressed the following research question:

> What are the underlying leadership dynamics that facilitate person-centered practice in nursing homes?

Leaders are defined as individuals holding formal leadership roles in nursing homes, such as nursing home managers and head nurses.

The Joanna Briggs Institute (JBI) Manual for Evidence Synthesis guided the conduct and synthesis of this review (32). The *a priori* protocol was registered in PROSPERO, with the registration number CRD42022366678.

2.1 Search strategy

Systematic searches were conducted in the databases CINAHL and PubMed. A specialist librarian was consulted during the development of the search strategy and carried out the searches to ensure rigor. Keywords and MeSH terms were used in various combinations with Boolean operators. The search included terms related to:

- Leadership (e.g., leader*, situational leadership, attitude of health personnel, staff attitude)
- Person-centred care (e.g., person-cent* care, personhood, individualized care, patient-centered care, personalized care, person-directed care planning, person-centred practice framework)
- Care settings (e.g., nursing home*, long-term care, residential facilities, homes for the aged, municipal home*, assisted living)
- Implementation and organizational context (e.g., implementation, culture change, quality improvement, organizational change, innovation, experience*, perspective*, framework)

Full details of the search terms and search strings for each database are provided in Supplementary Material S1.

The study adheres to the PRISMA guidelines for systematic review (33). The inclusion and exclusion criteria are presented in Table 1.

The year 2012 was selected as the starting point for the review because healthcare systems have undergone substantial changes over recent decades (34). Studies across diverse healthcare systems with different financial systems are included in this review, as the focus is on leadership dynamics that facilitate the adoption and maintenance of person-centered practice, independent of health policy structures or cultural contexts. We did not restrict inclusion to studies using a specific theoretical framework (e.g., McCormack and McCance's Person-centred Practice Framework). However, studies were only included if they explicitly referred to person-centeredness. Figure 1 presents the PRISMA flow diagram of the study selection process.

2.2 Quality assessment of the studies

The quality of the included articles was assessed by two authors (ACLL and CB) using the appropriate JBI Critical Appraisal Tool based on the study design: (i) JBI Critical Appraisal Checklist for Qualitative Research or (ii) JBI Critical Appraisal Checklist for analytical cross-sectional studies. Each author conducted assessments independently and then compared their results. Minor disagreements arose but were resolved through discussion until consensus was achieved. No established parameters exist for weighting qualitative studies (35). In this review, all criteria were deemed of equal importance. A study was classified as high quality if it achieved a score above 70%, moderate quality if it

TABLE 1 Inclusion/exclusion criteria.

Inclusion criteria	Exclusion criteria
Peer-reviewed articles	Studies in languages other than English or a Scandinavian language
Studies published between 2012 and 2022	Conference abstracts
Presented data related to how leaders in nursing homes engage in person-centered processes	Review articles
Studies using qualitative/quantitative/ mixed methods	Thesis
Reported primary research	Comments
Leader and staff perspectives	Editorials
	Books
	Protocols

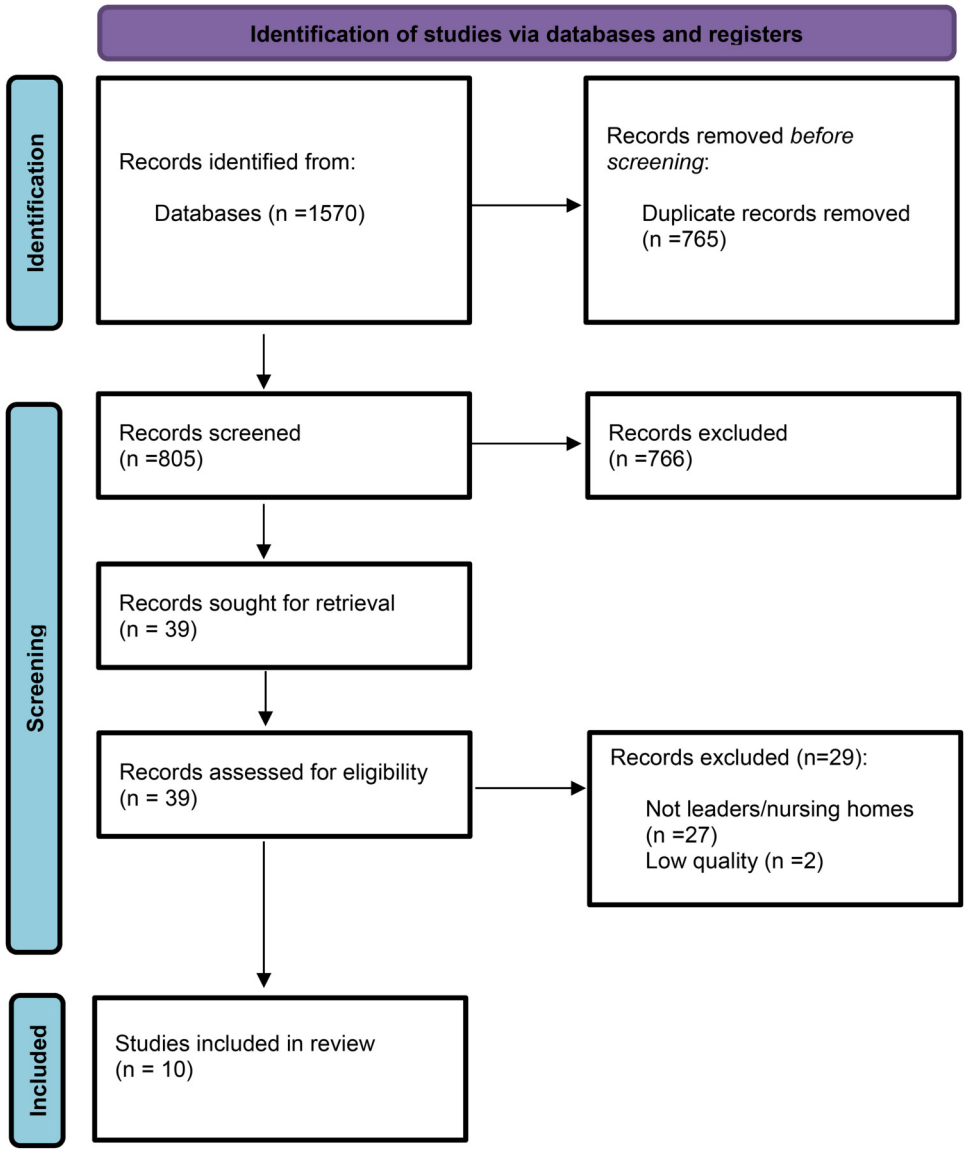

FIGURE 1
PRISMA 2020 flow diagram for new systematic reviews (33).

TABLE 2 Schematic overview of the synthesis process using JBI's convergent integrated approach (37).

Step	Description
Step 1	Compilation of qualitative findings (authors' themes, subthemes, and supporting quotations) and qualitized quantitative data.
Step 2	Inductive analysis of the extracted data to develop descriptive categories based on similarity in meaning, involving initial independent coding and discussion.
Step 3	Interpretive synthesis of the categories into overarching synthesized findings through collaborative analysis, ensuring integration across data sources.

scored between 50% and 70%, and low quality if it scored below 50%, as outlined by Dijkshoorn et al. (36). Only high and moderate-quality studies were included in the final synthesis. Two studies were excluded due to insufficient quality.

2.3 Data extraction

The JBI QARI data extraction form for interpretive and critical research (32) served as our tool for data extraction, as outlined in Table 3. Data extraction was conducted for both qualitative and quantitative studies (32, 37). From qualitative studies, we extracted the authors' interpreted findings, such as thematic categories or subthemes, along with supporting interpretations and illustrations. For quantitative studies, we followed the approach described by Lizarondo et al. (37), in which narrative descriptions of results reported by the study authors are extracted and, where appropriate, rephrased or condensed to ensure clarity and relevance to the review objective. This allowed us to integrate quantitative data with qualitative findings by transforming them into textual representations, a process known

TABLE 3 JBI QARI data extraction form for interpretive and critical research.

Study (Ref. number) | Country	Design and method	Study aim	Sample description and setting	Relevant findings
Backman et al. (39) Sweden	A cross-sectional design using valid and reliable questionnaires. Data were analyzed using multiple linear regression, including interaction terms.	To explore the association between leadership behaviors among managers in aged care, and person-centeredness of care and the psychosocial climate.	3,661 staff members in residential aged care facilities in Sweden.	Leadership behavior significantly impacts person-centeredness practice and influences the psychosocial climate. Leadership is most needed in units that are less person-centered, suggesting managers need to lead the way more strongly toward excellence in environments where care is less person-centered. Managers have an important role in promoting, developing, and supporting a PCC philosophy and practice of care.
Backman et al. (40) Sweden	A descriptive interview study with semi-structured interviews.	To explore how managers describe leading towards person-centered care in nursing homes.	Twelve nursing home managers within eleven highly person-centered nursing homes purposively selected from a nationwide survey of nursing homes in Sweden.	Leading towards person-centered care was described as having a personal understanding of the PCC concept and how to translate it into practice and maximising the potential of and providing support to care staff, within a trustful and innovative workplace. Managers coordinate several aspects of care simultaneously, such as facilitating, evaluating, and refining the translation of person-centered philosophy into synchronized care actions. To lead PCC, managers may need to be present at the unit.
Backman (41) Sweden	A national, cross-sectional survey. Descriptive statistics and regression modeling were used to explore associations.	To explore the relationship between leadership, person-centered care, and stress of conscience.	2,985 staff members and their managers from 190 nursing homes throughout Sweden.	Leadership was associated with a higher degree of PCC, indicating that a leadership most prominently characterized by coaching and giving feedback, relying on staff and handling conflicts constructively, experimenting with new ideas, and controlling work individually can contribute to a higher degree of PCC provision. Managers play a crucial leadership role in motivating and empowering staff to deliver PCC.
Duan et al. (42) USA	A cross-sectional design using an online survey.	To (1) test the domain-specific relationships of culture change practices with resident quality of life and family satisfaction, and (2) examine the moderating effect of small-home or household models on these relationships.	102 nursing home administrators in the USA.	Changing restrictive institutions to person-centered homes, referred to as NH culture change, is complex and multifaceted. The findings revealed that culture change operationalized through physical environment transformation, staff empowerment, staff leadership, and end-of-life care was positively associated with at least one domain of resident quality of life and family satisfaction, while staff empowerment had the most extensive effects.
Hamiduzz-aman et al. (43) Australia	Qualitative semi-structured interviews and focus-group interviews.	To explore the factors that shape the dimensions of personalized dementia care in rural nursing homes.	104 Australian care staff participated in interviews and/or focus groups.	The issues of leadership and workplace culture are of importance in the implementation of personalized care in residential dementia care. An authoritative leadership style discourages staff to implement personalized care and to be innovative in dementia care. A lack of consideration of family members' views by management and staff, together with a poorly integrated, holistic care plan, limited resources, and absence of ongoing education for staff, resulted in the ineffective implementation of personalized dementia care.
Jacobsen et al. (44) Norway	A mixed-method study.	To investigate which factors hindered or facilitated staff awareness related to confidence-building initiatives based on PCC.	299 Norwegian staff members responded to the staff survey at baseline and 228 at follow-up.	The results indicated a development toward more PCC being performed compared to the situation before the education intervention. The involvement of leaders appeared to be a key issue in facilitating successful implementation. Leadership, in interplay with staff culture, was the most important factor hindering or promoting staff awareness related to confidence-building initiatives, based on PCC.

(*Continued*)

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TABLE 3 Continued

Study (Ref. number) | Country	Design and method	Study aim	Sample description and setting	Relevant findings
Lynch et al. (45) Ireland	Qualitative approach using a complex action research design with multiple methods: non-participatory observation, critical and reflective dialogues with participants, narratives from residents, focus groups with staff, and reflective field notes	To implement and evaluate the effect of using the PCSLF to develop PCC within nursing homes.	Observation: 11 sessions, Household activity ($n = 4$): 1 leader, 3 staff. Meal times ($n = 6$): 2 leaders, 4 staff. Meal times ($n = 2$): 1 leader, 1 staff. Meaningful interactions ($n = 5$): 1 leader, 4 staff. Leadership behavior ($n = 7$): 7 leaders (across 3 sessions). Connecting with residents ($n = 5$): 1 leader, 4 staff. Team meetings ($n = 22$): 6 leaders, 16 staff (across 2 meetings). Leadership meeting ($n = 6$): 6 leaders. Residents' Narratives: Convenience sampling at two time points ($n = 8$). 4 residents at time 1, 4 different residents at time 2. Focus Groups (Leaders): Time 2 ($n = 6$): All 6 nursing home leaders. Focus Groups (Staff): Purposive sampling ($n = 6$). 2 staff from each of 3 households (1 nurse, 1 carer per household). All from a private nursing home in Ireland.	Seven core attributes of the leader that facilitate person-centeredness in others were identified relating to the essence of being; harmonising actions with the vision; balancing concern for compliance with concern for person-centeredness; connecting with the other person in the instant; intentionally enthusing the other person to act; listening to the other person with the heart; and unifying through collaboration, appreciation and trust.
Rokstad et al. (46) Norway	Qualitative descriptive design. Focus-group interviews.	To investigate the role of leadership in the implementation of PCC in nursing homes using Dementia Care Mapping.	18 staff members and 7 leaders from 3 different nursing homes in Norway.	The different roles of leadership characterized as "highly professional", "market orientated" or "traditional", seemed to influence to what extent the Dementia Care Mapping process led to the successful implementation of PCC.
Røen et al. (47) Norway	Cross-sectional survey.	To explore and understand the association between PCC, and organizational, staff, and unit characteristics in nursing homes.	1,161 Norwegian staff members from 175 nursing homes.	"Empowering leadership" is associated with PCC. Empowering leadership is a managerial style supporting and encouraging the caregivers to take the initiative and to participate in decisions regarding daily care. An innovative climate was associated with PCC.
Røsvik & Mjørud (48) Norway	Qualitative individual interviews.	To explore managers' and leaders' experiences to identify factors that facilitate or impede implementation and use of the VIPS practice model in domestic nursing care and long-term care institutions.	17 managers/head nurses representing 10 workplaces in Norway.	Three global categories described the implementation process: factors that impact the decision made at the municipal level to implement PCC, which highlights the decision-making process before the implementation in the unit; requirements for a good start at the unit level, that is leadership commitment, stability among the staff group and staff training; and finally, factors that help to support the new routines in the unit, such as a determined head nurse, leaders who establish structure, mastery, and positive results and supervising the staff.

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as qualitization (37). Data extraction was initially conducted by the first author (CAH) and subsequently reviewed by co-authors LBO and IF to ensure accuracy and consistency. No disagreements arose that required further resolution.

2.4 Data synthesis

JBI's convergent integrated synthesis approach (32, 37) was used to synthesize data from the included primary studies. The synthesis process is summarized in Table 2, which provides a schematic overview of how the JBI convergent integrated approach was applied. The table outlines the steps from compiling primary data to generating synthesized findings.

Thematic categories were developed through an inductive analysis of the extracted data, which included authors' interpretive themes, subthemes, and supporting quotations from qualitative studies, as well as qualitized narrative findings from quantitative studies. During the process, findings were grouped based on similarity in meaning, with attention to recurring concepts, language, and underlying assumptions about leadership and person-centeredness. Contrasting perspectives were also explored to ensure a nuanced interpretation. Initial coding and categorization were performed independently by three reviewers (CAH, IF, LBO), followed by collaborative discussion to refine and consolidate categories.

Subsequently, one researcher (CAH) led the synthesis process by analyzing the descriptive categories for overarching patterns and integrating them into synthesized findings. This interpretive synthesis was carried out in ongoing dialogue with the co-authors (IF and LBO), ensuring that the final themes were grounded in the evidence and represented both convergence and variation across included studies.

3 Results

3.1 Study selection

The search yielded 1,570 potentially relevant papers. The papers were imported into EndNote software and subsequently transferred to Rayyan (38) for deduplication. Five members of the review author team independently screened the studies by title and abstract (CAH, LBO, LH, AKH, IF). For a paper to be considered relevant, it needed to include the terms "management" and "nursing home," or their synonyms, in the text, in addition to adhering to the inclusion and exclusion criteria. The reviewers then divided into two groups and compared their results, identifying 39 articles. In the following screening phase, the five review authors independently assessed the full text of the 38 articles for final inclusion. Any discrepancies in selection during the review process were resolved through discussion.

The final sample comprised ten studies: six qualitative and four quantitative (Figure 1). Four of the studies were conducted in Norway, three in Sweden, one in Australia, one in Ireland, and one in the USA. Perspectives from both formal leaders (nursing home managers and head nurses) and non-managerial staff (e.g., registered nurses, enrolled nurses, and nursing assistants) were represented. The quality assessment of the included studies is presented in Table 4.

3.2 Result of data synthesis

The data synthesis led to three synthesized findings: (i) Visionary leadership and empowerment; (ii) Consistent and systematic approach for person-centered outcomes; and (iii) Leadership through role modeling. These findings were arrived at through the use of the JBI's convergent integrated synthesis approach, as described earlier (32). Table 5 presents the results of the data synthesis following the convergent integrated approach (37), in which findings from included studies were grouped into thematic categories and further integrated into three overarching synthesized findings. The structure aims to illustrate how multiple qualitative findings were converged through interpretive analysis into higher-order syntheses, supported by excerpts from the primary studies.

3.3 Visionary leadership and empowerment

The results in this synthesized finding highlight how the leaders had clear and shared visions for person-centered practice

TABLE 4 Result of the quality assessment of the included studies.

3A.) JBI critical appraisal checklist for qualitative studies		
Study	Criteria[a] 1 2 3 4 5 6 7 8 9 10	Total/10
Backmann et al. (40)	+ + + + + − − + + +	8/10
Hamiduzzaman et al. (43)	+ + + + + − − + + +	8/10
Jacobsen et al. (44)	+ + + + + − + + + +	9/10
Lynch et al. (45)	+ + + + + − − + + +	8/10
Rokstad et al. (46)	+ + + + + + + − + −	8/10
Røsvik &Mjørud (48)	+ + + + + − − + + +	8/10

[a](1) Congruity between stated philosophical perspective and the research methodology. (2) Congruity between research methodology and research question. (3) Congruity between research methodology and methods for collecting data. (4) Congruity between research methodology and the representation of the analysis. (5). Congruity between research methodology and the interpretation of results. (6) Statement locating the researcher culturally or theoretically. (7) Influence of the researcher on the research and vice-versa addressed (8). Participants and their voices adequately represented (9). Is the research ethical according to current criteria or, evidence of ethical approval by an appropriate body. (10) The conclusion drawn from the analysis or interpretation of the data.

3B.) JBI critical appraisal checklist for analytical cross-sectional studies		
Study	Criteria[a] 1 2 3 4 5 6 7 8	Total/8
Backman et al. (41)	− + + + + + + +	7/8
Backman et al. (39)	+ + + + + + + +	8/8
Duan et al. (42)	+ + + + + + + +	8/8
Røen et al. (47)	+ + + + + + + +	8/8

[a](1) Inclusion criteria clearly defined. (2) Study subjects and setting described in detail. (3) Exposure measured in a valid and reliable way. (4) Objective, standard criteria used for measurement of the condition. (5) Confounding factors identified. (6) Strategies to deal with confounding factors stated. (7) Outcomes measured in a valid and reliable way. (8) Appropriate statistical analysis used.

Table 5 Results

Synthesized finding	Visionary leadership and empowerment	Consistent and systematic approach for person-centered outcomes	Leadership through role modeling
Category	• Importance of clear visions and values • Empowering and enhancing staff performance	• Capability to organize and establish structure systematically • Continuous focus on person-centered outcomes	• Actively participating in care provision • Promoting a safe, supportive environment with a culture of continuous growth
Findings (Excerpts from included studies)[1]	The findings underline the need for a clear and coherent vision to obtain professional development and person-centered dementia care. Transformational and situational leadership, along with a clear vision defining PCC, seemed to be vital for successfully implementing PCC. Leaders have a central role in drawing up a clear and consistent professional vision. The leadership seemed to influence the nursing staff's experiences of empowerment and their ability to put the idea of PCC into action to meet the patients' needs. Encouraging the staff as a group to be actively involved and take shared responsibility for the residents' care is crucial, as demonstrated at the 'highly professional' nursing home. The staff felt empowered and trusted to make their own decisions in their daily care practice (46). The leaders described having a personal understanding and knowledge of the principles of PCC. The leaders described having a clear vision of what they wanted PCC to be, and how to integrate their vision into practice. Most managers described that talking about what person-centered care is and what it is not and having full focus on the care of the resident, was important. The managers worked actively to concretize the person-centered philosophy and to operationalize this in practice. The person-centered vision was made explicitly exemplifying and verbalising important concepts of PCC. The leaders encouraged the staff to adopt a reflective mindset. Value based issues and dilemmas were solved by turning the focus back to the resident (40). Higher levels of PCC was associated with empowering leadership, among other factors. An innovative climate was associated with PCC, describing this as taking the initiative and encouraging staff to find alternative ways to do things. The finding in the present study shows that especially "empowering leadership" is associated with PCC (47). The result of this study also empirically supports the theory of person-centered nursing confirming that leadership is a prerequisite for PCC on the unit. The impact of leadership behaviors on the psychosocial climate seemed to depend on the level of person-centeredness of care, indicating that leadership behaviors are of utmost importance for the psychosocial climate of staff and residents when the levels of person-centeredness of care are very low. On the other hand, when the person-centeredness of care is low, clinical leadership becomes more important for the overall climate, suggesting that managers need to lead the way more strongly toward excellence in environments where care is less person-centered (39). PCC was described as the organization's ethos, and improving the quality of care was the most important incentive for implementing PCCfor the leaders irrespective of management level. In the VPM, the head nurse is expected to attend each consensus meeting, supervise the staff, ensure the professional standards of the decisions, and provide recognition to the frontline staff. Doing all of this was described as difficult to accomplish but necessary (48). Staff empowerment had the most extensive benefits on resident quality of life, ranging from promoting residents' positive experience with meal services and day-to-day care to improving psychosocial well-being (specifically dignity, autonomy, and meaningful activities (42). This study illuminates some additional factors that shape the personalized dementia care	The leaders described being embedded in PCC in all their day-to-day activities. Leading PCC involves being able to maximize the potential of the team. The leaders reminded the staff about the objectives and goals connected with a approach. These managers also expressed that they wanted to see the person-centered philosophy integrated in all aspects of care and expressed that care routines were also re-directed from intuitional-like care to person-centered care. Assessing and calibrating the extent that staff was integrating PCC into practice was described as important since PCC was perceived as somewhat difficult to maintain. A PCC approach could easily fall off the track, they had to work actively to steer back on track, and it was necessary to hold on and not let go. The leaders applied innovative solutions when organizing work to adapt the organization to the needs and requests of the residents. The managers described the importance of clarifying different team roles and positions of their staff for enhancing PCC. By knowing the individuals in the staff group, the managers could identify different roles in the group and designate different positions so that the group's combined qualities and competencies were utilized to promote person-centered care. The managers explained that identifying and utilizing their staff's unique areas of knowledge and skills enabled the possibility of creating different areas of responsibility for the staff, making it possible for staff to share their skills amongst the team members and residents. The managers explained that identifying relational competencies between staff and residents was central to building and enhancing person-centered relationships. An important aspect for the leaders was to optimize person-centered support structures. Having a clear structure for care planning, as well as routines for evaluating PCC was described as important for development and maintenance, and new forums were developed, and existing forums were optimized and changed to facilitate this. The managers described that they created new forums to lead staff toward engaging in PCC. For example, some managers used existing quality registers for nursing interventions or as baseline tools to evaluate initiatives. The leaders organized and attended care meetings, and being involved in creating care plans based on the residents' needs provided a clear structure to follow. The managers described changing existing forums to facilitate PCC. For example, it was described that ordinary workplace meetings were used as forums to raise person-centered issues, as well as to follow-up on person-centered interventions (40). Stability in the unit was necessary in order to develop the competence and skills required to execute the functions of the VIPS practice model: [It is important] that the turnover is low, that people know what the primary tasks are, that they can document things, simply a well-driven unit. You need to sort out any chaos before you can implement something that requires professionalism and structure because you need structure to make it work. Upholding the new routines for the consensus meeting was highly dependent on the head nurses. In fact, their engagement was described as pivotal: It is the head nurse who makes the difference . . . a leader who schedules the meetings and organizes the time to hold them. The new systematic way of working also meant that interventions should be adjusted if necessary. The head nurse reminded the staff to be alert and make observations: I tell the frontline staff 'You need to document it [how the interventions work], then we can discuss it. You need to observe it and look into it before the consensus meeting when we are evaluating it'.	The staff felt leaders appreciated, supported, and encouraged their efforts for the residents and felt supported in delivering quality care. Participation from leaders in the nursing practice was considered crucial by the staff. In one of the nursing homes, the leaders were present on the ward daily making the staff feel supported and engaged. In another nursing home, the leaders could not be present at the ward and take part in tasks, which seemed to result in frustrated leaders and resigned staff. The leaders saw themselves as role models for the care staff. Leaders have a central role in being continuously supportive of the care staff and taking an active part in the care practice as role models (46). The impact of leadership behaviors on the psychosocial climate seemed to depend on the level of person-centeredness of care, indicating that leadership behaviors are of utmost importance for the psychosocial climate of staff and residents when the levels of person-centeredness of care are very low (39). Leading PCC involves providing individual support to care staff, within a trustful and innovative atmosphere. The leaders reported by being present in the unit on a daily basis and making own assessments, and taking control of the care situation, if necessary, the extent of PCC delivered was assessed. The leaders reported that they were able to coach staff in nursing interventions and also remind staff of objectives and priorities in conflict situations. Promoting a person-centered atmosphere was described to be important for enabling person-centered being and doing. An atmosphere underpinned by mutual trust, creativity, and innovation was central to providing PCC. An atmosphere of trust was described as crucial for developing PCC. Several managers described that one way of creating trustful relationships was by providing constructive and positive feedback to staff about their performance. Trust was achieved by the validation and recognition of staff competence and gradually handing over responsibility for the person-centered care to staff. The delegation was described to show that trust was in place. The managers described the importance of creating a space that encouraged staff to think outside the box and encouraged chance-taking and testing creative solutions in daily care as person-centered care was considered neither static nor standardised. Most managers described that it was important to be a role model and lead by example by being involved in the care. Also reported that they recognized, highlighted, and confirmed good examples in the clinical practice and used positive situations as a benchmark for care planning, and positive psychology seemed to be an important feature in supporting a person-centered atmosphere. Another important aspect of leading towards person-centered care was described as maximizing person-centered team potential. This was outlined as making the group function as a team, utilizing their positions, as well as competencies was considered necessary for promoting person-centered care (40). This study provides insights that leadership most prominently characterized by behaviors such as experimenting with new ideas, controlling work closely, relying on his/her subordinates, coaching, and giving direct feedback, and handling conflicts in a constructive way is positively associated with less staff stress of conscience as well as

