
**AIM:** To understand student nurse-patient interaction better and to assess the effectiveness of a teaching and learning resource consisting of tapes and transcriptions of actual nurse-patient interaction. **DESIGN:** Applied conversation analysis and analysis of semi-structured lecture evaluation forms. **BACKGROUND:** Little research discusses interpersonal skills (IPS) of student-nurses, even though policy initiatives and literature internationally promote patient-centred communication as being an indicator of high-quality healthcare. Literature also suggests that nursing education is often far removed from the realities which students experience during clinical practice. **METHODS:** Phase 1 of the study saw 10 student nurse-patient interactions audio recorded and transcribed and the data subjected to conversation analysis. Phase 2 saw tapes and transcripts of similar interactions used as a teaching resource with the same cohort of students (n = 48), student evaluations of the lecture were quantitatively and qualitatively analysed. **RESULTS:** Phase 1 demonstrated that, in variance to 'best-practice' recommendations, student nurse-patient interactions were task-centred and bureaucratically organized. In phase 2, after listening to and reading a transcript of similar interaction, students were able to identify the limitations of undertaking such an approach with patients, strongly suggesting that classroom-based knowledge is not always easily transferred into clinical practice. This teaching approach was positively evaluated, with written evaluations emphasizing the effectiveness of bringing the realities of clinical practice into the classroom. **CONCLUSION:** This study suggests that students have difficulty in transferring the principles of 'good' communication from the classroom into
their own interactions with patients. Students' written and spoken evaluations were reminiscent of the previous work performed in discussing the concept of a 'hidden curriculum' in professional training. RELEVANCE TO CLINICAL PRACTICE: The use of empirical data in the practice of IPS teaching is recommended as a means of closing the theory-practice gap. Student nurses and mentors need to consider the effect of the hidden curriculum on their IPS. (Source: PubMed)


BACKGROUND: Little is known about the extent to which primary care physicians (PCPs) practice patient-centered care, one of the Institute of Medicine's six dimensions of quality. This article describes the adoption of patient-centered practice attributes by PCPs.

METHODS: Mail survey; nationally representative physician sample of 1837 physicians in practice at least 3 years postresidency.

RESULTS: Eighty-three percent of PCPs surveyed are in favor of sharing of medical records with patients. Most physicians (87%) support team-based care. But, only 16% of PCPs communicate with their patients via e-mail; only 36% get feedback from their patients. Seventy-four percent of PCPs still experience problems with availability of patients' medical records or test results; less than 50% have adopted patient reminder systems. Thirty-three percent of physicians practicing in groups of 50 or more have adopted 6 to 11 of the 11 patient-centered care practices targeted in the survey compared with 14% of solo physicians.

CONCLUSION: Although some patient-centered care practices have been adopted by most PCPs, other practices have not yet been adopted as broadly, especially those targeting coordination, team-based care, and support from appropriate information systems. (Source: PubMed)

PURPOSE: Patient-centeredness has been advocated to reduce racial/ethnic disparities in health care quality, but no empirical data support such a connection. The authors' purpose was to determine whether students with patient-centered attitudes have better performance and are less likely to demonstrate disparities with African American compared with white standardized patients (SPs). METHOD: Third-year medical students were assessed by SPs at the Clinical Educational Center of the Johns Hopkins University School of Medicine in 2002. One African American and one white actor were trained as SPs for each of four case scenarios; students were randomly assigned to interact with either SP for each case. Before the exam, students were surveyed about their attitudes towards patient-centered medicine. Students with and without patient-centered attitudes were compared with regard to their performance with African American and white SPs. Outcome measures were student exam scores in interpersonal skill, history taking, physical exam, and counseling. RESULTS: All 177 of eligible students participated in all four case scenarios. With white SPs, students with patient-centered attitudes performed similarly to students without patient-centered attitudes in all four areas. However, with African American SPs, students with patient-centered attitudes performed significantly better than students without patient-centered attitudes in interpersonal skills (71.4 versus 69.4, P = .010), history taking (63.8 versus 61.1, P = .003), and counseling (92.1 versus 88.7, P = .002) and not significantly different in physical exam performance (73.6 versus 68.6, P = .311). CONCLUSIONS: Patient-centered attitudes may be more important in improving physician behaviors with African American patients than with white patients and may, therefore, play a role in reducing disparities. (Source: PubMed)

