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Development of patient-centred care in acute hospital settings: A meta-narrative review

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ABSTRACT

Background: Patient-centred care is widely recognised as a core aspect of quality health care and has been integrated into policy internationally. There remains a disconnect between policy and practice, with organisations and researchers continuing to offer definitions and frameworks to suit the operational context. It is unclear if and how patient-centred care has been adopted in the acute care context.
Aim: To understand the development of patient-centred care in the context of acute hospital settings over the past decade.
Methods: A literature review was conducted in accordance with RAMESES standards and principles for meta-narrative reviews. Five databases (Medline, CINAHL, SCOPUS, Cochrane Library, JBI) were searched for full-text articles published between 2012 and 2021 related to patient-centred care in the acute care setting, in the context of nursing, medicine and health policy. Literature reviews and discussion papers were excluded. Articles were selected based on their relevance to the research aim. Descriptive and thematic analysis and synthesis of data were undertaken via an interpretivist process to understand the development of the topic.
Results: One hundred and twenty four articles were included that reported observational studies (n = 78), interventions (n = 34), tool development (n = 7), expert consensus (n = 2), quality improvement (n = 2), and reflection (n = 1). Most studies were conducted in developed countries and reported the perspective of patients (n = 33), nurses (n = 29), healthcare organisations (n = 7) or multiple perspectives (n = 50). Key words, key authors and organisations for patient-centred care were commonly recognised and provided a basis for the research. Fifty instruments measuring patient-centred care or its aspects were identified. Of the 34 interventions, most were implemented at the micro (clinical) level (n = 25) and appeared to improve care (n = 30). Four articles did not report outcomes. Analysis of the interventions identified three main types: i) staff-related, ii) patient and family-related, and iii) environment-related. Analysis of key findings identified five meta-narratives: i) facilitators of patient-centred care, ii) threats to patient-centred care, iii) outcomes of patient-centred care, iv) elements of patient-centred care, and v) expanding our understanding of patient-centred care.
Conclusions: Interest in patient centred care continues to grow, with reports shifting from conceptualising to operationalising patient-centred care. Interventions have been successfully implemented in acute care settings at the micro level, further research is needed to determine their sustainability and macro level implementation. Health services should consider staff, patient and organisational factors that can facilitate or threaten patient-centred care when planning interventions.
Tweetable abstract: Patient-centred care in acute care settings – we have arrived! Is it sustainable?

What is already known

- Patient-centred care is widely recognised as a core aspect of quality health care globally.
- Patient-centred care has been successfully implemented for primary care, aged care, and chronic conditions.
- A gap exists as to whether health services and clinicians have adopted patient-centred care in the acute care context.

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What this paper adds

- This review reports that implementing patient-centred interventions in the acute hospital setting can improve care quality, patient and staff experiences, and care efficiencies.
- Facilitators of patient-centred care were more commonly identified than threats, indicating a positive slant towards what staff and organisations 'can do' rather than what they are 'not doing'.
- Organisations should create a patient-centred culture supported by policies and systems, and equip staff with the personal skills, resources, and workforce needed to deliver patient-centred care effectively in order to realise improvements in patient outcomes.

1. Background

The notion of placing the patient at the centre of their care was first introduced by Carl Rogers in the 1950s as an alternate to traditional approaches for psychotherapy (Rogers, 1951). Since then, the concept of patient-centred care has been explored extensively (Langberg et al., 2019; Mead and Bower, 2000), with definitions, frameworks and nomenclature continuing to evolve. Definitions commonly involve understanding the patient as a person, the patient-healthcare professional relationship, and coordination of care across the healthcare system (Langberg et al., 2019). Conceptual frameworks for patient-centred care have been developed across nursing and medical disciplines and health care policy with some commonalities, yet standardisation is lacking (Kitson et al., 2012). In recent years, the concept of 'person-centred care' has developed and shares similarities to patient-centred care, such as empathy, communication, holistic care and patient engagement; with less focus on the sick-role and more emphasis on personhood and achieving a meaningful life (Håkansson Eklund et al., 2019). Other centredness-related terms such as patient- and family-centred care and client-centred care are similarly described in literature (Feldthusen et al., 2022). Whilst there are some explicit differences between the concepts, they each support a fundamental approach to care that considers the individual needs of the patient. Thus, these concepts are considered synonymously to patient-centred care throughout this paper.

Recognised benefits of patient-centred care include a positive association between patient-centred care and health outcomes, patient safety, patient satisfaction and health care efficiencies (Bertakis and Azari, 2011; Doyle et al., 2013; Park et al., 2018; Rathert et al., 2013; Stewart et al., 2000). Subsequently, patient-centred practice has been widely acknowledged as a core aspect of quality health care and integrated into health policy internationally (Australian Commission on Safety and Quality in Health Care, 2019; Institute of Medicine, 2001; The King's Fund, 2013; World Health Organization, 2016). Further, patient-centredness and how patients experience care have become important measures of care quality and health service performance (Carinci et al., 2015; Edvardsson et al., 2017).

Healthcare organisations and institutes have long promoted a patient-centred approach and offered operational frameworks. In the late 1980s, the Picker Institute aimed to improve the patient experience through development of eight person-centred care principles that they continue to refine. The principles promote access to healthcare, trust, continuity of care, support for patient involvement and shared decisions, family involvement, information and communication, emotional support, and attention to physical and environmental needs; and are central to patient experience measures used in the United Kingdom's National Health Service and internationally (Picker Institute, 2022). In the United States, the Institute of Medicine acknowledged patient-centredness as one of six key aims for health care reform in their 2001 report, *Crossing the Quality Chasm* (Institute of Medicine, 2001). They promoted care that puts the patient first, acknowledges individuals' needs, preferences, and values, includes shared information and decision-making, and involves loved ones. The institute, now known as the National Academy of Medicine, continue to integrate patient-centred care into their framework for healthcare improvement (National Academy of Medicine, 2017). The World Health Organisation similarly identified patient-centred care as crucial for improving inequities in health care and provided a framework for people-centred health services (World Health Organization, 2016). They considered a people-centred approach as one that organises care around individuals' perspectives and needs and supports them to make decisions and participate in their own care.

Researchers have further focussed on the roles of professional groups in delivering patient-centred care. Mead and Bower (2000) proposed a conceptual framework for patient-centredness in medicine that involves the patient's biopsychosocial factors, the patient as a person, a therapeutic alliance between the doctor and patient, shared power and responsibility, and the influence of the doctor as a person. Langberg et al. (2019) recently built on this work, replacing 'the doctor as a person' with 'coordinated care', which includes accessibility, continuity of health care and care pathways. Nurses' roles in person-centred care were conceptualised in McCormack and McCance's (2006) Person-centred Nursing Framework, which considered nurses' attributes, the care environment, person-centred processes and expected outcomes of effective person-centred nursing. The framework was later expanded to include the broader 'macro' context of health care policy and strategy and emphasised the role of relationships and work cultures in fostering and empowering person-centred practice (McCormack and McCance, 2016). In a 2012 review, Kitson et al. (2012) explored patient-centred care in nursing, medicine and health policy, identifying three core elements across the professional groups: patient participation and involvement, the patient-clinician relationship, and healthcare context.

