

PATIENT-CENTERED CARE
ANNOTATED BIBLIOGRAPHY
OCTOBER 2007 - NEW CITATIONS

Birks, Y. F., & Watt, I. S. (2007). Emotional intelligence and patient-centred care. *Journal of the Royal Society of Medicine*, 100(8), 368-374.

The principles of patient-centred care are increasingly stressed as part of health care policy and practice. Explanations for why some practitioners seem more successful in achieving patient-centred care vary, but a possible role for individual differences in personality has been postulated. One of these, emotional intelligence (EI), is increasingly referred to in health care literature. This paper reviews the literature on EI in health care and poses a series of questions about the links between EI and patient-centred outcomes. Papers concerning empirical examinations of EI in a variety of settings were identified to determine the evidence base for its increasing popularity. The review suggests that a substantial amount of further research is required before the value of EI as a useful concept can be substantiated. (Source: PubMed)

Devore, S., Berrong, B., & Clark, G. (2007). Using technology to facilitate a patient-centered care delivery process. *Computers, informatics, nursing : CIN*, 25(5), 309-310.

Progress West HealthCare Center (PWHC) recently opened a 72-bed green field hospital that uses technology incorporating patient- and family-centered processes to promote safe and efficient care. A key feature is integration of the various technologies with each other and with clinical processes. To facilitate better patient learning and educational opportunities, ceiling-mounted patient touch devices were installed in every room. These devices allow patients to search and choose education based on their diagnosis. Implementation of

radiofrequency identification technology was implemented to support better patient flows. A hands-free device allows clinicians and patients to communicate with a touch of the button or a command of the voice. This system was integrated with physiologic monitors and the patient call system. (Source: QSEN Team)

Earp, J. A. L., French, E. A., & Gilkey, M. B. (2008). *Patient advocacy for health care quality: Strategies for achieving patient-centered care*. Sudbury, Mass.: Jones and Bartlett Publishers.

What is patient advocacy? -- The U.S. health care system and the need for patient advocacy -- Family-centered care -- E-patients -- The long reach to basic healthcare services -- The clinician's experience -- Accessing the patient's world -- Advocacy and patient literacy -- Improving the quality of care through research -- The contributions of patient advocacy in patient safety -- Planetree, a hospital model for patient-centered care -- Confronting the hidden curriculum in medical education -- Advocacy for improving end-of-life care -- Did patient/consumers cause the healthcare crisis? -- Advocacy for residents in long term care -- Access to healthcare -- Research advocacy in traditional research settings -- Educating for health advocacy in settings of higher learning -- Clinical advocacy -- Using the law to strengthen the patient's voice -- Patient advocacy.

Houck, N. M., & Bongiorno, A. W. (2006). Innovations in the public policy education of nursing students. *The Journal of the New York State Nurses' Association*, 37(2), 4-9.

Nurses are the voice of patients. Nurses speak for those who cannot speak for themselves. Today's nurses need to find their voice and discover the power of public policy as a vehicle for patient-centered care. New York is a vast and varied state with multiple, competing healthcare interests. Nurses in New York need to be prepared to navigate the halls of power as patient-centered advocates. Nurses benefit from an education that teaches them to move comfortably in complex healthcare

environments. This article describes the integration of an innovative, curricula-wide, public policy initiative with senior nursing students in a baccalaureate nursing program. We discuss the overall goals of the learning-centered program and the specific classroom and field assignments. Students described the results of this innovative teaching strategy as a life-changing event where they find their voice as an agent for their patients. (Source: PubMed)

Jones, A. (2007). Admitting hospital patients: A qualitative study of an everyday nursing task. *Nursing inquiry*, 14(3), 212-223.

In recent years new modes of nursing work have been introduced globally in response to radical changes in healthcare policies, technology and new ideologies of citizenship. These transformations have redefined orthodox nurse-patient relationships and further complicated the division of labour within health-care. One distinctive feature of the work of registered nurses has been their initial assessment of patients being admitted to hospital, and it is of interest that this area of nursing practice remains central to the registered nurse's role at a time where other areas of practice have been relinquished to other occupational groups. This qualitative study, drawing on conversation analysis and ethnographic techniques, explores this area of everyday nursing work. Initial nursing assessments have attracted considerable interest in the nursing literature, where it is clearly stated that assessments should be patient centred and seen as the important first step on the road to a therapeutic nurse-patient relationship. Results from this study lead to the conclusion that the actual nursing practice of patient assessment on admission to hospital is at odds with the recommendations of the literature and that a more routinised, bureaucratic form of work is devised by nurses as a means of expediting the process of admission. (Source: PubMed)

Kneebone, R. L., Nestel, D., Vincent, C., & Darzi, A. (2007). Complexity, risk and simulation in learning procedural skills. *Medical education*, 41(8), 808-814.