medical profession meet patients' needs and expectations: (1) improving access to and continuity with clinicians, (2) increasing patients' participation in care by making it easier for patients to express their concerns and involving them more actively in the design of their care, (3) supporting patient self-management through systems that facilitate goal setting and that increase patient and family confidence in self-care, and (4) establishing more efficient and reliable mechanisms for coordinating care among settings. (Source: QSEN Team)


Five years after *To Err Is Human*, U.S. healthcare systems have not yet accomplished a focus on patient centeredness and the development of patient-professional partnerships to effect a safety culture change. The implementation of electronic medical records, diffusion of safe practices, team training, and full disclosure to patients following injury will hasten the pace of change. Without significant training and practical education for clinicians and other providers, however, fragmented systems will not undergo the overhaul needed to improve safety in healthcare settings. (Source: QSEN Team)


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)


The survey by West et al. raised numerous patient safety issues faced by nurses under difficult working conditions. Such surveys play a vital role in drawing attention to strengths and weaknesses in the management of nursing services and in suggesting next steps for research and policy efforts. This commentary concludes that researchers must continue to document the impacts of staffing and other working conditions in hospitals. Further, they must begin to evaluate specific approaches for improving nurse practice environments in hospitals. (Source: QSEN Team)


Quality and Safety Education for Nurses (QSEN) addresses the challenge of preparing nurses with the competencies necessary to continuously improve the quality and safety of the health care systems in which they work. The QSEN faculty members adapted the Institute of Medicine competencies for nursing (patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics), proposing definitions that could describe essential features of what it means to be a competent and respected nurse. Using the competency definitions, the authors propose statements of the knowledge, skills, and attitudes (KSAs) for each competency that should be developed during pre-licensure nursing education. Quality and Safety Education for Nurses (QSEN) faculty and advisory board members invite the profession to comment on the competencies and their definitions and on whether the KSAs for pre-licensure education are appropriate goals for students preparing for basic practice as a registered nurse. (Source: PubMed)

*Synergy: The Unique Relationship Between Nurses and Patients* offers a practical and intuitive framework that resonates with nurses from varying subspecialties, levels of expertise, and roles—from staff nurse to chief nurse executive. It resonates with clinicians because it describes what nurses do based on the primacy of patients and optimal nurse-patient relationships. (Source: Publisher)


This paper describes a model of nursing practice developed by the American Association of Critical-Care Nurses Certification Corporation. The fundamental premise, known as the Synergy Model, is that patient characteristics drive nurse competencies. When these match and synergize, the result is optimal outcomes for the patient. The major tenets of the Synergy Model are presented: patients' characteristics of concern to nurses, nurses' competencies important to patients, and patients' outcomes that result when patients' characteristics and nurses' competencies are mutually enhancing. Although the Synergy Model is a blueprint for the certification of acute and critical care nurses, it is relevant to the entire profession. (Source: QSEN Team)