(*Continued*)

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Table 5 Continued

Synthesized finding	Visionary leadership and empowerment	Consistent and systematic approach for person-centered outcomes	Leadership through role modeling
	dimensions, for example, quality of care is impacted by leadership, person-centered communication of staff with residents, and the personal and social life of staff (43). The quantitative data (…) indicates that a positive staff evaluation of their leaders predicts a more positive perception of their institution as to the commitment to PCC (44). The residents who live in Household B have a great life here and our mission is to work as a team to make this vision a reality. the leader needs to be vibrant, have amazing energy to support the team, engender trust and lead on PCC… (Pat, carer in focus group with staff; time 2). The recent team building sessions have strengthened each team member's contribution to the overall team and their belief in the vision… (Mary, carer in focus group with staff; time 2). (…) they are an enthusiastic, flexible and confident team and both leaders of the household work well together showing trust and appreciation for each other and for the overall team… (reflective dialogue with Bell, care manager; time 3) (45).	To manage to conduct the consensus meetings regularly in the units, the meetings were all planned ahead regarding time and participants: For things to work, you need leaders who create structure, structure with fixed meeting times, and full-time employees [present]. They made schedules, so staff could be prepared for the meetings: We planned the next meeting early on; they [the frontline staff] knew 14 days in advance. It gives them time to process it in their heads (48). The consistent and systematic pursuit of effectiveness and service was perceived as conflicting with the values of PCC (46). This leader carefully mapped which residents shared things in common with each other and with staff members and carefully planned for the 'right matching' and also, for the gradual implementation of the decision-making model. (44). A flamingo looking at its own reflection in the water represents the importance of getting the balance right between compliance and the culture of PCC. It constantly changes… sometimes the ripples make the reflection bigger…when a HIQA inspection is due… compliance seems heavier than person-centeredness…constant emphasis on paperwork. Having a consistent team helps to keep the balance… the images of the flamingo are equal then… (Maggie, staff nurse in focus group with staff; time 2 (45).	with increased PCC. The positive correlation between leadership and PCC suggests that by fostering trust, delegation, and innovation, managers can further promote this care approach (41). Leadership and organizational culture were found by the staff as key to practicing a holistic care management plan for Residents with dementia. The hierarchical leadership and relationships discouraged them to work as a team for incorporating the components of personalized dementia care in their everyday care service. Some staff stipulated that how authoritative leadership influenced their care activities. While some clinical managers discussed the difficulties in engaging the care workers into personalized care, several care workers emphasized the need to improve respect among the staff [horizontal and vertical] in order to implement a new model of care. (43). The respondents underlined that leaders at all levels in the organization had to be committed for the ethos of PCC to become a reality: We were very clear that this was not just another project; this should be the way we work, how we do things (#8). Some staff needed support from the head nurse to do this, and one head nurse said she encouraged them by stating: This is your job, and I know you can do it (#15) (48). Fostering leadership of direct care staff also showed a favorable impact on three quality of life domains including dignity, autonomy, and meaningful activities. (42). Respondents who evaluated their leaders as open and inclusive were most likely to think that their institution is committed to PCC. The leader gave freedom to staff with regard to how they organized their daily tasks, but she immediately intervened when the care work did not work out well. Leadership and staff culture appear to be pivotal factors in promoting or hindering PCC, a necessary pre-condition for confidence building initiatives in staff-patient relationships, based on PCC. Respondents who evaluated their leaders as open and inclusive were most likely to think that their institution is committed to PCC. The leadership stands out as a very important factor. As an example from the facilitator notes, in one home, the number of attendants dropped when the leader was on sick leave, from an average of 13 in the first four sessions, to five in the last 2 months when the leader was absent. How staff perceived their leaders was found to predict how staff perceived the presence or absence of PCC. By acting as internal facilitators, the leaders' activities directly and indirectly increased the potential for success stories in terms of more person-centered and restraint- free care to happen. The ethnographic studies make clear, however, that the manner in which the leaders are involved is important for the success or lack of success of the implementation (of PCC) (44). She [the leader] treats us all like we all have star qualities—she knows the stage each of us is at. I think she works hard at getting us enthusiastic about doing the best we can …She's always supporting us to develop innovative ways to give care in a person-centered way… (Noleen, staff nurse in focus group with staff; time 2). They identified a resident, and with the resident's agreement, worked together to tailor the resident's shower, breakfast, medications and dressings all around what suited the resident —not as a series of isolated tasks, but in a smooth integrated way. The two leaders brought this change in practice to the monthly household team meeting in order to increase the staff's knowledge and understanding of PCC using the "living" example, and to help integrate the approach into their day-to-day practice. (45).

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through the following categories: (i) Importance of clear visions and values, and (ii) Empowering and enhancing staff performance.

3.3.1 Importance of clear visions and values

Several of the reviewed papers identified the need for a clear, coherent vision in fostering professional development, establishment, and delivery of a person-centered practice (39, 40, 45–47). Leadership did not encompass a passive role; the leaders were at the forefront, actively shaping and defining visions and values into the professional practices of their teams. From the statement, "the managers in this study described having a personal understanding and knowledge of the principles of PCC, and also a clear vision of what they wanted it to be' (40, p. 175), it is evident that leaders had a deep connection with the principles of PCC. For them, the vision of PCC was not just a mere policy tick-box but resonated with their beliefs and understanding about care. Further, several staff members had high expectations of their leaders in terms of supporting the staff team, as illustrated by the following quote:

> "The leader needs to be vibrant, have amazing energy to support the team, engender trust and lead on person-centered care…" Carer (45).

3.3.2 Empowering and enhancing staff performance

Findings in this category focused on how leadership facilitated empowerment, autonomy, and the enhancement of staff performance within the realm of person-centered practice. Four studies highlighted the critical role of leader-facilitated staff empowerment, viewed from various perspectives (42, 45–47). Duan et al. (42) discovered that empowering staff significantly improved the quality of life for residents, with positive impacts observed in meal services, daily care, and psychosocial well-being aspects like dignity, autonomy, and engaging activities. Similar findings were reported by Røen et al. (47) and Rokstad et al. (46), both noting a positive correlation between PCC and empowered staff. Rokstad et al. (46) further observed how leadership seemed to influence staff's sense of empowerment and their ability to implement PCC effectively:

> "The staff felt empowered and trusted to make their own decisions in their daily care practice." Leader. (46, p. 23).

Elevated levels of PCC were associated with empowering leadership, among other factors. An innovative climate, typified by initiative and the encouragement of alternative methods and approaches, was also linked to PCC (47). Lynch et al. (45) found that the leaders empowered staff performance by encouraging innovative, individualized approaches, aligning with each team member's development level.

3.4 Consistent and systematic approach for person-centered outcomes

In this synthesized finding, the importance of having a systematic approach and a structured plan in the workplace to achieve person-centered goals is highlighted. In addition, the importance of maintaining focus on the goal was emphasized. The synthesized finding is reflected in the subcategories (i) Capability to organize and establish structure systematically, and (ii) Continuous focus on person-centered outcomes.

3.4.1 Capability to organize and establish structure systematically

Four of the articles emphasized the importance of having a systematic approach to person-centered practice (40, 44, 46, 48). Leaders strategically utilized both new and existing forums to promote person-centeredness. Whether through ordinary workplace meetings or specially created platforms, the agenda often revolved around person-centered issues and interventions. This involved planning meetings, scheduling various activities, and reminding the staff of objectives and goals connected with a person-centered approach (40, 48). Furthermore, a consistent and stable team in the department was underscored as a crucial component in achieving systematic organization and structure (45, 48).

The way of organizing and being systematic in the approach to achieving a person-centered practice also manifested itself in other ways, such as identifying different qualities among the staff so that staff and residents were matched based on the chemistry they had with each other (44), or seeing themselves as a team where the aim was to bring out the best in each other as quoted by this leader:

> "I talk a lot about that we are like a football team, everyone cannot be Ibrahimović… but I think it's so important… "I think like this, we must have positions, as we are a team, sometimes you do more of this and less of that, but that does not mean that we are doing a poorer result, maybe better, as the result will be better when we position ourselves." (40, p.178).

Thus, the capability to organize and establish structure systematically was not just about administrative processes or maintaining consistency within staff. The focus also lay in understanding how to best utilize the unique strengths and dynamics of each staff member to achieve the overarching goal of person-centered practice.

3.4.2 Continuous focus on person-centered outcomes

Within this category, the need for having a continuous focus on person-centeredness became evident (40, 46, 48). Establishing person-centered practice was not a one-time event; rather, it required sustained dedication and vigilance. As one leader articulated:

> "We have to keep the idea of person-centeredness warm all the time" (46, p. 21).

Encouraging staff to observe, reflect, and share their thoughts seemed to be emphasized as valuable in the process of enhancing person-centered outcomes. In maintaining focus on person-

centered practice, several elements were involved. One of the elements was to keep the awareness high about the concept, and to see and recognize the residents' needs:

> "If you lived here, what would be most important for you? - What do you think is most important for the persons living here?" Leader (40., p.176).

Røsvik and Mjørud (48) on their side pointed out the importance of observing and documenting how the interventions worked, in order to evaluate together in staff meetings.

3.5 Leadership through role modeling

A recurring topic was the importance of the leaders leading by example. The importance of role modeling was emphasized both by the leaders and by the employees. The synthesized findings are divided into the following categories: (i) Actively participating in care provision, and (ii) Promoting a safe and supportive environment with a culture of continuous growth.

3.5.1 Actively participating in daily routine

When leaders were visibly present and validated the staff's approach to resident care, staff satisfaction and their motivation to provide personalized care were notably enhanced. The role of a leader extended beyond just oversight; they acted as both a support mechanism for the staff and as an integral part of residents' day-to-day care (40, 44–46, 48). As one leader detailed:

> "I am out on the wards, I'm visible on a daily basis, and I follow up by asking questions: How is it going? How are we doing? What can we do here? How can we think concerning this…?" (40, p. 177).

Rokstad et al. (46) documented varying perspectives on this theme. In one nursing home, leaders and staff concurred on the importance of leaders' involvement in daily care. The care staff felt both inspired and supported to deliver quality care, and the leaders conveyed appreciation for their dedication and skills. In contrast, another nursing home saw a disconnect when leaders couldn't be present, resulting in disheartened leaders and a resigned staff. Both groups found this scenario challenging, with one leader commenting:

> "I cannot be present on the ward on a daily basis, so I have to lead the care practice through others. I find this frustrating." (46, p. 21).

Another study found that staff in one nursing home faced challenges with a leader who did not engage in daily activities, describing their leader as "distant" and "lacking involvement in staff and residents' matters." (44).

This category also shines a light on leaders as role models in a person-centered practice. Their involvement in nursing was viewed as more than just practical assistance; it symbolized leading by example (40, 43, 46):

> "Most managers described that it was important to be a role model and lead by example by being involved in the care." (40).

The active involvement of leaders in caregiving underscored how a person-centered approach was as much about hands-on participation as about guiding principles.

3.5.2 Promoting a safe, supportive environment with a culture of continuous growth

Several studies highlight the significance of not only adopting a person-centered approach for residents but also treating staff according to the principles of person-centeredness (40, 41, 43, 44, 46, 48). Moreover, it seemed like when employees perceived their leaders as open and inclusive, they were more inclined to believe that the institution genuinely valued person-centeredness (44).

Another key element identified was the commitment of leaders to embed the ethos of person-centeredness deeply within the organizational culture (42, 44, 48). The leaders in Røsvik and Mjørud's study (48) emphasized that leaders, regardless of their management level, should prioritize PCC as the main framework for addressing value-based issues and ensuring person-centered solutions for residents:

> "The respondents underlined that leaders at all levels in the organization had to be committed for the ethos of person-centered care to become a reality: We were very clear that this was not just another project: this should be the way we work, how we do things." (48).

Rokstad et al. (46) also emphasized the inherent responsibility of leaders to provide continuous support to care staff. This finding is echoed in Lynch et al. (45), where a nurse described how her leader demonstrated support:

> She treats us all like we all have star qualities—she knows the stage each of us is at. I think she works hard at getting us enthusiastic about doing the best we can … (45).

Further findings from Backman et al. (39) illustrated the impact of leadership behaviors, especially in shaping the psychosocial climate for both staff and residents, with this influence being even more pronounced when PCC was inadequate.

4 Discussion

The findings from this study highlight several key dynamics underlying effective person-centered leadership in nursing homes, particularly the importance of visionary leadership and empowerment, a consistent and systematic approach, and the importance of modeling person-centered values and behaviors. This discussion aims to interpret the key findings of the study

and situate them within the broader context of relevant existing literature.

4.1 Visionary leadership and empowerment

The findings underscore the necessity for nursing home leaders to possess a cohesive vision and set of values aligned with person-centered principles, ensuring these visions transcend superficial policies and resonate with leaders' core beliefs (39, 40, 45–48). These findings align with previous research indicating that leaders who deeply understand and embody person-centered principles are better positioned to implement them effectively in practice (30). Earlier studies also support the importance of a shared vision as an essential feature of leadership behavior. Martin et al. (49) found that vision provides orientation and meaning for leaders and their teams, helping them focus their energies and engage in the transformation of practice. A 2022 systematic overview of reviews by Feldthusen et al. (50) describes numerous prerequisites for facilitating person-centered practices in healthcare, including the formation of a vision.

The correlation between empowered staff and person-centeredness underscores the significance of effective leadership in fostering staff empowerment through support, autonomy, and opportunities for agency (45–47). Prior research (51) corroborates these findings, suggesting that empowering staff improves outcomes for nursing home residents and enhances staff motivation and job satisfaction. Additionally, Ta'an et al. (52) found that highly empowered nurses displayed higher performance than less empowered nurses in hospitals. Conversely, Feldthusen et al. (50) found that a lack of influence over policies, procedures, and practices contributed to feelings of disempowerment among healthcare professionals. These factors, coupled with rising workloads and insufficient support, adversely impacted their psychological well-being and their ability to deliver PCC (50).

4.2 Consistent and systematic approach for person-centered outcomes

The findings indicate that fostering person-centered practices requires systematic approaches and structured planning from leaders (40, 48). For instance, one nursing home in the study implemented systematic review meetings to evaluate care plans and PCC practices, which were deemed crucial for developing and maintaining person-centered practice (40). This finding aligns with international literature, where previous research supports the necessity of a systematic approach and regular evaluation to sustain high-quality person-centered practice (11, 53). These findings suggest that nursing home leaders should prioritize the development of structured care planning and evaluation routines to ensure consistent and high-quality PCC.

A stable workforce was identified as critical for achieving systematic organization and structure, ensuring a well-coordinated department, and promoting expertise development among staff (48). Stable staffing allows for continuity of care, which is essential for building trust and understanding between residents and caregivers. When staff members are familiar with the residents and their specific needs, they can provide more personalized and effective care (5). However, research by Moore et al. (54) suggests that consistent leadership may be even more critical. Consistent leadership provides direction, stability, and a clear vision, which are vital for sustaining person-centered practices (22). These findings underscore the importance of maintaining a stable workforce and ensuring continuity in leadership roles to effectively implement and maintain person-centered practice.

4.3 Leadership through role modeling

A recurring theme was the profound impact of leaders actively modeling person-centered behaviors (40, 43, 45, 46). By serving as visible role models, the leaders reinforced the importance of person-centered values and inspired staff to adopt similar practices. Numerous studies have underscored the leader's role as a model for expected behaviors (49, 54–57). However, what sets this context apart is that leaders also serve as role models in their execution of daily patient care, as evidenced in the study by Rokstad et al. (46), where staff regarded leader participation in nursing practice as crucial. While leader involvement in daily care can enhance understanding and presence, several challenges may emerge. Challenges such as role confusion, time pressure, insufficient clinical competence, and inadequate resource allocation can impede effective leadership and optimal care. Of particular concern is the potential lack of clinical competence among leaders. Although many leaders possess healthcare backgrounds (58), their clinical skills may not be as current as those of staff who work with patients daily. Moreover, Kirchhoff and Karlsson (59) found that first-line nurse managers frequently face role conflict or feel 'squeezed' by the competing demands of their responsibilities as registered nurses and leaders. This dual pressure can result in significant stress, emotional exhaustion, and an inclination to resign from their leadership roles.

A key finding was that the majority of the included studies emphasized the importance of adopting a person-centered approach not only for residents but also for treating staff according to the principles of person-centeredness (40, 41, 43, 44, 46, 48). Such findings illustrate the paradigm shift from the traditionally PCC, which primarily focuses on the patient as the sole important person in the relationship, to person-centered practice, which encompasses all individuals in the relationship, including healthcare professionals (7). Buetow (60) refers to this shift as viewing patients and healthcare personnel as "moral equals," indicating that to provide effective PCC, healthcare professionals must also feel that their personhood is respected and recognized.

Backman et al. (39) discovered that the influence of leadership behaviors on the psychosocial climate was contingent on the degree of PCC, suggesting that leadership behaviors are critically important for the psychosocial well-being of staff and residents. Furthermore, Jacobsen et al. (44) found that staff perceptions of

their leaders were indicators of the presence or absence of PCC in the nursing home. These findings align with research by Seljemo et al. (23) and Zonneveld et al. (24), who emphasize that the significance of leadership behaviors, rather than just leadership styles, is crucial in nursing home care.

4.4 Rethinking leadership expectations in nursing homes

The data from all included studies underscore the extensive and multifaceted expectations placed on leaders in nursing homes (39–48). Beyond ensuring the implementation of person-centered practices, leaders are tasked with a wide range of responsibilities, including administrative tasks, role modeling, and direct involvement in care activities (40, 43–46, 48). Persistent challenges in nursing home leadership, such as understaffing, financial constraints, limited resources for staff development, and blurred work-life boundaries, further exacerbate expectations (58, 61, 62). Such demands mirror the traditional "heroic" model of leadership, where leaders are expected to manage and resolve all organizational issues independently (63). This model raises questions about its feasibility and sustainability in the context of modern nursing homes.

There is an apparent contradiction between the expectations placed on leaders and the principles of person-centered practice, which advocate for shared responsibility and collaborative approaches (5). A disconnection between expectations and the support provided to leaders can lead to burnout and reduced effectiveness in leaders (59, 62) and diminish their ability to foster a person-centered culture. This issue highlights the need to rethink traditional leadership models in nursing homes.

4.5 Shifting towards integrated leadership models

The findings of this review point to the potential benefits of shifting towards a more integrated leadership model that aligns with person-centered values. In particular, distributed leadership may offer a valuable contribution by supporting a more balanced distribution of responsibilities and tasks across different organizational levels (64). In this model, administrative duties may be delegated to specialized personnel, while clinical leadership is exercised by experienced nurses closer to care delivery. By embedding distributed leadership within broader person-centered strategies, nursing homes may cultivate cultures where leadership is enacted through relationships rather than imposed hierarchically. This can enhance staff engagement and competence (62, 65) and support the sustainable implementation of person-centered practices. Moreover, person-centered leadership plays a crucial role in nurturing such practices by emphasizing staff empowerment, fostering teamwork, and aligning leadership actions with the core values of PCC (22). According to McCormack and McCance (11), the goal of person-centered processes is to create a "healthful culture", an environment that promotes both staff well-being and quality of care. Emerging research on healthful leadership further reinforces its role in establishing supportive and sustainable workplaces (66).

By integrating the principles of person-centered and distributed leadership, healthcare organizations can enhance the well-being of both staff and leaders, ultimately improving care outcomes (11, 22, 64). Further support for this integrated approach comes from recent work by Cable, McCance, and McCormack (67), who explored how person-centered nursing leadership can be cultivated through transformative professional development. They emphasize that becoming a person-centered leader is a process of *knowing, being, and becoming*, an internal journey that fosters authenticity and relational depth in leadership.

Taken together, these insights suggest that developing integrated leadership models may be key to the sustained success of person-centered practices in nursing homes.

5 Conclusion

This systematic review has identified the underlying leadership dynamics facilitating person-centered practice in nursing homes. The analysis revealed three key themes: visionary leadership and empowerment, a consistent and systematic approach to achieving person-centered outcomes, and leadership through role modeling. The findings collectively indicate that substantial responsibility lies with leaders to effectively implement and sustain person-centered practice, in addition to fulfilling their broader managerial duties and obligations. These findings suggest a potential benefit of exploring a more integrated leadership model that draws on distributed and person-centered leadership models. Such a model could lead to a more sustainable and supportive environment for both leaders and staff, ultimately improving the quality of care. This synthesis of existing research provides valuable insights for nursing home leaders and policymakers striving to enhance PCC and highlights the importance of supporting leaders in their efforts to create and sustain person-centered environments.

