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A Concept Analysis of Person-Centered Care

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The term *person-centered care* (PCC) has been frequently used in the literature, but there is no consensus about its meaning. This article uses Walker and Avants's method of concept analysis as a framework to analyze PCC. A literature search was completed and data were collected using several search engines (CINAHL, Medline, PubMed, and Cochrane Review). The key words used were "individualized-care," "person-centered care," "patient-centered care," "client-centered care," and "resident-centered care." Attributes, antecedents, and consequences of PCC were identified. Empirical referents were provided to measure PCC from the perspective of the person receiving care and finally, a model case provides an exemplar of the concept.

Keywords: *concept analysis; person-centered; patient-centered; individualized care; client-centered; resident-centered*

Health care in America has been described as fragmented and impersonal (Institute of Medicine [IOM], 2001). The traditional clinician-centered or disease-focused medical model is being changed to one in which care is customized to each person. "Person-centered care" (PCC) has been recognized as one of the critical elements needed in the redesign of our nation's health care system (IOM, 2001). This is a monumental task for the traditional health care setting where efficiency, standardization, and architectural design were created to organize systems around medical providers rather than patients.

PCC is an essential component of quality health care delivery, and the concept is increasingly being advocated and incorporated into the training of health care providers (Lauver et al., 2002). The use of PCC terminology is frequent, but the concept is vague. Moreover, the practice of PCC is dependent on the setting in which care is provided. This creates confusion, influences the development of theory, and affects the implementation of PCC practices. Therefore, the purpose of this article is to provide a concept analysis of PCC in the context of an inpatient post–acute health care environment.

Literature Review

A literature search was completed and data were collected using several databases (CINAHL, Medline, PubMed, and Cochrane Review). No time period was delimited in the search to capture the historical evolution of this concept. The key words used were "individualized-care," "person-centered care," "patient-centered care," "client-centered care," and "resident-centered care." Related words describing care such as "personalized" and "focused" also were included. The initial search identified 17,751 citations. After limiting the search to those written in English and adjusting the age to an adult population (≥19 years), the number was reduced to 3,666 citations. After exclusions were applied to select only those articles that contained the original key words in the title, the total decreased to 217 citations. Abstracts from those articles were reviewed, and 167 citations were removed because they did not contain reference to the terms'

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meaning or use in the body of the text. Finally, an ancestry search was conducted from all the articles retrieved to capture other key resources. A total of 50 articles were used in this concept analysis.

Similar Terms

In the literature, the word *person* in PCC is used interchangeably with patient, client, and resident. This variance depends on the context in which care is provided. Hospitals use the term *patient-centered care* whereas nursing homes use *resident-centered care*. The intent of the care delivery, however, is congruent among all, advocating that care should be individualized around the *person* regardless of the health care setting.

Historical Evolution

The concept of PCC has a long history and tradition in health care. Lauver et al. (2002) argued that the origins of this concept could be traced back to Florence Nightingale, "who differentiated nursing from medicine by its focus on the patient rather than the disease" (p. 246). Carl Rogers, an American psychologist, created the notion of person-centeredness in the early 1940s. The principles of his theory were that each individual (a) possesses considerable qualities, (b) can draw strength from available resources, and (c) can find a way to remedy difficulties (Rogers, 1961).

The term *patient-centered medicine* was coined by Balint in the 1960s, who proposed how physicians should interact with their patients (Balint, 1968). The emphasis was on understanding patients and their unique circumstances as a way of providing care. Since that time, several authors built on Balint's work and multiple dimensions of PCC have been discussed in the literature. According to Lipkin, Quill, and Napodano (1984), the person-centered practitioner must have the basic knowledge, attitude, and skills to provide PCC. The context of a patient interview should be conducted in a way that allows the patient to share his or her unique story promoting trust and confidence, clarifying symptoms and concerns, generating and testing hypotheses that may include biological and psychosocial dimensions of illness, and creating a foundation of genuine trust for an ongoing relationship.