OBJECTIVE: To develop clinical practice guidelines for the support of the patient and family in the adult, pediatric, or neonatal patient-centered ICU.
PARTICIPANTS: A multidisciplinary task force of experts in critical care practice was convened from the membership of the American College of Critical Care Medicine (ACCM) and the Society of Critical Care Medicine (SCCM) to include representation from adult, pediatric, and neonatal intensive care units. EVIDENCE: The task force members reviewed the published literature. The Cochrane library, Cinahl, and MedLine were queried for articles published between 1980 and 2003. Studies were scored according to Cochrane methodology. Where evidence did not exist or was of a low level, consensus was derived from expert opinion. CONSENSUS PROCESS: The topic was divided into subheadings: decision making, family coping, staff stress related to family interactions, cultural support, spiritual/religious support, family visitation, family presence on rounds, family presence at resuscitation, family environment of care, and palliative care. Each section was led by one task force member. Each section draft was reviewed by the group and debated until consensus was achieved. The draft document was reviewed by a committee of the Board of Regents of the ACCM. After steering committee approval, the draft was approved by the SCCM Council and was again subjected to peer review by this journal. CONCLUSIONS: More than 300 related studies were reviewed. However, the level of evidence in most cases is at Cochrane level 4 or 5, indicating the need for further research. Forty-three recommendations are presented that include, but are not limited to, endorsement of a shared decision-making model, early and repeated care conferencing to reduce family stress and improve consistency in communication, honoring culturally appropriate requests for truth-telling and informed refusal, spiritual support, staff education and debriefing to minimize the impact of family interactions on staff health, family presence at both rounds and resuscitation, open flexible visitation, way-finding and family-friendly signage, and family support before, during, and after a death. (Source: PubMed)

Teaching the highest quality and safest practice has long been a goal of faculty members in pre-licensure nursing education programs. This article will describe innovative approaches to integrating quality and safety content into existing clinical practica. The core competencies identified by the Quality and Safety Education for Nurses project—patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics—serve as the framework for the teaching/learning exercises. The strategies described require a shift in attention rather than changes in course content and can be included in any clinical rotation in an acute care setting. (Source: PubMed)


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)


This article is the first in a series highlighting parental roles in family-centered care. A brief history of family-centered care from the 1960s to the present provides the context for the development of numerous roles parents have begun to play in the health care system. This background is followed by a mother’s description of the steps in her own evolution as a
"parent advocate." Deborah Dokken first developed her voice in the health care system as a parent to three premature infants, one of whom survived. Dokken used the skills she developed as a NICU parent to help other families through a peer-support program. She was subsequently invited to serve on a hospital’s Ethics Committee; later to participate as a co-investigator and consultant on a palliative care education project; and most recently to be a member of several federal level health care advisory committees. Several themes in her development as a parent advocate included: readiness and commitment to assume new roles; the open support of at least one care professional in each setting; the identification of roles that matched her interest, background, and skills; and a growing conviction of her ability to contribute in a holistic way. Subsequent articles in this series will introduce other parents as they describe a variety of parental roles in family-centered care. We hope that illustration of these roles will inspire further involvement of parents in the pediatric health care system, at all levels. (Source: PubMed)


The organization of patient care in many acute care institutions lacks a foundation in nursing theory, yet preliminary evidence of the value of professional nursing care is increasing. The process and preliminary benefits of organizing patient care according to a professional practice model are presented using a collaborative partnership between an acute care organization and a school of nursing. A pilot implementation plan with formative and summative evaluation provided preliminary evidence used in project expansion. (Source: PubMed)


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.


This study explored patients' experiences of participation and non-participation in their health care. A questionnaire-based survey method was used. Content analysis showed that conditions for patient participation occurred when information was provided not by using standard procedures but based on individual needs and accompanied by explanations, when the patient was regarded as an individual, when the patient's knowledge was recognized by staff, and when the patient made decisions based on knowledge and needs, or performed self-care. Thus, to provide conditions for true patient participation, professionals need to recognize each patient's unique knowledge and respect the individual's description of his or her situation rather than just inviting the person to participate in decision making. (Source: PubMed)