5.1 Strengths and limitations

The strength of the study lies in summarizing knowledge in an area with limited existing evidence. Furthermore, the study is conducted systematically and rigorously, adhering to a recognized framework for systematic reviews. The included studies were critically appraised by multiple reviewers to enhance objectivity and reduce bias.

However, some limitations are evident in this review. The most notable is the imbalance in the distribution of findings among the included articles. Some articles contribute numerous findings, while others provide less. To ensure transparency, the details of which findings are extracted from each article are presented in the results section (see Table 5).

Of the ten included studies, seven were conducted in Norway and Sweden. This raised questions about our search

terms and whether different words or concepts might be used in other countries. We extensively used various MeSH terms and examined search terms from comparable studies. Additionally, a specialized librarian conducted the searches. Despite these efforts, we acknowledge the possibility of overlooked factors. Furthermore, the review included only two databases, CINAHL and PubMed. While these databases are highly comprehensive within the scope of nursing and health services research, the use of additional databases might have yielded a small number of additional studies, and this is acknowledged as a limitation.

In our searches, we have not differentiated between professional and administrative leadership, and there might be differences in how closely these various levels work with the staff. There are also different ways of organizing nursing homes in various countries, which have not been considered in this study.

In addition to the limitations already discussed, we acknowledge potential methodological and theoretical constraints in this review. Methodologically, the search was limited to two databases (CINAHL and PubMed), which may have excluded relevant studies indexed elsewhere. Furthermore, while our inclusion criteria focused on studies that involved formal nursing home leaders, the variation in how leadership roles are defined and reported across countries and studies may have introduced some ambiguity.

Variability in study designs, populations, and outcome measures has made drawing definitive conclusions challenging, but such diversity also provides a comprehensive overview of the existing evidence and highlights areas where further research is needed.

5.2 Implications of the results for practice, policy, and future research

The findings of this review highlight the need for leadership approaches in nursing homes that are actively aligned with person-centered values and enacted through everyday leadership behaviors. In practice, this calls for leaders who can articulate and embed a clear vision for care, empower staff, and lead by example through consistent engagement in care provision. Establishing such leadership requires not only structural support but also the cultivation of reflective practice, where leaders routinely assess and adapt their approaches based on feedback, values, and situational demands.

From a policy perspective, these findings point to the importance of leadership development programs that prioritize relational and values-based competencies alongside organizational skills. Policies aimed at improving care quality in nursing homes should therefore support leadership models that encourage reflection, staff involvement, and shared responsibility.

Future research should explore how leadership practices can be systematically developed and sustained over time to promote person-centered practice in nursing home settings. Longitudinal studies may help clarify how specific leadership behaviors support the creation of person-centered cultures, enhance staff well-being, and improve person-centered outcomes for residents.

Author contributions

CA-H: Conceptualization, Formal analysis, Investigation, Project administration, Supervision, Validation, Writing – original draft, Writing – review & editing. LO: Conceptualization, Investigation, Writing – original draft, Writing – review & editing, Formal analysis. VG: Conceptualization, Writing – review & editing, Writing – original draft. A-CL: Conceptualization, Writing – review & editing, Writing – original draft. AH: Conceptualization, Investigation, Writing – review & editing, Writing – original draft. CB: Conceptualization, Writing – review & editing, Writing – original draft. LH: Conceptualization, Investigation, Writing – review & editing, Writing – original draft. GR: Writing – review & editing, Writing – original draft. BM: Validation, Writing – review & editing, Writing – original draft, Conceptualization. IF: Conceptualization, Investigation, Writing – original draft, Writing – review & editing, Formal analysis.

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Person-centred care for migrants: a narrative review of healthcare literature

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According to the World Migration Report, the number of international migrants has steadily increased in the past 50 years. This has led to an increasing need for healthcare to incorporate a variety of perspectives for migrants. However, healthcare systems still show gaps in accommodating diverse cultural perspectives. Given the increasing attention to person-centred care, there is both an opportunity and a need to explicate how person-centred care (PCC) can help to improve healthcare for migrants. Therefore, we conducted a narrative literature review on cultural dimensions of PCC practice for migrants. A scoping review by Forsgren et al. (2025) identified 1,351 articles from a search of PubMed, Scopus, PsycINFO, CINAHL, and Web of Science databases. From these, nine studies that met the following inclusion criteria were selected: (1) about cultural dimensions of health care for migrants (immigrants and refugees), (2) in any health care settings, (3) written in English, and (4) published within the last 10 years (January 1, 2023-December 31, 2023). The studies included participants from diverse ethnicities, racial backgrounds, and countries of origin. Seven studies were undertaken in primary care, long-term care, or outpatient clinics; one study was on health education; and one additional study focused on the acute care environment. The review led to three main practices: (a) enhancing migrants' ability to participate in their healthcare, (b) building intercultural partnerships, and (c) promoting cultural education of healthcare providers. These practices underscore the significance of respecting diverse cultural beliefs about shared decision-making and understanding how PCC practice is perceived in different cultural contexts. The results also indicate a need for educational programs that equip healthcare providers with intercultural communication skills and knowledge to provide culturally sensitive PCC. Overall, this study highlights the importance of integrating PCC with interculturalism as a way to foster a more nuanced and responsive understanding of the cultural dimension of care.

KEYWORDS

person-centred care, cross-cultural care, interculturalism, migrants, ethnicity, culturally sensitive care

Introduction

Throughout the 20th century, many countries have undergone demographic changes in social structures, economics, and politics. These changes have led to a worldwide increase in migrants; i.e., people living outside their country of birth, including refugees and asylum seekers (1). According to the 2020 World Migration Report, the number of international migrants has steadily increased over the past 50 years, with more than 281 million people living outside their country of origin. This number has more than doubled since 1990, and migrants account for 3.6% of the world's population (2), with 37.6 million refugees living in foreign countries (3). Given the global financial crisis, climate change, and advancements in transportation and communication technologies, a new wave of migration is expected to occur globally (4). This wave of migration is likely to lead to an increased demand for healthcare services among migrant populations. However, there are still significant gaps in healthcare for migrants (5, 6). This includes major challenges faced by migrants that arise due to cultural differences that influence their interactions with healthcare providers, which often hinders their ability to receive appropriate care. The UCL–Lancet Commission on Migration and Health defined culture as "a linked group of customs, practices, and beliefs jointly held by individuals, social networks, and groups. These factors help define who they are, where they stand in relation to those within and beyond the group, and give meaning and order to life" (7). In a policy brief on Cultural Contexts of Health and Well-being, the World Health Organization further explicated the dynamic interrelatedness of culture and health, where culture is understood as "not a static set of beliefs and practices, but rather an ever-emerging array of collective values, ethics, assumptions and ideals" (8).

There are both structural and interpersonal challenges that migrants encounter when receiving healthcare, including the difficulties migrants experience in adapting to a different healthcare system and while also coping with cultural misunderstanding and bias. For instance, Muslim women in North American countries often experience discrimination, insensitivity, and healthcare providers' lack of knowledge about their religious and cultural practices during their healthcare visits (9–12). These negative experiences can likely lead to undesirable consequences, such as avoiding follow-up appointments and facing difficulty managing chronic conditions (13). In addition, research shows that the stress of adapting to the healthcare system can increase the risk of cardiovascular and mental health conditions (14–16). Therefore, addressing both structural and interpersonal aspects of cultural difference is essential for mitigating challenges that migrants may experience (17, 18).

Person-centred Care (PCC) offers one approach to embracing cultural differences by prioritizing the holistic treatment of individuals and empowering them to participate in their own healthcare decisions. PCC foregrounds human dignity and autonomy, stressing the rights of patients as decision-makers in their care process (19). Thus, it challenges the traditional view of patients as mere recipients of healthcare by emphasizing partnership and shared decision-making that is grounded within the patient's narrative, preferences, beliefs, and values (20–22). PCC encourages a comprehensive approach, taking into account the patient's societal and cultural context to identify the most appropriate treatment and care (23, 24). This approach presents an opportunity to embrace cultural differences and promote optimal healthcare for migrants.

Although PCC can offer various benefits, there may also be unintended consequences. Concerns have been raised that PCC is grounded in individualistic values that may not be suitable for people who have inherited collectivist cultural values (25, 26). Much of the PCC literature reflects a Westernized and individualistic cultural context. This raises critical questions about the cultural adaptability of PCC and how PCC can meet the healthcare needs of migrants who have diverse cultural backgrounds. In cultures where the decision is made by the community or by the family, the PCC's emphasis on individual autonomy may not align with their cultural values (25, 27). The potential for PCC as an approach to better meet the healthcare needs of migrants, therefore, warrants critical examination.

To further explore this opportunity, we conducted a review of studies that offer insights into the cultural dimensions of PCC for migrants. Our review question was: How have PCC involving cultural dimensions of care for migrants been practiced?

Method

We employed a narrative review approach to critically analyze and interpret cultural aspects of PCC. Narrative reviews are often used to provide summaries and analyses of literature on specific topics to introduce theories or diverse viewpoints, enabling the exploration of lesser-studied areas (28). This is accomplished by synthesizing various literary sources to provide a multifaceted understanding of a topic and offer critiques of prior studies, which is crucial in establishing directions for future research (29, 30). Considering the lack of empirical studies available, a narrative review allows for a flexible approach to include diverse perspectives that may not meet stringent inclusion criteria of structured review types (30). To enhance the rigour of this study, the Scale for the Assessment of Narrative Review Articles (SANRA) was used to ensure that all aspects of the review process were thoroughly covered (31).

Our review builds on an overarching scoping review of international literature on PCC conducted by Forsgren et al. (32) Forsgren et al. included different terms referring to the concept of PCC, such as "people-centred", "family-centred", and "patient-centered", variations on term endings (e.g., centric, centeredness) and accompanying terms (e.g., care, practice, approach) to capture the broad range of relevant studies. The core element of the PCC is that patients are recognized as individuals with unique insights into their health conditions and integral members of the healthcare team alongside professionals and other significant individuals in the patient's life. The scoping review involved a comprehensive search of index terms and free text words related to PCC in several databases, which resulted in

94,236 citations. Based on the above definition and corresponding inclusion criteria, Forsgren et al. identified 1,351 relevant articles by employing a methodology that combined manual and text-mining screening.

The 1,351 articles were screened by CS in ongoing consultation with all co-authors to identify studies that were: (1) about cultural dimensions of healthcare for migrants (immigrants and refugees), (2) in any healthcare setting, (3) written in English, and (4) published within the last 10 years (January 1, 2013–December 31, 2023). The search was limited to the past 10 years to ensure relevancy to the current practices and migration contexts, given the rapid changes in healthcare delivery and migration landscape in recent years. Exclusion criteria were: (1) reports about theories, theoretical models, or frameworks, (2) review studies that did not include original data, (3) studies on cross-cultural topics that did not involve migrants as subjects of the study, and (4) studies that focused on social determinants other than migrant status. After an initial screening of titles and abstracts, CS conducted a full-text review of all potentially relevant citations. The screening results were discussed and verified with all co-authors via regular meetings through which consensus on the final set of included studies was achieved. As a result, nine studies were included in the analysis. The flow diagram summarizes the reason for selecting these nine studies (Supplementary Figure S1, Adapted PRISMA flow diagram).

The EPPI-Reviewer software was used for coding and data extraction of the included studies, which was led by CS in ongoing consultation with all co-authors. The nine relevant studies were organized into a tabular format, including publication year, first author, country, title, study purpose, study area, participants' ethnicities, and research methods (Table 1). Each study was read multiple times to extract and organize data relevant to the review questions. Following an interpretive approach, the synthesis involved constructing key themes informed by critical reflections by all co-authors and theoretical underpinnings of PCC; subsequently, the themes were interpreted as overall PCC practices that involve cultural dimensions of care.

TABLE 1 Characteristics of articles reviewed for cross-cultural aspects of PCC.

Author Year Title	Purpose	Care setting Country	Target population	Research methods
Bentwich et al. (2018) How figurative language may be related to formal caregivers' person-centred approach toward their patients with dementia	To explore how figurative language may be related to formal caregivers' person-centred approach toward their patients with dementia	Long-term Care, Israel	Immigrant caregivers from the Soviet Union, Jews born in Israel, and Arabs ($n = 20$)	Qualitative study Interviews
Durante (2016) Family-centered Care as a predictor of early intervention outcomes for ethnically diverse families	To examine the experiences of racially and ethnically diverse families in early intervention with regard to family-centered service delivery	Public Health, USA	Caucasian, African American, and Hispanic families with children who are less than 31 months of age ($n = 3,338$)	Quantitative study Secondary analysis
Guerrero et al. (2010) Racial and ethnic disparities in pediatric experiences of family-centered Care	To examine racial and ethnic disparities in the receipt of family-centered Care among a general population of US children	Public Health, USA	White, black, Latino, and other race children ($n = 4,278$)	Quantitative study Survey
Ingram et al. (2015) Using participatory methods to enhance patient-centred mental health care in a federally qualified community health center serving a Mexican American farmworker community	To assess and address gaps in perceptions of mental healthcare between providers and migrant workers living in a US–Mexico Border community	Primary Care, USA	Mexican American farmworkers and federally qualified community health center staff ($n = 80$)	Qualitative study Focus groups and interviews
Montes & Halterman (2011) White-Black disparities in family-centered Care among children with autism in the United States: Evidence from the NS-CSHCN 2005–2006	To compare the reported receipt of family-centred Care between parents of white and black children with autism spectrum disorder (ASD) in the United States	Public Health, USA	Parents and guardians of white and black children with ASD ($n = 35,386$)	Quantitative study Secondary analysis
Tucker et al. (2011) Patient-centered, culturally sensitive healthcare	To explain and improve healthcare for ethnically diverse patients seen in community-based primary care clinics	Primary Care, USA	African American and non-Hispanic White Americans ($n = 229$)	Quantitative study Survey
Wall et al. (2013) 'Patients' perceived cultural sensitivity of health care office staff and its association with 'patients' health care satisfaction and treatment adherence	To examine that patient-perceived cultural sensitivity of front desk office staff has a significant positive association with patient treatment adherence	Primary Care, USA	White American, African American, Hispanic, American Indian/Native American, Asian/Asian, American/Pacific Islander, other race ethnicity ($n = 1,191$)	Quantitative study Survey
Watt et al. (2013) Family-centred Care: A qualitative study of Chinese and South Asian immigrant parents' experiences of Care in pediatric oncology	To describe Chinese and South Asian immigrant 'parents' experiences of Family-centred care in pediatric oncology settings in Canada	Acute Care, Canada	First-generation Chinese and South Asian parents of children with cancer who were at least 6 months post-cancer diagnosis ($n = 50$)	Qualitative study Interviews
Wilkerson et al. (2010) Assessing patient-centered care: One approach to health disparities education	To compare the reliability, validity, and feasibility of an embedded patient-centred care scale with the use of a single culturally challenging case in measuring students' use of person-centred care behaviours as part of a comprehensive objective structured clinical examination (OSCE)	Health education, USA	Senior medical students at two California medical schools ($n = 322$)	Quantitative study Observational study

Results

Of the nine original studies, seven were conducted in the United States, one in Canada, and one in Israel. Regarding healthcare settings, seven studies were conducted in primary care, long-term care, or outpatient clinics, and the remaining studies were conducted in medical school acute care settings. Migrants (i.e., those born outside of the host country) in the included studies exhibited a diverse range of ethnicities, racial backgrounds, and countries of origin, including Caucasian, African American, Hispanic, American Indian, Asian/Asian American/Pacific Islander, Chinese, South Asian, individuals from the former Soviet Union, Jews born in Israel, and Arabs. The studies covered a broad range of participants, including patients (covering both children and adults), healthcare providers and staff, parents or family members, and students (see Table 1).

Culture in the studies reviewed has been conceptualized in distinctive ways. Culture is understood both as the characteristics of a specific group with shared beliefs, values, customs, and behaviours, and also as a dynamic construct that is shaped by social interactions and that changes over time (33, 34). The included studies on PCC reflect an evolving understanding of culture that highlights the importance of being responsive to the fluid and diverse cultural identities that migrants bring to healthcare experiences. This aligns with the fundamental concept of PCC, which embraces responsiveness to individuals' unique experiences and the diverse cultures that migrants bring to healthcare. Building on these understandings, the synthesis identified the following three main practices about PCC for migrants: (a) enhancing migrants' ability to participate in their healthcare, (b) building intercultural partnerships, and (c) promoting cultural education of healthcare providers.

Enhancing migrants' involvement in their healthcare

Migrants often face language barriers and communication challenges. These barriers can hinder their ability to clearly communicate their experiences as well as healthcare preferences, which can reduce their ability to participate in their healthcare (35, 36). Overcoming language barriers and meeting the linguistic needs of migrants is vital to ensure that they receive adequate care (36). Receiving care in migrants' native language can enhance a shared understanding of health and foster a sense of respect from healthcare providers (37). The reviewed studies recommend a variety of strategies to improve communication with migrants facing language barriers including: (a) providing clear action-oriented steps, assessing migrants' comprehension, (b) using interactive communication loops, (c) reducing the use of medical terminology, and (d) employing medical interpreters are recommended strategies (36, 37). PCC studies also propose that educational materials for migrants be supplemented with culturally and linguistically appropriate content to ensure that patients receive more relevant and accurate information (37). These approaches not only mitigate language barriers but also empower migrants to take an active role in their healthcare. By adopting these approaches, PCC can encourage healthcare providers to uphold migrants' rights and dignity by promoting their participation in decision-making (34, 36, 38).

Building intercultural partnerships

PCC highlights the importance of building intercultural partnerships, where individuals from diverse cultural backgrounds work together through mutual understanding and collaboration. To promote this partnership, PCC studies note the importance of developing cultural sensitivity. Cultural sensitivity is more than simply recognizing the unique cultural experiences of migrants; it involves respecting and responding to their unique cultural needs (34). Cultural sensitivity can be achieved by healthcare providers paying close attention to the expectations of migrants and being responsive to the unique attitudes, emotions, and situations of migrants (33, 36, 38, 39). This includes allocating sufficient time to provide medical information and building trust through emotional empathy and attentiveness (34–36, 38, 39). Culturally sensitive care increases migrants' trust and comfort, leading to positive health outcomes and satisfaction (37). This approach can also improve the ability of migrants to manage their interpersonal interactions and take ownership of their healthcare.

PCC studies also draw attention to the need for understanding that migrants are not a homogeneous group with uniform needs. Each migrant faces healthcare issues and circumstances contextually (35, 39). If there are discrepancies between how migrants perceive illness and the explanation provided by healthcare providers, migrants may lose motivation to follow the suggested treatment regimen (33, 35). Thus, healthcare providers should continually assess whether their practices are aligned with migrants' unique cultural contexts (35, 36, 40). This practice requires healthcare providers to shift away from Western-centric models of care towards embracing culturally responsive approaches (40).

PCC studies also point out that healthcare providers must avoid imposing decision-making roles on migrants that may not be aligned with their cultural beliefs and norms. For example, some cultures may take a family decision-making process, whereas others may take a community-based decision-making process (40). As well, in some families, the patient will make their own decision, whereas others will not, and this is often determined by culture. Therefore, clear expectations should be set early on through transparent communication, allowing migrants to be involved in the decision-making process in a way that is consistent with their cultural norms (38, 40). The PCC studies show that the more opportunities migrants have to exercise control over their care, the more inclusive and culturally sensitive care can be achieved (40).

Promoting cultural education of healthcare providers

PCC studies underscore the significance of cultural education for healthcare providers. By learning about different cultures,

healthcare providers can broaden their understanding of diverse cultural needs (33, 34, 37). PCC studies emphasize that cultural education should go beyond acquiring knowledge about different cultures. Rather, cultural education should foster self-assessment and reflection, awareness of cultural diversity, and adaptability to different cultural contexts (33, 35, 38, 39). Specifically, cultural education should enhance the providers' ability to engage in culturally sensitive interactions with migrants. This includes developing healthcare professionals' skills in communication and counselling, which are essential for eliciting migrants' personal narratives (33, 36, 38). Furthermore, cultural education should be a resource for healthcare providers to become aware of cross-cultural barriers, such as implicit bias, health disparities, and inequities (36–38). All healthcare workers who provide services to migrants and their communities, not only healthcare professionals, need cultural education. Thus, this education should be tailored to the specific roles of healthcare workers to maximize its effectiveness (34, 35).

Discussion

This review was conducted to offer insights into the application of cross-cultural PCC for migrants. We identified several important practices accentuating the need to: (a) enhance migrants' ability to participate in their healthcare, (b) build intercultural partnerships, and (c) promote cultural education of healthcare providers. The results further draw attention to the importance of distinguishing intercultural care from cross-cultural approaches.

Cross-cultural approaches and PCC share commonalities in acknowledging cultural diversity and aim to meet the needs of all people (41). Both approaches underscore the values, preferences, languages, and traditions of migrants as important considerations in their care. However, there are also notable differences. Cross-cultural approaches tend to view migrants as a collective group and support the notion of culture as a set of shared values (42). In contrast, PCC tends to view each migrant as a person with a unique experience and focuses more on individual narratives (27). As such, PCC seeks to promote an individualist approach that integrates migrants' personal stories into healthcare decision-making, thereby ensuring that treatments are tailored to individuals. In this regard, bringing together PCC and interculturalism may provide an alternative approach to developing a more nuanced understanding of migrant care.

Interculturalism is an approach that extends beyond merely acknowledging different cultural groups, as it places greater emphasis on interaction and understanding between cultures. Unlike deterministic perspectives that view cultures as fixed identities defined by geographical boundaries, interculturalism highlights that culture is dynamic and continuously evolving (41, 43, 44). It also acknowledges that individuals may have multiple cultural identities. Interculturalism encourages harmonious coexistence among individuals from diverse cultural backgrounds by shifting focus from differences to commonalities (43). Both interculturalism and PCC share the understanding that culture can be influenced by various intersectional factors. Thus, no two migrants' experiences can be the same (26, 45, 46). This perspective supports that healthcare requires a flexible and tailored approach to care that respects each migrants' unique cultural and personal circumstances.

Established PCC frameworks, such as McCormack and McCance's Person-Centred Practice Framework and the University of Gothenburg Centre for Person-Centred Care (GPCC) framework, align with the core value of interculturalism. They draw attention to the importance of understanding individual narratives and context, respecting beliefs and values, and fostering partnerships between patients and healthcare providers (47, 48). However, these frameworks still lack explicit attention to cultural diversity. In this regard, there is an opportunity to integrate interculturalism in PCC frameworks with the goal of developing a more nuanced understanding of culturally sensitive healthcare for migrants. When integrated with an intercultural perspective, PCC requires a foundation of self-reflection on cultural biases and stereotypes, an appreciation of diversity, and finding common ground as a basis for meaningful interaction and relationships. In this approach, no cultural perspective is considered superior, and cultural humility, or respecting others' cultural values, becomes the foundation (49). Additionally, this integration requires individuals to take responsibility for continually recognizing their own cultural biases while striving to form equitable partnerships with migrants (50). This demands a flexible mindset, concern for both self and others, and a belief in the inherent equal value of all human beings (51).