Despite organisations' and researchers' efforts to operationalise patient-centred care, there exists a disconnect between policy and practice (Taylor and Groene, 2015). Barriers and facilitators to the provision of patient-centred care have been identified at the micro (clinical), meso (health service or organisation) and macro (health system or government) level. Facilitators to patient-centred care include clinicians' personal characteristics, a positive workplace culture, leadership, and organisational support (Moore et al., 2017; Vennedey et al., 2020). Conversely, barriers include clinicians' attitudes and understanding of patient-centred care, traditional healthcare approaches and workplace cultures, poor development of patient-centred interventions and fragmented care systems (Moore et al., 2017, Vennedey et al., 2020). McCormack and McCance noted 'context' to be the biggest challenge for person-centred care (2011), as researchers continue to explore how to implement patient-centred care in select contexts.

Patient-centred care has been successfully implemented for primary care, aged care, and chronic conditions (Blake et al., 2020; Park et al., 2018), with key conceptual frameworks for patient-centred care based on research in these settings (McCormack and McCance, 2006; Mead and Bower, 2000). Arguably, long-term care settings present an opportunity to build clinician-patient relationships, get to know the patient as a person and coordinate individualised care, whereas acute hospital settings may be more challenging. It is unclear if and how health services and clinicians have adopted patient-centred care in the acute care context. Current literature reviews of patient-centred care in acute settings are limited to focused care contexts, such as falls, dementia care, and clinical handover (Avanecean et al., 2017; Brooke and Ojo, 2018; McCloskey et al., 2019). A comprehensive review of literature that examines how patient-centred care has developed in acute settings in recent times is lacking. This narrative review aims to understand the development of patient-centred care in the context of acute hospital settings over the past decade.

2. Methods

The meta-narrative review was guided by RAMESES standards for meta-narrative reviews (Wong et al., 2013). A meta-narrative review is a systematic method of reviewing complex topic areas that have been studied by different researchers, using different research methods, and

from different perspectives (Wong et al., 2013). It allows synthesis of heterogeneous bodies of evidence and considers evolution of the topic over time and across research traditions (Greenhalgh et al., 2005). Given the vastness of patient-centred care as a concept, and its range of applicability across health care, a meta-narrative approach is suitable for this topic.

2.1. Search process

An initial broad search of literature was conducted to scope research on the topic, refine search terms and identify key publications. Kitson et al. (2012)'s narrative review provided a sound overview of patient-centred care in acute health care from 1990 to 2010, and so a similar approach was used in this review. Health databases (Medline, CINAHL Plus, Scopus, Cochrane Library, and the Joanna Briggs Institute) were systematically searched using the key terms 'patient-, person-, or consumer-centred care', 'patient-, person-, or consumer-focussed care', 'hospital', 'nursing', 'medicine', and 'health policy'. Searches were limited to articles published in English between 2011 and 2021. An example of the search strategy is shown in supplementary file 1, Table 5. Reference lists of selected articles were hand searched.

2.2. Selection and appraisal

Titles and abstracts were screened, and relevant articles assessed in full by the lead investigator (CJ) for eligibility using the SQ3R technique of survey, question, read, recall, and review (Jesson et al., 2012). Outcomes were peer-reviewed by project supervisors (FG and GL) and uncertainties discussed for consensus. Research articles with a focus of patient-centred care in an acute care setting from a nursing, medicine, or health policy perspective were included. In keeping with Kitson et al. (2012)'s approach, studies were excluded if not an acute care hospital focus, did not involve nursing or medical professions, or reported family-centred care alone. Given the broad range of publications on the topic, it was decided to further exclude specialised care settings, such as the labour ward, rehabilitation unit, mental health unit and operating theatre, and treatments that did not represent general acute care contexts. Literature reviews, concept analyses, commentaries and discussion papers were excluded. References were managed using EndNote™ (The EndNote Team, 2013).

To capture the true extent of published research on patient-centred care in acute hospital settings, articles were evaluated based on their relevance to the research topic. Formal quality appraisal was not applied due to the heterogeneity of research methods and traditions, and inclusivity of the review.

2.3. Data extraction

Details of included articles (author, year, title, journal, country) and their abstract information (aim, methods, sample, key findings, conclusion) were extracted into a summary table developed for this review. Data that aligned with the research aim and principles of meta-narrative reviews were extracted, that is: research context, patient-centred interventions, instruments for measuring patient-centred care, historical basis for the research (principle of historicity), perspectives captured by the research (principle of pluralism) and practical application for the findings (principle of pragmatism) were noted (Wong et al., 2013).

2.4. Data analysis and synthesis

Data analysis and synthesis involved an interpretive process of immersion in the data and regular discussions between the research team to consider how the data addressed the research aim, the synthesis of concepts and development of meta-narratives (Wong et al., 2013).

Frequency counts were obtained to describe characteristics of included articles and capture development of the research topic over time. Study types (determined by research purpose), study methods (determined by data type), instruments that measured patient-centred care, research perspectives (pluralism), publication year and country were counted and mapped over time.

Interventions and key findings were analysed thematically using an adapted reflexive approach through familiarisation with the data, generating categories, constructing and revising sub-themes, defining themes and presenting results (Clarke et al., 2019). Patient-centred interventions were categorised by type, level of implementation (micro, meso or macro) and whether the intervention improved care. Key findings were examined in relation to patient-centred care or aspects of patient-centred care, and meta-narratives identified. Clinical applicability (principle of pragmatism) of findings were considered.

Background information was analysed to identify the historical basis for the research (principle of historicity), that is the research purpose, key patient-centred care concepts or assumptions that underpinned the research, and commonly cited authors or works. Research purpose data were categorised into common themes that emerged from the literature.

3. Results

Initial searches identified 3, 583 articles from which 3, 360 ineligible articles and duplicates were removed on screening of titles and abstracts, two were unable to be retrieved and a further 97 met exclusion criteria upon full text review. Excluded articles often did not have patient-centred care as a research focus, involved non-hospital, non-acute or specialised care settings (such as patient-centred medical homes, nursing homes, telehealth, labour ward, primary care and chronic care), or were discursive papers. A total of 124 articles were included in this meta-narrative review (Fig. 1). Article characteristics are described below, followed by key findings of the review: historical basis to the research, instruments that measured patient-centred care, patient-centred interventions, and meta-narratives from the research.