AIM: The purpose of this article was to examine issues that new nurses encounter as they enter nursing practice, particularly in an evidence-based practice environment. BACKGROUND: These issues are not new. In part, these issues arise from our failure to acknowledge the developmental issues that new nurses experience on entry to practice and the lack of role
models in evidence-based practice and holistic care. EVALUATION: This article synthesizes research reported over the last decade to delineate the issues of transition to practice and strategies that have proven effective in addressing them. KEY ISSUES: The key issues relate to the need to support new nurses in evidence-based and holistic practice, the strategies needed to do so, and the nurse manager's role in this process. CONCLUSIONS: We must invest resources in assisting new nurses into practice, which may have benefits in terms of both recruitment and retention of new nurses in practice. (Source: PubMed)

Finkelman, A. W., & Kenner, C. (2007). Teaching IOM: Implications of the Institute of Medicine reports for nursing education. Silver Spring, MD: American Nurses Association. Teaching IOM focuses on the core competencies derived from the IOM reports on quality and health care and how to use these reports in the classroom. The companion CD-ROM provides additional material for incorporating content into curricula and teaching-learning experiences. It includes PowerPoint presentations with notes on the book's five major topics: healthcare safety, healthcare quality, public health safety and quality, healthcare diversity, and linkage between research and evidence-based practice. The content is appropriate for graduate or undergraduate students. (Source: QSEN Team)

Gerteis, M. S. (Ed.). (1995). Through the patient's eyes: Understanding and promoting patient-centered care. San Francisco, CA: Jossey-Bass. In this comprehensive, research-based look at the experiences and needs of patients, the authors explore models of care that can make hospitalization more humane. Through the Patient's Eyes provides insights into why some hospitals are more patient-centered than others; how physicians can become more involved in patient-centered quality efforts; and how patient-centered quality can be integrated into health care policy, standards, and regulations. The authors show how, by bringing the patient's perspective to the design and delivery of health services, providers can improve their ability to meet patient's needs and enhance
the quality of care. (Source: Publisher)

Gilbert, J. H. (2005). Interprofessional education for collaborative, patient-centred practice. *Canadian journal of nursing leadership, 18*(2), 32-6, 38. Interprofessional education has been defined as "occasions when two or more professions learn from and about each other to improve collaboration and the quality of care." Much that has been written about interprofessional education (IPE) and the interprofessional team has concentrated on two or at most three professions, primarily medicine, nursing and pharmacy. Educational programs described in the literature tend to focus on activities involving students, practitioners or both. Very little has been written about the structural changes that need to be made within universities, colleges and the healthcare industry such that IPE becomes a joint responsibility across a number of jurisdictions that may then effectively influence institutional practice. (Source: Publisher)

Haase-Herrick, K. S., & Herrin, D. M. (2007). The American Organization of Nurse Executives' Guiding Principles and American Association of Colleges of Nursing's Clinical Nurse Leader: A lesson in synergy. *The Journal of nursing administration, 37*(2), 55-60. The membership of the American Association of Colleges of Nursing, in partnership with its practice partners, has initiated a national effort to create a new nursing role that is more responsive to the realities of a complex, technologically advanced, ever-changing healthcare system. This new role is the clinical nurse leader. Nurses in this new role will be prepared at the master's level and will act as lateral integrators of care, patient advocates over the many components of the continuum, and information manager to the multiple disciplines involved in care. (Source: Publisher)

nursing (BSN) education. This study examined recent BSN program graduates' views about clinical nursing educator attributes that enhance the ability of the graduates to provide safe, effective patient care. In this descriptive study, 6 participants were interviewed using grounded theory techniques. The study framework blended the elements of cognitive field theory, the humanistic philosophy of teaching and learning, the gestalt theory of learning, and Hergenhahn's behavioral change model. Participants identified three attributes of a good clinical nursing educator: knowledge, interpersonal presentation, and teaching strategies. Analysis revealed that educator attributes and phases of the clinical experience process together form the foundation for clinical experience praxis. Educators can improve the clinical education experience by developing teaching strategies and evaluation tools that build on the positive attributes and phases of the clinical experience identified in this study. (Source: PubMed)