Integrating interculturalism into healthcare requires effective communication that acknowledges and navigates culturally shaped beliefs and practices. This can be facilitated by implementing education about intercultural communication to enhance cultural sensitivity and improve how healthcare providers interact with migrants. This requires a well-balanced approach to education around three key components: cognitive, affective, and behavioural (52–55). The cognitive component involves the ability to understand and correctly interpret both verbal and nonverbal messages. The affective component involves the ability to empathize with and respect the emotions and lived experiences of individuals from different cultural backgrounds (53, 54). The behavioural component refers to how effectively and appropriately individuals apply the cognitive and affective components in real-life interactions (56). For example, education on intercultural communication could include interactive training sessions for providers to practice and engage in discussions about how to improve cognitive awareness (e.g., interpreting body language), affective response (e.g., demonstrating empathy) and behaviour strategies (e.g., adapting communication style) (53–55).

The findings of this review also provide insights into potential system-level changes to support PCC for migrants. Clearly, it is important for the voices of migrants to be represented when making changes that affect their healthcare services. Interculturalism emphasizes that cultural influences are not unidirectional, but rather multidirectional (57). This means ensuring that the perspectives and practices of migrants are valued in healthcare services and systems. It is particularly important to recognize migrants as agents, not only by listening to their needs, but by supporting migrant-led improvements to

the care they receive. To enhance migrants' involvement and build intercultural partnerships, healthcare organizations and policymakers may consider implementing intercultural mediators who can help to reduce cultural misunderstandings while ensuring that migrants receive healthcare that aligns with their culturally shaped views of health and healthcare (58, 59). Intercultural mediators are professionals with training in understanding cultural differences and representing the perspectives of all cultures in healthcare delivery (58–60). In this capacity, their role is not limited only to finding common ground for communication, but also to promoting balanced power dynamics so that care decisions affecting migrants do not solely reflect the healthcare professional's advice.

Limitation of the study

This review was based on nine studies, seven of which were conducted in the United States one in Canada, and one in Israel, and should, therefore, not be regarded as representative of healthcare for migrants globally. Additionally, the review was based on studies conducted within several distinct healthcare settings. Thus, PCC practices across different care contexts are not represented in the synthesis. Given the small number of studies identified and considering the limited representation of different healthcare systems (i.e., predominantly in the United States of America), there is a significant opportunity for further research and theoretical development on PCC for migrants by integrating interculturalism into existing PCC frameworks and practices.

The selection of studies was based on a database of research explicitly inquiring about PCC as a concept (including various terms for the concept). Limiting the scope to PCC studies may have excluded valuable insights from other studies that investigated cultural aspects of migrant healthcare. Future research could expand on this work by examining how PCC relates to other theoretical frameworks and approaches to migrant care.

Conclusion

As the global migrant population continues to grow, the demand for culturally inclusive care has increased in healthcare. This narrative review study explores the cultural dimension of PCC in the context of migrants' care and identifies three significant practices. First, PCC prioritizes empowering migrants to be actively involved in their healthcare decision-making as well as striving to reduce language barriers. PCC also points to the importance of building intercultural partnerships through cultural sensitivity and respecting migrants' culturally shaped beliefs and experiences. Lastly, PCC requires strengthening cultural education by focusing on meaningful interaction. The findings point to an opportunity to integrate PCC and interculturalism as an approach to promote inclusivity and cultural sensitivity in healthcare, with the goal to foster cultural humility among healthcare providers and ultimately improve healthcare outcomes for all people, including migrants.

Author contributions

CS: Conceptualization, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. EF: Conceptualization, Methodology, Writing – review & editing, Funding acquisition. JÖ: Conceptualization, Methodology, Writing – review & editing, Funding acquisition. RS: Conceptualization, Methodology, Supervision, Writing – review & editing, Funding acquisition.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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The author(s) declare that no Generative AI was used in the creation of this manuscript.

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Supplementary material

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Implementation of learning into person-centred practice: evidence of impact from community nursing preparation programmes

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Introduction: There has been a global move towards personalising and "humanising" healthcare and promoting caring cultures. Education is addressing this agenda by incorporating person-centred principles into teaching and learning. The aim of this research was to explore the implementation of person-centred learning into healthcare practice. More specifically, this study aims to explore community nurses' implementation of learning about person-centredness in their practice and to demonstrate the impact of person-centred curriculum.
Methods: A cross-sectional quantitative survey design was used with community nursing graduates and current students who engaged with person-centred curricula.
Results: Significant improvements were found in three constructs of person-centred practice—*clarity of beliefs and values, knowing self and developed interpersonal skills*.
Discussion: These findings provide support for the development of pre-requisites of person-centred practice, rather than person-centred processes in pre-registration curricula. With key pre-requisites for person-centred practice such as leadership attributes of knowing self and of advanced communication skills, learners and graduates will be able adopt healthful leadership practices which are vital in developing others and in creating person-centred cultures.

KEYWORDS

leadership, community nursing, education, person-centred curriculum, person-centred practice inventory

Introduction

Following the World Health Organisation's (1) commitment to placing people at the centre of healthcare, there has been a shift in the focus of health and social care systems globally. This shift is concerned with humanising healthcare where human rights principles such as dignity; respect for diversity and non-discrimination, accessibility, and equity; involvement and participation; partnership and empowerment are adopted as core values (2). According to McCormack and McCance (3), these principles reflect person-centredness. Current professional standards in nursing have responded to the WHO's agenda by moving from a technical focus in their standards to a stance that incorporates person-centred principles (4–6), although the challenge for curriculum leaders is operationalising these standards (7–13).

Despite these developments, it is reported that person-centred principles were not consistently applied in education curriculum; rather, they reflected heuristics prepared without a solid theoretical foundation of person-centredness (14, 15). In response to these challenges, a Person-centred Curriculum framework (PCCf) was developed with leaders and practitioners from education and practice (16). The framework presents as an open system, rather than an educational programme, and considers the centrality of shared values, the strategy, systems, and structure of the curriculum as well as leadership style, staff competence and capability (17). Consequently, there is a growing body of evidence that offers insight into person-centred practitioners' learning and leadership (16, 18–22). There is, however, a limited understanding of the sustainability of knowledge implementation post-graduation.

There is increasing global recognition of the importance of preparing healthcare professionals to deliver person-centred care (PCC), yet many programmes still lack consistent integration of PCC pedagogies (20, 23). Literature suggests that while curricula may include elements of PCC, these are often fragmented or under-theorised (14). Cardiff et al. (24) and Lynch et al. (25) emphasise that embedding reflective and relational components like "knowing self" fosters leadership and sustainable person-centred cultures. Furthermore, Heron's (26) facilitation theory and Dewing et al.'s (24) work on flourishing workplaces underline that learning environments must mirror the person-centred values they seek to instil. Despite promising models, there remains a gap in longitudinal evidence assessing the transition from person-centred learning to person-centred practice (21, 22).

The purpose of this research was to explore the implementation of person-centred learning into healthcare practice by community nurses. The aim was to explore long-term changes to the knowledge and practice of person-centredness in graduates compared to students on the programmes. We hypothesised that there would be significant positive changes in the knowledge and practice of person-centredness in community nursing graduates compared to the students on the programme. We further hypothesised, based on the nature of content and approaches within these nursing programmes that the changes would be prominent in the following domains of person-centred practice, as defined in the Person-centred practice framework (Figure 1) –

i. *Knowing self* and *Developed inter-personal skills* (Pre-requisites for person centred practice)
ii. *Shared decision-making systems* (Practice environment)

Methods

The current study was conducted within three community nursing programmes—two within the Postgraduate Diploma in Person-centred Practice [Specialist Community Public Health Nursing (SCPHN)] and the Postgraduate Diploma in Person-centred Practice (District Nursing) (DN). These programmes reflect the PCCf and aim to develop leaders in community nursing. In the United Kingdom, SCPHNs are Health Visitors and School Nurses who form part of multi-professional care pathways supporting healthy pregnancy, and children aged 0–19 years while district Nurses play a key role in leading the integrated team in offering care and support to those whose needs are best met in a home setting.

Design and sampling

A quantitative survey-based research design was used to explore implementation of learning into practice, specifically regarding developing person-centred culture and practice. The study received ethical approval from the Ethics committee at the authors' institution. An online version of the Person-centred Practice Inventory—Staff (PCPI-S) was deployed using Qualtrics online survey tool (29).

Purposive and convenience sampling was used. Graduates and part-time and full-time students were approached for participation and participant recruitment was facilitated through professional networks. Potential participants were briefed in online information sessions and a weblink to the online survey was provided. All participants were adults with the capacity to give informed consent, and there was no age restriction or exclusion based on other demographic variables. Consent was recorded on the first page of the online survey. Only after participants had clicked "agree" were they able to proceed to the survey.

Data collection and analysis

PCPI-S is a standardised and psychometrically validated instrument (30) which consists of 17 constructs with 59 items in total. Each item asks participants to rate their agreement on a Likert scale of 1 (strongly disagree) to 5 (strongly agree). PCPI–S is a reliable instrument with high validity and is suitable for electronic distribution and data collection (30). Demographic data were also collected, namely age, sex, length of time since qualifying as a nurse, discipline, are they a student, if so what point of the programme were they at, number of years since qualifying from the programme, as was space for open comments to collect any other relevant information they wished to provide that may not have been captured in the PCPI-S e.g., information on current workplace, work environment, culture, and staff relationships.

Data from the survey were labelled, ID corrected and entered in a missing data analysis. This statistical analysis looked for discernible patterns of missingness and imputed missing data. Upon imputation, the data were entered in a Bayesian pairwise correlation analysis to explore the correlations between factors of interest. Factors of interest included domain and construct scores on PCPI-S, as well as specialisation and qualification of the participants (i.e., students vs. graduates). Demographic variables were entered as potential confounding variables in order to control their effects. Jeffrey's (31) suggestions were used to determine the statistical support for presence of a correlation ($BF_{10} > 3$ strong evidence, $BF_{10} > 100$ decisive etc.).

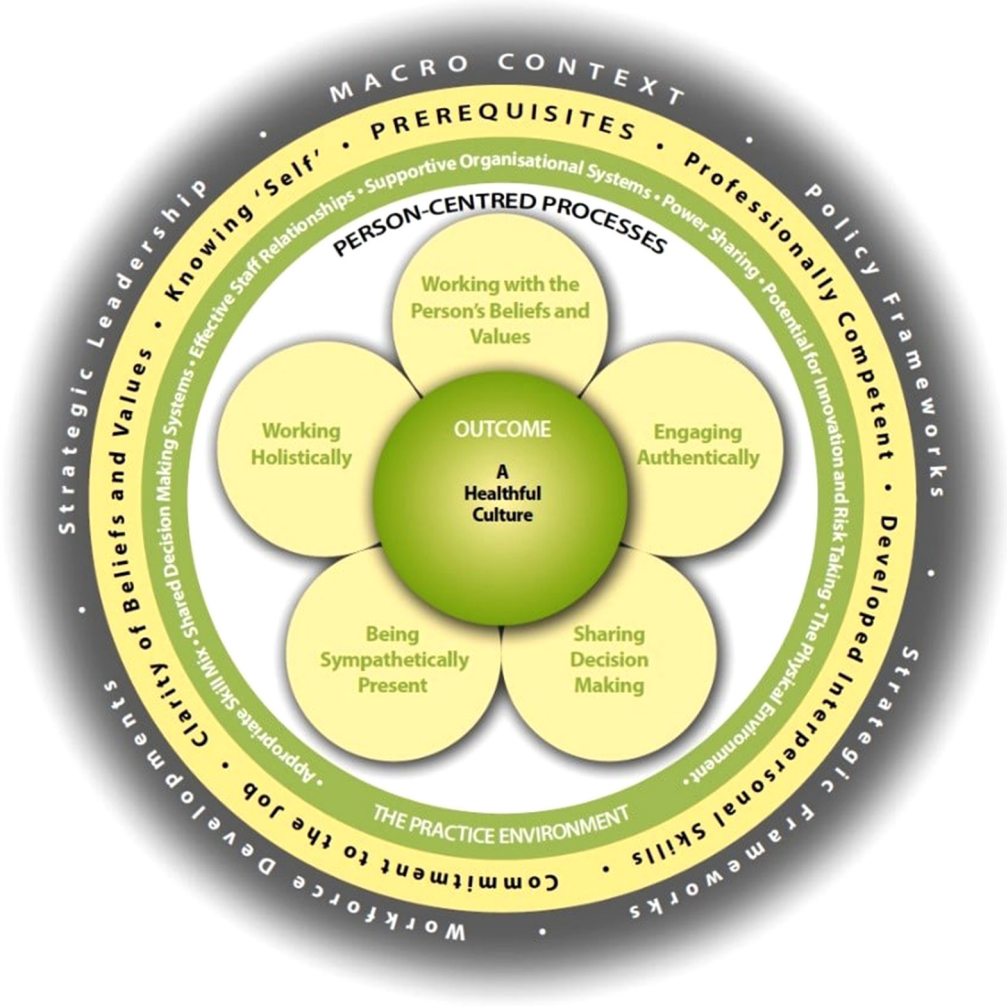

FIGURE 1
The person-centred practice framework (28).

Pearson's correlation coefficients were used to estimate the strength of the relationships among the variables. Finally, analyses of variance (ANOVAs) were conducted to examine the statistical difference between person-centred domain scores of current students and recent graduates. Statistical significance threshold was set at $p < 0.05$. All the analyses were conducted using R v 4.0.3 (32) and R Studio v 1.3.1093 (33). Bayesian correlation analyses and independent samples t-test were conducted using JASP (34).

Qualitative data from the open text questions were analysed using thematic analysis (35). This method served well to generate themes, identifying patterns of meaning. To undertake analysis, data were prepared by collating the text in table form and *familiarisation* was achieved by reading and re-reading the text. Initial codes were generated and checked by CD and JC. Through dialogue and debate, themes were generated, reviewed and then refined until the final themes were identified and named.

Results

Demographics

105 students enrolled on the programme at the time of the research and approximately 279 past graduates (from previous 5 years of the programmes) were approached for this study. 85 participants filled the survey, and 67 completed responses were retained. A summary of the participant demographics is provided in Table 1.

Quantitative findings

Specialisation and qualification (qHV, qDN, sHV, sDN & sSN) were entered as independent variables in a Bayes ANOVA with all the domains of the PCPI as dependent variables. Bayes ANOVA model with *Pre-requisites* domain showed statistically supported

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TABLE 1 Demographic characteristics of the sample.

Qualification	Qualified (n = 22)		Student (n = 35)		
Specialisation	qHV	qDN	sHV	sSN	sDN
N	14	8	13	9	13
Years since qualification (Avg)	3.14	1.62	–	–	–
Caseloads (Avg)	1.86	1.25	–	–	–
Sex (number of males)	0	2	0	0	0

Ten participants did not provide their demographic details. Specialisations were qHV, qualified specialist community public health nurse—health visitor; qDN, qualified specialist practitioner district nurse; sHV, student specialist community public health nurse—health visitor; sSN, student specialist community public health nurse—school nurse; sDN, student specialist practitioner district nurse.

differences (BF_M = 38.8). Other domains of the PCPI did not show any statistically supported differences (*Care environment* BF_M = 1.93; *Care processes* BF_M = 2.26). *Post-hoc* comparisons across specialisations for *Pre-requisites* revealed statistically supported differences between qHV and sDN (uncorrected BF_{10} = 741, corrected posterior odds = 236.70) and qDN and sDN (uncorrected BF_{10} = 40.13, corrected posterior odds = 12.80).

Following this, individual constructs within the Pre-requisites domain were entered as dependent variables to tease out the nuances of these differences. Among these, *Developed interpersonal skills* (BF_M = 22.26), *Knowing self* (BF_M = 14.28) and *Clarity of beliefs and values* (BF_M = 23.11) showed statistically supported differences. Individual *post-hoc* comparisons for these are listed in Table 2.

TABLE 2 Individual *post-hoc* comparisons for constructs of the pre-requisites domain.

	Average differences in scores	Uncorrected BF10	Corrected posterior odds
Developed interpersonal skills			
qHV—sDN	0.59	60.50	19.33
qDN—sDN	0.60	7.92	2.53
sHV—sDN	0.50	4.48	1.43
Knowing self			
qHV—sSN	0.99	9.74	3.11
qHV—sDN	0.71	60.51	19.33
qDN—sDN	0.56	6.03	1.92
Clarity of beliefs and values			
qHV—sDN	0.73	14.36	13.85
qDN—sDN	0.92	46.57	14.88
sHV—sDN	0.59	13.28	4.24

Qualitative findings

Three primary themes emerged from the qualitative responses: (1) Barriers within the practice environment, (2) Role-driven perceptions of agency, and (3) Emotional labour and moral tension.

1. Barriers within the Practice Environment

Participants across specialisations described a shared experience of under-resourced work environments, citing staff shortages, high caseloads, and systemic rigidity as major impediments to enacting person-centred practice:

> "Constant demands due to understaffing due to a lack of staff and services has made the job difficult to manage and I am very stressed most of the time."—Student District Nurse

> "Large caseloads, limited protected time, staff shortages and lack of support are the main challenges within this role."—Qualified Health Visitor

Emerging from the Covid-19 pandemic, the practice environment was described as a high stress environment featuring time constraints, understaffing, absenteeism, and lack of resources. This aligns with quantitative findings that showed no significant differences in the "practice environment" domain, suggesting that structural limitations may mute the implementation of person-centred values despite individual preparedness.

Other respondents perceived the practice context was not conducive to being person-centred augmenting the differences in the Pre-requisite domain. They emphasised the need to care for themselves, reflecting the construct of *Knowing self*:

> "I also feel there should be more care and attention for the staff to have team building events to help to allow the staff working in very intense environments to destress and feel safe amongst their colleagues"—Student Health Visitor

Psychological distress, the perception of not being heard, and lack of respect and recognition were highlighted by one sDN and one qDN.

> "I often feel self-care within teams is an issue. Staffing and burn out, stress levels all contributing to lack of respect for team members. I think we are person centred towards our patients and families but lack the same values within teams"—Student District Nurse

2. Role-Driven Perceptions of Agency

Students frequently reported feelings of powerlessness, highlighting their limited ability to challenge systemic barriers or initiate change:

> "I feel I am not able to put what I have been taught on the DN course into practice due to lack of staff and time constraints."—Qualified District Nurse

In contrast, some qualified participants described themselves as advocates and change agents, reflecting a greater sense of agency:

> "I am an advocate for person-centred care! In my practice, with my team and often strive to encourage it at management level. The majority of my team feedback that they are well supported and enjoy my leadership style which involves treating them as the individuals they are"—Qualified District Nurse

This contrast supports the finding that development in "Knowing Self" and interpersonal skills (pre-requisites) was more pronounced in qualified professionals than students.

Responses were split into participants who perceived they had agency in being person-centred and those who did not.

> "Sometimes it is difficult to deliver the care and attention to the child or young person that you would like to due to the lack of staff and resources available"—Student Health Visitor

Qualified nurses described respecting individuality, adaptability, and supportiveness.

> "Treating individuals in a person-centred approach in practice on a regular basis is rewarding and essential"—Qualified District Nurse

3. Emotional Labour and Moral Tension

Many participants described a tension between their internalised values and the realities of practice, reflecting moral distress and a sense of loss when unable to practice person-centredness:

> "There's guilt when you can't deliver care the way you were trained to. It weighs on you." — Student Nurse

> "I came from the CAMHS service which was very challenging emotionally. I value the person-centred approach because it recognises these emotional layers."—Student Health Visitor

This underscores the emotional toll of person-centred care in unsupportive environments, aligning with literature on emotional labour in healthcare.

Discussion

Findings of this study confirmed our first hypothesis which are consistent with in-house programme evaluations and pre-registration curricula grounded in person-centredness (10–12). Post-registration programmes in this study were effective in developing and sustaining knowledge implementation of person-centredness demonstrating significant differences in the domains of the Person-centred Practice Framework (PCPF). Application of the PCPF helps practitioners apply principles of person-centredness in practice, consistent with the framework aims (16–18).

Whilst the findings of Cook et al. (10) reported the development of pre-registration nurses' caring attributes (person-centred processes), the current study did not demonstrate these changes. Person-centred processes are, according to McCormack and McCance (3) the ways in which learners and practitioners engage with others. These processes have the intention of creating connections between persons and include working with the person's beliefs and values; being sympathetically present; engaging authentically; working holistically; and sharing decision-making. As Cook et al. (10) contend, these attributes are developed in pre-registration programmes, so it is perhaps unsurprising that post-registration learners in this study did not show development in this domain.

Findings of the current research show significant positive changes in the knowledge and practice of person-centredness in graduates compared to the post-registration students specifically in the pre-requisites domain of person-centredness (3, 20). Consistent with our second hypothesis, learners experience most significant development around the pre-requisites domain of the PCPF, particularly around the constructs of "knowing self" and and their "developed interpersonal skills". There is a growing body of evidence to suggest "knowing self" is a key leadership attribute that contributes to the creation of healthful cultures (23, 24). In Cardiff et al.'s (24) model of person-centred leadership, "knowing self" is a precursor to engage authentically and compassionately with associates. By adopting relational practices such as "presencing", "sensing", "balancing", "communing", and "contextualising".

Inconsistent with our final hypothesis, the results did not demonstrate notable changes within the practice environment domain of the PCPF, although thematic analysis gave some insight into the impact of context. The qualitative findings reinforce the critical interplay between individual readiness and environmental receptiveness. While learners developed intrapersonal attributes essential to person-centredness—such as reflective self-awareness and interpersonal skills—the practice environment often failed to scaffold or reward these attributes. The pervasive references to burnout, resource constraints, and feeling undervalued mirror existing research on moral injury and dissonance in nursing (13, 15, 24, 36–38). Notably, while students described frustration and helplessness, qualified professionals more often articulated a proactive, leadership-driven stance. This may reflect both their increased seniority and accumulated confidence, as well as the impact of the post-registration curriculum.

While learners gained skills such as reflective awareness and communication, systemic constraints often limited their enactment. These results echo Heron's (26) assertion that transformational learning must be situated within cultures that enable facilitation, not just instruction. If the curriculum fosters person-centred values but the clinical setting inhibits their expression, the outcome is often cognitive-affective dissonance. As one participant summarised:

> "We are person-centred towards our patients and families but lack the same values within teams."—Student District Nurse

This points to an under-addressed but critical facet of person-centred culture: intra-team dynamics. Internal team respect and psychological safety are prerequisites for delivering genuinely

person-centred care externally. These findings also point to a dual responsibility: educators must cultivate intrapersonal development, and healthcare systems must evolve to support relational practices at scale.

Implications for practice

Future iterations of person-centred curricula should explicitly bridge the gap between educational ideals and systemic implementation. Strategies may include: embedding simulation-based training focused on managing moral distress; equipping students with negotiation and advocacy skills; and supporting practice educators to role-model person-centred leadership within hierarchical systems.

As McCormack et al. (17) argue, system-level alignment is key. Educators cannot shoulder the burden alone—organisational leaders must partner to ensure that the workplace is not just a site of care delivery, but a co-facilitator of cultural change. Future implementation of person-centred curricula must be complemented by structural supports in practice settings. Protected time for reflection, recognition of emotional labour, and mentorship from person-centred leaders could help bridge the theory-practice gap. Embedding PCC not just in curriculum but also in institutional culture is essential for sustainability, as highlighted by Dewing et al. (24) and McCormack et al. (17). Further research could examine interventions where educational-practice alignment has led to measurable cultural shifts.