3.1. Article characteristics

Of the 124 included articles, 78 reported observational studies, 34 involved an intervention, seven reported tool development and testing, two reported expert consensus, two reported quality improvement and one reported critical reflection. Only one interventional study was a randomised control trial. Quantitative (n = 56), qualitative (n = 43), and mixed methods (n = 14) data were reported. Eleven articles described intervention development and/or implementation processes without data collection. Most studies were conducted in developed countries such as the United States (n = 36), Australia (n = 19), the United Kingdom (n = 12) and Sweden (n = 9), and eight studies were conducted across multiple countries. The number of articles published each year has generally increased over the decade (Fig. 2), with no notable trends over time in relation to study types, methods, research perspectives or countries published. There was increase in use of the term 'person-centred' in titles (n = 26), particularly since 2018, although 'patient-centred' was more frequently used overall (n = 53).

Research perspectives were considered in relation to the sample data reported. Samples involved either a single group of patients (n = 33), nurses (n = 29), healthcare organisations (n = 7), researchers (n = 2), doctors (n = 1), carers (n = 1) or managers (n = 1); or a combined group of health professionals (n = 50), including allied health, families, students, volunteers, healthcare assistants, and non-clinical staff. Patient samples involved adults (n = 49), children/parents (n = 5), consumer representatives (n = 6) or were not specified (n = 9), and commonly represented general inpatient populations (n = 31). Some studies examined specific patient populations, such as older adults (n = 6), persons of colour (n = 2) or those with a specific condition such as orthopaedic (n = 3), cardiac (n = 2), pain (n = 2), palliative care, chronic lung disease, low acuity presentation, autism or chronic illness (n = 1 each).

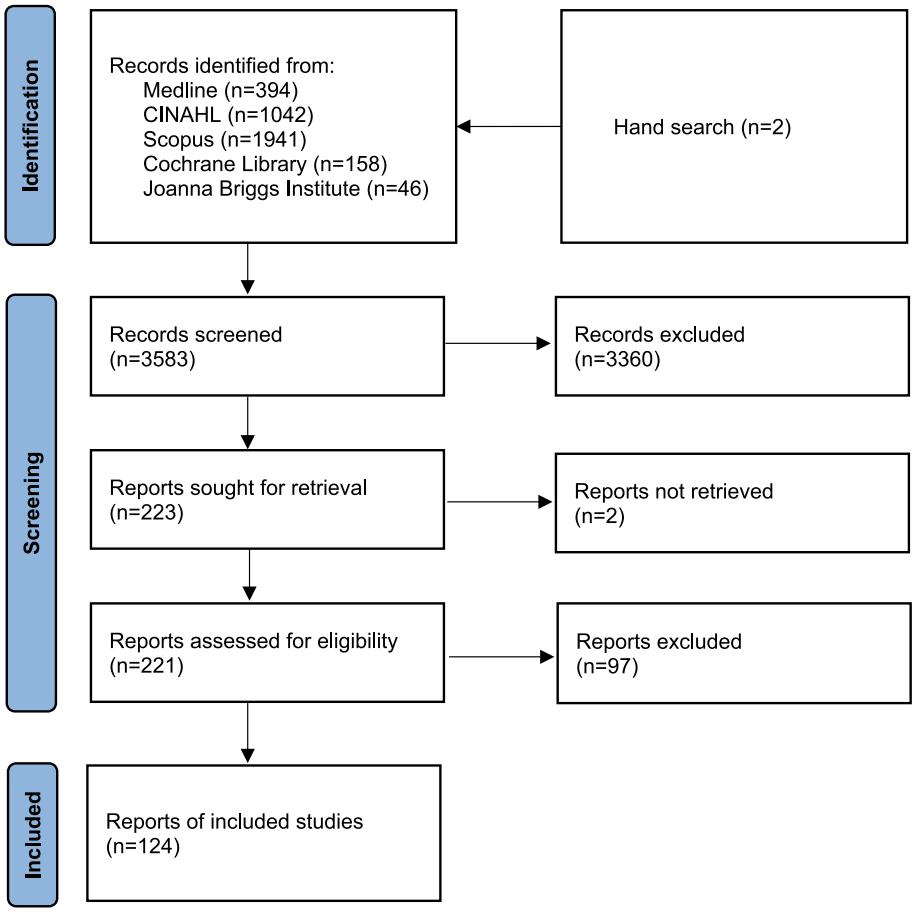

Fig. 1. PRISMA flow diagram of article selection.

3.2. Theoretical basis and purpose of the research

In keeping with the meta-narrative review principle of historicity (Wong et al., 2013) and to better understand the reserach, theory that shaped the research and the research purpose were considered for each article and synthesised. Regarding theoretical basis, most authors acknowledged benefits of patient-centred care and determined it an essential component of care quality, offering definitions, concepts, and recommendations from seminal works. Although broad patient-centred care frameworks and definitions were provided, researchers often aimed to explore distinct features of patient-centred care, such as patient involvement, individualised care and empathy. Commonly cited works, authors, and organisations are shown in Table 1.

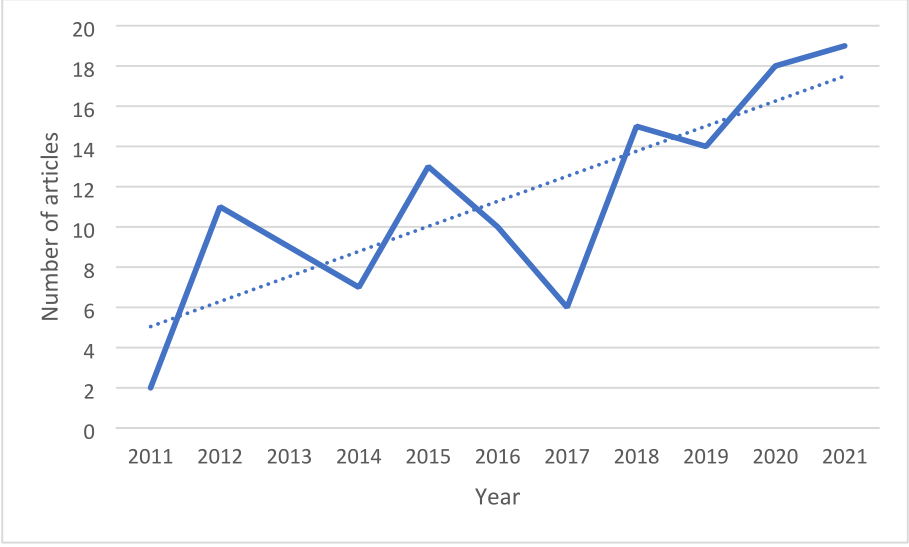

Fig. 2. Number of articles published between 2011 and 2021.

Table 1
Commonly cited key works, authors, and organisations for patient-centred care.