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)

Institute for Alternative Futures. (2004). *Patient-centered care 2015:*

Patient-centered care has attracted leaders in visionary healthcare organizations, research institutions and public policy centers who advocate that patients’ interests and concerns should be at the center of their own healthcare experience. They have been swimming against a current of forces that push the quality of patient care below such issues as rising healthcare costs, medical liability, staffing shortages, and access to care. In 2004, patient-centered care is rarely the central concern of hospitals, nursing homes or medical practices in the U.S., Canada or Europe. In order to channel the highest aspirations of healthcare leaders, the Picker Institute, a leader in measuring the nature and quality of patient-centered care, commissioned the Institute for Alternative Futures (IAF) to help create a shared vision for patient-centered care. This report is an invitation to help shape such a shared vision. (Source: Publisher)


BACKGROUND: The foundation of client-centred practice is the therapist's capacity to view the world through the client's eyes and to develop an understanding of the lived experience of disability. PURPOSE: This paper describes the evaluation of an educational initiative promoting student empathy to the lived experience of disability. METHODS: Pairs of first-year occupational therapy students visited adults with disabilities who shared their knowledge and experience of living with a disability. Students reflected on their visits in journals, which were later analyzed using pattern matching. FINDINGS: Students appeared to appreciate the co-existence of health and disorder and demonstrated a holistic understanding of living with a disability. Little attention was focused on cultural and institutional environments. Students struggled to define the nature of their relationship
with their tutors. Practice Implications. The evaluation confirmed our belief that this educational initiative could facilitate student empathy, consistent with critical features of client-centred practice. (Source: PubMed)


Written especially for nurses in all disciplines and health care settings, this book focuses on the hands-on role nurses play in the delivery of care and their unique opportunity and responsibility to identify potential sentinel events. Topics include preventing medication and transfusion errors, as well as preventing suicide, falls, and treatment delays. New chapters address wrong-site surgery perinatal injuries or death, and injuries or death due to criminal events. Learn how to: better recognize the root causes of specific sentinel events; identify strategies to prevent sentinel events from occurring; and overcome obstacles in the areas of staffing, training, culture of safety, and communication among the health care team. (Source: Publisher)


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)


This article examines the provision of patient-centred care in an intensive care unit where patients' autonomy may be compromised. It discusses the Synergy Model as a framework for encouraging nurses to transform a technical and potentially dehumanising environment into a humane and healing place. (Source: PubMed)


Experiential techniques, such as role plays and simulations, are recommended to achieve nursing home staff training and development objectives. Experiential techniques can be customized to match the learning styles and preferences of all levels of nursing staff. Nursing staff's reactions to and benefits from such techniques are a necessary first step in the evaluation of a skills training program. Project RELATE (Research and Education for Living with Alzheimer's Disease: Therapeutic Eldercare) measured reactions to and knowledge gained by nursing staff using such techniques in training person-centered care. Findings suggest experiential techniques are efficacious as learning methods. (Source: PubMed)


This article describes a teaching strategy that focuses students' attention on the humanistic imperative in nursing practice. The Humanistic Teaching
Method provides a framework for adapting nursing courses to accommodate person-to-person, human-centered nursing care alongside scientific and technological competencies. Through this approach, students integrate concepts such as humanism, existentialism, and phenomenology into patient interactions. In addition to producing a favorable effect on patients and colleagues, this approach contributes to personal gratification in making a difference in the lives of others. Pedagogical strategies currently in use may need to be modified to accommodate the humanistic conceptual framework. (Source: PubMed)


**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)

interventions: Implications for incontinence. *Nursing research, 53*(6 Suppl),
S30-5.