Limitations

Despite a rigorous recruitment campaign, the study achieved a moderate sample size ($n = 67$), with a response rate of approximately 79% from those who accessed the survey. This limits the generalisability of the findings, particularly given the diversity of roles, settings, and healthcare systems within which community nurses operate. Although efforts were made to ensure representation across different specialisations (e.g., Health Visiting, School Nursing, and District Nursing), the sample may not fully reflect the broader population of community nurses, particularly those practicing in varied institutional or regional contexts beyond the study sites. Furthermore, the reliance on self-reported data introduces potential response bias, as individuals who felt strongly (positively or negatively) about their experiences may have been more likely to participate.

The low overall participation rate relative to the total number of eligible graduates and students ($n = 384$ approached) could be attributed to several factors, including the perception that the study was evaluative of one's professional competence or learning, as well as the known challenges of research participation in practice-based professions, where staff face significant workload pressures and limited time for non-clinical activities. These constraints likely skew the sample toward those with a higher degree of professional reflection or institutional engagement, potentially limiting the variability of responses. Additionally, the study's focus on a single national context (UK) further limits international transferability, particularly to systems with different nursing education structures or community health policies.

Therefore, while the results provide valuable insight into the impact of person-centred curricula, they should be interpreted as exploratory and context-bound. Future research should aim to replicate these findings using larger, more diverse, and ideally longitudinal samples to examine the sustainability of learning transfer into practice across time and setting. Mixed-method or multi-site designs that include objective indicators of practice environment and leadership context may also enhance the robustness and applicability of future evaluations.

Conclusion

Current professional standards in nursing are moving from a technical focus to more person-centred principles in response to changes in WHO's policy commitments. The aim of this study was to evaluate the implementation of person-centred learning that is applied and sustained in practice. This study provides evidence that person-centred nursing programmes create an environment which allows the students to develop their pre-requisites for person-centred practice. Educators must encourage reflexive principles such as knowing self and clarity of beliefs and values to develop interpersonal skills in programme content. Furthermore, it is evident that practice educators and leaders need to provide more supportive environments where students and graduates feel able to practice person-centredness and promote person-centred ways of working.

Data availability statement

The raw data supporting the conclusions of this article will be made available by the authors, without undue reservation.

Ethics statement

The studies involving humans were approved by Queen Margaret University Ethics Board. The studies were conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study.

Author contributions

VT: Software, Visualization, Validation, Conceptualization, Supervision, Methodology, Data curation, Investigation, Resources, Writing – review & editing, Writing – original draft, Formal analysis. JC: Formal analysis, Writing – original draft, Methodology, Investigation, Writing – review & editing. CD: Writing – review & editing, Conceptualization, Investigation, Writing – original draft, Supervision, Funding acquisition, Validation, Project administration, Resources, Formal analysis, Methodology.

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The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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The contribution of a person-centred model of Lean Six Sigma to the development of a healthful culture of health systems improvement

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Background: A failure to distinguish between person-centredness, person-centred care, and person-centred cultures can result in improvement initiatives focusing solely on improvement initiative metrics and outcomes, excluding the authentic experiences of patients and staff. Building on the foundational work of Dewing and McCormack, we have designed, piloted, and implemented the Person-centred Lean Six Sigma (PCLSS) model in public and private acute and community healthcare settings across Ireland. This model uses Lean Six Sigma, a widely adopted improvement methodology, through a person-centred lens with which improvement practitioners and healthcare staff can inspect their Lean Six Sigma practice and critically evaluate whether, to what extent, and how it is synergistic with person-centred approaches.
Aim: This paper explores the deployment of the PCLSS model across four clinical study sites and examines its alignment with McCance and McCormack's conceptual work on healthful cultures, evaluating its contribution to creating cultures that support sustainable improvement, compassion, and respect.
Methods: The PCLSS model was embedded within a university-accredited education programme for healthcare staff. The model was applied across four distinct healthcare settings in Ireland: a public acute teaching hospital, a private full-service acute hospital, an integrated ophthalmology service bridging hospital and community care, and a public rehabilitation hospital. A case study methodology was used to examine implementation and impact.
Results: Across all four sites, the PCLSS model facilitated improvements in operational efficiency, staff and patient engagement, interprofessional collaboration, and reflective practice. The model supported leadership at all levels, fostered sustainable change, and successfully mapped onto key domains associated with healthful cultures, as articulated in the work of McCance and McCormack.

Conclusion: The PCLSS model represents a sustainable, values-based approach to improvement that aligns operational excellence with person-centred principles. Its application contributes meaningfully to the development of healthful cultures in healthcare organisations.

KEYWORDS

Lean Six Sigma, person-centred care, healthful cultures, healthcare improvement, systems thinking, reflective practice, staff empowerment, sustainable change

1 Introduction

1.1 Background: person-centred care and Lean Six Sigma

Person-centredness continues to be a cornerstone of contemporary healthcare, influencing how care is delivered and experienced and how improvements are made within healthcare systems (1). At its core, it promotes meaningful relationships between all those involved in care. It is defined as "an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives" (1). Person-centred care is the operational enactment of these values in day-to-day clinical encounters and focuses on planning and delivering care in a way that is meaningful to each individual (2). Person-centred cultures represent the broader organisational embodiment of these principles, reflected in leadership, governance, infrastructure, and values systems (1). Distinguishing between person-centredness, person-centred care, and person-cultures is essential for embedding authentic, sustainable change (3).

Lean is a process improvement methodology that focuses on the elimination of non-value-added (NVA) activities—those steps in a process that do not add value from the perspective of the person receiving or delivering care (3). Examples of the impact of NVA include prolonged wait times for diagnosis, intervention or treatment (4, 5), variable access to sufficient treatment such as physiotherapy or occupational therapy (6), or lack of system oversight of care between acute hospitals and community settings (7). Six Sigma is a data-driven methodology aimed at minimising unwanted process variation that can lead to errors, inconsistencies, or inefficiencies, such as variability in medication administration (8) or delays in moving older persons from acute care to home settings (9).

When combined, Lean Six Sigma (LSS) integrates Lean's reduction of non-value-added activities focus with Six Sigma's variation-minimising rigour to optimise healthcare processes, improve reliability, and enhance patient outcomes (3, 4). It has become one of the most widely adopted methodologies in international healthcare improvement practice (3, 10).

While LSS offers structured methods for problem-solving and process improvement, its application in healthcare has often been technical in focus, sometimes failing to account for the relational and cultural aspects of care (3, 11). When deployed without attention to human values, LSS risks becoming a decontextualised and at times, reductionist-focused toolkit that overlooks the experiences of patients and staff (12). However, reports of recent work at both local and systems levels in healthcare settings (13) demonstrate the potential synergy between LSS and person-centredness when framed intentionally through models such as the Person-centred Lean Six Sigma (PCLSS) model, creating opportunities to embed relational and cultural values at the heart of improvement work (14).

1.2 The development of the PCLSS model

The PCLSS model's conceptual foundation is rooted in the idea of "human flourishing", which can be described as a state in which individuals experience sustained well-being and function at their best (15). This includes resilience—the capacity to adapt and grow following periods of challenge, drawing on positive psychology principles from authors such as Seligman (16).

To support workplaces in enabling human flourishing Dewing et al. (17) and Dewing and McCormack (18) developed the Compliance, Service Improvement and Innovation (CoSII) model (Figure 1). The CoSII model positions service improvement, including Lean Six Sigma, alongside compliance and innovation within a broader person-centred cultural framework. It acknowledges that organisations may fluctuate between these orientations over time, and that culture change is a dynamic, evolving process.

This conceptual foundation laid the groundwork for the development of the Person-centred Lean Six Sigma (PCLSS) model. The CoSII model illustrated that even structured methodologies like Lean Six Sigma can align with person-centred principles when applied intentionally. Building on this insight, Teeling et al. (3, 11) explored the points of synergy and divergence between Lean Six Sigma and person-centred approaches. Through a realist review of the literature and a realist evaluation of real-world practice, they examined how Lean Six Sigma could contribute to the development of person-centred cultures—insights that informed the creation of the PCLSS model (14).

The Person-centred Lean Six Sigma (PCLSS) model (Figure 2) comprises eight interrelated components drawn from Lean Six Sigma practice: Voice of the Customer, Respect for Person, Observational Studies (known as Gemba, taken from the Japanese), Staff Empowerment, Quality as an Influencer, Core Values, First Principles, and Standardisation. These components are grouped into three categories — synergy, divergence, and mutual influence, representing how each relates to the principles of person-centredness. The model does not assume alignment

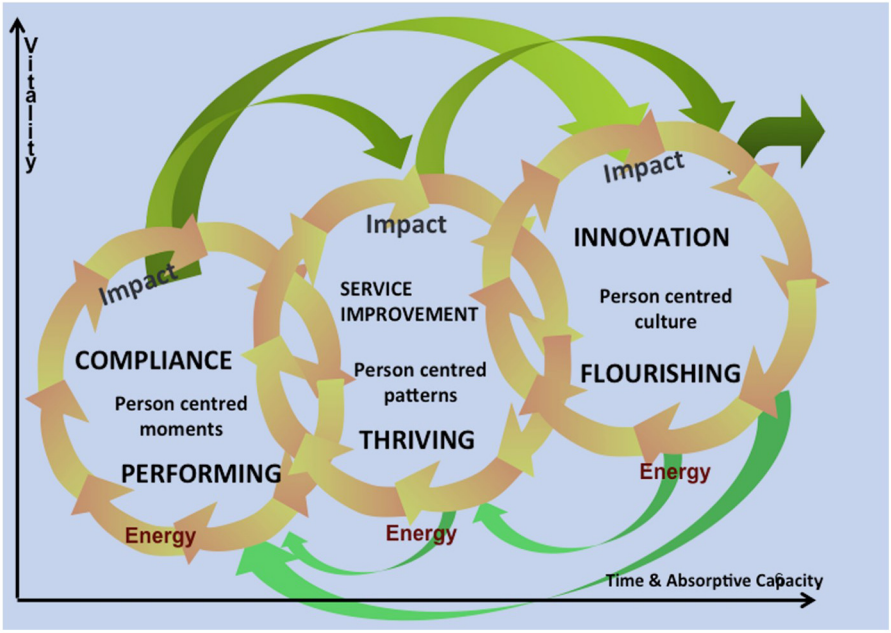

FIGURE 1
The compliance, service improvement and innovation model (CoSII). This Venn-style model presents three overlapping domains: Compliance, Service Improvement, and Innovation, each aligned with stages of person-centred moments (performing), patterns (thriving), and cultures (flourishing). It originated from a practice-development programme focused on energy and movement as drivers of change. Organisational activities populate different domains: compliance emphasises technical adherence; improvement embodies process-driven engagement; innovation enables flourishing cultures. Axes illustrate how emotional and motivational energies are generated across domains, reinforcing that sustainable person-centred culture requires movement through and across these interlinked spaces. Reproduced with permission from "The Compliance, Service Improvement and Innovation Model (CoSII)" by Brendan McCormack and Tanya McCance.

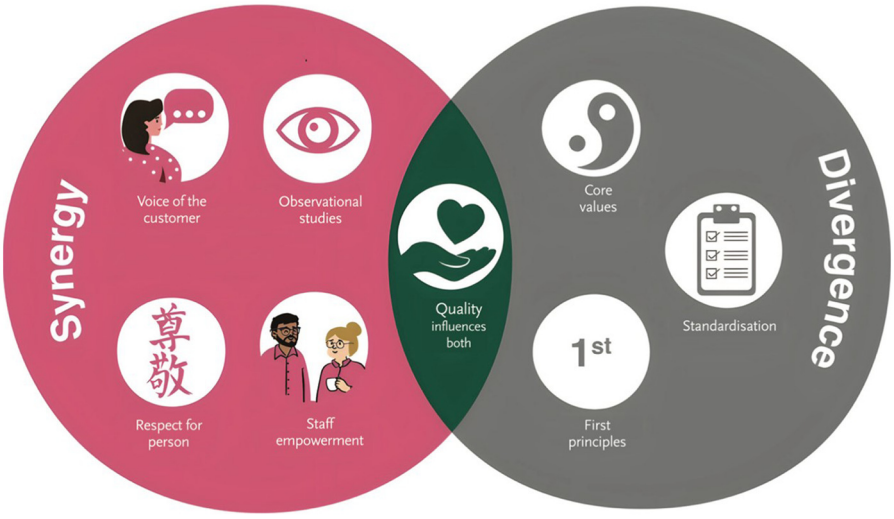

FIGURE 2
The person-centred Lean Six Sigma model. This circular model presents eight Lean Six Sigma components viewed through a person-centred lens, grouped into three domains: Synergy, Divergence, and Mutual Influence. Voice of the Customer, Respect for Person, Observational Studies (Gemba), and Staff Empowerment are located in Synergy, reflecting strong alignment with person-centred principles. Core Values, Standardisation, and First Principles are positioned in Divergence, where potential tensions may arise. The central overlapping space, containing *Quality as Influencer*, represents the intentional integration of relational and technical logics, drawing on the contrasting perspectives represented in the Synergy and Divergence domains. Acknowledging that understandings of quality are shaped by context, culture, and system priorities, the model avoids collapsing these domains into one. Instead, it foregrounds how quality may serve as a bridge between paradigms, enabling Lean Six Sigma to be adapted through a person-centred lens to support healthful, values-based improvement. Reproduced with permission from "The Person-centred Lean Six Sigma Model" by Seán Paul Teeling.

between the two paradigms, but instead provides a structure to examine points of harmony, challenge, and integration.

The PCLSS model offers a reflective and practical resource for Lean Six Sigma practitioners seeking to apply process improvement through a person-centred lens. While it retains key terminology from Lean Six Sigma, each component is interpreted through a relational perspective that prioritises values-based improvement and collaborative engagement. The model invites users to consider where Lean Six Sigma principles may align with, diverge from, or be adapted to person-centred ways of working. For example, the term "Voice of the Customer" is a Lean Six Sigma term that is intentionally retained within the model, which is explicitly designed for use by LSS practitioners who wish to apply LSS through a person-centred lens. However, the model emphasises that when operating within person-centred contexts, the Voice of the Customer must be understood as the authentic, participatory, and inclusive engagement of those receiving and delivering care. This includes collaborative activities such as listening, co-design, shared decision-making, and enabling ownership of change. It asks practitioners to ensure that their engagement is relational, not transactional, and that improvement efforts are shaped by the lived experiences of patients, families, and staff (11, 14).

The overlapping space in the centre of the model, Quality as Influencer, represents the intentional integration of selected relational and technical logics. Rather than collapsing synergy and divergence, it offers a conceptual meeting point that prompts critical reflection on how quality is understood, prioritised, and enacted across paradigms. The model acknowledges that "quality" is not a fixed concept but one that is contextually constructed, ranging from measurable outcomes to shared values and lived experience (3, 11, 14). This complexity challenges practitioners to engage with both the methodological rigour of Lean Six Sigma and the relational depth of person-centred approaches. In doing so, the model reinforces that while tensions may arise, both paradigms ultimately seek to contribute to quality improvement, a shared goal embedded at the heart of this overlap (3, 11, 14).

The model was developed through a realist-informed methodological approach, drawing on a multi-stage inquiry into how Lean Six Sigma contributes to person-centred care and cultures in healthcare settings (3, 11, 12, 14). Initial Programme Theories (IPTs) were generated through a realist review of the literature and collaborative engagement with an expert panel (3). This panel included senior clinical managers, front-line nurses and allied health professionals, person-centred practice researchers, improvement facilitators, and international academic advisors with specialist expertise in both person-centred methodologies and Lean Six Sigma (3). The IPTs were tested across study sites through realist evaluation, using context–mechanism–outcome (CMO) configurations to identify patterns of how Lean Six Sigma interacts with relational working and cultural conditions (3). The resulting Programme Theories (PTs) were then synthesised into a conceptual understanding that directly informed the structure of the model. Specifically, these PTs revealed recurring areas of alignment, tension, and co-adaptation between Lean Six Sigma and person-centred principles, which shaped the grouping of model components into synergy, divergence, and mutual influence (3, 11, 14).

Throughout the development of the PCLSS model, ongoing learning was integrated into a university-accredited postgraduate education programme in Person-centred Six Sigma for healthcare professionals across Ireland (12). The programme aimed to support practitioners in using the model to lead local improvement initiatives rooted in both technical rigour and relational values. The education curriculum included training in Lean Six Sigma tools and frameworks, systems thinking, structured facilitation, Voice of the Customer, Gemba observations, and reflective dialogue. In addition, participants were guided to examine their own improvement practice (i.e., their facilitation) through the lens of person-centredness and to co-design change initiatives aligned to service values.

The model has been applied across 12 healthcare sites in Ireland, spanning acute, community, and integrated settings, demonstrating its adaptability and potential for supporting cultural transformation in diverse service contexts (14). It is also currently in use in 12 countries, where both teams and individuals have adopted it to enhance person-centred Lean Six Sigma improvement efforts.

1.3 Healthful cultures

McCance and McCormack (19) developed the concept of healthful cultures through their work on person-centred practice and its cultural outcomes (20). Healthful cultures are defined as "contexts that are energy-giving for the benefit of health and wellbeing" — environments where both those delivering and those receiving care can flourish (19). These cultures are underpinned by respect for the person, mutual understanding, and shared decision-making. Importantly, they extend beyond individual behaviours to system-wide values and relationships (1, 19).

The Person-centred Practice Framework (Figure 3) (19) provides the basis for informing care-delivery models (21), curriculum frameworks (22), and research methodologies and practices (23). Over more than 20 years of research and practice development, McCormack and colleagues have identified key components of person-centred practice that contribute to the development of healthful cultures. These components include macro-contextual influences (strategic, political, and policy-related), staff attributes, the nature of the practice environment, person-centred processes, and person-centred outcomes. The framework highlights the complexity of healthcare systems and the dynamic interplay between individuals and structures.

A key characteristic of a healthful culture is that it does not prioritise the experience of people receiving care at the expense of staff wellbeing; rather, both are seen as interdependent. For cultures to be healthful, all persons must be energised by the context in which they work, and this energy must connect with the personhood of all involved (19).

While values such as compassion and kindness are important, McCance and McCormack (19) argue that they are not sufficient

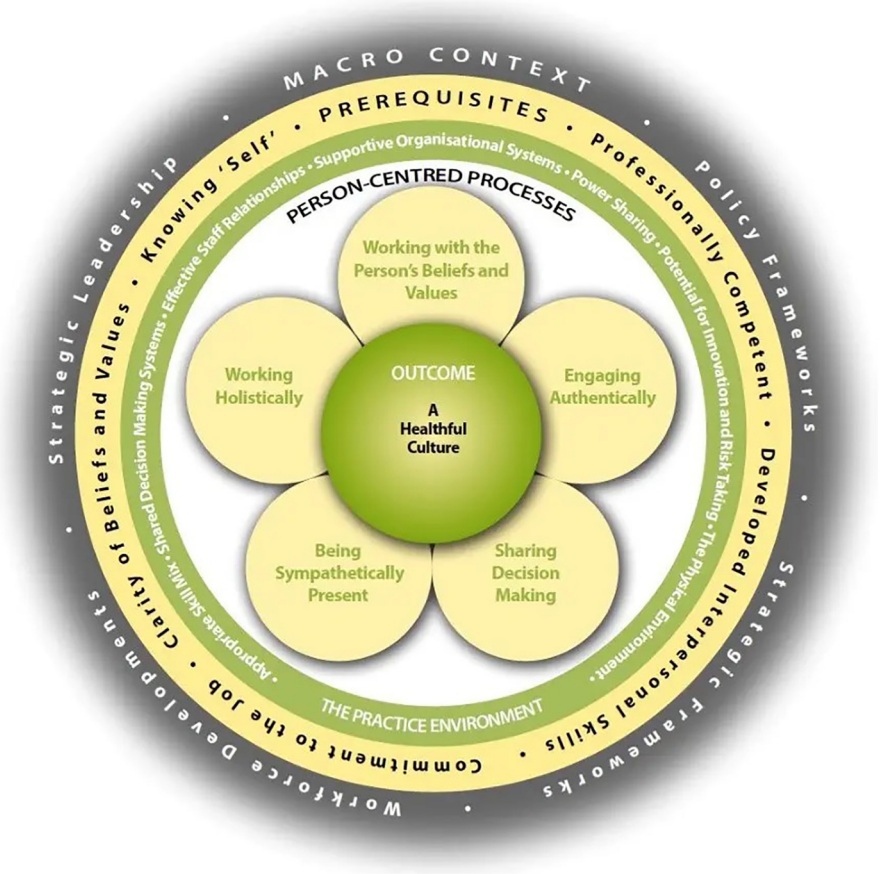

FIGURE 3
The person-centred practice framework source: This concentric model depicts the core domains that enable person-centred practice and the development of healthful cultures. At the centre are person-centred outcomes, supported by layers representing person-centred processes, the practice environment, staff attributes, and the macro context. Each layer is interdependent and connected, highlighting dynamic relationships between individuals, teams, and systems. The framework emphasises that person-centredness is shaped by contextual, relational, and structural factors, and that its enactment requires alignment across all levels of a healthcare system. Reproduced with permission from "Person-centred Practice Framework" by Brendan McCormack and Tanya McCance, licensed under CC-BY-NC-ND.

on their own to deliver person-centred practice. A shared language and system-wide understanding of person-centredness are essential to move beyond aspirational statements into practical, sustainable change. This aligns with global policy trends, including the World Health Organisation's (24) framework on people-centred healthcare, which emphasises integrated, strategic approaches to health system reform that centre on individuals, relationships, and local contexts.

1.4 Purpose of this paper

This paper seeks to explore the contribution of the Person-centred Lean Six Sigma (PCLSS) model to the development of healthful cultures in healthcare settings. While existing literature has articulated the importance of relational, person-centred approaches and the structured rigour of Lean Six Sigma, few studies have examined how these can be meaningfully integrated and applied to drive cultural change (3, 11). Notable exceptions include the work of Ward et al. (13), Teeling et al. (7) and Daly et al. (25), who have demonstrated the value of a whole-system, person-centred approach to improvement.

We propose that the PCLSS model provides a values-based, improvement-oriented framework that can support the cultivation of healthful cultures, as defined by McCance and McCormack (19, 20). To evidence this, we present four anonymised case studies of the model's implementation across diverse healthcare settings in Ireland. Through comparative analysis of the four studies, we examine how the model was used, what patterns emerged, and the extent to which its application aligned with the domains of the McCance and McCormack's work on Healthful Cultures.

This paper contributes to the ongoing discourse on how improvement methodologies can move beyond technical outcomes to embrace person-centred values, and how healthcare organisations can transition from isolated implementation to sustainable cultural transformation through reflective, participatory practice.

2 Methods

2.1 Study design

Sites were selected for inclusion based on three key criteria:

1. Staff who facilitated the improvement had completed training and education in the Person-centred Lean Six Sigma (PCLSS) model through a university-accredited education programme.
2. At the time of the study, the organisation was actively applying the PCLSS model to a defined improvement initiative/initiatives.
3. Senior management support was demonstrated through active leadership, resource allocation, and strategic alignment of improvement work with organisational goals, which aimed to deliver excellent, safe, quality, person-centred care.

A qualitative, instrumental multiple case study design was employed to explore the contribution of the PCLSS model to the development of healthful cultures within healthcare organisations. Instrumental case study designs enable an in-depth examination of a broader phenomenon through the investigation of multiple bounded cases (26). In this study, four healthcare sites were purposively selected based on their formal adoption and active implementation of the PCLSS model within organisational quality improvement initiatives. Each case was distinct in service type and context but shared the common feature of explicitly applying the PCLSS model to quality improvement activities.

- Study Site 1: Public Acute Teaching Hospital
- Study Site 2: Private Full-Service Acute Hospital
- Study Site 3: Integrated Community-Acute Ophthalmology Services
- Study Site 4: Public Rehabilitation Hospital

Each site applied the PCLSS model to one or more service improvement initiatives (Table 1).

