Using the care processes construct of McCormack and McCance's person-centred framework to critically analyse nursing care delivered: a case study

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Introduction

The concept of person-centred nursing care relies on the development of therapeutic relationships which places the person at the core of all interactions and includes all the significant people in their lives (Thomas *et al.* 2018). The person-centred framework is primarily based on the value of respect for every person and is facilitated by a collaborative culture of empowerment (McCormack and McCance 2010, 2017). The drive to move the delivery of nursing care from a philosophy that is medically orientated to one that provides holistic care remains challenging due to organisational culture, time restraints and an increased emphasis on targets (Turner-Stokes 2007, Reed 2011). In order for the person-centred framework to enhance quality of care delivered, nurses must progress through each construct and process to promote an overall feeling of wellbeing and satisfaction whilst involving the person in their own care in a therapeutic environment. This paper will critically analyse the care provided for Robert (pseudonym) (Box 1), a person living with dementia in an older persons care ward, using two care processes from the person-centred framework namely: working with patients' beliefs and values, and shared decision-making.

The Nursing and Midwifery Council (NMC 2018a) require nurses to deliver, lead and organise care that is person-centred, compassionate and based on best available research evidence. McCormack *et al.* (2011) suggest that healthcare organisations find it challenging to progress from 'person-centred moments' to 'person-centred care' as the foundation to an ethos of person-centred teams and organisations. Reflection on the prerequisites of person-centred care is a necessary primary consideration, followed by an evaluation of the care environment (Figure 1). These domains are both necessary in order to deliver safe and effective care through the care processes. Achievement of the person-centred outcomes is the core domain of the framework (Wolstenholme *et al.* 2017). Working with patients' beliefs and values, engagement, having sympathetic presence, sharing decision-making and providing holistic care are the processes that aim to create a culture of person-centred nursing (McCormack and McCance 2006). According to Dewing (2008), personhood is a vital aspect of person-centred care as it establishes a significance that every person has different values and a moral worth. When nursing people with dementia, personhood highlights their right to societal value, irrespective of their level of cognitive impairment. Personhood is dependent on other people and recognises that personal identity persists

despite the most disabling effects of cognitive decline. Learning about the complete person and finding ways of maintaining personhood though interactions and conversations are fundamental aspects of delivering person-centred processes (Fazio *et al.* 2018).

Engaging with patients' beliefs and values

Engaging with patients' beliefs and values supports one of the central philosophies of successful person-centred nursing. This construct highlights the significance of acquiring knowledge of what the person values and how they visualise and understand what is occurring in their life (Kennedy *et al.* 2017). McKeown *et al.* (2010) found that using a life story approach can promote person-centred care for older people with dementia and their families. However, in order for this approach to be adopted effectively and maintained in everyday practice, a practice development approach needs to be implemented. Robert played musical instruments from a young age and has a particular interest in jazz. Playing music by Frank Sinatra and communicating with Robert about music had a calming effect on him and enabled him to open up more about his life. Due to the COVID 19 pandemic, nurses may have more time to talk with their patients and build relationships with them which Arkelev *et al.* (2018) argued beneficial instead of undertaking organisational and technical tasks. However, Backman *et al.* (2020) suggest that nurses are aware of the concept of person-centred care but lack the knowledge of how to transfer it into practice. It is therefore vital that nurses have a knowledge of their own beliefs and values and self-awareness of how their opinions can impact the decisions their patient makes. Moody *et al.* (2018) highlight the link with the prerequisite 'knowing self' and the associated implication that nurses must have an understanding of how they behave as a person in order to help others. However, critics such as Moore *et al.* (2017) have argued that barriers such as traditional practices and strict organisational culture have hindered nurses from self-reflection and the adoption of continuous advances to practice development.