BACKGROUND: Nurse researchers in incontinence have focused on testing
the effects of standardized interventions; however, nurses in practice
usually customize interventions with patients. Patient-centered
interventions promise to bring research and practice closer together.
Tailored interventions, one kind of patient-centered intervention, have
been associated with improved health outcomes and can guide research
interventions regarding incontinence. OBJECTIVES: To define the concept
"patient-centered," discuss four kinds of patient-centered interventions,
offer examples of tailored interventions, and suggest ideas for future
incontinence research. METHODS: Existing literature on patient-centered
interventions was analyzed to generate a plan for future research.
RESULTS: Research is needed to demonstrate the efficacy of patient-
centered interventions in outcomes, to determine bio-psycho-social factors
of subgroups (race, gender, ethnicity) in order to more accurately describe
prevalence rates and create effective interventions, and to find common
variables among successful interventions. CONCLUSIONS: Developing and
testing patient-centered interventions regarding incontinence promises to
advance knowledge about more effective interventions, conditions under
which they are more or less effective, and how they are effective. (Source: PubMed)

strategy. *Nursing times, 102*(25), 34-36.
City Hospitals Sunderland developed a 'pen portrait' initiative as part of their nursing strategy to ensure patients are the centre of services. This article outlines the development of pen portraits and evaluates the impact they have had on patient care. (Source: PubMed)


**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)


**BACKGROUND:** Communication problems in health care may arise as a result of health care providers focusing on diseases and their management, rather than people, their lives and their health problems. Patient-centred approaches to care are increasingly advocated by consumers and clinicians and incorporated into training for health care providers. The effects of interventions that aim to promote patient-centred care need to be evaluated. **OBJECTIVES:** To assess the effects of interventions for health care providers that aim to promote patient-centred approaches in clinical consultations. **SEARCH STRATEGY:** We searched
Medline (1966 - Dec 1999); Health Star (1975 - Dec 1999); PsycLit (1887-Dec 1999); Cinahl (1982 - Dec 1999); Embase (1985-Dec 1999) and the bibliographies of studies assessed for inclusion. SELECTION CRITERIA: Randomised controlled trials, controlled clinical trials, controlled before and after studies, and interrupted time series studies of interventions for health care providers that promote patient-centred care in clinical consultations. Patient-centred care was defined as a philosophy of care that encourages: (a) shared control of the consultation, decisions about interventions or management of the health problems with the patient, and/or (b) a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease). The participants were health care providers, including those in training. DATA COLLECTION AND ANALYSIS: Two reviewers independently extracted data onto a standard form and assessed study quality for each study. We extracted all outcomes other than health care providers' knowledge, attitudes and intentions. MAIN RESULTS: 17 studies met the inclusion criteria. These studies display considerable heterogeneity in terms of the interventions themselves, the health problems or health concerns on which the interventions focused, the comparisons made and the outcomes assessed. All included studies used training for health care providers as an element of the intervention. Ten studies evaluated training for providers only, while the remaining studies utilised multi-faceted interventions where training for providers was one of several components. The health care providers were mainly primary care physicians (general practitioners or family doctors) practising in community or hospital outpatient settings. In two studies, the providers also included nurses. There is fairly strong evidence to suggest that some interventions to promote patient-centred care in clinical consultations may lead to significant increases in the patient centredness of consultation processes. 12 of the 14 studies that assessed consultation processes showed improvements in some of these outcomes. There is also some evidence that training health care providers in patient-centred approaches may impact positively on patient satisfaction with care. Of the eleven studies
that assessed patient satisfaction, six demonstrated significant differences in favour of the intervention group on one or more measures. Few studies examined health care behaviour or health status outcomes. REVIEWER'S CONCLUSIONS: Interventions to promote patient-centred care within clinical consultations may significantly increase the patient centredness of care. However, there is limited and mixed evidence on the effects of such interventions on patient health care behaviours or health status; or on whether these interventions might be applicable to providers other than physicians. Further research is needed in these areas. (Source: PubMed)