TABLE 1 Summary of PCLSS model use by study site.

Study site	Improvement types	Time since organisational Lean Six Sigma deployment
Study Site 1: Public Acute Teaching Hospital	Dermatology outpatient access; Rehabilitation coordination	12 years
Study Site 2: Private Full-Service Acute Hospital	Surgical note documentation; Discharge pathway redesign; Outpatient access	8 years
Study Site 3: Integrated Community-Acute Ophthalmology Services	Referral redesign; Optometry-led care; Cataract surgery pathway	5 years
Study Site 4: Public Rehabilitation Hospital	Visiting policy redesign	3 years

Study Sites 1 to 3 implemented multiple projects across different service areas or clinical pathways, demonstrating the model's scalability and adaptability. For example, the Private Full-Service Acute Hospital and the Integrated Ophthalmology Services each addressed several distinct but complementary workstreams. In contrast, the Public Rehabilitation Hospital focused on a single, high-impact initiative related to visiting policy, reflecting its more recent adoption of the PCLSS model. Project focus, scope, and scale varied across settings, reflecting the flexibility of the PCLSS model to support both targeted and system-wide improvement. While a formal economic evaluation was not within the scope of this study, feasibility considerations were visible across sites. The model was applied in each site with implementation supported by locally available resources within existing quality or improvement departments. Costs primarily related to staff education and training in person-centred Lean Six Sigma, study leave to support this, and protected clinical time for project work. These were absorbed within organisational development budgets or supported through existing quality improvement initiatives, indicating that the model can be feasibly embedded in routine practice without requiring substantial external investment.

2.2 Data collection

2.2.1 Documentary analysis

To support rigour and enable meaningful cross-site learning, documentary analysis and semi-structured interviews were carried out across all four sites. The research team obtained ethical approval to access qualitative and quantitative materials generated independently by local project teams during their implementation of the PCLSS model. These site-led projects were self-directed, with improvement aims designed and owned locally (see Table 1), and each site used the PCLSS framework to structure their design, implementation, and evaluation processes.

Each local team comprised interdisciplinary frontline healthcare professionals, including nurses, doctors, health and social care professionals, and administrative staff, all of whom had completed university-accredited education in Person-centred Lean Six Sigma (12). In the course of their work, these teams collected project-specific data using Lean Six Sigma tools and techniques, including Gemba observations, interviews, focus groups, and service user feedback (referred to as Voice of the Customer within Lean Six Sigma). These data were generated as part of each site's improvement activity and embedded in their reflective and evaluative practices.

The research team did not collect these data but instead undertook a structured documentary analysis of the existing material. This analysis aimed to examine how the PCLSS model had been applied in diverse, real-world settings, to identify contributions to healthful cultures, and to support cross-case insight and learning.

Documentary data reviewed included:

- Lean Six Sigma project documentation and outcome reports

- Site-generated surveys, interview transcripts, focus group summaries, and Gemba observation notes
- Staff reflective accounts and narrative feedback
- Presentations and internal evaluation reports prepared by local teams

2.2.2 Semi-structured interviews

In addition to analysing site-generated documentation, the research team conducted semi-structured interviews with staff who had participated in the PCLSS initiatives ($n = 16$) across the four sites. A member of the research team, experienced in person-centred practice and quality improvement using Lean Six Sigma, but not involved in project delivery, conducted all interviews to support relational sensitivity, reflexivity, and openness.

An interview schedule was developed by the research team, structured around the eight core components of the Person-centred Lean Six Sigma (PCLSS) model: *Voice of the Customer, Respect for Person, Gemba (observational study), Staff Empowerment, Quality as an Influencer, Core Values, First Principles,* and *Standardisation*. These were mapped to the healthful culture domains identified by McCormack and McCance (19), including values-based leadership, inclusive practice, and staff well-being.

The schedule aimed to explore staff experiences of applying the model, while supporting critical reflection and values alignment. To ensure a person-centred orientation, the interview questions incorporated elements drawn from the Claims, Concerns and Issues (CCI) tool (27). This structure encouraged participants to identify what worked well, what challenges were encountered, and what uncertainties or questions remained.

For example, questions under *Voice of the Customer* included:

- "How were service users involved in your project?"
- "Did their involvement shape the design or implementation of changes?"
- "Were there any tensions or challenges in responding to feedback?"

Under *Staff Empowerment*:

- "Did you feel you were able to lead or initiate change?"
- "What supported or inhibited your ability to act?"
- "What would help strengthen staff empowerment in future initiatives?"

Similar exploratory questions were posed across the remaining domains to elicit both practical and cultural insights. Interviews concluded with open reflections, such as:

- "What impact, if any, did the project have on your team's culture?"
- "How did the PCLSS model influence your experience of person-centred working?"

Each interview lasted 30–45min, was audio-recorded with participant consent, transcribed verbatim, anonymised, and analysed thematically. The integration of a person-centred approach and reflective orientation with research participants enabled the research team to explore both implementation outcomes and the underlying cultural and relational mechanisms that shaped them.

2.3 Data analysis

We drew on Braun and Clarke's (28) six-stage process of thematic analysis to guide the analysis of data within each case study, before drawing comparisons across cases. While the core stages were followed, the approach was adapted to suit the study's aims. Specifically, a hybrid inductive-deductive approach was adopted (29), allowing patterns to be generated directly from the data before being organised and interpreted in relation to McCance and McCormack's (19) work on Healthful Cultures. This adaptation enabled an open exploration of the data while also aligning emerging themes with an established body of work to enhance analytical depth and rigour.

The adapted process involved the following stages:

- Familiarisation: The research team first familiarised themselves with the collected data independently, then collectively, to support reflexivity and enhance analytical credibility (30). This included reviewing project documentation, reflective accounts, Voice of the Customer feedback, and observational data from Gemba, with repeated reading to develop a shared understanding of the material.
- Initial Coding: The data were coded by identifying meaningful units of information related to key aspects of person-centred practice, culture, and improvement outcomes. The coding process was inductive, generating codes directly from the data without pre-existing hypotheses (28). To ensure coding consistency, the research team collaboratively developed working definitions for key codes as they emerged. Initial coding was conducted independently by team members, followed by comparison and discussion to reach consensus on code application. Discrepancies were resolved through reflective team dialogue, supporting a transparent and reflexive approach to theme development. Data that did not align directly with Healthful Cultures was reviewed carefully; where appropriate, it was grouped under broader improvement outcomes related to service delivery. No significant data were excluded as redundant or unlabelled, ensuring a comprehensive account of the dataset.
- Generation of Themes: Through an iterative process, the research team grouped related codes into broader themes through comparison, discussion, and refinement (29).
- Review and Refinement of Themes: Once initial themes were established, they were reviewed for coherence and relevance through team discussions, incorporating feedback from all members. Themes were refined and redefined to ensure they accurately captured the complexity of the data.
- Mapping to Healthful Cultures: Themes were developed inductively from the case study data through open coding and iterative refinement. In the second stage of analysis, these emergent themes were deductively mapped onto the six domains of McCance and McCormack's (19) Healthful

Cultures. This mapping process allowed the research team to explore the alignment between the themes generated from the PCLSS model's implementation and the principles of healthful cultures. The six domains used for mapping were: Leadership, Person-Centred Processes, Staff Empowerment, Collaborative Relationships, Supportive Practice Environments, and Shared Values and Vision. This two-stage approach ensured that the analysis remained grounded in the data while also linking the findings to an established theoretical model.

This process ensured that the analysis was grounded in the data and examined through a person-centredness theoretical framework, being rigorously examined to identify meaningful insights into the role of the PCLSS model in fostering healthful cultures in healthcare environments.

3 Results

This study explored how the Person-centred Lean Six Sigma (PCLSS) model contributed to developing healthful cultures across four healthcare settings. Findings are presented in three parts:

1. First, key improvements and impacts are outlined for each study site (Section 3.1).
2. Second, a cross-site comparative analysis identifies shared features of person-centredness and contextual adaptations (Section 3.2).
3. Third, these findings are mapped onto McCance and McCormack's (19) Healthful Cultures work (Section 3.3) to explore the contribution of the PCLSS model to developing healthful cultures.
4. Finally, we detail Quantitative Outcome Measures (Section 3.4).

3.1 Overview of findings from study sites

3.1.1 Study site 1: public acute teaching hospital

This site focused on reducing waiting times for dermatology outpatient appointments and streamlining access to rehabilitation for older adults (5). Efficiency gains included reduced time to appointment, standardised triage, and coordinated discharge processes. Staff described a growing sense of control and reduced stress due to equitable workload distribution and system-level visibility. Patient confusion around care transitions was addressed through co-designed communication tools and simplified referral pathways.

3.1.2 Study site 2: private full-service acute hospital

The PCLSS model was used at this site to improve service efficiency and care coordination. Examples included improving surgical note documentation (31), standardising discharge pathways (32), and enhancing outpatient access (33). Staff reported improved interdepartmental collaboration and a greater ability to contribute to meaningful change. The cultural shift was characterised by an increased sense of shared responsibility and respect for staff input.

3.1.3 Study site 3: integrated community-acute ophthalmology services

This regional initiative bridged hospital and community services to enhance ophthalmology pathways. Use of the PCLSS facilitated the redesign of referral processes, increased optometry-led care, and improved access to surgery. The Voice of the Customer was central, with structured engagement of staff and patients. Reflective practice, collaborative learning, and shared ownership of change were integral to implementation, contributing to a strong sense of system-wide cohesion.

3.1.4 Study site 4: public rehabilitation hospital

This hospital used the PCLSS model to redesign visiting policies, focusing on balancing safety, therapeutic goals, and person-centred values. Data-informed Gemba observations and surveys captured the voices of patients, staff, and visitors. Resulting changes included extended visiting hours, greater flexibility, and new guidelines that were co-designed and widely accepted. Staff reported reduced conflict, enhanced clarity, and improved morale. Patients and families experienced improved access, respect for preferences, and shared decision-making.

Across all sites, the PCLSS model enabled the co-creation of solutions tailored to local context, while reinforcing a broader cultural shift toward inclusivity, empowerment, and reflective practice.

3.2 Comparative analysis

3.2.1 Commonalities across sites

Despite differences in setting, scale, and focus, several patterns emerged:

- Person-centred engagement: All sites emphasised the importance of Voice of the Customer and inclusive decision-making, resulting in interventions that reflected the real needs and values of persons delivering and receiving care.
- Empowerment and participation: Staff reported feeling more empowered and supported to initiate and lead change. The use of structured improvement initiative facilitation by qualified Lean Six Sigma practitioners was widely credited with fostering psychological safety and encouraging shared ownership.
- Sustainability and spread: Improvements were sustained and often led to second-generation projects. Sites developed mechanisms (e.g., dashboards, daily huddles, rotation of roles) to ensure continuity and adaptability.

3.2.2 Differences in application

While the core model remained consistent, each site adapted its use of the PCLSS to its context:

- The Public Acute Teaching Hospital prioritised pathway coordination and clinical flow, with strong leadership from Lean Six Sigma-trained facilitators.
- The Private Full-Service Acute Hospital leveraged the model for cross-departmental redesign and data-driven innovation, particularly around documentation and discharge.
- The Integrated Ophthalmology Services initiative used the model for system-wide transformation, aligning hospital and community operations through co-designed regional governance.
- The Public Rehabilitation Hospital applied the model to enhance patient and family experiences, embedding relational practice into institutional policy and practice environments.

These variations affirm the model's adaptability, reinforcing its relevance across complex and evolving care contexts.

3.2.3 Contextual enablers across sites

The PCLSS model demonstrated adaptability and success across the study sites, and several contextual enablers emerged that shaped the implementation process. These enablers were addressed through ongoing reflection and adaptation to the local context. Key enablers were:

- Leadership Engagement: Strong and consistent leadership commitment was identified as essential to the sustainability of improvement initiatives. Sites with robust leadership engagement demonstrated greater momentum, resource allocation, and staff empowerment, while variations in leadership commitment posed challenges to maintaining improvement efforts over time.
- Staff Engagement and Training: Staff participation varied, with some concerns raised regarding the balance between clinical responsibilities and improvement activities. Time constraints impacted engagement; however, flexibility in project scheduling and additional support helped address these challenges. In Sites 1, 2, and 3, dedicated improvement facilitators and/or colleagues who had completed the Lean Six Sigma education programme provided structured support to staff. In site 4, where dedicated improvement teams were not in place, support was provided by colleagues engaged in improvement initiatives, helping to maintain momentum and foster broader participation.
- Alignment with Organisational Culture: Integrating person-centred values with existing operational practices was a key enabler. The PCLSS model's emphasis on meaningful, non-volume-based metrics—such as care experience, responsiveness, co-designed processes, and relational quality (the empathy and strength of interactions between staff, patients, and families)—served as a useful conduit for aligning everyday practice with organisational culture and values.
- System Integration: Fragmented care pathways and communication challenges initially acted as barriers to improvement in some settings. These challenges were gradually addressed through increased collaboration across teams, iterative refinement of processes, and better integration of the PCLSS model into routine practice, ultimately enabling more coordinated and person-centred care.
- Implementation History and Cultural Readiness: Sites with longer-established Lean Six Sigma foundations demonstrated greater readiness for PCLSS implementation, showing more openness to participatory facilitation, reflective practice, and person-centred approaches. Familiarity with structured improvement methods, collaboration, and reflective learning contributed to the faster embedding of the PCLSS model. This reinforces broader findings that developing healthful, improvement-oriented cultures requires time to build trust, shared learning, and collective ownership of change (19, 34, 35).

Table 2 provides a high-level summary of how the shared features identified across the four study sites align with McCance and McCormack's (19) Healthful Cultures work.

3.3 Mapping shared features to healthful cultures

We now discuss these findings in greater detail, exploring how each site's unique context contributed to developing a healthful culture by applying the findings of the use of the PCLSS model to McCance and McCormack's (19) Healthful Cultures work.

3.3.1 Leadership

The application of the PCLSS model strengthened relational leadership practices across all study sites, consistent with the Healthful Cultures (19). Leadership was found not to rely on hierarchical, top-down models, but instead demonstrated shared, enabling approaches that fostered trust, empowerment, and collective ownership of improvement work. Staff consistently described leadership as a relational process that supported meaningful engagement. A participant from site 1 noted, "The leadership during our project wasn't about one person telling us what to do … . it felt like we were all part of it. The … . model made leadership much more about connection and support", highlighting the emphasis on inclusivity and empowerment. Similarly, a participant from Site 2 observed, "You could see the shift … . instead of directing us, leaders started asking us how they could support the changes we wanted to make", reflecting a move toward enabling rather than directive leadership practices. This approach was reinforced at Site 3, where staff described, "PCLSS helped us see leadership as something shared. It wasn't top-down anymore; everyone had a voice, and that changed the culture completely". One team member from Site 4 reflected on the relational nature of leadership, stating, "Leaders here now genuinely ask, "What do you think?" … less likely to hand down decisions". These findings illustrate how relational leadership practices, as supported by the PCLSS model, helped create the enabling conditions necessary for the development of healthful, person-centred cultures across diverse healthcare settings.

TABLE 2 High-level summary of mapping to healthful cultures.

Healthful cultures domain	Study site 1: public acute teaching hospital	Study site 2: private full-service acute hospital	Study site 3: integrated community-acute ophthalmology services	Study site 4: public rehabilitation hospital
Leadership	Collective	Relational	Relational	Relational
Person-Centred Processes	Working with a person's beliefs and values Engagement Shared decision-making Providing holistic care	Working with a person's beliefs and values Engagement Shared decision-making Providing holistic care	Working with a person's beliefs and values Engagement Shared decision-making Providing holistic care	Working with a person's beliefs and values Engagement Shared decision-making Providing holistic care Sympathetic presence
Staff Empowerment	Co-designed care pathways	Staff engagement, training	System-wide collaboration, confidence	Empowerment in managing visits
Collaborative Relationships	Interdisciplinary collaboration, team trust	Cross-department collaboration	Interprofessional collaboration	Staff and family collaboration
Supportive Practice Environments	Psychological safety, reduced stress	Valued staff, involvement	Clear roles, staff engagement	Supportive policies, easy implementation
Shared Values and Vision	Patient flow, care coordination	Shared responsibility, teamwork	Access to care, integrated service delivery	Family involvement, therapeutic balance

3.3.2 Person-centred processes

Across all study sites, the PCLSS model was found to support the embedding of person-centred processes, aligning with McCance and McCormack's Healthful Cultures work (19). Staff did not describe care as purely task- or process-driven; rather, there was a consistent emphasis on working collaboratively with service users to co-create meaningful care pathways. A staff member from Site 1 reflected this shift, stating, "We stopped designing services for clinical partners (General Practitioners) and started designing with them … the (PCLSS) work made that a real focus, not just a nice to have", illustrating how service design became genuinely collaborative. Similarly, a participant from Site 2 observed, "(the model) helped us to look at processes through the patient's eyes, not just the service's needs … completely reframed how we work", highlighting the refocusing of improvement priorities around individual experience. Staff at Site 3 described a move away from compliance-driven change, noting, "Before PCLSS, processes were about ticking boxes. Now, every change we make is about making things better for the individual at the centre". This cultural shift was reinforced at Site 4, where one team member reflected, "The Voice of the Customer work opened our eyes … emphasis on patients and families shaping how we did things". These findings demonstrate how the PCLSS model helped operationalise person-centred processes as core to system redesign rather than peripheral considerations.

3.3.3 Staff empowerment

The PCLSS model contributed significantly to fostering staff empowerment across all study sites. Rather than improvement being driven exclusively by senior leaders, frontline staff were actively enabled to identify, test, and implement change initiatives, consistent with relational and enabling leadership approaches. A staff member from Site 1 noted, "I've never felt so trusted to make improvements … PCLSS didn't just give us tools — it gave us permission to change things that didn't make sense", demonstrating the cultural shift toward distributed ownership of change. A participant from Site 2 similarly reflected, "Once we learned the method, it gave us real confidence … we weren't just waiting for someone else to fix problems anymore", highlighting the growth in individual agency. Staff at Site 3 described the dynamic nature of this empowerment, sharing, "Instead of waiting for approval … we felt empowered to test small changes ourselves. That energy spread through the team". One team member from Site 4 emphasised how this empowerment became embedded in daily work, stating, "PCLSS changed the culture from "that's management's job" to "we all have a role in making things better" … That's still growing now". Collectively, these accounts illustrate how the PCLSS model activated mechanisms of empowerment that were essential to sustaining person-centred improvement efforts.

3.3.4 Collaborative relationships

Collaboration across professional groups and departments was consistently strengthened through applying the PCLSS model across all sites. Staff were not found to work in isolated silos but instead engaged in sustained, interdisciplinary collaboration aligned with the Healthful Cultures. A staff member from Site 1 explained, "We used to work in silos … through PCLSS, we started genuinely collaborating across departments … it felt like everyone was pulling together", describing a tangible cultural shift. A participant from Site 2 reflected, "Working with other teams wasn't an add-on anymore … it became part of how we solved problems, right from the start", emphasising how cross-functional working was normalised. Staff at Site 3 noted the re-establishment of meaningful connections, commenting, "I didn't realise how disconnected we were … until we started co-designing pathways. Suddenly, conversations opened up everywhere". One team member from Site 4 similarly observed, "PCLSS taught us that no one group has all the answers … Collaboration became our new normal". These reflections underscore how the PCLSS model helped dismantle professional silos and foster genuinely collaborative relationships in support of sustainable improvement.

3.3.5 Supportive practice environments

The PCLSS model was found to contribute to the development of supportive practice environments characterised by psychological safety, shared learning, and open communication across the study sites. Rather than environments marked by fear of blame or rigid hierarchies, staff described work settings where reflection and improvement were encouraged. A staff member from Site 1 highlighted this change, stating, "There's more a sense of psychological safety now … it's okay to say, "This isn't working" without fear. That started with the PCLSS approach". A participant from Site 2 echoed this, observing, "Even small changes to how we meet and reflect … made work feel safer and more open … people felt heard". Staff at Site 3 reinforced the role of psychological safety in cultural change, sharing, "Before, raising problems felt risky … Now it feels expected — and that's made a huge difference to morale". One team member from Site 4 illustrated how positive reinforcement supported change, noting, "Small improvements like celebrating quick wins … made work feel more energising. It wasn't all about targets anymore". These findings highlight the critical role of supportive environments in enabling healthful cultures, with the PCLSS model serving as a catalyst for their development.

3.3.6 Shared values and vision

A clear sense of shared values and collective purpose was consistently evident across all study sites following the application of the PCLSS model. Rather than being driven by disparate departmental agendas or compliance-focused targets, teams articulated a unified commitment to person-centred improvement. A staff member from Site 1 described this shift, stating, "We're no longer chasing random KPIs … the work helped us build improvement goals that reflect what matters to patients and staff". A participant from Site 2 similarly reflected, "The model helped us agree on what "good care" actually looks like … now everyone's aiming for the same things, not just following checklists". At Site 3, staff described how these shared values permeated onboarding practices, sharing, "Even new staff pick up on the culture straight away … that wouldn't have happened without the clarity we gained through the (PCLSS) model". One team member from Site 4 emphasised the significance of this cultural embedding, noting, "The biggest change is we now have a common purpose that guides what we do every day … not just a poster on the wall". Collectively, these reflections illustrate how the PCLSS model supported the articulation and enactment of shared values and vision across diverse healthcare settings.

3.4 Quantitative outcome measures

The preceding thematic analysis, mapped to McCormack and McCance's Healthful Cultures work, demonstrated how the PCLSS model supported the development of healthful cultures across a range of healthcare settings. Key themes included shared values and vision, relational leadership, and supportive environments that empowered staff and prioritised person-centred care. To complement these qualitative insights, we now present verified quantitative outcome data from each study site. These data illustrate how the application of the PCLSS model was associated with measurable improvements in access to care, service efficiency, and stakeholder experience.

At Study Site 1, a large public teaching hospital, improvements to referral, triage, and waiting list management in a dermatology service led to a reduction in total outpatient waiting list numbers from 3,736 in September 2020 to 2,228 by June 2021 (a 40% reduction). The number of patients waiting over 12 months for an appointment decreased by 60% (from 1,615 to 634). Mean wait times fell across all triage categories, including a 61% reduction in the "Urgent" category (from 118 to 45 days), 70% in the "Soon" category (517 to 155 days), and 32% in the "Routine" category (358 to 241 days). The Mann–Whitney *U*-test confirmed a statistically significant reduction in waiting times post-intervention ($p < 0.001$) with a median decrease of 169.95 days (5).

At Study Site 2, a private full-service acute hospital, improvements that were implemented included system wide work to support the safe and person-centred resumption of services following COVID-19 restrictions. Comparing July–December 2020 to the same period in 2019, inpatient admissions increased by 6%, inpatient surgeries by 21%, and outpatient surgeries by 4%. These gains occurred despite reduced activity earlier in the year due to lockdown. Patient satisfaction rose from 93% to 95%, and notably, there were zero reported cases of in-hospital COVID-19 transmission from March to December 2020 (25).

At Study Site 3, an integrated care initiative introduced a model for immediate sequential bilateral cataract surgery (ISBCS). This led to a 66% increase in surgeries completed on half-day lists (from 6 to 10 per list), while mean turnover time between surgeries was reduced from 13.8 to 8.7min. Patient visits were reduced from five to three per episode of care. Each bilateral surgery delivered cost savings of €450 (direct), €400 (indirect), and reduced patient travel by approximately 167 km—saving 1 tonne of CO_2 for every 30 surgeries performed.

