

# Measuring person-centred care in a sub-acute health care setting

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## Abstract

**Objective:** A more appropriate tool to measure the client experience of person-centred care is required to complement other existing measures of quality. A tool developed in the United Kingdom was trialled to determine its utility with a frail older Australian population.

**Design:** A random sample of clients recently discharged from a sub-acute setting over a 6-month period in 2005 were sent a questionnaire and invited to respond, a reply-paid envelope being provided for the return of the questionnaire. The questionnaire comprised the 20-item tool and space to provide additional qualitative comments.

**Setting:** The inpatient wards of a sub-acute facility in Melbourne.

**Participants:** From the random sample of 144 discharged clients, 78 responded to the questionnaire.

**Main outcome measure:** 20-item Patient-Centred Inpatient Scale (P-CIS) developed by Coyle and Williams (2001).

**Results:** Overall, there was a fundamental core of person-centredness as demonstrated by a ratio score of 0.68. Personalisation and respect dimensions are the main strengths of person-centred care in the health care setting in which the P-CIS was trialled, with personalisation scoring 0.75 and respect scoring 0.77. The miscellaneous compo-

## What is known about the topic?

Person-centred care is considered the optimal way to deliver health care. Health care settings rely heavily on the concept of satisfaction to capture the client experience of care delivery. However, satisfaction is unable to encompass the range of feelings, values and experiences of a person as when health care is provided. So instruments measuring client satisfaction cannot capture key characteristics of person-centred care.

## What does this paper add?

This paper advances the debate on measuring the client experience in health care settings. It identifies a way to capture key features of a person-centred approach to care through a measure of personal identity threat which can be used with a frail older population.

## What are the implications for practice?

The P-CIS provides a way to identify strengths and weaknesses in person-centred care delivery in the inpatient setting. It provides a framework enabling care providers in inpatient settings to monitor and modify practice to optimise person-centred care.

nents scored 0.69. The findings show that areas of the client experience warranting priority quality improvement effort are specific to the dimensions of empowerment (0.58), information (0.58) and approachability/availability (0.43).

**Conclusions:** The P-CIS demonstrates the potential to be a contributing component that informs the monitoring and improvement of quality person-centred care in Australian inpatient health care settings.

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PERSON-CENTRED CARE is considered the optimal way of delivering health care and has been defined simply as “valuing people as individuals”.<sup>1</sup> This approach to care is built on the concept of personhood envisaged by Tom Kitwood as the “status or standing bestowed upon

one human being by others in the context of a relationship”<sup>2</sup> The term “person-centred” reflects the fundamental notion of the person being the focal point in a partnership that is both respectful and reciprocal. While personhood as the fundamental concept of a person-centred care approach has been embraced for over twenty years in the context of dementia care, it has not always been so readily accepted in health care more broadly. Recent appraisals suggest that the original vision of person-centred care has been lost in common usage of the term.<sup>3</sup> In the United Kingdom, where person-centredness has been the basis of health care policy for some time, critics have gone so far as to say that it is nothing more than a political slogan to identify a user-oriented approach to care.<sup>4</sup> Calls to refocus on a “relationship-centred approach” to care are signalling the need to bring back the essence of Kitwood’s original perspective and clarify person-centredness for practical application.

In Australia, health care policy, particularly policy relating to the care of older people, is also built on principles reflecting a person-centred approach to care, and similar issues seem to be emerging in relation to the meaning of person-centred care in practice. This is reflected in the way in which we currently measure person-centredness in health care settings. Many health care workers believe that they already provide person-centred care. Yet there is little evidence to illustrate that it is being monitored or measured in a way that reflects the true nature of person-centred care, especially from the client or patient perspective. While supporting a person-centred approach to care, many health services are still relying on satisfaction surveys to provide a valid client perspective of person-centred care. This assumes that the concept of satisfaction provides the appropriate context in which to measure person-centred care.