Key works	Description
Crossing the Quality Chasm (Institute of Medicine, 2001)	Report on health care quality in the US that recommended six major aims for improvement, the third being patient-centredness
Patient-centredness: A conceptual framework and review of literature (Mead and Bower, 2000)	Conceptual framework for patient-centredness in the doctor-patient relationship
The impact of patient centred care on outcomes (Stewart et al., 2000)	Cohort study that reported positive patient outcomes associated with patient-centred communication in primary care visits
What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing (Kitson et al., 2012)	Narrative review that identified core elements of patient-centred care across nursing, medicine, and health policy
Putting patients first: Designing and practicing patient-centered care (Frampton et al., 2003)	Textbook that guides implementation of the Planetree patient-centred care model in health care organisations (US focus)
Through the patient's eyes: Understanding and promoting patient-centered care (Gerteis et al., 2002)	Textbook, based on research by the Picker/Commonwealth Program for Patient-centred Care, that considers the patient perspective for health care planning and administration (US focus)
Key authors	**Description**
Brendan McCormack (UK/AUS) and Tanya McCance (UK)	Co-authors of numerous textbooks and articles for person-centred nursing practice, including the commonly cited person-centred nursing framework
Riitta Suhonen (FIN)	Multiple publications related to individualised nursing care
Ronald M Epstein (US)	Publications on the value of patient-centred care, communication, and shared decision-making in medicine
David Edvardsson (AUS)	Multiple publications for person-centred nursing care, particularly in aged care, dementia, and Alzheimer's disease
Jan Dewing (UK)	Co-author in several person-centred nursing care publications, particularly relating to older persons and dementia
Angela Coulter (UK)	Author of publications regarding patient involvement, shared decision-making, and patient experience
Key organisations	**Description**
Picker Institute (Europe/International)	Organisation focussed on person-centred care; developed the eight Picker principles of person-centred care based on research
World Health Organisation (International)	Agency of the United Nations that directs international health; produced frameworks for people-centred health care policy
Australian Commission of Safety and Quality in Health Care (AUS)	Government entity that developed standards for health care in Australia, with partnering with consumers being one of eight national standards
The King's Fund (UK)	Health charity working to improve health care in England; published articles guiding patient-centred care in the NHS
Institute for Patient and Family-Centered Care (US)	US organisation that provides leadership, education, and guidance of best practices for patient- and family-centred care
Planetree International (US/International)	International organisation focussed on patient-centred care and the patient experience, offering patient-centred care tools and certification

In terms of the research purpose, researchers generally described gaps in literature regarding the application of patient-centred care in select contexts and populations, as well as challenges in its application. Whilst some researchers aimed to better understand or measure patient-centred care practices in their ward or healthcare organisation, others sought to explore patient-centred care from a different perspective, such as a select country, patient group, or clinician group. Many researchers reported implementation of new initiatives that aimed to improve patient-centred practice in their organisation.

3.3. Instruments that measured patient-centred care

A finding that emerged during the meta-narrative review was the variety of instruments used to measure patient-centred care. Ten instruments measured patient or person-centred care directly, as listed below, from the perspective of staff (n = 5), patients (n = 2), both staff and patients (n = 1), or the organisation (n = 2). Detailed information can be found in supplementary file 1, Table 6. A further 40 instruments measured a phenomenon related to or resulting from patient-centred care, such as patient experience, patient satisfaction, individualised care, quality of life, caring behaviours, and compassion. The most cited instruments were the Hospital Consumer Assessment of Healthcare Professional and Systems (HCAHPS) (n = 7), Individualised Care Scale (n = 6), Picker Patient Experience Questionnaire (n = 3), and EQ-5D instruments (n = 3).

Instruments that measured patient- or person-centred care directly, and years cited:

- Patient- and Family-Centred Care: A Hospital Self-Assessment Inventory (2015)
- Patient-centred Care Scale (2015)
- Patient-centred Innovation Questionnaire (2018)
- Patient-centred Outcomes Questionnaire (2021)
- Patient-Practitioner Orientation Scale (2014)
- Person-centred Care of Older People with Cognitive Impairment in Acute Care (2019, 2021)
- Person-centred Climate Questionnaire - Patient (2015, 2017)
- Person-centred Climate Questionnaire - Staff (2021)
- Person-centred Practice Inventory - Staff (2017, 2021)
- Planetree and Picker Self-Assessment Tool for Organisations (2018)

3.4. Patient-centred interventions

Patient-centred interventions were reported in 34 of the 124 articles. Most interventions were implemented at the micro (clinical) level (n = 25), fewer at the meso (health service or organisation) level (n = 9), and none at the macro (health system or government) level. Improvement in care was reported empirically in 23 articles. In seven articles the authors indicated care improvement but did not report data. One article reported both improved patient experience scores and increased complaints post implementation of an innovation

to increase family presence and involvement. Four articles described intervention development and did not report outcomes. Most interventions involved a change in practice or care process (n = 21), whilst others involved staff training (n = 6), change in service design or delivery (n = 6), and patient-centred staff roles (n = 1). Bundled patient-centred care interventions were reported in six articles.

Intervention types were analysed and synthesised, with three major themes identified: i) staff-related interventions, ii) patient and family-related interventions, and iii) environment-related interventions (Table 2). Staff-related interventions were most common and involved a wide range of innovations such as staff training, individualised care plans and bedside communication. Patients and families were often involved in care, care planning and using communication tools. Environment-related interventions were less common and involved physical re-design of the hospital or ward.

3.5. Meta-narratives

Analysis exposed the complexity of patient-centred care, with researchers exploring a range of perspectives, contexts, meanings, and associations. Five meta-narratives with 16 sub-themes were identified based on analysis of the articles (Table 3) and are discussed below. Meta-narratives were often interconnected.

3.5.1. Meta-narrative 1: facilitators of patient-centred care

Researchers commonly identified factors that improved or supported patient-centred care. Staff-related attributes and behaviours were most frequently reported. Behaviours and actions such as interpersonal communication, involving the patient and family in care, providing patients with information about their condition and treatment, engaging with patients and getting to know them as a person were facilitators often identified by patients. Personal attributes such as professional competence, job satisfaction and empathy were identified by healthcare professionals.

Many researchers reported organisational factors that facilitate patient-centred care commonly in conjunction with staff-related factors. Systems, polices and roles that support patient-centred care, staff training and a positive work culture were frequently identified. Tools and interventions to support patient-centred care involved patient-centred care plans, bedside communication and bundles consisting of multiple patient-centred care interventions. Less frequently reported were patient-related facilitators that included patients' understanding of their condition or treatment, and willingness to engage in patient-centred care.