At Study Site 4, a public rehabilitation hospital, a person-centred visiting policy was co-designed with staff, patients, and families. Surveys indicated strong support for increased flexibility, privacy, and inclusivity. The new policy incorporated extended visiting hours, access for children, and greater use of shared spaces. Staff feedback indicated greater ease in implementing the revised policy and increased feelings of being heard and respected. Over 90% of patients and visitors and 75% of staff supported proposals to open the hospital canteen in the afternoon to further improve the visiting experience.

Together, these outcomes demonstrate the potential of the PCLSS model to generate measurable service improvements while upholding person-centred values. Quantitative gains were achieved in areas such as access, efficiency, safety, satisfaction, environmental impact, and staff empowerment. These results underscore the practical value of aligning Lean Six Sigma methodologies with relational principles to drive meaningful, sustainable change in healthcare. The implications of these findings are explored further in the following Discussion.

4 Discussion

4.1 Embedding healthful cultures through the PCLSS model

The findings of this study demonstrate that the Person-centred Lean Six Sigma (PCLSS) model is not only adaptable across diverse healthcare contexts but also strongly aligned with the development of healthful cultures. By synthesising the technical structure of Lean Six Sigma with the relational principles of person-centredness, the model offers a credible pathway to sustainable culture change within healthcare systems (3, 14).

4.2 Leadership as an enabler of sustainable improvement

Leadership practices emerged as critical to the success and sustainability of the PCLSS model. Leaders who modelled person-centred values, facilitated staff empowerment, and prioritised authentic communication (34) were identified as essential enablers of sustained improvement. Conversely, where leadership engagement was absent or transactional, teams faced challenges in embedding change. These findings reinforce the importance of leadership approaches that enable relational cultures and continuous improvement. The PCLSS model is consistent with leadership principles used in Lean Six Sigma improvement initiatives, which emphasise leadership commitment, daily management systems, and continuous staff engagement to drive performance improvement. Shortell and colleagues (35) found that hospitals with established Lean implementations—characterised by strong leadership involvement and structured daily management practices—reported more positive performance outcomes. The PCLSS model cultivates the leadership behaviours essential for sustaining Lean initiatives and embedding a culture of continuous, person-centred improvement by fostering participatory facilitation and inclusive dialogue. Relational leadership can act as a catalyst for organisational readiness, alignment with values, and investment in staff training, which were identified as key contextual factors influencing the extent of success and sustainability of the model.

4.3 Addressing philosophical tensions between Lean Six Sigma and person-centredness

While early literature on Lean Six Sigma in healthcare highlighted philosophical tensions, such as privileging efficiency over individual experience (36), there has been limited empirical engagement with how such tensions might be meaningfully addressed. Our earlier realist review found that only a small number of studies referenced both paradigms, and fewer still examined their intersection in depth (3, 4, 11, 37). As a result, a significant gap exists in understanding how person-centred principles and Lean Six Sigma practices can be integrated to support sustainable improvement. Our ongoing programme of research (3–7, 9, 11, 13, 31–33, 38) seeks to address this gap through empirical, realist, and applied work.

In doing so, we have also drawn on wider critiques of Lean implementation in healthcare. For example, Kaplan et al. (39) discuss failures of alignment between technical models and complex healthcare settings. Dixon-Woods et al. (40) and Flynn et al. (41) similarly warn against adopting improvement methodologies without attending to relational and cultural dynamics. These perspectives have shaped the development of the Person-centred Lean Six Sigma (PCLSS) model, which seeks not to eliminate tensions between paradigms, but to make them visible and usable through intentional reflection and design.

As outlined earlier, the model presents eight Lean Six Sigma components structured into domains of synergy, divergence, and mutual influence, offering a framework to explore both alignment and conflict. Crucially, the central overlapping space, Quality as Influencer, was conceived not as a point of philosophical fusion, but as a critical site of negotiation. It acknowledges that "quality" is not universally defined: it may refer to measurable outcomes, values-based experiences, or culture change (3, 11, 14). By positioning quality as a dynamic and contextually shaped concept, the model supports reflective adaptation of Lean Six Sigma through a person-centred lens.

What is reiterated here is the model's intended function as both a practical tool and a philosophical provocation. Rather than offering a prescriptive solution, the PCLSS model encourages practitioners to navigate methodological rigour and relational responsiveness side by side. It invites users to examine how quality is interpreted in their own settings, and how Lean Six Sigma tools, such as Voice of the Customer or Gemba, might be enacted in more participatory and inclusive ways. In this way, the model becomes a structured means of exposing and working with tensions, rather than denying them.

This study, which applied the model across diverse clinical settings, four of which are presented in this paper from a wider pool of twelve evaluation sites, enabled further testing of this reconciliation. Our findings show that, when guided by shared values and relational leadership, the integration of technical and relational work not only mitigates philosophical tensions, but also creates the conditions for healthful cultures to flourish.

4.4 Demonstrating the application of the PCLSS model in diverse settings

In this paper, we illustrated how the PCLSS model was applied in four diverse healthcare settings as part of a broader twelve-site programme of work. This study builds on previous concerns by testing a deliberately person-centred reframing of Lean Six Sigma that integrates relational principles into technical structures. Through this application, we explored how aligning person-centred and improvement paradigms could create the conditions for healthful cultures to flourish.

4.5 Participatory practice, relational leadership, and cultural change

A core strength of the PCLSS model lies in its capacity to enable meaningful staff engagement at all levels. Rather than imposing externally driven, top-down change, the model supports co-creating local solutions through participatory facilitation, reflective practice, and inclusive dialogue (5, 25, 32). The university-accredited education programme, which embedded the PCLSS model into staff development, leadership practice, and systems thinking, was previously identified as a significant enabler of participatory approaches in earlier research (12, 38). Comparative analysis across all four sites in this study further reinforces these findings, demonstrating the central role of structured education in embedding person-centred improvement practices and fostering cultural change. This approach nurtures psychological safety, builds interprofessional trust, and encourages systems thinking, all of which are fundamental to sustaining improvement cultures (13, 34). The study highlights that technical tools alone are insufficient to achieve meaningful and lasting change (3, 12), and this tools-based approach may not actually achieve culture change (42). It appears that the integration of relational and technical work in the approach facilitators of change take, embedded within the PCLSS model, activates the mechanisms needed to cultivate and sustain healthful workplace cultures in healthcare systems. Mapping the findings to McCance and McCormack's (19) Healthful Cultures work confirms that improvements enacted through the PCLSS model extend beyond technical process optimisation. Engagement with the PCLSS helps transform leadership practices, strengthen relational connections, and positively impact the lived experiences of staff, patients, and families. Healthful cultures are characterised by shared values, collaborative working, empowered decision-making, and collective leadership (19), all consistently evident across the study sites.

4.6 Alignment with established culture frameworks

Importantly, these findings also align with Manley and colleagues' (43) conceptualisation of effective workplace cultures. The PCLSS approach reflects the enabling factors identified by Manley et al., such as collective leadership, skilled facilitation, shared values, and supportive learning environments. By fostering workplace cultures where staff feel valued, psychologically safe, and engaged in collaborative improvement, the model contributes directly to both system performance and human flourishing. Notably, each site reported a ripple effect, where initial improvement projects catalysed further innovation and ongoing development of a person-centred improvement culture. This reflects the dynamic and evolving nature of healthful cultures, which are sustained through experiences of success, relational connectedness, and the visibility of shared achievements (19).

4.7 Limitations and generalisability

While the findings offer transferable insights for improvement practice, this study is contextually bounded in scope. The PCLSS model was deliberately developed to support healthcare practitioners and teams to apply Lean Six Sigma in a person-centred manner. While it is applicable across a wide range of healthcare settings, including public and private, as well as acute and community services, it is specifically intended for use by those employing Lean Six Sigma. However, as noted, Lean Six Sigma has become one of the most widely adopted methodologies in international healthcare improvement practice (3, 10), and the PCLSS model has now been translated into German and Spanish, with use reported across 12 countries. This reflects its growing accessibility and practical relevance for diverse health systems seeking to embed person-centredness within technical improvement work. Rather than offering a rigid toolkit, the model provides a flexible framework that can be locally adapted while remaining grounded in its core principles. This paper extends the evidence base for the model, demonstrating its contribution to cultivating healthful, person-centred cultures through the intentional integration of technical and relational approaches.

While the model demonstrated feasibility across four diverse settings, including public acute, private acute, community hospital, and rehabilitation care, this study did not include a formal analysis of implementation costs or long-term scalability, with all study sites at different stages of implementation (Table 1). Costs were primarily associated with staff study leave, protected staff time for project work, and access to education in Person-centred Lean Six Sigma. However, organisations reported the outcomes detailed in Section 3.4 as representing a visible return on investment (ROI), particularly through improvements in service processes, patient experience, and team culture. These perceived benefits, alongside high levels of staff engagement and leadership in local improvement efforts, contributed to the model's acceptability and uptake. Future work may benefit from dedicated economic evaluation and exploration of model adaptation in lower-resource systems.

We acknowledge that the literature cited in this study includes a concentration of work by the lead authors and their close collaborators. This reflects the relatively limited body of research to date that directly explores the intersection of Lean Six Sigma and person-centred care. Rather than indicating insularity, this underscores the originality of the work and the emerging nature of this field. The development of the PCLSS model has been shaped through a cumulative programme of realist review, realist evaluation, and applied research (3, 11, 14), which explicitly engages with wider theoretical and critical perspectives. These foundational studies have laid the groundwork for further testing and development by a broader range of research teams in varied contexts.

5 Conclusion

This study demonstrates that the PCLSS model offers a distinctive and sustainable approach to healthcare improvement

by integrating technical excellence with relational, person-centred values. Across four diverse healthcare settings, the PCLSS model supported the development of healthful cultures in ways that reflect the enabling factors including transformational leadership, skilled facilitation, shared values, and supportive learning environments (19, 42). Specifically, staff were empowered through education, facilitation, and active participation, aligning with the creation of supportive learning environments; collaborative relationships were built through interdisciplinary engagement and co-design, underpinned by shared values; shared leadership emerged through distributed responsibility and inclusive decision-making, supported by transformational leadership; and system-wide trust was fostered through consistent facilitation, reflective practice, and transparent communication. These interconnected elements demonstrate how the PCLSS model operationalises the relational and technical conditions needed to embed a person-centred, improvement-focused culture.

A critical finding was the importance of cultural readiness in shaping the successful adoption and impact of the model. Sites with a longer history of structured improvement work displayed greater openness to participatory approaches and a stronger capacity to embed person-centred processes. This reinforces that building healthful, sustainable cultures is a dynamic, evolving process that requires time, leadership commitment, and shared ownership of change (44).

By fostering participatory facilitation, reflective practice, and inclusive dialogue, the PCLSS model activates the mechanisms needed to sustain improvement over time. It enables organisations to move beyond a narrow focus on process optimisation, creating environments where both staff and patients can flourish. Ultimately, the PCLSS model makes a distinctive contribution to the creation of healthful cultures—cultures where relational, technical, and organisational practices align to support human flourishing as a central goal of healthcare improvement.

Data availability statement

The datasets presented in this article are not readily available without access through the corresponding author commensurate with Ethical approval. Requests to access the datasets should be directed to sean.p.teeling@ucd.ie.

Ethics statement

This study's work emerged from a PhD study conducted according to the guidelines of the Declaration of Helsinki and approved by the Institutional Review Board (IRB) of The Mater Misericordiae University Hospital, protocol code 1/378/2022, on 24 October 2018. Further ethical approval for the Private sector was approved by the IRB of the Beacon Hospital on 18th January 2023, protocol code BEA0200 Lean Study.

Author contributions

ST: Conceptualization, Data curation, Formal analysis, Methodology, Project administration, Software, Supervision, Visualization, Writing – original draft, Writing – review & editing. DB: Conceptualization, Formal analysis, Methodology, Validation, Writing – review & editing. AD: Funding acquisition, Methodology, Project administration, Resources, Visualization, Writing – review & editing. AK: Methodology, Visualization, Writing – review & editing. CD: Validation, Writing – review & editing. AI: Validation, Writing – review & editing. MM: Formal analysis, Writing – review & editing.

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Developing person-centred care in hospices through the voice and leadership of nursing: lessons from the United Kingdom

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Introduction: Nursing leadership and the voice of nurses are crucial for developing person-centred care in hospices. Concerns have been raised that, as palliative care has evolved from its original vision and become more integrated into the mainstream healthcare system, it has increasingly become medicalised. This paper presents an emancipatory practice development programme aimed at enhancing the visibility and voice of nursing and nurse leadership to improve person-centred care in hospices across the United Kingdom.

Methods: The project was a 10-month collaborative education programme for nursing practice leaders in hospices throughout the United Kingdom, running from September 2023 to July 2024. A total of 24 clinical and practice development leaders from eight different hospices participated. The Kirkpatrick model for evaluating learning programmes was adapted to create a framework for assessing the programme's outcomes and impact. The evaluation process utilised Collaborative Critical Creative Inquiry.

Results: The key findings from the evaluation indicate that the programme created conditions for the participants to gain transformative insights and understanding that positively impacted their practice through emancipatory practice development.

Discussion: The programme enabled leaders of person-centred care in hospices to rekindle their vision for palliative care practice. The participants became more aware of how care was constructed within their organisations and recognised the assumptions that were often taken for granted—assumptions that influenced daily care practices that sometimes leaned towards a traditional medical model. They acquired new skills and knowledge that empowered them to engage more intentionally in making changes to enhance person-centred care.

Conclusion and implications for practice: Humanising healthcare is a global agenda, and within hospice care, nurses are at the heart of transforming care to be more person-centred. They are well-positioned to reclaim the core principles of palliative care, as developed by Cicely Saunders, and push back against the medical model that has overshadowed the development and integration of palliative care into current healthcare systems. Nurses are expert practitioners and leaders who hold positions of authority within their organisations. Yet, for many, their change-making potential is not realised. Innovative learning and development programmes are an essential part of humanising healthcare, and emancipatory practice development programmes can unlock nurses' potential to lead this transformation.

KEYWORDS

person-centred practice, palliative care, practice development, nurse leadership, hospice

1 Introduction

Dame Cicely Saunders, the founder of the hospice movement, humanised care for dying people through her transformative philosophy and principles of care in the 1960s (1). She recognised the limitations of the biomedical model for those who were dying and challenged the overemphasis on disease and the curative focus of the British National Health Service, where death was often seen as a failure. Thus, those who were dying in hospitals were left to die alone as healthcare staff feared death and felt helpless (2). Through the development of the model of *total pain*, Saunders illuminated the needs of dying people and proposed principles of care to meet these needs (3). Her holistic model responded to the suffering of the dying person—not only physical pain but also the emotional, social, and spiritual distress associated with facing one's own death. Saunders' model of care is still regarded as best practice for those with incurable long-term conditions and those who are dying, as recommended by the World Health Organization (4).

Person-centred care is also recognised globally as an essential component of 21st-century healthcare and a vital element in improving the quality of care (5). Scholars within nursing have identified a humanistic orientation as the essence of nursing care, describing it as fundamentally valuing human beings (5).

At its core, person-centred care focuses on the personhood of all those involved in care, with a strong emphasis on healthy and therapeutic relationships—highlighting the relational aspect of care (6). The person-centred framework developed by McCormack et al. was created to operationalise person-centredness in healthcare practice, underpinned by humanistic care theory (7). There is growing evidence that this approach leads to improved health outcomes, particularly for people with long-term conditions (8, 9). The framework has been implemented in healthcare systems worldwide to transform and improve care.

There is a strong alignment between the principles of person-centred care and palliative care nursing, both of which are grounded in the original philosophy and principles of palliative care as developed by Cicely Saunders (1). Both models emphasise a holistic approach that challenges the traditional disease-focused biomedical model of healthcare (10). They share an unwavering focus on what matters to the individual and those close to them. Within this focus lies a moral imperative and a therapeutic intent, expressed through relationships built on effective interpersonal processes (7). This reflects a broader notion of health than the biomedical model—one that embraces all dimensions of human existence and supports living a meaningful life, even in the face of death (11).

While it is widely acknowledged that these two models of care are often better suited to meeting the needs of people requiring palliative care, it remains challenging to fully embed them in practice (10). One reason for this is the ongoing medicalisation of healthcare and the entrenched hierarchy of the traditional biomedical model (12).

Nurses are uniquely positioned to challenge this hierarchy and lead the implementation of care that is driven by person-centred palliative principles. The theoretical and practical orientations of nursing align closely with the humanist perspective of Cicely Saunders and the person-centred care theory developed by McCormack et al.

Nursing leadership and the voice of nurses are key to the development of person-centred palliative care in hospices (13). Nurses represent the largest regulated healthcare professional workforce delivering palliative care across a range of clinical settings (14). They have diverse roles and responsibilities, and the caring and artistic dimensions of nursing are fundamental to palliative and end-of-life care (15). However, concerns have been raised that, as palliative care has evolved and become integrated into mainstream healthcare, it has become increasingly medicalised due to the inherited hierarchy of the biomedical model (16). This has led to a lack of visibility of the nursing contribution to palliative care and diminished recognition of their essential role. There is concern that the medicalisation of palliative care has silenced the voice of nursing and diluted the artistic elements of nursing practice (14, 15), resulting in a less articulated contribution to care (15).

The purpose of this paper is to present findings from an Emancipatory Practice Development (ePD) programme. The programme focused on developing and strengthening the visibility and voice of nursing and nurse leadership to enhance person-centred care in hospices across the United Kingdom.

1.1 Context

The practice development project was a 10-month collaborative education programme for leaders of nursing practice in hospices across the United Kingdom (see Table 1). Participants included 24 clinical and practice development leaders from eight hospices —two in Scotland and six in England—who held pivotal roles in leading and implementing direct care and/or driving change and improvement within their organisations (see Table 2). Hospices were selected to ensure geographical diversity and were invited to participate in the project.

Invitation emails were sent to the nursing care leaders within each hospice, offering the opportunity for two to three members of staff to take part. The eligibility criteria required participants to hold a role in practice development or serve as an operational manager of nursing care. One hospice team withdrew from the programme midway due to time constraints and organisational changes, although they actively participated during the first half.

The programme comprised 7 workshop days delivered over a 7-month period. Of these, two workshops were held face-to-face—one at the beginning and one at the end of the project.

Each hospice received mentorship from one of three facilitators throughout the programme. All materials were hosted on a password-protected online learning platform, accessible only by participants and facilitators. A WhatsApp group was also created for those who wished to maintain direct contact during the programme.

The programme was designed to be flexible, allowing each participant to develop a contextualised practice development plan tailored to their own hospice setting.

TABLE 1 Overview of the themes of each day during the 7 days of the course.

Day 1	• Appreciate the value of Practice Development as an approach • Recognise its contribution to outcomes—for patients, nurses, the wider multidisciplinary team (MDT), and the organisation • Understand the place of practice development in enabling person-centred practice/nursing care • Create an intention to translate the theory of practice development (PD) into practice • Offer tools/approaches to support the development of the practice of nursing
Day 2	• Appreciate what a flourishing culture looks and feels like—for patients, professionals, and the organisation • Recognise the relationship between a flourishing culture and the nurse who is flourishing in their role • Appreciate how organisational culture will shape the culture of care • Recognise structures and processes that contribute to a flourishing culture • Identify behaviours that support and confirm a flourishing culture
Day 3	• Appreciate the different elements of/contributors to person-centred practice • Recognise the contribution of nursing to person-centred practice and what is unique to nursing within the wider MDT • Appreciate the place of values and beliefs held by individuals and organisations in shaping practice • Acknowledge how the culture of the unit/organisation supports or inhibits person-centred practice • Recognise the value of a shared vision as a starting point to the journey of practice development • Become familiar with the journey of practice development as a basis for an organisational action plan
Day 4	• Appreciating what contemporary transformational leadership looks like • Feeling confident to utilise a coaching approach in the development of others • Appreciating the talents across a team to achieve person-centred care
Day 5	• Appreciate how/where nurses can most effectively contribute to positive outcomes for patients, each other. and the organisation through their practice • Recognise the value of stories of nurses' practice to help identify key moments in care and how they are best enhanced • Identify what needs to be protected, enhanced. or introduced in terms of nursing practice to improve or maintain the quality of care • Consider how the profession of nursing is advanced at the local level to ensure its appropriate impact
Day 6	• Test the value of a theory of change in shaping intention, plans, and evaluation • Explore ways of maintaining ambition and momentum beyond initial enthusiasm • Recognise the place of personal and professional leverage to support change • Identify how a practice development approach fits into broader strategies for improvement in care and its evaluation • Create a story that requests long-term local investment in this work
Day 7	• Reflect on the progress and challenges of individual hospices as a basis for driving person-centred palliative nursing—through further learning and financial and other investment/support in this work at the national and organisational levels • Review the details of the programme and the experience of learning as a basis for developing it further • Describe future support required from each other, CARE, academic leaders, and beyond • Confirm offers of talent and support to the community • Establish community of practice (as required)

1.2 Underpinning theory of the programme

ePD was the foundational approach to learning and development within the programme. Over the past two decades, ePD has evolved as a continuous process for cultivating person-centred cultures and care (17). Accordingly, the programme was designed with a flexible and reflective structure, enabling participants to gain insights and knowledge relevant to their personal and professional development and their specific contexts.

TABLE 2 Number and role of participants from each hospice.

Hospice no.	Participants' roles
1	Staff Nurse; Head of Wellbeing Service; Ward Team Leader
2	Ward Sister; Clinical Service Manager; Senior Staff Nurse
3	Consultant Nurse; Ward Manager; Deputy Ward Manager
4	Practice Development Facilitator; Quality Lead; Charge Nurse; Staff Nurse
5	Charge Nurse; Nurse Manager; Inpatient Unit
6	Matron; Nurse, Inpatient Unit; Clinical Lead; Inpatient Unit
7	Assistant Director of Service; Ward Sister; Clinical Lead; Inpatient Unit
8	Clinical Service Manager; Ward Sister; Senior Staff Nurse

The ultimate purpose of the programme was to create conditions that would enable participants to develop the knowledge and skills necessary to transform care to be more person-centred. Through the lens of ePD, the focus was placed on the culture and context of care within each participant's practice area, with the responsibility for action falling to the participants themselves (18). The aim was to support the development of the participants' personhood, values, and beliefs as the foundation for their practice development and learning (19), ultimately enabling them to become person-centred facilitators in their own settings.

The programme remained true to the creative and reflective nature of ePD, recognising these as critical elements for transformation. The approach is grounded in critical social science, which is underpinned by the principles of enlightenment, empowerment, and emancipation (20). This involves raising consciousness, motivating participants to take action, and ultimately engaging in transformative practice (21).

Critical theory has been increasingly applied to healthcare research over the past two decades (22). As a philosophical approach, it challenges taken-for-granted assumptions, questions self-evident realities, and critiques unexamined policies, practices, and procedures. It explores power relations, knowledge formation, and claims to truth, offering tools to critically analyse ideological positions—an approach highly relevant to the findings of this evaluation.

Emancipatory Practice Development also draws on Habermas' dualist theory of society, which distinguishes between the lifeworld (the realm of human experience and meaning) and the system (the realm of economic and technological structures) (22). This theoretical positioning warns against reducing human experience to technical or economic considerations. In this programme, we intentionally focused on the lifeworld—i.e., the lived experiences of participants—rather than on technical skill acquisition alone.

The ePD approach fosters learning that is grounded in the realities of practice. It differs from traditional technical approaches by prioritising critical reflection and the

development of the individual as a change agent. The aim is to support participants in identifying the gap between current and desired practice and to explore what is needed to bridge that gap to enable more person-centred care (23). The core focus of the programme was to support the development of new insights and understandings that are transformative in nature (17).