### **Issues with satisfaction as a measure of person-centredness**

Client satisfaction has commonly been used to assess quality of care, and in turn, to inform

quality improvement activities. Results from satisfaction surveys can be very influential in terms of “determining service structure, development and financial support”.<sup>4</sup> Yet, serious reservations have been raised about the validity of both the concept and measures of satisfaction.<sup>5,6</sup>

While satisfaction surveys have a role in health service evaluation, their utility in measuring person-centred care is limited, particularly to inform quality improvement activities. When clients express satisfaction, it cannot be assumed that they have judged their care to have met their needs and expectations.<sup>6,7</sup> Satisfaction is unable to encompass the range of feelings, values and experiences a person has when health care is provided.<sup>8</sup> While patients describe negatively perceived experiences within individual interviews, they tend to record high levels of satisfaction regarding the same aspect of care in response to a questionnaire.<sup>9,10</sup> Turriss reminds us that satisfaction is a socially constructed idea embedded with underlying assumptions.<sup>11</sup> She argues that the current understanding of the concept manifests as a “checklist approach to achieving patient satisfaction, rather than developing an understanding of the larger issues underlying individual experiences of health care.”<sup>11</sup>

Quality issues that are important for patients and relatives are not always evaluated in care audits. Qualitative research found that attributes of the nature of care are patient focused.<sup>12</sup> More specifically, the nature of care was about involving patients, acknowledging individuality, individualised holistic care, and not only relating to need but also anticipating needs. A close, sociable patient–staff relationship was identified in which patients were known as “people”: a relationship through which bonds/rapport developed, open communication and information transferred freely, staff were accessible and available to patients, spent time with patients and demonstrated kindness, concern, compassion and sensitivity.<sup>12</sup> Values underlying the care relationship have been identified as equality (experience-based knowledge being as valuable as professional-based knowledge), partnership (accountable, committed and active partners in care) and

interdependence (mutual respect, trust and acceptance).<sup>13</sup> Therefore, the experiences of interactional and interpersonal elements of care provided are key issues in quality for patients.

### **People's experiences of being treated as individuals: the basis of a measure of person-centred care**

Dissatisfaction with a health care experience has a long-term impact on the patient–practitioner relationship and health-related behaviours.<sup>14</sup> Yet, given that levels of satisfaction dominate reporting structures, it appears that there is a lack of appreciation for the meaning of dissatisfaction and what it can tell health care providers. Research in the acute setting suggests that patients, while expressing satisfaction, do make “compromises” which “they think they must accept as a necessary part of their stay in the ward”.<sup>15</sup> These compromises may well be a response to a threat to their integrity.<sup>16</sup>

A process of “preserving integrity” which patients use to deal with, avoid or reduce issues of their vulnerability has been identified.<sup>17</sup> Integrity in this context specifically refers to being able to protect oneself, maintain dignity, be an individual and have control over one's situation.<sup>17</sup> Additional research revealed that both patients and nurses experience threats to integrity and that a reciprocal influence exists between the threats to nurses' and patients' integrity.<sup>16</sup> In essence, when nurses experienced a threat to integrity it was likely to affect their approach to patients, compounding the threat to the patient's integrity.

To preserve their integrity, nurses needed to be able to fulfil their *professional* role of delivering quality nursing care to all patients assigned to their care (thus preserving *patients'* integrity), fulfil the requirements of the *organisation* (hospital) while at the same time maintaining their own *personal* integrity. Patients, on the other hand, needed to feel safe and retain all aspects of their *personal* integrity while ill and in hospital, to retain and restore the person in the patient role. For them to achieve this, they had to rely to a large extent on the nurses, as well as their own actions and those of relatives or friends.<sup>16</sup>

Once again, the context of the relationship between staff and patient is highlighted as significant.