Stewart et al. (1995) suggested that for physicians to be more person-centered, they needed to gain an understanding of the patients and the diseases or conditions through a process of addressing both the patient's and the physician's agenda. Six dimensions of PCC were identified: exploring the experience of the illness, understanding the person as a whole, agreeing to the plan for health care management, including prevention and promotion of health, focusing on the doctor–patient relationship, and being realistic about personal limitations. The common theme in the work by both Lipkin et al. (1984) and Stewart et al. (1995) was that interpersonal relationships between physicians and patients are paramount to providing PCC.

The Picker-Commonwealth Program for Patient-Centered Care began in 1987 to promote the movement of patient-centeredness into a comprehensive health care system as a way to delivering better health care services. The focus was on patients' needs, and seven dimensions were identified:

> (1) respect for patients' values, preferences, and expressed needs; (2) coordination and integration of care; (3) information, communication, and education; (4) physical comfort; (5) emotional support and alleviation of fear and anxiety; (6) involvement of friends and family; and (7) transition and continuity. (Beach, Saha, & Cooper, 2006, p. 2)

This program was the first to identify that PCC should not only occur at the interpersonal level between a care provider and patient but also at the organizational level.

To further the evolution, Mead and Bower's (2000) review of the literature resulted in a clarification of the dimensions of PCC. They created a conceptual framework that included five dimensions of person-centeredness. Their dimensions were "biopsychosocial perspective, patient as person, shared power and responsibility, the therapeutic alliance, and doctor as person" (Mead & Bower, 2000, p. 1088). These authors recognized that person-centeredness was a proxy for quality care and that key elements included the ability of the practitioner to understand the unique needs of each person and to create a healthy interpersonal relationship.

In nursing, the interpersonal relationship between the nurse and client has been described as the crux of nursing (Peplau, 1997). The nurse–client relationship influences the quality of care provided, and the goal of the interpersonal relationship is to support the client's overall health and well-being (Gastmans, 1998). However, an interpersonal relationship on its

own does not mean the relationship is person-centered. Moreover, some would argue that the use of the words such as *patient* or *noncompliance* describes an interpersonal relationship as one where the clinician assumes the authority, power, and control (Ingram, 2009; Leplege et al., 2007; Slater, 2006). In contrast, the practice of PCC creates an interpersonal relationship that shifts the focus from the clinician to the person for whom care is being delivered, thus giving control to that individual.

Since the 2001 publication of IOM's report *Crossing the Quality Chasm*, there has been a surge in publications about PCC. A concept analysis concerning person-centeredness (Slater, 2006) and a dimensional analysis of PCC (Hobbs, 2009) have both contributed to the development of this concept. Slater's (2006) concept analysis identified the health care environment as having an influence on person-centered delivery of care. However, the author did not identify it as an antecedent and no clarification was provided as to how the environment affects PCC. The antecedents identified by Slater were dignity, autonomy, respect, and therapeutic relationship; attributes identified were individuality, respecting values, and empowerment; and consequences identified included improved health outcomes and perceived improved relationship. Hobbs's (2009) dimensional analysis of patient-centered care took a much broader approach. The focus was on the acute care setting and the analysis identified *therapeutic engagement* as the process for PCC. The consequences included effective care, less suffering, and met needs. The conclusion from the author was that PCC is a complex concept that required more clarification (Hobbs, 2009).

Definition of Person-Centered Care

The IOM (2001) defined PCC as "care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p. 49). McCormack (2003) defined PCC as "the formation of a therapeutic narrative between professional and patient that is built on mutual trust, understanding and a sharing of collective knowledge" (p. 203). Suhonen, Välimäki, and Leino-Kilpi (2002) defined PCC as being comprehensive care that meets each patient's physical, psychological, and social needs. None of these definitions represent PCC in its entirety. Therefore, for the purpose of this analysis, a combination of

these definitions will be used to provide the most complete definition of this concept. PCC is a holistic (bio-psychosocial-spiritual) approach to delivering care that is respectful and individualized, allowing negotiation of care, and offering choice through a therapeutic relationship where persons are empowered to be involved in health decisions at whatever level is desired by that individual who is receiving the care.