3.5.2. Meta-narrative 2: threats to patient-centred care

Staff, patient, and organisational-related threats often mirrored facilitators to patient-centred care. Unwillingness by clinicians to engage in patient-centred care, poor communication, burnout, and insufficient clinical knowledge and experience were identified as staff-related factors that can negatively impact patient-centred care. Similarly, patient-related factors included unwillingness to engage in patient-centred care and poor communication with clinical staff. High workload, poor staffing, lack of organisational support, poor work culture and inadequate resources for patient-centred care were frequently cited organisational level threats.

3.5.3. Meta-narrative 3: outcomes of patient-centred care

Positive outcomes and associations were reported in all but one article. Improvements in patient satisfaction, care quality, experience, effectiveness, and health outcomes were associated with patient-centred care. Improvements in health care efficiencies, staff experience, and costs were also reported. Patient-centred care was reported to mitigate negative effects of staff shortages and shifts lengths, and positive impacts buffered negative impacts of patient involvement. One article noted that a 'customer service' approach to patient-centred care obscured clinical work and challenged professional roles.

3.5.4. Meta-narrative 4: elements of patient-centred care

Elements of patient-centred care were often explored or identified in relation to specific contexts and populations. Ways of working with the patient, such as information sharing, patient involvement in care, staff-patient communication and interpersonal relationship, patient empowerment and creating a patient-centred environment were frequently cited elements. Staff qualities and skills for providing patient-centred care were often explored or identified and included compassion, empathy, communication, respect, dignity, responsiveness, and cultural competence. Seeing the patient as an individual was important, and involved understanding and appreciating each person's background, needs, knowledge, capabilities, and support network.

3.5.5. Meta-narrative 5: expanding our understanding of patient-centred care

Many researchers aimed to address gaps in teaching, measuring, and understanding patient-centred care. Authors reported novel and creative methods for teaching and learning patient-centred care such as using the patient narrative, reflection on patient-centredness and staff rotations to a patient-centred ward. Instruments to measure patient-centred care or its aspects were developed and reported in six articles. Patient-centred care was explored in vulnerable patient groups such as older persons, patients with dementia, palliative care patients, persons of colour and persons with chronic illness or disability. Researchers also considered the broader context of patient-centred care at system, national, and international levels. Several authors reported a disconnect between organisational value of patient-centred care and its operationalisation at the clinical level, with some acknowledging contextual influences of patient-centred care, a culture of task-focussed care and the decline of service and staff capacity to provide

Table 2
Patient-centred care interventions.

Theme	Sub-theme	Categories
Staff-related interventions	Staffing to support patient-centred care	Increased staffing, patient-centred leaders, huddles, patient-centred model of care, reduced patient loads
	Patient-centred care education	Patient-centred care training, creative methods for teaching patient-centred care, patient-centred care toolkits
	Communication and information sharing	Bedside handover, bedside whiteboards, scripted communication, patient access to medical notes, customer-focussed communication, patient teach back
	Individualised care	Care customised for the individual, patient-centred care tools, patient-centred assessment
	Interprofessional collaboration	Multi-disciplinary care, interprofessional rounding
Patient and family-related interventions	Family involvement	Family involved in care or care decisions, open visitation
	Patient interaction and involvement	Patient involvement in bedside handover or rounding, patient involvement in care or care planning, whiteboard/notepad for staff-patient communication, shared decision-making, scripts to facilitate patient interaction, more time with patients
	Patient empowerment	Education for self-management, shared decision-making, service co-design
Environment-related interventions	Bringing care to the patient	Multi-specialty hospital units, modular nursing care, central resources that move to the patient
	Environments that support patient-centred care	Patient-centred ward and hospital designs, patient-centred care dashboards

Table 3
Meta-narratives of patient-centred care research.

MN 1. Facilitators of patient-centred care		
Sub-theme		Categories
Staff-related factors that facilitate patient-centred care	Attributes	Professional competence[9, 14, 15, 16, 17]
		Job satisfaction/engagement[6–9]
		Willingness to engage in patient-centred care[3, 4, 5]
		Higher compassion satisfaction[1, 2]
		Higher education/qualification[9,12]
		Cultural awareness[8, 13]
		Higher level of empathy[6, 10]
		Knowledge and experience of patient-centred care[3]
		Higher level of self-efficacy[6]
		Higher level of self-compassion[11]
		Fewer years' experience[16]
	Behaviours	Interpersonal communication[4, 15, 18, 19, 20, 21, 22, 23, 24, 25, 26]
		Supporting patient involvement[19, 21, 22, 23, 28, 33, 35, 36, 37]
		Supporting family involvement[15, 21, 24, 33, 36, 40, 41, 42]
		Providing patients information[14, 21, 24, 27, 28, 29, 30]
		Leading patient-centred care[7, 19, 43, 44, 45, 46]
		Getting to know/engaging with patients[4, 21, 22, 23, 35]
		Caring and respectful behaviours[19, 31, 32, 33]
		Providing individualised care[34, 36, 37, 38]
		Teamwork, inter-professional collaboration[44, 46, 47]
		Building trust[21, 34]
Patient-related factors that facilitate patient-centred care		Understanding of the condition or treatment[27, 28, 29, 48]
		Willingness/ability to engage in patient-centred care[4, 19, 26]
		Trust between patients and staff[34]
		Gratitude[26]
		Male gender[31]
		Lower levels of education[31]
		Speak native language[31]
		Higher health status[27]
Organisational factors that facilitate patient-centred care		Systems/policies that support patient-centred care[4, 7, 23, 24, 41, 46, 52, 55, 56, 57]
		Positive work culture[4, 7, 14, 34, 44, 49]
		Roles to support patient-centred care[7, 12, 50, 53, 54]
		Patient-centred care education/training for staff[3, 44, 51, 52]
		Adequate staffing or permanent nursing staff[17, 43, 50]
		Engagement with consumer groups[23, 54, 57]
		Patient-centred environment[15, 57]
		Larger/metropolitan hospital[59, 60]
		Higher structural empowerment[1, 8]
		Policies that support family involvement[40, 41]
		Adequate resources for patient-centred care[43]
		Low-turnover wards[53]
		Interprofessional/team model of care[58]
Tools and interventions that support patient-centred care		Patient-centred care plans[36, 37, 38, 41, 46, 68, 69]
		Grouped interventions or bundles[47, 56, 57, 70, 71]
		Bedside whiteboards or notes[29, 30, 35, 65, 66]
		Bedside handover[61, 62, 63, 64]
		Rounding[21, 67]
		Structured approach to implementing patient-centred care[46, 56]
MN2. Threats to patient-centred care		
Sub-theme		Categories
Staff-related factors that threaten patient-centred care	Attributes	Burnout and emotional fatigue[1, 2, 6, 19, 72]
		Insufficient clinical knowledge and experience[3, 15, 48]
	Behaviours	Unwilling to engage in patient-centred care[14, 15, 23, 33, 42, 44, 48, 54, 75]
		Poor communication[4, 15, 18, 22, 34, 73, 74]
		Insufficient information provided to patients[21, 31]
		Lack of teamwork[22]
		Task-focussed nursing[76]
Patient-related factors that threaten patient-centred care		Unwillingness to engage in patient-centred care [19, 22, 39, 54]
		Poor communication[4, 34, 73]
		Medical condition and care needs[19]
		Pain[27]
		Poor functional state[77]
		Poor health literacy[54]
		Female gender[78]
Organisation-related factors that threaten patient-centred care		High workload/staff demand[2, 5, 19, 23, 33, 43, 44, 52, 72, 73, 74]
		Lack of organisational support[4, 5, 9, 14, 15, 52, 54, 56, 73, 79, 81]
		Poor work culture[3, 4, 19, 33, 49, 54, 79]
		Inadequate resources for patient-centred care [4, 15, 19, 44, 52, 73]
		Poor staffing[19, 52, 54, 73, 80]
		Environmental stressors, busy ward[15, 21, 53, 80]
		Nursing role constraints[33, 65]
		Smaller, rural hospital[59, 60]
		Budget constraints[54]