Clarke *et al.* (2003) suggested that using the biographical or life story approach enabled nurses to view the patient as a person while also helping to build relationships with them and their families. Contrastingly, some participants in this study did not believe such an approach would benefit all patients as some are more modest than others and like to maintain a degree of privacy. This links directly to working with patients' beliefs and values in that nurses need to be aware of what is truly important to the person and incorporate this into their modified plan of care (McCormack and McCance 2010). Robert enjoyed dancing around the floor when the music was on and this really added to his satisfaction with care and overall wellbeing. However, this had to be balanced against Robert's risk of falls and

the restricted physical environment. These findings provide an important consideration for nursing in relation to creating a balance between taking risks and considering professional accountability based on the patients' values and beliefs (Jakimowicz *et al.* 2017). The Royal College of Nursing (RCN 2019) suggest that all healthcare providers have a duty to ensure patient safety is at the core of quality healthcare and the public must be guaranteed that the services provided are dependable and safe. Additionally, healthcare environments must have an appropriate number of suitably trained staff and sufficient ratios of registered nurses and healthcare assistants in order to improve patient's outcomes, reduce risks and increase productivity (Borneo *et al.* 2017). Despite this evidence, research undertaken by the RCN (2017) suggests that 55% of participants reported a shortage of registered nurses and 41% of participants reported a shortage of healthcare support workers on their last shift. Robert required assistance of one member of staff with all moving and handling activities, and the physiotherapist had recommended the use of a zimmer frame. However, Robert tended to be non-concordant with respect to use of zimmer frame. According to the National Institute for Health and Care Excellence (NICE 2014), an environment containing a skill mix of staff nurses more than 60% equated to less falls. In contrast, Twigg *et al.* (2014) argue that there is insufficient evidence to suggest that increasing staffing levels and improving skill mix as a cost-effective benefit for patients' overall satisfaction with care. In order to overcome the risk and provide Robert with a safe and effective moving and handling care plan, collaboration with the patient, his family and other members of the multi-disciplinary team was required (Standing 2011).

Shared decision-making

The shared decision-making process within the framework concentrates on practitioners enabling patient involvement in decision-making. It is directly associated with the previous construct working with patient's beliefs and values and must take into consideration these values and beliefs when negotiating to develop a genuine foundation for decision-making and the successfulness of this negotiation is largely based on the success of collaborative communication (McCormack and McCance 2010). The NMC (2018b) argue that nurses must instil confidence in their patients and empower them to be active participants in discussions regarding their treatment and care. However, DeMartino (2017) argues that the person may not have the cognitive ability to make the best decision regarding their wellbeing. Robert had a Mini Mental State Examination (MMSE) (Folstein and McHugh 1975) assessment when he arrived in the older persons care ward which suggested that he had moderate dementia. As a result of this assessment, it was considered that Robert lacked capacity at that particular

point in time to make decisions about his care. However, Breton *et al.* (2019) suggest that the MMSE is not suitable for use in hospital settings as it is a less sensitive tool for mild cognitive impairment analysis and diagnosis. Custodio *et al.* (2017) further report that the MMSE is particularly unsuitable for less-educated populations because its low validity and diagnostic accuracy in this population. Indeed. Pottie *et al.* (2016) found no evidence to suggest the effectiveness of screening for cognitive impairment on patient outcomes (functional ability, quality of life, healthcare use and safety) and family/caregiver outcomes (quality of life, caregiver burden).

Robert's wife and daughter attended a zoom multi-disciplinary meeting where it was decided that Robert would be best placed in a nursing home. Robert insisted every day that he wanted to return home to his hobby of caring for pigeons despite not having pigeons since the 1990s. Decision-making with respect to Robert's care reflected a paternalistic model with healthcare professionals articulating and implementing what they consider best for the patient, with limited patient participation. Lepping *et al* (2016) emphasise the importance of steering healthcare professionals away from a paternalistic framework in favour of informed consent, autonomy and shared decision-making. However, informed consent and autonomy are underpinned by competent decision-making capacity, which is not always present in older persons with dementia. Findings from a study by Cole *et al.* (2017) suggest that the paternalistic model within healthcare can be an expectation of some older persons in the event that they do not have the capacity to make decisions themselves. This is an important consideration for collaborative decision-making to ensure nurses perceives themselves as trusted advocates for their patients rather than 'in charge' of them, and advocate patient values and preferences during the process of negotiated decision-making (McCormack and McCance 2010). The values of both nurses and patients need to be respected in dynamic and collaborative person-centred decision-making (Newell and Jordan 2015).