As a person-centred approach to care is a policy directive in Victorian health care settings, the need for a more appropriate tool to measure the client experience of that approach to care is required to complement other existing measures of quality. Reliance on standard satisfaction surveys will not provide a client perspective on the key elements of a person-centred approach to care. A study exploring the meaning of dissatisfaction with health care found people described feeling dehumanised, objectified, negatively stereotyped, disempowered and devalued, thereby conveying the idea that their sense of self had been undermined.<sup>18</sup> “Threats to personal identity were found to underpin almost all accounts of negative experiences of health care.”<sup>15</sup> Hence, if personal integrity is not preserved in the health-care setting, personhood is not maintained, creating dissatisfaction with the health care experience. Coyle has identified a key variable for understanding dissatisfaction with health care as the concept of “personal identity threat”.<sup>14</sup>

From this qualitative work, a 72-item questionnaire was developed.<sup>19</sup> The questionnaire was piloted, tested and refined and then used in a cross sectional survey of inpatients from various wards discharged from a large Scottish teaching hospital.<sup>19</sup> Following analysis of the results, a rigorous process with established criteria for item retention reduced the questionnaire to a 20-item tool, the Patient-Centred Inpatient Scale (P-CIS) measuring the client experience of personal identity threat. The final scale was unidimensional, had good reliability ( $\alpha=0.91$ ), good content validity (due to the initial qualitative study) and construct validity was established by examining scales scores in relation to age.<sup>20</sup> Coyle and Williams indicate that while further work is needed to explore sensitivity of the P-CIS over time to gender differences, initial findings indicate that compared with satisfaction questionnaires, the scale may be better able to detect change longitudinally and comparatively, and, with its ability to detect significant differences

with a relatively small sample size, it could be particularly useful for use in routine practice.<sup>20</sup>

The potential usefulness of the P-CIS for quality assurance purposes lies in its capacity to reflect problematic experiences and negative feelings about health care, thereby generating a more robust starting point from which to address issues specific to the delivery of person-centred care. Given the issues associated with satisfaction surveys, particularly with older people, and the inability of such tools to measure person-centred care, the aim of this study was to ascertain the utility of the P-CIS with a frail older Australian population. In particular, the aim was to examine the convenience of its use and its effectiveness to inform quality improvement activities to optimise person-centred care.

## Methods

Clients discharged from a sub-acute facility in Melbourne, Australia, over a 6-month period in 2005 provided the sampling frame for this study. Using discharge lists from the previous 2-week period, random numbers were electronically generated against each name, following which columns were sorted by random number and name. The first fifteen from each list were sent a copy of the questionnaire and invited to respond, a reply-paid envelope being provided for the return of the questionnaire.\* In addition to the P-CIS, space was provided for clients to include comments at the end of the questionnaire. From a random sample of 144 discharged clients, a total of 78 clients responded, a response rate of 54%. Data from the questionnaires was analysed using SPSS, version 13 (SPSS Inc, Chicago, Ill, USA). Proportions were calculated for all responses.

In Coyle and Williams' pilot instrument, five specific dimensions were identified that included personalisation, empowerment, information, approachability/availability and respect, leaving

additional service-related items in a "miscellaneous" dimension.<sup>19</sup> Core statements for each of these dimensions remain in the P-CIS. The domains and corresponding items are presented in Box 1. Scoring for the P-CIS is based on positive responses to the statements scoring highest — so where the statement is positive the scoring is highest with strongly agree (5 points) through to strongly disagree (1 point). Where the statement is negative, the opposite scoring is applied. Scores are presented in this paper as ratios to simplify interpretation. Hence, a perfect score equals 1.

## Results

Clients responding were an average age of 82 years (SD 7.32 years), the majority were women (92%) and they had been discharged following an average length of stay of 28 days (SD 8.92 days). While the mean age and length of stay reflects the overall population of this facility (82 years, 26 days respectively), this is an especially high percentage of female respondents given that the casemix for that period was 64% women, 36% men.

Core statements for each of the P-CIS dimensions were examined against the various dimensions of person-centredness identified to assist clinical and management staff in the interpretation of the information. Box 1 provides frequencies in percentages for all response categories, with combined percents for agreement and disagreement immediately below, across each item of the scale. The statements are grouped within the dimension to which they belong. Each item was written as a positive or negative statement and the "positive responses" are bolded in Box 1.