Defining Attributes

Walker and Avant (2005) described attributes or characteristics of a concept as the "heart of a concept analysis" (p. 68). The goal is to identify the attributes that are the most frequently associated with the concept. Identifying the key characteristics of the concept not only assists in clarifying a phenomenon but also helps differentiate it from another similar or related one (Walker & Avant, 2005). Themes with common traits were collapsed to capture the essence of the attribute. The analysis of PCC in a post–acute health care setting resulted in the following defining attributes: (a) holistic, (b) individualized, (c) respectful, and (d) empowering. These characteristics appear consistently throughout the literature concerning PCC and reflect the essence of the concept. Visual representation of the concept analysis components is found in Figure 1.

Holistic

Holistic care is described as a behavior that recognizes and values whole persons as well as the interdependence of their parts (McEvoy & Duffy, 2008). The whole person is described as the biological, social, psychological, and spiritual aspects of an individual (McCormack, 2003). Providing holistic care allows the clinician to better understand how an illness affects the entire person and how to respond to the true needs of an individual (Mead & Bower, 2000). Care that focuses on biological illness without considering the psychological or social impact hampers healing and contributes to poor outcomes (Suhonen, Välimäki, & Katajisto, 2000).

Individualized

The term *individualized* is the most frequently acknowledged attribute of PCC. In a PCC environment, the clinician considers the unique needs and the specific health concerns of the person to
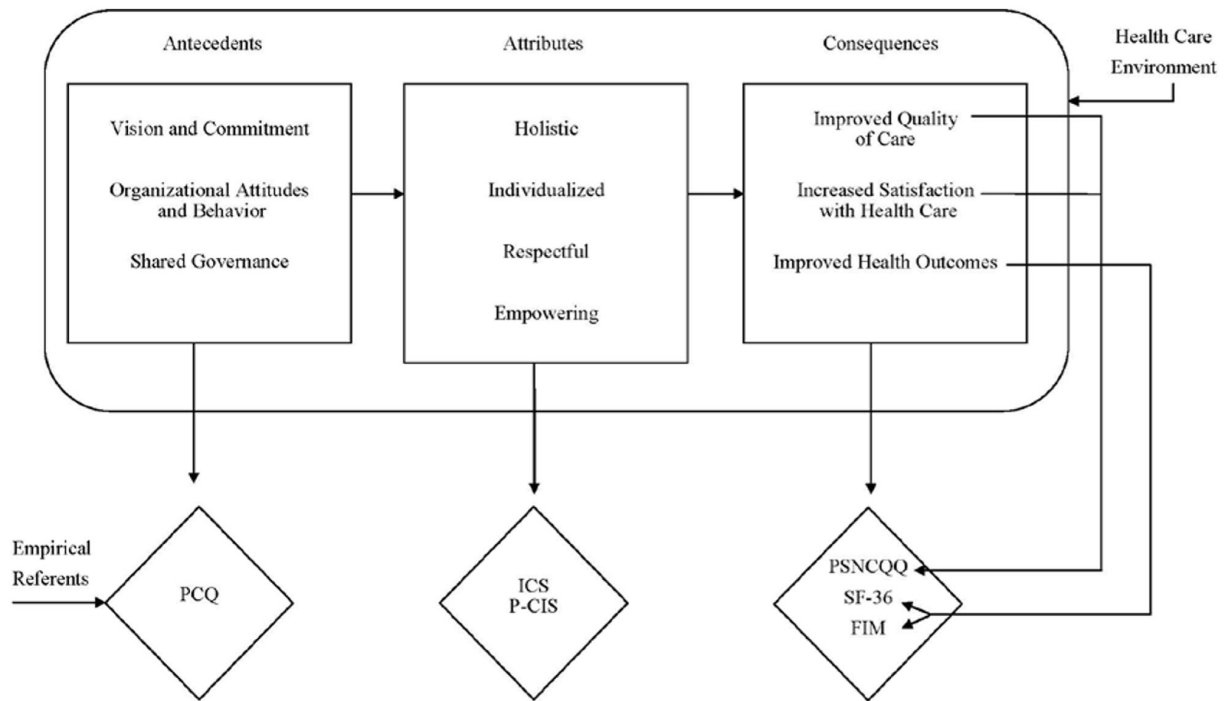
Figure 1. Antecedents, Attributes, and Consequences of Person-Centered Care in a Post–Acute Health Care Environment