(continued on next page)

Table 3 *(continued)*

MN 3. Outcomes of patient-centred care	
Sub-theme	Categories
Outcomes of patient-centred care that impact patients	Improves patient satisfaction[23, 25, 28, 29, 35, 63, 86, 87, 88] Improves care quality[32, 47, 68, 83, 84, 85] Improves patient experience[26, 52, 82] Improves care effectiveness[41, 70] Improves family experience[52] Improves health outcomes[28]
Outcomes of patient-centred care that impact health service /staff	Improves care efficiency[41, 58, 63, 70] Positives mitigate negatives [of patient-centred care][83, 84, 89] Improves staff experience of care[52] Improves staff attitudes and empathy[68] Reduces costs[63] Undermines professional roles[71] Increases revenue through increased customers[25]
MN 4. Elements of patient-centred care	
Sub-theme	Categories
The patient as an individual	Individuality/personhood[88, 92, 93, 94, 95, 96] Patient needs[41, 91, 97, 98] Family[42, 94, 98, 99] Pain management[34, 90, 91] Knowledge of condition or treatment[28, 48] Patient vulnerabilities[14] Fundamental care[19] Quality of life and functionality[69] Patient space[94]
Working with the patient	Information sharing[27, 28, 29, 30, 31, 64, 65, 87, 90, 95, 99, 101, 102] Patient involvement in care[28, 39, 64, 89, 91, 95, 98, 100, 101] Staff-patient communication[4, 64, 65, 66, 87, 95, 99] Interpersonal relationship[90, 95, 100, 101, 103] Patient empowerment[21, 69] Providing a patient-centred care environment[98, 99] Patient participation in care design[64] Mutual trust[103]
Staff qualities and skills for providing patient-centred care	Compassion/empathy[10, 11, 72, 90, 94, 96, 98, 102, 103, 104] Effective communication[20, 74, 77, 90, 95, 98, 103, 105] Courtesy and respect[90, 94, 96, 98, 103] Maintain privacy and dignity[64, 68, 75, 96] Responsive/attentive[94, 95, 96, 100] Cultural competence[13, 94] Professional expertise[98, 99] Maintain safety[90, 98] Flexibility in providing care[90] Being physically present[95]
MN 5. Expanding our understanding of patient-centred care	
Sub-theme	Categories
Methods for teaching and understanding patient-centred care	Patient narratives to understand patient-centred care[106, 107] Reflection[108, 109] Creative methods of teaching patient-centred care concepts[104] Interprofessional learning[108] Patient-centred care curriculum[51] Patient-centred care clinical rotation[51]
Instruments for measuring patient-centred care	Instrument for measuring provision/ability to provide patient-centred care[111, 112, 113, 114] Instrument for evaluating implementation of patient-centred care [110] Instrument for evaluating aspects of patient-centred care[115]
Better understanding patient-centred care for select patient groups	Older persons[33, 77, 97, 117] Patients with dementia[16, 50, 93] Chronic illness[48, 116] Palliative patients[41, 98] African American females[82] Persons of colour[116] Young persons[48] Persons with autism[15]
Better understanding the broader state of patient-centred care	Gap between values and practice of patient-centred care[14, 54, 79, 81, 121] Context influences patient-centred care[117, 118, 119, 120] Priorities for patient-centred care research and improvement[122, 123] Service/staff capacity for patient-centred care has declined over time[72] Incongruence between patient and staff perceptions of patient-centred care[119] Determinants of patients' attitudes towards patient-centred care[102] Nursing often task-focussed over patient-centred[76] Consider aspects of change when implementing patient-centred care[124]

patient-centred care over the past decade. Priorities for patient-centred care research were identified in two studies.

4. Discussion

Over the past decade publications on patient-centred care in the acute hospital setting have grown exponentially. In comparison to literature from previous decades it appears the focus has shifted from defining and conceptualising (Kitson et al., 2012; Mead and Bower, 2000) to implementing and practicing patient-centred care. Kitson et al. (2012) posed the question 'are we any closer to operationalizing patient-centred care?', the answer now appears to be 'yes'. This review found that patient-centred interventions have been implemented and tested, instruments developed, elements explored, facilitators and threats identified, and understanding of patient-centred care in various contexts and populations in acute hospital settings expanded. Key works from the early 2000s continue to provide a theoretical basis for current patient-centred research and health care organisations continue to develop their support of patient-centred health care globally.

Findings from this review suggest that implementing patient-centred interventions in the acute hospital setting can improve care quality, patient and staff experiences, and care efficiencies. This is congruent with a synthesis of recent evidence from systematic reviews published on the effects of patient- and family-centred care interventions that reported positive outcomes for patients, family members and healthcare providers (Park et al., 2018). Previously, literature reported mixed relationships between patient-centred care and clinical outcomes (Rathert et al., 2013). The reason for this shift is unknown, though might suggest better understanding and operationalisation of patient-centred care in recent times contributing to effectiveness. The meta-narrative from this review, *expanding our understanding of patient-centred care,* highlights developments in teaching, measuring and better understanding patient-centred care in different contexts to support its implementation.

Interventions for patient-centred care were mostly implemented at the micro level, few at the meso level, and none at the macro level. Interventions often involved communication, information sharing and involvement in care at the bedside on a single ward/unit or for a single group of patients. Implementing these interventions at the clinical (micro) level positively impacted care however, the longevity of such interventions is unknown. Santana et al. (2018) emphasises the need for healthcare systems (macro) and organisations (meso) to provide the foundation for patient-centred practice, create a patient-centred culture, integrate patient-centred care into staff and patient programs, and support the workforce to provide patient-centred care, to sustain these processes. Similarly, McCormack and McCance (2016) promote healthcare policy, strategy, leadership and education as building blocks for enabling patient-centredness and embed the macro context into their person-centred practice framework. System-level concerns of declining staff and service capacity for patient-centred care and a culture of task-oriented nursing practice were noted in this review, as well as several organisation-level threats to patient-centred care. It is therefore important that health services and organisations understand current issues and factors that support and hinder patient-centred care when implementing patient-centred processes.