### Personalisation

Treating the client as a "whole person" is the essence of a person-centred approach to care. Four items (statements 1 to 4) on the scale are associated with "personalisation". The majority of clients in this health care setting experienced a welcoming environment in which they developed friendly relationships with staff. Just over two-

\* An administrative issue restricted access to discharge lists for one 2-week period in month 2 and one 2-week period in month 5. Six questionnaires were not posted in month 4.

## I Dimensions of person-centred care: client responses by item<sup>20</sup>

		Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
Personalisation	The doctors understood fully what I was going through (+)	22.6	45.2	22.6	6.5	3.2
		<b>67.8%</b>			9.7%	
	I was made to feel at home very quickly (+)	35.5	38.7	9.7	16.1	0
		<b>74.2%</b>			16.1%	
Personalisation	By the time I left I felt the staff were my friends not just staff members (+)	31.0	48.3	6.9	10.3	3.4
		<b>79.3%</b>			13.7%	
	The service was designed more for the convenience of staff than for patients (-)	3.2	12.9	16.1	48.4	19.4
		16.1%			<b>67.8%</b>	
Empowerment	I felt as though the staff and I were partners in the whole process of my care (+)	29.0	51.6	16.1	3.2	0
		<b>80.6%</b>			3.2%	
	Nobody asked me what I thought about my treatment (-)	19.4	25.8	19.4	25.8	9.7
		45.2%			<b>35.5%</b>	
Empowerment	The nurses didn't seem to listen to what I said (-)	9.7	9.7	12.9	48.4	19.4
		19.4%			<b>67.8%</b>	
	The nurses always listened attentively to what I said (+)	32.3	45.2	9.7	12.9	0
		<b>77.5%</b>			12.9%	
Information	At times I felt the doctors did not want me to ask questions (-)	12.9	19.4	25.8	25.8	16.1
		32.3%			<b>41.9%</b>	
	I wish the doctor had given me a fuller explanation of my condition (-)	22.6	25.8	6.5	32.3	12.9
		48.4%			<b>45.2%</b>	
Information	I was sometimes left waiting, not knowing what was going on (-)	12.9	19.4	16.1	45.2	6.5
		32.3%			<b>51.7%</b>	
	The doctors should have given me more information about my treatment (-)	25.8	29.0	9.7	25.8	9.7
		54.8%			<b>35.5%</b>	
Approachability/availability	I was often unable to locate nurses for assistance (-)	6.5	32.5	3.2	48.4	9.7
		39.0%			<b>58.1%</b>	
	Sometimes I felt a bit abandoned by the staff while in hospital (-)	3.2	25.8	0	58.1	12.9
		29.0%			<b>71.0%</b>	
Approachability/availability	I would have liked to speak with the nurses more often (-)	9.7	41.9	9.7	32.3	6.5
		51.7%			<b>38.8%</b>	
	I would have liked to speak to the doctors more often (-)	23.3	30.0	23.3	16.7	6.7
		53.3%			<b>24.4%</b>	
Respectfulness	Sometimes the staff stood near me talking about me as if I wasn't there (-)	6.5	12.9	6.5	48.4	25.8
		19.4%			<b>74.2%</b>	
Respectfulness	The staff were very concerned about my privacy (-)	32.3	48.4	6.5	12.9	0
		<b>80.7%</b>			12.9%	
Miscellaneous	I had plenty of choice in the food they provided (+)	25.8	38.7	6.5	19.4	9.7
		<b>64.5%</b>			39.1%	
Miscellaneous	While in hospital I was waited on hand and foot (+)	16.1	45.2	6.5	25.8	6.5
		<b>61.3%</b>			32.3%	

Positive (+) and negative (-) signs at the end of each statement identify the statement context. Highlighted percentages indicate the positive responses for the specific items.

thirds of responding clients indicated that doctors conveyed a full understanding of what the client was going through, although it is noteworthy that 22.6% were uncertain about this element of personalisation. Although some clients felt the service was designed more for the convenience of staff than for them (16.1%) and a similar number were uncertain, the majority disagreed with this view (68%).