provide customized interventions (McCance, 2003). Individualization cannot be achieved without understanding the person's life situation in addition to his or her ability or desire to make decisions and take control of his or her care (Suhonen et al., 2002; Suhonen, Välimäki, & Leino-Kilpi, 2005). Personal life situations include having knowledge about culture, beliefs, traditions, habits, activities, and preferences (Suhonen, Välimäki, et al., 2005). According to Edvardsson, Koch, and Nay (2009), individualizing care demonstrates appreciation of the unique history and personality of people while recognizing their perspectives and customizing care that best meets their needs. Care should be organized by patients' personal needs and preferences instead of institutional standards or routines, which Suhonen et al. (2002) argued is the opposite of individualized care because one size does not fit all (Leplege et al., 2007).

Respectful

Being respectful also is an important attribute of PCC and is frequently referred to as a "right" and the driving force behind this concept (McCormack, 2003). The right to be treated with respect allows for individuals to be recognized as competent to make decisions about their own care (Leplege et al., 2007). Patients are increasingly regarded as active health care consumers and have the right to choices in their service and care (Mead & Bower, 2000). Offering choices in care recognizes and respects the inherent value of each individual, supports a person's strength and abilities, and encourages human freedom (Rader & Lavelle, 2008). Respect for basic choices in daily routines includes preferences about food and meal times, who visits and when, waking and sleep times, privacy, and bathing (Kantor, 2008).

Empowering

Empowerment is an equally important attribute. It encourages autonomy and self-confidence, two important factors when an individual is most vulnerable (Suhonen et al., 2000). Self-confidence promotes self-determination, which facilitates the person's participation in decision making. Participating in care decisions concerning treatment suggests that individuals have input into their own care (Suhonen et al., 2000) and can result in individuals performing, by themselves, various types of self-treatment that a few years ago would have only been performed

by a trained health care provider (Leplege et al., 2007). Strategies such as assisting an individual to learn and obtain information, supporting the individual's choices, and effective communication and negotiation are needed for a person to genuinely feel empowered to be involved in health care decisions (McCarthy & Freeman, 2008).

Antecedents

Walker and Avant (2005) described antecedents as events that occur prior to the concept. Without the antecedents, caregivers will not be able to provide PCC effectively. Evidence exists recognizing the health care climate of an inpatient setting as the primary determining factor of influence on the ability of nurses to provide care that is centered on the person (Edvardsson et al., 2009). The health care environment (physical and cultural) dictates the parameters for nursing care and either fosters or stifles the ability for care to be individualized to each client. Within the health care environment, the antecedents that create a person-centered climate include (a) vision and commitment, (b) organizational attitudes and behaviors, and (c) shared governance.

Vision and Commitment

The context of the care environment has the greatest impact on the operationalization of PCC practices (Douglas & Douglas, 2005; Edvardsson et al., 2009; Hobbs, 2009; McCormack, 2003). Within the built environment, the climate and culture created by organizational leaders supports the committed vision of PCC. There are links between environmental characteristics and patient health outcomes (Rader & Lavelle, 2008). Moreover, the environmental culture can influence a person's health by influencing the behaviors, actions, and interactions of the staff providing the care (Rader & Lavelle, 2008). This influence can be as subtle as communication through images, symbols, and metaphors. Because the type of care delivered is dependent on the contextual setting, a nurse's ability to provide care is constrained within the specific contexts and the resources available (Hobbs, 2009). Therefore, a culture that values respect, empowerment, and choice for patients and staff is paramount.