BACKGROUND: A complex chain of events underpins every clinical intervention, especially those involving invasive procedures. Safety requires high levels of awareness and vigilance. In this paper we propose a structured approach to procedural training, mapping each learner's evolving experience within a matrix of clinical risk and procedural complexity. We use a traffic light analogy to conceptualize a dynamic awareness of prevailing risk and the implications of moving between zones. THE IMPORTANCE OF CONTEXT: We argue that clinical exposure can be consolidated by simulation where appropriate, ensuring that each learner gains the skills for safe care within the increasingly limited time available for training. To be effective, however, such simulation must be realistic, patient-focused, structured and grounded in an authentic clinical context. Challenge comes not only from technical difficulty but also from the need for interpersonal skills and professionalism within clinical encounters. PATIENT FOCUSED SIMULATION: Many existing simulations focus on crises, so clinicians are in a heightened state of expectation that may not reflect their usual practice. We argue that simulation should also reflect commonly occurring non-crisis situations, allowing clinicians to develop an awareness of the complex events that underpin clinical encounters. We describe a patient-focused approach to simulation, using simulated patients and inanimate models within realistic scenarios, to ground experience in authentic clinical practice and bring together the complex elements that underpin clinical events. APPLICATIONS: Although our argument has evolved from surgical practice and operating theatre teams, we believe it can be widely applied to the increasing number of health care professionals who perform clinical interventions. (Source: PubMed)

Lein, C., & Wills, C. E. (2007). Using patient-centered interviewing skills to manage complex patient encounters in primary care. *Journal of the American Academy of Nurse Practitioners*, 19(5), 215-220.

PURPOSE: To describe effective and efficient patient-centered

interviewing strategies to enhance the management of complex primary care patient encounters. DATA SOURCES: Research literature and applied case study analysis. CONCLUSIONS: Patient-centered interviewing can enhance effectiveness of care in complex patient encounters. A relatively small investment of time and energy has positive yields in regard to improvements in longer term physiological status, treatment adherence, quality of life, patient-provider working relationship, and patient and nurse practitioner satisfaction. IMPLICATIONS FOR PRACTICE: Use of patient-centered interviewing strategies can enhance effectiveness of patient care processes and outcomes while retaining efficiency of patient management. (Source: PubMed)

Markova, T., & Broome, B. (2007). Effective communication and delivery of culturally competent health care. *Urologic nursing : Official journal of the American Urological Association Allied*, 27(3), 239-242.

Effective communication between patients and health care providers is a critical element to quality health care. Becoming aware of patients' attitudes, beliefs, biases, and behaviors that may influence patient care can help clinicians improve access to and quality of care. Health care providers should develop a strategic plan for improvement, then implement and evaluate the plan to include structured, continuously improving progress toward achieving cultural competency goals. In this challenging health care environment, health care providers need the skills to explore the meaning of illness, to determine patient's social and family context, and provide patient-centered and culturally competent care. (Source: PubMed)

Schoot, T., Hirsch, M., & de Witte, L. (2007). Development of competencies aimed at client-centred care: An evaluation study. *Learning in health & social care*, 6(2), 104-117.

The aim of this study was to evaluate a learning programme for Dutch community nurses and auxiliary nurses aimed at the development of competencies with respect to client-centred care for chronically ill clients.

The study was guided by the Kessels's Eight-fields model. Several stakeholders, including clients, participated in the development, execution and evaluation of the programme. The concept of client-centred care, client goals and competencies for nurses were identified systematically. Competencies identified were a care-process in dialogue, enabling client participation and dealing with tensions. Principles of development of competencies were applied in the design of learning activities. The programme was evaluated at three levels: learning processes; performance of competencies in practice; and perceived client-centredness by clients. (Source: Publisher)

Shaller, D. (October 2007). *Patient-centered care: What does it take?* The Commonwealth Fund.

http://www.commonwealthfund.org/usr_doc/1067_Shaller_patient-centered_care_what_does_it_take.pdf?section=4039

This paper was commissioned by The Picker Institute to explore what it will take to achieve more rapid and widespread implementation of patient-centered care in both inpatient and ambulatory health care settings. The findings and recommendations of this paper are based largely on a series of interviews with opinion leaders selected for their experience and expertise in either designing or implementing strategies for achieving excellence in patient-centered care. (Source: Publisher)

Sisterhen, L. L., Blaszak, R. T., Woods, M. B., & Smith, C. E. (2007). Defining family-centered rounds. *Teaching and learning in medicine, 19*(3), 319-322.