### **Empowerment**

Statements 5 to 8 cover “empowerment”, another important component of person-centredness, often associated with having a say in treatment or “being involved”.<sup>19</sup> The data collected in this pilot showed that 80.6% of respondents felt as though they were partners with the staff in the process of care. Nevertheless, 44% of this group indicated that nobody asked them what they thought about their treatment. Of all the clients responding to the survey, 45.2% said that no-one asked them what they thought of their treatment. Overall, the majority of respondents agreed that nurses listened to what they said.

### **Information**

There is a general misconception that being person-centred means sharing all information and all decisions, when in fact being person-centred means taking into account the client’s desire for information and for sharing decision making and responding appropriately.<sup>21</sup> The data collected on statements 9 to 12 in the dimension of “information” illustrate that the P-CIS can provide a snapshot of the perceptions of the patients’ experience of interaction and the flow of information. For example, with regard to the item about wanting a fuller explanation of their condition, clients were split, with 48.2% indicating they did want more explained and 45.1% reporting they did not agree with the statement; whereas over half (54.9%) of respondents felt that the doctors should have provided information about their treatment and just over a third said they did not agree that more information should have been provided. This is not necessarily surprising, given that not everyone will want the same level of

information.<sup>22</sup> Nearly one-third of respondents did feel that at times the doctors did not want them to ask questions, but this item had the highest level of uncertainty among respondents (25.8%).

### **Approachability and availability of staff**

Although the majority of respondents reported that they did not feel abandoned by the staff while in hospital (71%), 39% did indicate that they were often unable to locate nurses for assistance. Just over half of all clients responding to the survey indicated that they would have liked to speak with the nurses (51.7%) and the doctors (53.3%) more often.

### **Respectfulness**

Clients responding to the survey commonly identified that respect towards them was demonstrated by staff. 74.2% disagreed with the statement “sometimes the staff stood near me talking about me as if I wasn’t there.” Similarly, 80.7% reported that staff were very concerned about their privacy, 13% reported they were not concerned.

### **Miscellaneous**

The final two items relating to service revealed that close to two-thirds of respondents felt they were waited on hand and foot (61.3%) and also offered plenty of choice in the food provided (64.5%).

### **Person-centredness scores**

Results for the pilot showed the overall Person-Centred Care Score was 0.68, revealing a fundamental core of person-centeredness in the approach to care. Examining the various dimensions of the client experience of person-centred care allows for the identification of key areas that would benefit from consideration in relation to quality improvement. Personalisation and respect dimensions were the main strengths of person-centred care in the health care setting in which the P-CIS was trialled, with personalisation scoring 0.75 and respect scoring 0.77. Empowerment

## 2 Respondent comments compared with P-CIS dimensions

P-CIS dimensions	Respondent comments
Personalisation	This was my first time. I miss the girls.
Empowerment	They [staff] were very interested in how to help me.
Information	I was never told what was the matter with me. Lack of communication including between staff! Nobody would tell me what was going on.
Approachability/Availability	I was left wondering. I felt left out. I was always in the bedroom by myself.
Respectfulness	I wasn't always dressed right before wheeling to the toilet or shower in front of others. Lack of privacy in bathroom and people in and out of the room all the time.
Miscellaneous	From my first night there I've felt as if I had been taken care of.

and information dimensions scored 0.58 and approachability/availability scored the lowest at 0.43. The miscellaneous components scored 0.69.

### Qualitative comments

Twenty respondents provided comments in the space provided at the end of the questionnaire. Although many indicated positive experiences over half of the comments received were too vague to link to components being measured. "All the staff were great", "Staff were excellent", "Thanks to all the staff, doctors and nurses etc," and "Very impressed with the nursing care"; these statements are representative of the nature of these comments. However, as Box 2 illustrates, there were some specific comments that highlighted dimensions of the P-CIS, particularly around the lower scoring dimensions of information and approachability/availability.

### Discussion

The ceiling effect usually seen in satisfaction surveys with older clients has long been problematic for the use of information in monitoring quality and identifying areas for improving quality of care. Results of the trial of the P-CIS indicate that, specific to identifying whether clients are being treated as "individuals", the tool is more sensitive as a measure of client views in

routine clinical practice than standard satisfaction surveys.