Organizational Attitudes and Behaviors

McCormack and McCance (2006) asserted that for PCC to occur, changes in service delivery are required at both individual and organizational levels. Hobbs (2009) suggests that organizations need to be less focused on the command and control style of leadership and more on shared governance. Organizational leaders set the tone for the cultural environment by their attitudes and behaviors. The philosophy of putting the relationship before the task when planning care sets the stage for a PCC culture (Rader & Lavelle, 2008). Kramer et al. (2009) stressed that staff cannot control practice or engage in activities related to PCC at the bedside unless the same sanction and endorsement for activities exists at the organizational level. This is referred to this as "rule orientation" (McCormack, 2003). Rule orientation is the ability to determine when and how to deviate from the established norms and standards when the situation dictates. This requires nurses to believe they can balance patient values and organizational values in care delivery (McCormack, 2003). Lack of support by organizational leaders to create a PCC culture prevents nurses from incorporating personalized care into their daily care practice.

Shared Governance

Shared governance is described by Porter-O'Grady (2003) as shared decision making between line staff and organizational leaders. Shared governance empowers direct care workers to become part of the decision-making process (Burger et al., 2009). Brown and Miller (2003) refer to this as decentralizing decision making, explaining that when the administrator or unit manager makes decisions regarding a person's care, staff members are not able to personalize the care they provide and PCC decreases. Therefore, input and feedback from staff who work at the bedside is critical for decisions regarding changes to policies and procedures, redesigning the physical environment, and determining the effect of changes on daily workflow (Burger et al., 2009).

Consequences

Consequences are events that occur as a result of the concept (Walker & Avant, 2005). Although the consequences, or outcomes, of PCC were identified, there

were minimal descriptions of what was meant by each consequence, and it was unclear how one consequence was differentiated from another. However, the three primary consequences identified for patients were (a) improved quality of care, (b) increased satisfaction with health care, and (c) improved health outcomes.

Improved Quality of Care

According to Donabedian (1980), the quality of care provided to an individual in a health care setting is dependent on three elements: structure, process, and outcomes. The structure reflects the physical environment, the process reflects the nurse–client interaction, and the outcomes reflect health care status at discharge. Quality health care has also been described as responsive, respectful, timely, and performed by staff with confidence (Huycke & All, 2000). Blumenthal (1996) emphasized that the primary measurement of quality care is the interpersonal relationship between those providing care and those receiving care. Giving quality care is more than just providing a task. The therapeutic contribution provided within each interaction is the aspect on which quality care is measured (Kitson, 1986). Care that is more person-centered improves the quality of care experienced because its focus is not on task completion but personal customization (McCormack, 2003).

Increased Satisfaction With Health Care

Satisfaction with the health care experience in a post–acute health care setting is influenced by several elements, including the (a) expectations of care, (b) quality of the care provided, (c) physical setting, and (d) services available within the setting (Suhonen, Leino-Kilpi, & Välimäki, 2005). However, nursing care has been identified as the strongest predictor of patient satisfaction with the overall health care experience (Laschinger, Hall, Pedersen, & Almost, 2005). PCC improves satisfaction because interactions are tailored to the unique needs of each person and includes the individual in health care decisions, both of which have been identified as critical elements to improving satisfaction in an inpatient health care environment (McCormack & McCance, 2006).

Improved Health Outcomes

Health outcomes encompass a person's functional status and overall well-being (Haffer & Bowen, 2004).

The importance of functional status is related to a person's role function and therefore is unique to each individual. Functional status includes the ability to carry out activities of daily living, such as locomotion, communication, eating, bathing, dressing, transferring, and toileting (Kanaan, 2000). Although not important to all persons, it can include the participation in life situations and society, such as working outside of the home, hobbies, and maintaining a household (Kanaan, 2000). The specific role function of an individual is a key driver for determining the importance of functional status and quality of life (Guyatt, Feeny, & Patrick, 1993). Although functional improvement in general is important to the overall measurement of health outcomes, it is only important if the person recovering perceives it as improving role function in their life. Well-being is the subjective measure regarding how a person feels about his or her life (Harter & Gurley, 2008). Diener (2005) describes well-being as how a person evaluates his or her life, including both the positive and negative experiences. Measuring the health outcomes of individuals in a post–acute health care setting contributes to understanding the effects of the health care practices and interventions received in that environment (National Institutes of Health, 2005). Nurses who provide PCC contribute to increasing the individual's feelings of well-being, which in turn improves the person's functional abilities (McCormack & McCance, 2006). Because role function, functional ability, and well-being are specific to each individual, a person-centered environment allows the outcomes to be defined by the individual receiving care.