Numerous staff-, patient- and organisation-related factors that can facilitate or threaten patient-centred care were identified in this review, with many factors having a bi-directional impact. Staff-related factors, such as interpersonal communication, engagement in patient-centred care and providing information to patients; and organisational-factors, such as systems and policies, workplace culture, staff ratios and patient-centred training and resources, appeared to both facilitate and threaten patient-centred care. Of note, many facilitators were staff-related, whereas many threats were organisation-related. Findings are similar across other health contexts and disciplines. A study involving managers from various professional groups identified staff values, leadership, satisfaction, and cultural diversity as key enablers; and staffing constraints, high workloads, resources and environmental constraints as key barriers to patient and family-centred care in an acute care hospital (Lloyd et al., 2018). Moore et al. (2017) reported similar staff-related and organisational barriers and facilitators for implementing person-centred care across different healthcare contexts, and additionally identified patient-centred research projects as a facilitator. Interviews with chronically ill patients identified comparable clinical (micro) and organisational (meso) level factors, as well as factors at the macro level such as fragmented care provision across the health system, and poor understanding of financial reimbursement (Vennedey et al., 2020). No macro level factors that may facilitate or threaten patient-centred care were identified in this review. Patient-related factors were identified, which are rarely reported in literature as research often focussed on patients' perceptions of patient-centred care, rather than their capacity and willingness to engage in the practice.

This review identified three key elements of patient-centred care across the literature that both align with and expand upon previous conceptual frameworks and definitions. The first element, getting to know *the patient as an individual*, understanding their unique needs, abilities, experiences, and vulnerabilities aligns with core aspects identified by Langberg et al. (2019) and Kitson et al. (2012), as well as the Institute of Medicine's, 2001 definition for patient-centred care (Institute of Medicine, 2001) and key processes in McCormack and McCance's (2016) person-centred practice framework. Additionally, this review identified pain management, the importance of family, and the patient's desire for space as important aspects of this element. The second element, *working with the patient* incorporates information sharing, patient and family involvement, shared-decision making, and the staff-patient relationship, which are consistently highlighted in current definitions and frameworks (Institute of Medicine, 2001; Kitson et al., 2012; Langberg et al., 2019; McCormack and McCance, 2016).

Note. Articles cited in this table, as indicated by superscript, are: 1. (Alhalal et al., 2020), 2. (Jakimowicz et al., 2018), 3. (Castellà-Creus et al., 2019), 4. (Chaboyer et al., 2016), 5. (Jensen et al., 2021), 6. (Gountas et al., 2014), 7. (McDonough and Pemberton, 2013), 8. (Papastavrou et al., 2015), 9. (Slater et al., 2015), 10. (Bayne et al., 2013), 11. (Savieto et al., 2019), 12. (Idvall et al., 2012), 13. (Dobrowolska et al., 2020), 14. (Laird et al., 2015), 15. (Nicholas et al., 2020), 16. (Petty et al., 2019), 17. (Tiainen et al., 2021a, 2021b), 18. (Ahmed et al., 2020), 19. (Conroy, 2018), 20. (Custer et al., 2019), 21. (Jerofke-Owen and Bull, 2018), 22. (Oxelmark et al., 2018), 23. (Vidal, 2014), 24. (Yoo and Shim, 2020), 25. (Abu-Ghname et al., 2021), 26. (Lindauer et al., 2021), 27. (Leino-Kilpi et al., 2015), 28. (Sepucha et al., 2018), 29. (Tan et al., 2013), 30. (Weinert, 2017), 31. (Kandelaki et al., 2016), 32. (Edvardsson et al., 2017), 33. (Mitchell and McCance, 2012), 34. (Avallin et al., 2018), 35. (Johnson et al., 2021), 36. (Dykes et al., 2020), 37. (Fowler and Reising, 2021), 38. (Lydahl, 2021), 39. (Tobiano et al., 2015), 40. (Gasparini et al., 2015), 41. (Vasquez et al., 2019), 42. (Mackie et al., 2021), 43. (Bachnick et al., 2018), 44. (Jardien-Baboo et al., 2016), 45. (Lalleman et al., 2017), 46. (Rosengren, 2016), 47. (Harper et al., 2020), 48. (Miles et al., 2020), 49. (Alharbi et al., 2012), 50. (Bateman et al., 2016), 51. (Ratanawongsa et al., 2012), 52. (Yeung et al., 2021), 53. (Grealish et al., 2019), 54. (Taylor and Groene, 2015), 55. (Jardien-Baboo et al., 2019), 56. (Small and Small, 2011), 57. (Woitas et al., 2014), 58. (Sanning Shea and Hoyt, 2012), 59. (Cardinali et al., 2021), 60. (Zhou et al., 2021), 61. (Bradley and Mott, 2014), 62. (Kerr et al., 2014) 63. (Salani, 2015), 64. (Friesen et al., 2013), 65. (Goyal et al., 2020), 66. (Farberg et al., 2013), 67. (Brosinski and Riddell, 2020), 68. (Johnston et al., 2015), 69. (Lopez-Lopez et al., 2020), 70. (Fiorio et al., 2018), 71. (Mikesell and Bromley, 2012), 72. (Lown et al., 2019), 73. (Byers, 2017), 74. (Reddin et al., 2019), 75. (Asmaningrum et al., 2020), 76. (van Belle et al., 2020), 77. (Schnabel et al., 2020), 78. (Teunissen et al., 2016), 79. (Sharp et al., 2018), 80. (Kollstedt et al., 2019), 81. (Lord and Gale, 2014), 82. (Aragon et al., 2018), 83. (Jarrar et al., 2018), 84. (Jarrar et al., 2019), 85. (Rathert et al., 2015), 86. (Gurdogan et al., 2015), 87. (Harrison et al., 2019), 88. (Suhonen et al., 2012a, 2012b), 89. (Arnetz et al., 2016), 90. (Esmaeili et al., 2016), 91. (Flynn et al., 2021), 92. (Ceylan and Eser, 2016), 93. (Clissett et al., 2013), 94. (Mayfield et al., 2020), 95. (Mohammadipour et al., 2017), 96. (Asmaningrum and Tsai, 2018), 97. (Etkind et al., 2020), 98. (Virdun et al., 2020), 99. (Osuoha et al., 2021), 100. (Marshall et al., 2012), 101. (Tobiano et al., 2016), 102. (Tsimtsiou et al., 2014), 103. (Ferguson et al., 2013), 104. (Dewar, 2012), 105. (Slatore et al., 2012), 106. (Ford et al., 2011), 107. (Park et al., 2021), 108. (Okougha, 2013), 109. (Timlin et al., 2018), 110. (Huang et al., 2018), 111. (Hwang, 2015), 112. (Slater et al., 2017), 113. (Vepraskas et al., 2021), 114. (Werner et al., 2021), 115. (Jones et al., 2018), 116. (Bennett et al., 2020), 117. (Nilsson et al., 2019), 118. (Berghout et al., 2015), 119. (Suhonen et al., 2012a, 2012b), 120. (Gualandi et al., 2021), 121. (Rozenblum et al., 2013), 122. (Synnot et al., 2019), 123. (Bragge et al., 2021), 124. (Angelini et al., 2021).