In this trial for example, the findings showed that areas of the client experience warranting attention were specific to the dimensions of empowerment, information and approachability/availability. How might this inform quality improvement activities? The relationship between clients and health care professionals has been identified as fundamental to a person-centred approach to care. On a continuum of care, individualised, needs-related care with staff demonstrating involvement, commitment and concern is fundamental to good quality care, whereas routine care delivered in an impersonal manner by distant staff that do not know or involve clients is a hallmark of a poor quality care experience. The P-CIS data showed that more than half of respondents indicated that they would like to have spoken to the doctors and nurses more often and felt the doctor should have given them more information about treatment. Furthermore, nearly half said they would have liked a fuller explanation about their condition from the doctor, and a third or more of clients reported feeling as if they were left waiting, not knowing what was going on or being unable to locate nurses for assistance. There were also 45% of clients who indicated that nobody asked them what they thought about their treatment. A picture emerges that suggests client

involvement is an area to which priority should be given. A more positive client experience of care could be fostered with quality improvement activities targeting client involvement, and a good starting point in the light of the results would be to address elements of communication between health care staff and clients. As Coyle and Williams point out in discussing similar findings in relation to client involvement in their own research: "Asking patients what they think of their treatment may be an easy but effective step to improve the quality of their experience."<sup>19</sup>

There are a number of limitations that warrant recognition in the P-CIS trial reported in this paper. The large proportion of female respondents, small overall sample size, specific care setting and lack of more detailed demographic data collected restrict any comprehensive statistical analysis and generalisations. However, as a small project aimed specifically at ascertaining the utility of the P-CIS with a frail older Australian population it provided insight into how such a tool might be used to identify strengths and weaknesses in person-centred care delivery.

While we recognise that there will be issues in relation to clients with cognitive impairment and those from a non-English speaking background completing the survey, it appears to work well with many clients from a frail older population as a self-completion questionnaire provided post-discharge. This means that it can readily be incorporated into post discharge procedures for monitoring and quality improvement. Further work with a larger sample would be required to examine gender differences and different methods of administration, particularly given the poor response rate from males. Consideration should also be given to what extent other clinical and support staff would be involved in facilitating person-centred care across the different care settings. The P-CIS focus on medical and nursing staff may be more suited to the acute setting in which it was originally developed. Nevertheless, ongoing use of the scale in the Australian context will provide the opportunity to validate the P-CIS and to further develop the P-CIS for use with

non-English-speaking background populations and those with cognitive impairment, as well as exploring its utility across care settings. Coyle and Williams point out that when using client perspectives in the context of quality assurance, it is important for providers to concern themselves with the views of those with negative experiences and disappointments with health care.<sup>19</sup> As a measure of personal identity threat the P-CIS provides this perspective from clients specific to the delivery of person-centred care.

Work continues to move forward on the concept of satisfaction, which should not be overlooked. When seen as a multidimensional concept based on the relationship between experiences and expectations, a strong measure of client satisfaction can be a useful tool in gathering client perspectives that can inform quality improvement.<sup>23</sup> Larrabee and Bolden point out that although there is quite a large range of tools available for measuring patient satisfaction with nursing care quality, many have not benefited from input from patients about what constitutes nursing care quality, highlighting the need to use "qualitative data about the dimensions of their own populations' definitions of good nursing care when selecting a patient satisfaction instrument, interpreting survey data and implementing improvement activities".<sup>24</sup> In terms of measuring client satisfaction with the overall health care experience, the same principle should apply. Some research has identified the need to combine qualitative and quantitative data to best understand the client experience.<sup>25</sup> The point is that reliance on one method of eliciting client perspectives of care is likely to result in a less than reliable or holistic picture of how clients experience the delivery of care that is purported to be person-centred. The P-CIS demonstrates the potential to be a contributing component that informs the monitoring and improvement of quality person-centred care in Australian inpatient health care settings.

### Competing interests

The authors declare that they have no competing interests.

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