

Person-centred care

Possibilities, barriers and effects in hospitalised patients

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- I. Wolf A, Olsson LE, Taft C, Swedberg K, Ekman I. Impacts of patient characteristics on hospital care experience in 34,000 Swedish patients. *BMC Nursing* 2012, 11:8. (Epub ahead of print. Open Access)
- II. Wolf A, Olsson LE, Swedberg K, Ekman I. Self-efficacy and functional status in patients with heart failure. *Manuscript*
- III. Wolf A, Ekman I, Dellenborg L. Everyday practice at a medical ward. A 16-month ethnographic field study. *BMC Health Services* 2012, 12:184. (Open access)
- IV. Ekman I, Wolf A, Olsson LE, Taft C, Dudas K, Schaufelberger M, Swedberg K. Effects of person-centred care in patients with chronic heart failure: the PCC-HF study. *Eur Heart J.* 2012;33(9):1112-9. (Open access)

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PERSON-CENTRED CARE

POSSIBILITIES, BARRIERS AND EFFECTS IN HOSPITALISED PATIENTS

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Abstract

The need for a person-centred rather than disease-centred approach to care is considered an important part of care today. However, healthcare professionals still tend to focus on the disease within the person rather than on the person with the disease. Envisioning care tailored to each patient's capabilities and needs, the perspective of this thesis places the person with a long-term illness at the centre of the care process. The core concept of person-centred care (PCC), as defined in this thesis, is a partnership between the patient (and often relatives) and healthcare professionals that is based on respect and dignity. The patient's narrative is a prerequisite for this relationship, which also must be safeguarded through documentation.

The overall aim of this thesis was to investigate the possibilities, barriers and effects of a PCC in the everyday hospital setting focusing on persons with chronic heart failure (CHF). Ethnographic fieldwork, a patient-reported care experience questionnaire and interviews were used to explore the possibilities and barriers of PCC. The effects of PCC were investigated using a quasi-experimental before and after design. In a national sample of patients hospitalised in Sweden during 2010, patients with poor self-rated health and physical dependence reported significantly less positive care experiences regarding communication of care and participation than patients with good self-rated health and without physical dependence ($p < 0.0001$). Ethnographic fieldwork in a university hospital ward revealed a care environment with structures that either promoted or impeded both the patients' and healthcare professionals' different actions and relationships. The design of the hospital environment, focus on biomedical routines and limited opportunities for dialogue, restricted the choices available to both patients and healthcare professionals. The healthcare professionals, primarily registered nurses, felt that the structures restricted their ability to provide optimal care for the patient, which in turn made them feel guilty. The patients seemed to accept the prerequisites of the hospital structures and routines and assumed a role of passive recipients of care. However, patients with CHF often have untapped personal resources (e.g., independence and vitality) prior to hospitalisation that may potentially be exploited to engage the patient and improve care. Levels of self-rated independence (Activities of Daily Living - ADL) and beliefs in one's ability to achieve/attain goals in life (self-efficacy) were high. However, when patients were grouped by functional impact of symptoms on everyday life, a significant negative correlation between poor functional status and low self-efficacy ($r = -0.27$, $p < 0.001$) was found. Patient interviews strengthened the quantitative findings that patients were independent prior to hospital admission, and described a pattern wherein patients increasingly restricted their social spaces to areas nearby their homes during illness deterioration. In the PCC intervention group ($n = 125$) length of indexed hospital stay (LOS) was one day shorter ($p = 0.16$) and ADL was better ($p = 0.07$) than in the conventional treatment group ($n = 123$). When the PCC intervention was fully implemented by the healthcare professional during the entire hospital stay (per protocol analysis, $n = 74$) LOS was reduced by 2.5 days ($p = 0.01$) and ADL level was preserved ($p = 0.04$). Despite reduced LOS, health related quality of life (HRQoL) and time-to-first readmission did not differ between groups.

Implementation of PCC in the hospital setting requires increased equality and awareness of the capabilities and resources of both patients and healthcare professionals. The care environment with its almost hegemonic focus on the biomedical explanatory model and routine-based structures restricts the choices available to both patients and healthcare professionals, hence counteracting PCC. The findings suggest that a fully implemented PCC approach shortens hospital stay and maintains functional performance in patients hospitalised for worsening CHF, without increasing risk for readmission or jeopardising patients' HRQoL. The use of patient narratives in combination with simple instruments to uncover the inherent resources of the patient as a starting point for initiating the partnership may serve as a basis for and facilitate collaboration between professionals and patients in setting common care/treatment goals.

Keywords: patient-centered care, care experience, chronic heart failure, care management