BACKGROUND: Physicians are required to provide safe, effective, and high-quality care that is patient-centered. Continuing to meet the educational needs of residents and medical students in the setting of patient-centered care will require developing new models for hospital "work rounds." Family-centered rounds is a model of communicating and learning between the patient, family, medical professionals, and students on an academic, inpatient ward setting. Unfortunately, in the medical

literature, there is no consensus on the definition of family-centered rounds. SUMMARY: Despite the increased utilization of hospitalists and the recognition that bedside teaching has many benefits, bedside rounds are underutilized. In this article, we present a description of family-centered rounds that is supported by a review of the literature on bedside teaching, family-centered care, and interdisciplinary care. The key difference between family-centered rounds and traditional bedside teaching is the active participation of the patient and family in the discussion. Interdisciplinary care implies that professionals from a variety of disciplines work collaboratively to develop a unified care plan. Family-centered rounding provides an interface between families and medical professionals that allows education of medical students and residents as well as the development of a unified care plan. CONCLUSIONS: Family-centered rounds hold potential to create a patient-centered environment, enhance medical education, and improve patient outcomes. The model is a planned, purposeful interaction that requires the permission of patients and families as well as the cooperation of physicians, nurses, and ancillary staff. (Source: PubMed)

Tucker, C. M., Mirsu-Paun, A., Van den Berg, J. J., Ferdinand, L., Jones, J. D., Curry, R. W., et al. (2007). Assessments for measuring patient-centered cultural sensitivity in community-based primary care clinics. *Journal of the National Medical Association, 99*(6), 609-619.

OBJECTIVE: To develop and test the reliability of three race/ethnicity-specific forms of the pilot Tucker-Culturally Sensitive Health Care Inventory (T-CUSHCI) for use by patients at community-based primary care centers to evaluate the level of patient-centered cultural sensitivity perceived in the health care that they experience. METHODS: This research involved two studies using independent samples of primary care patients. In study 1, mostly low-income African-American, Hispanic and non-Hispanic white American patients (N=221) rated the importance of specific provider and office staff behaviors and attitudes, and center

policies and physical environment characteristics that were earlier identified in previous focus groups as characteristics of patient-centered culturally sensitive healthcare. In study 2, three pilot race/ethnicity-specific T-CUSHCI patient forms were constructed from the items rated as at least important in study 1. Mostly low-income African-American and non-Hispanic white American patients (N=180) provided data to determine the reliability of the T-CUSHCI patient form for their racial/ethnic group. RESULTS: The pilot T-CUSHCI-African-American patient form and the pilot T-CUSHCI-non-Hispanic white American patient form were found to have Cronbach's alpha coefficients ranging from 0.71-0.96 and six-month test-retest and split-half reliabilities ranging from 0.92-0.99. CONCLUSION: The pilot T-CUSHCI patient forms (one each for African Americans, Hispanics and non-Hispanic whites) should be further tested using a national sample of patients. In the interim, these inventory forms can be used as clinical tools to obtain patient feedback for providing "individualized" patient-centered culturally sensitive healthcare. (Source: PubMed)

Vanhaecht, K., De Witte, K., Depreitere, R., Van Zelm, R., De Bleser, L., Proost, K., et al. (2007). Development and validation of a care process self-evaluation tool. *Health services management research : An official journal of the Association of University Programs in Health Administration*, 20(3), 189-202.

Clinical pathways are used as a method of organizing care processes. Although they are used worldwide, the concept remains unclear, with little understanding of what exactly is being implemented. A recent systematic review revealed that, although a tool exists to score the instrumental qualities of clinical pathways, no tools are available to assess how the clinical pathway influences the process of care. These tools are needed for a better understanding of the impact of clinical pathways on the length of hospital stay and patient outcomes. In this study, a Care Process Self-Evaluation Tool (CPSET), based on the clinical

pathway concept, for assessing the organization of the process of care has been developed and tested. Qualitative and quantitative methods, involving 885 professionals and patients, were used in the development and validation. The CPSET is a valid and reliable 29-item instrument for assessing how the process of care is organized. The CPSET has five subscales: patient-focused organization, coordination of care, communication with patients and family, cooperation with primary care and monitoring/follow-up of the care process. The CPSET can be used in the audit and accreditation of care processes and will help managers and clinicians to understand better how care processes are organized.

(Source:PubMed)