Empirical Referents

Empirical referents are described by Walker and Avant (2005) as groups of actual phenomena that demonstrate the occurrence of the concept. PCC is typically measured from the perspective of the person receiving care. Measuring delivery of PCC in a postacute, inpatient environment is critical for assessing and improving individualized care at the bedside. There were four instruments identified in the literature used to measure PCC in a postacute inpatient setting. However, the Person-Centered Climate Questionnaire (PCQ; Edvardsson et al., 2009) and the Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ; Laschinger et al., 2005) did not measure the core concept of PCC as described in this analysis and focused more

Table 1. Instruments Used to Measure PCC

Instrument	Author	Concept Elements	Description of Instrument
Person-Centered Climate Questionnaire (PCQ)	Edvardsson, Koch, and Nay (2009)	Antecedent	17-item instrument used to measure the extent to which the climate (ambiance, culture, and safety) of the inpatient setting is person-centered
Individualized Care Scale (ICS)	Suhonen, Leino-Kilpi, and Välimäki (2005)	PCC	40-item instrument used to measure how nursing interventions support a patient's individual characteristics, personal life situation, and decisional control over care during a hospital stay
Patient-Centered Inpatient Scale (P-CIS)	Coyle and Williams (2001)	PCC	20-item instrument developed to capture the client's experience of "personal identity threat" in the health care setting
Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ)	Laschinger, Hall, Pedersen, and Almost (2005)	Consequences	19-item instrument designed to measure satisfaction with the quality of nursing care
Short Form-36 (SF-36)	Gandek, Sinclair, Kosinski, and Ware (2004)	Consequences	36-item survey that measures eight domains of health that fall into two categories (physical health and mental health): physical functioning, role limitation due to physical health, bodily pain, general health perceptions, vitality, social functioning, role limitations due to emotional problems, and mental health
Functional Independence Measurement (FIM)	Unsworth (2001)	Consequences	10-item scale used by the staff to measure independent performance in self-care, sphincter control, transfers, locomotion, communication, and social cognition at admission and discharge

Note: PCC = person-centered care.

on the antecedents and consequences of PCC. Moreover, the instrument used to measure the antecedents, PCQ, measures the effect of the antecedents and not the antecedents directly. The combined synergy from the antecedents creates the person-centered health care climate and the climate is what the client experiences. The science regarding PCC is still emerging, and although these instruments capture some of the attributes identified in this concept analysis, more work is still needed to test and refine current instruments and develop additional ones to measure PCC. The entire list of instruments that could be used to measure the PCC, antecedents, and consequences are summarized in Table 1, with reliability and validity summarized in Table 2.

Four of these instruments (PCQ, ICS, P-CIS, and PSNCQQ) have been used to measure the concept of PCC in primary acute care settings in Sweden, Finland, Australia, and Canada. None of these instruments have been used in a post–acute health care setting in the United States; therefore, further testing is needed to build on findings from these international studies and to strengthen the implementation and practice of PCC in the United States.

Model Case

The following is an exemplar of PCC because it demonstrates all the defining attributes of the concept. Mr. Trent was admitted to a rehabilitation center for therapy after an automobile accident left him severely injured and killed his best friend. The admitting nurse was expecting Mr. Trent when he arrived and escorted him (via wheelchair) to his private room. The nurse had received a report from the hospital prior to Mr. Trent's arrival and was aware of the medical circumstances surrounding his need for rehabilitation. During the initial assessment, the nurse inquired about Mr. Trent's occupation, religious preferences, and interests. Mr. Trent explained he was an accountant for a local sporting goods chain, practiced Buddhism, was a vegetarian, and enjoyed being outdoors often. He talked about his recent hospital experience, the kind staff and clean environment; however, he expressed frustration with all the rules and the loss of control with his life. At the end of the nurse's assessment, Mr. Trent began to cry. He explained the loss of his best friend in the accident and his inability to focus on spiritual healing. The nurse sat by his bedside and listened while Mr. Trent described the accident. The nurse encouraged