Collaborative decision-making is vital in nursing and involves discussing, negotiating and liaising with patients, relatives and other healthcare professionals to ensure delivery of high quality person-centred care that relates to patients' specific needs (Standing 2011). The NMC (2018a) require future nurses to work in association with people to foster person-centred care plans that understands the person's perspectives, individualities and preferences. Contrary to expectations, a barrier to this requirement is that nurses believe they already practice in a person-centred way despite patient surveys stating otherwise (Eaton 2015). Robert's care plan for eating and drinking stated that he was independent but in fact he required considerable encouragement. The care plan lacked information relating to his likes/dislikes and favourite meals of the day. It also did not take into consideration that he liked to get dressed before eating breakfast as this reminded him of his home life. A study

carried out by Broderick *et al. (2013)* highlighted that nursing care planning documentation was often incomplete and information relating to psychosocial attributes was predominately absent. The study did conclude that although nurses were engaging with their patients and worked with their values and beliefs, care plans were not completed in discussion with the patient, and there was no evidence within the care plan that suggested shared decision=making took place. Similarly, Jakobsson *et al.* (2019) agree that nursing documentation, in particular care pathways, should be considered and focused on the person as they provide a more meaningful relationship between the nurse and patient.

Concluding thoughts

To conclude, this paper has analysed the care provided for a patient using the two of the processes within the person-centred framework and how these processes contributed to the achievement of person-centred outcomes. The processes of the framework particularly focus on the patient, working with their beliefs and values and engaging in shared decision making to create a therapeutic culture. Drawing upon the work of Slater *et al.* (2017), recommendations as to how these care processes may be applied to day-to-day nursing practice are summarised in Table 1. Taking patients' values and beliefs into consideration enables the development of an understanding of what the patient values about their life and how they make sense of life experiences. This is directly associated with shared decision-making which centres on nurses empowering patients to be active participants in the decisions about their care. However, some patients may not have the capacity or cognitive ability to make informed decisions that reflect their best interests. Person-centred care planning allows for the adoption of meaningful relationships between nurses, carers and patients and these care plans can bridge the link between the processes of knowing what is important and building the base for decision-making that accepts a negotiated approach between nurses and patients. There is a powerful alliance between caring and person-centredness, with both concepts requiring the development of a positive workplace culture and therapeutic relationships.

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Box 1: Case study

Robert Green (Pseudonym) is a 82 year-old man who lives in a two-storey townhouse with his wife who is his next of kin. He has one daughter and one son. His daughter lives two hours away and works as a nurse in an intensive care unit. She visits her parents to provide support each week. His son lives overseas and can only visit once a year. Robert worked at the docks up until he retired twenty years ago. He cared for and raced pigeons all his life. Robert loves music and his family all played instruments in a group when they were younger. He also enjoys football and played for his country in his youth.

Robert was admitted to an older persons care ward following a fall at home. He was found by his wife lying on the kitchen floor when she returned from shopping. He sustained bruising to his forehead and left wrist. A CT scan detected no abnormalities and no fractures were found. Robert has a history of falls together with vascular dementia and hypertension. He remained in hospital in order to monitor his confusion levels, assess his risk of falls level and monitor any deterioration in his condition. A multi-disciplinary team meeting was held where it was decided that Robert would benefit from being placed in a nursing home on discharge.

Robert was independent with respect to activities of daily living prior to hospital admission but required considerable encouragement with all such activities during his hospital stay. He required assistance of one person with all moving and handling activities. The physiotherapist recommended the use of a zimmer frame but Robert was non-concordant with this recommendation. He liked to feed himself but became distracted quite easily at mealtimes. He liked to wash and dress himself and became quite agitated when assistance was offered.

Robert was anxious about being in hospital. He became increasingly more anxious as the day goes on and asked continuously to go home. His anxiety was alleviated by social interaction, music and colouring activities he calms down. The dementia support worker on the ward encouraged Robert to take part in a range of activities on the ward.