Facilitation is a core principle of ePD. It supports individuals and teams in understanding the context in which they work and identifying the characteristics of that context that may contribute to the gap between the current and desired practice. Thus, the central site of learning is everyday practice, with the goal of enabling meaningful change (17).

To further support participants, the Lantern Model of palliative care nursing was introduced as a theoretical framework. Developed by two of the authors (HR and MC), the Lantern Model highlights the specific skills and knowledge required in palliative care nursing (24, 25). It builds on the Person-Centred Practice Framework developed by McCormack et al. (7) and is rooted in the philosophy and principles of Dame Cicely Saunders. The Lantern Model adapts the person-centred framework to focus more specifically on the context, knowledge, and skills relevant to palliative care nursing in contemporary health and social care. It also reclaims Saunders' original vision as a guiding theoretical foundation for palliative care (24, 25).

2 Evaluation framework and methodology

We adapted the four-stage Kirkpatrick Model (26) to evaluate the outcomes and impact of the teaching programme, focusing on reaction, learning, and behaviour. This model is widely used to assess educational programmes (27). In our case, it provided a framework for presenting findings across four adapted levels: perceptions and attitudes, new insights and understanding, impact on behaviour in the workplace, and impact at the organisational (macro) level.

The analytical evaluation process was informed by Collaborative Critical Creative Inquiry, as developed by McCormack and Titchen. This approach allows for the integration of diverse datasets, including those derived from arts-based methods (28). Data collection was conducted over the course of the programme and aimed to gain an in-depth understanding of participants' experiences and the meaning they attributed to them.

2.1 Aims

The overall aim of the evaluation was to assess whether the programme had a transformative impact on the participants, as intended. The central research question was as follows:

> How does a person-centred palliative care development programme enable nursing leaders within a hospice context to grow and develop practice?

2.2 Ethical considerations

The evaluation was underpinned by a robust ethical framework aligned with the principles of person-centredness and embedded throughout the programme's delivery and evaluation. The key ethical considerations included the following:

- Ensuring voluntary participation,
- Maintaining anonymity and confidentiality, and
- Promoting psychological safety throughout the process.

The participants were informed that the evaluation would run in parallel with the programme and be embedded within it. Ways of working were established at the outset, with consistent "check-ins" throughout. For these reasons, formal ethical approval was not sought, as the evaluation was considered an integral part of the educational programme.

2.3 Data collection and analysis

The Collaborative Critical Creative Inquiry method allowed for multiple forms of data to be collected throughout the programme (28), focusing on the participants' reflections and descriptions of "in-the-moment" experiences. These reflections captured the participants' perceptions as they engaged with the development process.

To support this, reflective aids were used during workshops, including a Claims, Concerns, and Issues session, where the participants critically reflected on their own practices and the influence of their organisational context (29). This enabled them to identify areas of strength, concerns, and priorities for change. The format was based on Fourth Generation Evaluation (29).

Narrative writing was used to surface stories from practice, highlighting both positive examples and areas requiring improvement (30). Participants were also introduced to Haiku writing as a creative method for expressing their feelings and progress. While the traditional five-seven-five syllable structure proved restrictive, this was adapted into more flexible short poems of three to four lines (31).

An evaluation workshop was held on the final day of the programme, focusing on the enablers, challenges, and achievements throughout the change process. Each activity within the programme served a dual purpose: supporting individual and group learning and simultaneously generating data that reflected significant insights, learning, transformation, and outcomes.

Analysis was an iterative process embedded within the programme. It was guided by hermeneutic and interpretive approaches (18) and was conducted collaboratively with all the participants during the final workshop. This included a reflective exercise based on the following questions: "What do I see?", "What do I feel?", and "What do I imagine?"

3 Results

Four key themes emerged from the analysis and were aligned with the adapted Kirkpatrick evaluation framework. They are as follows:

- Perceptions and attitude change—exploring how the programme supported personal growth and shifts in mindset.
- New insights and understanding—identifying new competencies and knowledge gained through participation.
- Behavioural change in the workplace—examining how participants translated learning into practice.
- Impact at the organisational (macro) level—assessing broader systemic influence within the hospice setting.

In presenting the findings and the subsequent discussion, we will refer to the development of leaders in person-centred palliative care nursing practice within hospice organisations.

3.1 Perceptions and attitude change

The participants reported a strong sense of rekindling their vision for palliative care nursing practice during the programme. This renewed clarity and purpose translated into a deeper commitment to person-centred care and a strengthened engagement with practice development in their own settings. It was also evident that the programme enabled the participants to develop a clearer sense of themselves as leaders in person-centred palliative care.

3.1.1 Re-engaging with values and beliefs

The participants valued the opportunity to reflect on and share their personal values and beliefs in relation to nursing practice, particularly in connection with the original philosophy of palliative care as developed by Dame Cicely Saunders. This reflective process helped surface a shared vision of desired practice and highlighted the creative and relational nature of palliative care nursing. It also deepened the participants' understanding of the role of interpersonal skills as a core element of nursing expertise and contribution. Figure 1 demonstrates a word cloud displaying key themes related to caregiving qualities and values as seen by participants.

The programme's structure, which brought together participants from different hospices, fostered a strong sense of shared values and vision. This created a community of practice that supported mutual learning and a collective sense of purpose. The following poems, written by participants, reflect this shared experience:

> **Poem 1 (p7)**
>
> Inspiring change together
>
> Learning, growth, development
>
> Exciting future

FIGURE 1
One word description from particpants capturing the essence of palliative care nursing.

> **Poem 2 (p3)**
>
> Working together,
>
> meeting new people,
>
> united by a common aim

3.1.2 Rekindling the commitment to person-centred nursing practice

The shared vision and purpose cultivated during the programme created the conditions for the participants to reconnect with the unique contribution of palliative care. This was further supported by a focus on the positive impact of person-centred practice within the hospice context. Participants shared stories of good practice, which helped make their contributions more visible, better articulated, and appreciated, as evidenced by the following quote:

> "I loved how we started the day with an exercise on positive reflection- so often we are asked to focus on "what went wrong" or reviewing the negative." (p7).

Narratives shared from practice during the programme enabled participants to deepen their insights and gain greater clarity around the unique contribution of person-centred practice within the hospice setting. This was particularly evident in the short poems created by the participants, which reflected their evolving understanding. In addition, a new and critical awareness emerged around the use of language, namely, its role in articulating practice and fostering connection. This recognition brought a renewed sense of energy and purpose to the participants' leadership and practice development.

> **Poem 3 (p6)**
>
> Stories are our strength
>
> The best way to share

> Impact
>
> Power of Sharing
>
> **Poem 4 (p2)**
>
> Language is vital
>
> Open our minds to hope
>
> Share, Care, Grow, Flourish

It was evident that the programme enabled the participants to develop deeper insights and a heightened awareness of the unique contribution of person-centred palliative care within hospice settings. The narrative data demonstrated how viewing practice through the lens of the Lantern Model provided the participants with a language to articulate aspects of their work that are often hidden or poorly expressed. This gave them a new voice to make their contributions visible—contributions that are frequently taken for granted in the routines of daily practice. As a result, the participants were able to celebrate and acknowledge their role, which brought renewed energy and inspiration to their leadership in practice development.

3.2 Development of insights and understanding

The analysis demonstrated that the programme enabled the participants to gain new insights into and an understanding of their roles and of practice development. They became more able to recognise incremental change, even when progress was slow or subtle. It was also evident that the participants developed a heightened awareness of their role within the organisation, and a deeper appreciation of its essence and significance. Furthermore, there was a newfound confidence and resilience in viewing practice development as an ongoing journey—one marked by both high and low points, but sustained by purpose and reflection.

> **Poem 5 (p5)**
>
> Transformable train, running down the tracks
>
> Many miles to go
>
> Seeds of change will grow
>
> **Poem 6 (1 1)**
>
> Empathizer, Catalyst; Storyteller. Coach.
>
> So many strengths to harness
>
> To Shape
>
> To Lead
>
> **Poem 7 (1 9)**
>
> Proud of where we are
>
> Small steps…
>
> A transformation.
>
> A lightbulb moment

It was evident throughout the programme that the participants felt supported in their role as practice developers, which in turn enabled their personal and professional growth. This is reflected in the following quote from one participant:

> "Feeling supported in the role of practice development, I feel clearer about my strengths—energised, excited, and aware of the many possibilities ahead. New understanding and insight into the role of practice development are demonstrating transformation." (p21).

Alongside this sense of empowerment, participants also expressed an appreciation of the challenges inherent in the role. One participant noted the following:

> "Understanding [the need for change] will take time. [There is a need for] being visible enough in the midst of lots of 'other things'." (p17).

3.3 Impact on behaviour in the workplace

The analysis highlighted that the participants began engaging with greater intentionality in making changes to enhance person-centredness in their practice following the programme. This was evident in how they applied newly acquired knowledge and approaches within their workplace settings, as demonstrated by the following quote:

> "I am much more creative in my practice now—and even using poetry!" (p15).

Many of the participants adopted methods introduced during the programme, such as storytelling and positive reflection, to illuminate good practice and foster a culture of appreciation and learning. One participant stated the following:

> "Starting with a 'good care' reflection—this is something that we are using now with our registered nurses." (p11).

The participants also recognised the importance of developing a shared vision and clearly articulating the values and beliefs underpinning person-centred care. Several facilitated workshops

within their own teams to promote this focus, with one participant stating the following:

> "I will continue wider team engagement to clarify aims and our shared vision." (p8).

The programme fostered a stronger sense of role clarity and commitment to practice development within hospices. The participants became more intentional in their actions to influence and shift organisational culture, as evidenced by the following quote:

> "I need buy-in from our team in understanding how the micro actions affect the macro environment." (p21).

3.4 Impact on the macro level within the participants' organisations

The analysis revealed potential macro-level impact stemming from individual transformation during the programme. Most of the participants felt that being part of a community of learners had strengthened their vision and resilience. They reported feeling better equipped to face challenges and setbacks in their roles, including efforts needed "to raise awareness of person-centred development within the hospice" (p7) and to "open their organisation's eyes to new opportunities" (p11).

Despite this, participants expressed concerns about the implementation of change within their practice environments and questioned how well their organisational contexts were prepared to support transformation, as evidenced by the following quotes:

> "How do I carry these conversations [from the programme] into the hospice?" (p10).

> "How do I get engagement from the nursing team and help others come on the journey of change?" (p2).

> "How do I get buy-in from the team and senior managers, and keep the momentum and engagement in practice?" (p6).

On the final day of the programme, the participants worked in hospice-based teams to plan future intentions. They identified small-scale initiatives that could support the transformation towards more person-centred care. Many of these were micro actions with the potential to influence the macro system. Examples included the following:

- Facilitating workshops within their hospices based on learning from the programme,
- Revisiting the structure and format of multidisciplinary team meetings to enhance language and focus on person-centredness. and
- Promoting and implementing the Lantern Model as a framework for enhancing person-centred care, with some participants already initiating education and awareness activities around the model.

4 Discussion

Emancipation refers to the process of setting individuals free from unexamined, taken-for-granted assumptions and expectations (21). Throughout the programme, the participants were guided to critically reflect on and bring to light such assumptions—both personal and organisational—that may hinder the development of person-centred practice. The programme created opportunities to question established norms and routines within hospice care, many of which had previously gone unchallenged.

McCormack et al. describe programmes of this nature as creating a brave space—a psychologically safe yet challenging environment that enables effective transformation of practice (36). The findings from our project demonstrate that the programme successfully created such a brave space, where participants experienced meaningful transformation.

The following discussion explores this transformation through the lens of emancipation, focusing on the following three key themes that represent the mechanisms of change:

- Professional ideology brought to light,
- Practice knowledge brought to light, and
- Emancipatory practice brought to light.

4.1 Professional ideology brought to light

The participants were able to identify elements of behaviour and actions within their practice that reflected a person-centred orientation—values they strongly believed in but had not previously recognised or articulated. These aspects of their professional identity had remained hidden prior to the programme and were brought to light through reflective learning. This realisation fostered a sense of confidence and excitement about their practice, the care they provided, and its impact.

Through the programme, the participants gained a new understanding of their professional ideology. Ideology refers to the shared meanings and values of a group; it is socially constructed and does not exist as an objective truth but is made visible through the behaviours and actions of its members (32). It became evident that the ideology of the palliative care nurses and leaders—particularly those leading person-centred practice development—aligned closely with Cicely Saunders' philosophy, as articulated in the Lantern Model of Palliative Nursing (24, 25). Awareness of this alignment strengthened the participants' professional identity, which had previously been unspoken and obscured.

Trede et al. (32) argue that when professional ideology remains hidden, it is often because another profession has gained authority, social status, and dominance. Within traditional healthcare systems, the medical-biological model holds an authoritative position, shaping practice and discourse.

James and Field (33) highlight how the hospice movement became over-medicalised as it was integrated into mainstream healthcare. Power and domination within organisations influence who determines actions, what topics are discussed or avoided, and who has a voice in decision-making (34).

By raising awareness of power dynamics and ideological bias, the participants became more attuned to how authority was exercised within their organisations and how this influenced practice. They recognised that unexamined ideological biases could hinder the development of person-centred care. Identifying and challenging these biases became a vital part of their role as leaders in care transformation.

More than two decades ago, McCormack et al. (17) emphasised the importance of attending to cultural and contextual factors in humanising healthcare. Without this focus, they argued, the system cannot truly place the person at the centre of care. McCormack also called for a revolution in healthcare education, advocating for programmes that prioritise human elements alongside technical development (12).

More recently, Cook et al. called for innovative approaches to healthcare education, promoting congruence between education and practice to support the transformation of care and the humanisation of healthcare (35). Despite these calls, educational programmes have been slow to shift from a technical focus to more transformative and emancipatory approaches.

There is a need for organisational bravery among nurse practitioners and leaders to invest in learning and teaching programmes that enable teams to step back from routine practice and reflect on the deeper meanings attached to their work (36).

4.2 Practice knowledge brought to light

During the programme, the participants came to recognise that their approach to care was deeply rooted in moral and ethical intent. This realisation was significant, as they began to see how their values aligned strongly with person-centred practice and Cicely Saunders' philosophy of palliative care. These insights helped the participants understand that both models of care emphasise this orientation, which Saunders formulated as the expert practice knowledge essential for palliative and end-of-life care (1).

Throughout the programme, the participants also realised that the knowledge they considered central to their expertise was often subjective, embedded in experience, and taken for granted. The programme created conditions for consciousness-raising, enabling the participants to become aware of how their actions and behaviours were guided by deep, experiential knowledge. They began to recognise the knowledge base they operated from and its contribution to positive health outcomes for those they cared for.

This form of knowledge aligns with what Habermas described as practical knowledge (37). Habermas proposed that all knowledge is shaped by personal and professional interests and can be categorised into three distinct domains: technical, practical, and emancipatory. Each domain generates different types of knowledge, poses different questions, and influences different actions and perceptions of reality.

Practical knowledge is "stored" knowledge that guides practitioners' actions. It involves understanding intentions, meanings, values, and interests—both one's own and those of others—and is based on a reflexive and evolving understanding of the situation in which one is practising. Within nursing, this has been described as practice wisdom and professional artistry (38).

In contrast, technical knowledge, as defined by Habermas, is driven by a desire for control, prediction, and certainty. This aligns with the traditional biomedical model of healthcare, which prioritises efficiency, measurable outcomes, and curative approaches.

While Habermas argued that both types of knowledge are equally important (37), the modern healthcare system has inherited a hierarchy of knowledge that places technical knowledge—rooted in biomedical science—above practical and emancipatory knowledge. In the context of humanising healthcare, it is essential to challenge this hierarchy and recognise the value of practical knowledge and wisdom as equally vital.

Indeed, it is this form of knowledge that enables care to meet the needs of many individuals, particularly those with complex, long-term, or end-of-life conditions—as Cicely Saunders identified in the 1960s. The traditional biomedical model is increasingly ill-suited to address the challenges posed by an ageing population and the growing burden of chronic illness.

Person-centred practice development seeks to humanise healthcare by valuing both technical expertise and practice wisdom, ensuring that care is not only clinically effective but also ethically grounded, relational, and responsive to individual needs.

4.3 Emancipatory practice brought to light

The programme created conditions for raising awareness of the nature and importance of practice-oriented knowledge. This enabled the participants to recognise the need for applying the third type of knowledge described by Habermas—emancipatory knowledge. For Habermas, this form of knowledge is driven by the desire for liberation from unnecessary constraints and limitations (37). Emancipatory practice emerges when care is guided by less hierarchical, critically examined knowledge, and when the values and voices of all involved, including the patient, are treated as equal.

This orientation is foundational to Cicely Saunders' development of palliative care in the late 1950s and early 1960s, which challenged the dominance of technical knowledge in healthcare. Saunders responded by advocating for a model of care grounded in practice wisdom, relational expertise, and ethical intent (2).

Over recent decades, concerns were raised about the over-medicalisation of palliative care, particularly as it transitioned from its grassroots origins into mainstream healthcare systems

TABLE 3 Summary of the key findings.

Theme	Philosophy	Model of care	Key insights	Implications for practice
Perceptions and attitude change	Critical theory Habermas' emancipatory practice development	Cicely Saunders' model of palliative care The Lantern model	The participants rekindled their vision for person-centred palliative care and developed a stronger sense of identity as leaders	Strengthens leadership confidence and commitment to person-centred care
Practice knowledge brought to light	Critical theory Habermas emancipatory practice development	Cicely Saunders' model of palliative care The Lantern model	The participants recognised the value of moral, ethical, and experiential knowledge, often hidden in routine practice	Validates practice wisdom and highlights the need to challenge the dominance of technical knowledge
Emancipatory practice brought to light	Critical theory Habermas' emancipatory practice development	Cicely Saunders' model of palliative care The Lantern model	The participants became aware of organisational assumptions and power dynamics that hinder person-centred care	Encourages cultural change and critical reflection within hospice organisations
Behavioural change in the workplace	Critical theory Habermas' emancipatory practice development	Cicely Saunders' model of palliative care The Lantern model	The participants applied new methods (e.g., storytelling, poetry, and reflective practice) and facilitated team engagement	Demonstrates practical application of learning and potential for culture shift
Macro-level impact	Critical theory Habermas' emancipatory practice development	Cicely Saunders' model of palliative care The Lantern model	The participants initiated small-scale actions with the potential to influence organisational culture	Highlights the need for follow-up to assess long-term organisational transformation

(33). The programme enabled the participants to reflect on their own values and intentions, and to recognise when these were misaligned with the organisational values driving day-to-day practice. This critical awareness led to new insights into how organisational culture could either hinder or facilitate person-centred care, challenging the medicalisation of palliative care.

Throughout the programme, the participants gained a deeper understanding of how their roles involved challenging existing cultures and aligning with an emancipatory orientation to knowledge. They recognised their responsibility in addressing the imbalance within the hierarchy of knowledge, where technical expertise often overshadows relational and ethical dimensions of care. Emancipatory practice in palliative care embraces the complexity of practice, where facts, technical knowledge, values, and professional wisdom co-exist and inform one another.

The participants also developed greater insight into the need for cultural change, recognising their role in navigating and leading this journey. They became more aware of their organisational structures and contexts, and how these influenced the potential for transformation. Importantly, they acknowledged the emotional and professional demands of their role, including the need for self-care and resilience.

The programme helped the participants reframe change and transformation as a process or journey, rather than a series of immediate outcomes. This perspective enabled them to appreciate incremental progress and to develop new ways of measuring success through small but meaningful steps. See summary of key findings in Table 3.

5 Conclusion

This evaluation has demonstrated how an emancipatory practice development programme supported meaningful transformation among its participants. A key outcome was the development of increased confidence and strengthened intention in their roles as leaders of person-centred practice development within hospices. This transformation was underpinned by a growing awareness of their professional ideology, which had previously been suppressed by the dominant biomedical hierarchy embedded in healthcare systems.

The mechanism for this transformation was twofold. First, the programme enabled the participants to rekindle their vision for person-centred palliative care and to recognise the value of their practice knowledge, which is often overshadowed by the medical model. The participants gained clarity about their unique contributions and the impact of person-centred care on those they support. They also realised that the skills and knowledge they relied on were often embedded, taken for granted, and not visibly acknowledged. The Lantern Model provided a tangible framework for articulating and celebrating this expertise.

Second, the programme helped the participants become more aware of how care was constructed within their organisations and how taken-for-granted assumptions shaped daily practices. These assumptions, often biased and unexamined, were identified as barriers to person-centred care and became focal points for challenge and change.

This paper has outlined the underpinning mechanisms that support transformation within an emancipatory practice development programme. However, a limitation of this project is the lack of follow-up to assess the organisational-level impact of the programme. While the findings clearly demonstrate the programme's potential to transform individual leaders and practitioners, we were unable to track specific change initiatives or measure their outcomes within hospice settings.

Future evaluations should consider incorporating longitudinal follow-up to explore how individual transformation translates into

organisational change and the sustained development of person-centred care.

Data availability statement

The datasets presented in this article are not readily available because the data are confidential. Requests to access the datasets should be directed to eharaldsdottir@qmu.ac.uk.

Ethics statement

Ethical approval was not required for this study involving humans because the evaluation of the program was underpinned by a robust ethical framework that reflected the principles of person-centeredness and was embedded throughout the delivery and evaluation. The key ethical considerations of the evaluation focused on ensuring voluntary participation, anonymity and confidentiality for the participants, and the psychological safety of the participants throughout the process. The participants were informed that the evaluation would run in parallel and be embedded into the program. Ways of working were established at the beginning, with consistent "check-ins" throughout. For these reasons, formal ethical approval was not sought for this evaluation as it was integral to the education programme. This study was conducted in accordance with the local legislation and institutional requirements. The participants provided their written informed consent to participate in this study. Written informed consent was obtained from the individual(s) for the publication of any potentially identifiable images or data included in this article.

Author contributions

EH: Formal analysis, Data curation, Conceptualization, Methodology, Writing – review & editing, Writing – original draft. MC: Formal analysis, Writing – review & editing, Data curation. HR: Formal analysis, Writing – review & editing, Data curation.

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Conflict of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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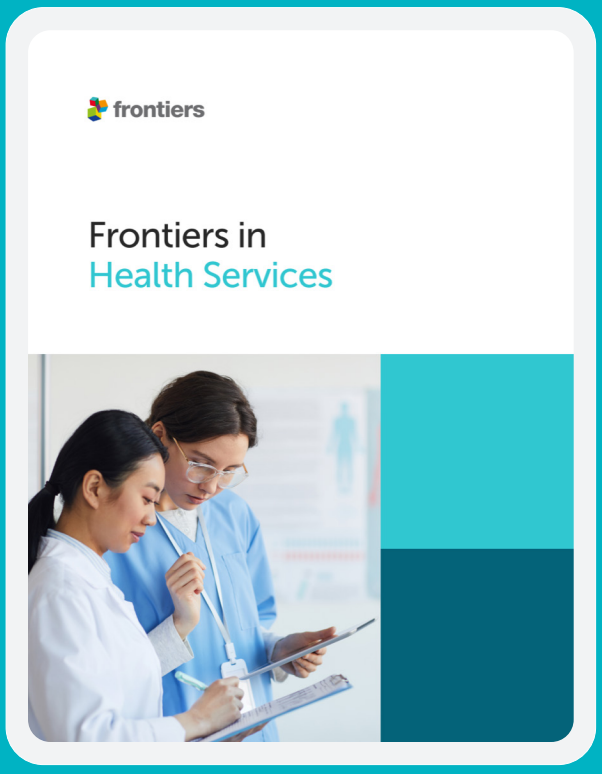

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