Table 2. Reliability and Validity of Instruments

Instrument	Reliability and Validity	Reference
PCQ	Construct validity estimated in two factors explaining 65% of total variance	Edvardsson, Koch, and Nay (2009)
	Cronbach's alpha of total scale (.90) and subscales—safety (.96) and hospitality (.89)	
	Item–total correlations ranging between .37 and .80	
	Test–retest reliability: intraclass correlations of .7	
ICS	Content validity was established by a critical ROL and four expert analyses; face validity was assessed by patient's views	Suhonen, Leino-Kilpi, and Välimäki (2005)
	Construct validity was established using a series of factor analysis, structural equation modeling, and correlations of predicted relationships between the dimensions and construct components	
	Pearson's correlation coefficients ranged from .88 to .93 between the subscales and the total domain for ICA and ICB	
	Internal consistency reliability of ICA α = .94 and ICB α = .93; the three subscales had αs from .85 to .90	
P-CIS	Reliability and validity information not presented	NA
PSNCQQ	Construct validity was established through exploratory factor analysis and confirmatory factor analysis	Laschinger, Hall, Pedersen, and Almost (2005)
	Cronbach α = .97; item–total correlations were high, ranging from .61 to .89	
SF-36	Internal consistency and test–retest reliability range from .89 to .94 for physical health and from .74 to .91 for mental health; factor analysis of two factors accounted for 81.5% of the total variance	Ware and Kosinski (2001)
FIM	Cronbach α on admission FIM = .99 and discharge FIM = .91	Hsueh, Lin, Jeng, and Hsien (2002)
	Spearman correlation on admission FIM = .74 and discharge FIM = .92	
	Interclass correlation on admission FIM = .55 and discharge FIM = .86	

Note: PCQ = Person-Centered Climate Questionnaire; ICS = Individualized Care Scale; P-CIS = Patient-Centered Inpatient Scale; PSNCQQ = Patient Satisfaction with Nursing Care Quality Questionnaire; SF-36 = Short Form-36; FIM = Functional Independence Measurement.

him to participate in grief counseling. He explained that he needed his room to be a place of healing. The nurse knew the importance of holistic care with healing and wanted to involve Mr. Trent in his recovery. Not being a Buddhist, the nurse asked Mr. Trent to explain what was needed. He asked if he could create a shrine for his Buddha with an offering bowl and incense. Other than the burning of incense, his request was easily honored. The nurse explained the safety concern about burning incense and Mr. Trent agreed, explaining that he would use the items without lighting them.

This case exemplifies the attributes of PCC. The nurse approached Mr. Trent's care from a holistic and individualized perspective by inquiring about his preferences and recognizing the importance of his spiritual connection to healing. His decision for spiritual healing was respected by honoring his religious beliefs. Moreover, he was empowered to participate in his recovery when the nurse inquired about how to create the healing environment specifically tailored to him. The nurse listened and personalized the setting after identifying the safety concern (lighting the incense) illuminating the point that the traditional health care setting can be personalized to the individual needing care if the organizational climate is appropriate.

Conclusion

This article described the concept of PCC by presenting the relevant historical evolution of the concept, its defining attributes, antecedents, consequences, empirical referents, and a model case. Providing clarity about PCC will allow for improvement in the delivery of PCC in the post–acute health care environment. Caregivers can use the attributes (holistic, individualized, respectful, and empowering) as a foundation for practice at the bedside. Organizational leaders can use the antecedents of the concept to create and sustain a PCC climate. Moreover, using

empirical referents to measure the practice of PCC is the key to validating that the organization's philosophy is congruent with PCC practice and that PCC has a positive effect on health outcomes.

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