Figure 1: Person-centred nursing framework (McCormack and McCance 2010)

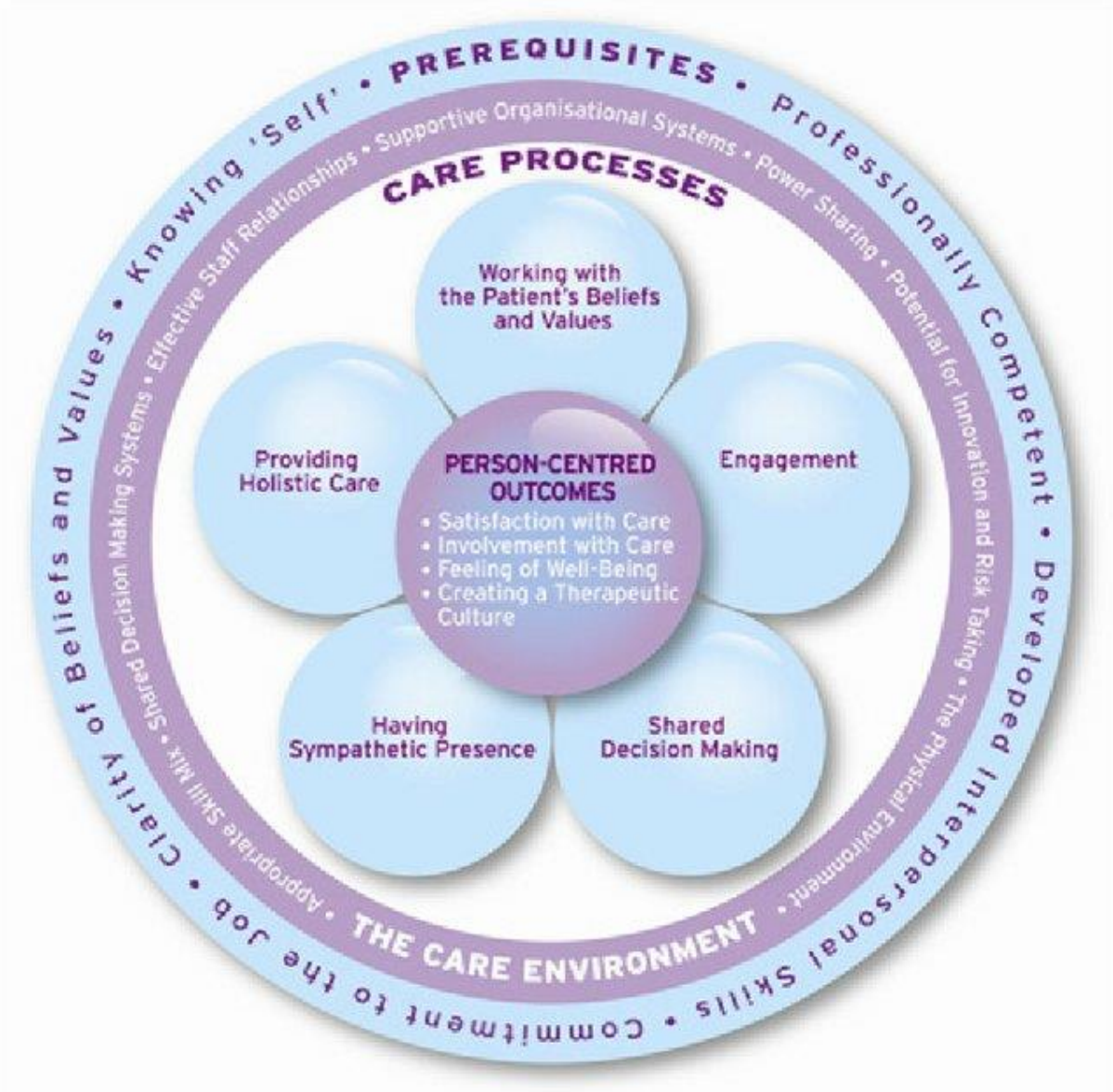

Table 1: Applying person-centred care processes to practice (Adopted from Slater et al. 2017)

Care process	Application to practice
Working with patients' beliefs and values	Integrating knowledge of the person into care delivery Encouraging people to discuss what is important to them Working with the person within the context of their families and carers Seeking feedback on how people make sense of their care experience
Shared decision-making	Including the family in care decisions where appropriate and/or in line with the person's wishes Working with the person to set health goals for their future Enabling people receiving care to seek information about their care from other healthcare professionals