The third element takes into consideration *staff qualities and skills for providing patient-centred care,* which are not specifically noted in the Institute of Medicine (2001)'s definition, or in Langberg et al. (2019)'s or Kitson et al. (2012)'s core aspects of patient-centred care. McCormack and McCance (2016) acknowledge staff-related 'pre-requisites' such as professional competence, interpersonal skills, commitment, values and beliefs and knowing self as key attributes for providing patient-centred care. In comparison, this review noted more tangible skills and qualities, such as compassion, empathy, effective communication, courtesy, respect, maintaining privacy and dignity, and being present and responsive.

Interestingly, Langberg et al. (2019)'s key dimension 'care coordination', and Kitson et al. (2012)'s core aspect 'the context where care is delivered' were not identified as key elements in this review. The review reported patient-centred care across various acute care contexts however, research and interventions were generally specific to the clinical area and seldom reported broader influences such as context or care coordination. In considering elements of patient-centred care from this review, it appears they are fundamentally similar to previously identified concepts, with more focus on staff attributes and less on the wider health care system.

A variety of instruments for measuring patient-centred care were identified, with no one standardised tool consistently reported. Researchers often used multiple instruments to measure various aspects of care in relation to patient-centred care. Similarly, Handley et al. (2021) identified nine surveys for measuring patient-centred care in the hospital setting, but none captured all eight of Pickers dimensions of patient-centred care. This is unsurprising given the complexity of patient-centred care and how it is considered across different contexts, populations, and operational levels. A standardised instrument would be useful for guiding and measuring implementation generally.

Overall, the increase in number of publications for patient-centred care over the past decade highlights the uptake of this approach to health care globally. Patient-centred interventions appeared to improve care, with most implemented at the clinical (micro) level, though long-term outcomes were seldom reported. Facilitators to patient-centred care often involved staff-related factors, such as communication and interpersonal skills, whilst threats were often organisation-related, such as work systems and culture, training, and resources. Staff qualities and skills were further highlighted as key elements for patient-centred care compared with previous patient-centred definitions and frameworks.

4.1. Strengths and limitations

Strengths of this review relate to the systematic and rigorous research methods and broad inclusivity of articles. The review adhered to RAMESES guidelines (Wong et al., 2013) and principles of meta-narrative review: pragmatism, pluralism, historicity, contestation, reflexivity and peer review (Greenhalgh et al., 2005). The inclusivity of evidence for this review allowed comprehensive exploration and a deep understanding of patient-centred care in the acute care setting.

Broad inclusivity and scope of the review was also a limitation. The vast amount of literature on the topic necessitated a defined scope for article inclusion. As such, specialised care settings, such as labour ward, operating theatre, and mental health unit, were excluded as the research team considered that these were less likely to reflect general acute care settings and processes. Whilst the results of this review are generalisable to acute care contexts, they may require consideration for specialised settings. Articles were also excluded if they did not involve nursing or medical professionals or reported family-centred care alone. The perspectives of families, carers and broader healthcare team (such as allied health) may not be captured in this review. These perspectives could contribute to more complete examination of person-centred care in the acute hospital setting.

Formal quality appraisal was not undertaken due to the heterogeneity of the research methods and inclusivity of the review. Articles were included based on their relevance to the research topic. Finally, findings related to *outcomes of patient-centred care* were derived through thematic analysis and not meta-analysis of empirical data. Statistical analysis of the effectiveness of patient-centred care was not an aim of this review.

4.2. Implications for practice and future research

Facilitators of patient-centred care were more commonly identified in this review than threats, indicating a positive slant towards what staff and organisations 'can do' rather than what they are 'not doing'. These facilitators should be considered for building staff and organisational capacity to provide patient-centred care. Similarly, factors that threaten patient-centred care should be considered in the planning, development, and implementation of patient-centred care initiatives. Patient-related factors that facilitate or threaten patient-centred care should be further explored to better understand how these might impact patient-centred care interventions. Future research should also explore meso- and macro-level interventions for patient-centred care and the impact of health system and organisational support on adoption and sustainability of micro-level initiatives. Organisations should support patient-centred research and report implementation outcomes.

As our understanding of patient-centred care continues to develop, so should frameworks. Current patient-centred care frameworks and definitions should be updated to reflect elements identified in this review and other relevant research. Future research should continue to examine the development of patient-centred care across acute care contexts and should include specialised care settings and multi-disciplinary and family/carer perspectives.

5. Conclusions

Patient-centred care has become recognised as a central component of health care quality and delivery, with organisational support and integration into health policy globally. The burgeoning body of literature for patient-centred care is testament to conceptual growth over the past decade and the shift to operationalising patient-centred care. This review highlighted that patient-centred interventions have been successfully implemented in acute care contexts with positive clinical outcomes. Interventions appeared to improve patient care and staff and health service performance, which is a shift from previously reported mixed outcomes. This shift may reflect better understanding and more effective integration of patient-centred frameworks into health care over time. The longevity of patient-centred interventions needs further exploration, and future research should consider implementing interventions at the meso and macro levels to help sustain patient-centred processes. In addition, health services should consider staff, patient and organisational factors that may facilitate or threaten patient-centred care when planning interventions. Organisations should create a patient-centred culture supported by policies and systems, and equip staff with the personal skills, resources, and workforce needed to deliver patient-centred care effectively. Future research for patient-centred care should include specialised care settings, multi-disciplinary groups, families, and carers, and explore patient-related factors that influence patient-centred care. It is recommended that conceptual frameworks and healthcare policy are regularly updated to reflect current literature on the topic.

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CRediT authorship contribution statement

Carrie Janerka: Conceptualization, Methodology, Formal analysis, Investigation, Data curation, Writing – Original draft, Visualisation, Project administration, Funding acquisition.

Fenella Gill: Methodology, Validation, Formal analysis, Resources, Writing – Review & editing, Visualisation, Supervision, Project administration.

Gavin Leslie: Methodology, Validation, Formal analysis, Writing – Review & editing, Visualisation, Supervision.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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