Providing patient-centered care (PCC) has been the focus of recent organizational restructuring and quality improvement efforts in health care. Much has been written about PCC in the past 5 years; however, there are multiple perspectives about the interpretation and implementation of this concept. Descriptions of PCC in the health care literature generally, in some way, refer to meeting patients' needs. Literature describing PCC falls into two categories. The first category interprets PCC as the reorganization of services around patients' needs. The second defines PCC as understanding patient-perceived needs, priorities, and expectations for health care. PCC, however, is still most often implemented from a traditional provider-centered, disease-focused framework that often results in patient care and outcomes that are not congruent with patients' preferences. Shifting to a model of care in which patients define their needs and priorities creates some unique issues in health care. Nursing, with its long-standing commitment to being patient focused, needs to lead the research effort to develop patient-centered models of care that consider and incorporate patients' preferences. Nurses must be mindful, however, of their socialization in the traditional model of care and the resulting underlying attitudes and assumptions they bring to their research and work with patients. (Source: PubMed)

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)


AIMS AND OBJECTIVES: The research aims to explore how preceptors interpret, operationalize, document and teach person-centred care as they guide students within an acute surgical environment. BACKGROUND: Person-centred care is a term that is widely used in the nursing literature; however, its interpretation in nursing practice remains virtually unexplored. This is of great significance to nurses in general but to Irish nurses in particular on whom this study is focused. As preceptor nurses have been identified as key people in the education of clinical students, it was considered important to explore how clinical preceptors promote person-centred care to current undergraduate nursing students. DESIGN AND METHOD: Using a case study design and a qualitative approach, six preceptors were chosen to participate in this study. Data were collected by means of participant observation, review of nursing care records and semi-structured interviews. Data were analysed in two stages. The first stage involved the identification of themes. In the second stage data were
analysed using a number of propositions to examine and explain what was gleaned from the data in the context of what was originally identified in the literature. RESULTS: Findings highlighted that preceptors had a limited conception of person-centred care. Measures of care reflected the medical model of nursing. Beyond that, preceptors expressed care in terms of good manners or respectful etiquette. Preceptors also had limited appreciation of what learning entails and were sceptical about classroom theory other than what they considered essential for safe practice. CONCLUSIONS: This study highlights that preceptors need both internal and external support to implement the changes advocated by the Commission in Nursing in 1998, the Nursing Education Forum in 2000, the Department of Health and Children in 2001 and An Bord Altranais in 2003. RELEVANCE TO CLINICAL PRACTICE: Person-centred care is a relatively new concept in nursing and recommended for practice. Preceptors need facilitation with its implementation. In an effort to promote changes in the delivery of health care, it is suggested that university-based lecturers empower students to practice evidence-based nursing as students and subsequently as qualified nurses. (Source: PubMed)

McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. Journal of advanced nursing, 56(5), 472-479. This paper presents the development and content of a person-centred nursing framework. BACKGROUND AND RATIONALE: Person-centred is a widely used concept in nursing and health care generally, and a range of literature articulates key components of person-centred nursing. This evidence base highlights the links between this approach and previous work on therapeutic caring. METHODS: The framework was developed through an iterative process and involved a series of systematic steps to combine two existing conceptual frameworks derived from empirical studies. The process included the mapping of original conceptual frameworks against the person-centred nursing and caring literature, critical dialogue to develop a combined framework, and focus groups with practitioners and co-researchers in a larger person-centred nursing
development and research project to test its face validity. FINDINGS: The person-centred nursing framework comprises four constructs - prerequisites, which focus on the attributes of the nurse; the care environment, which focuses on the context in which care is delivered; person-centred processes, which focus on delivering care through a range of activities; and expected outcomes, which are the results of effective person-centred nursing. The relationship between the constructs suggests that, to deliver person-centred outcomes, account must be taken of the prerequisites and the care environment that are necessary for providing effective care through the care processes. CONCLUSION: The framework described here has been tested in a development and research project in an acute hospital setting. Whilst there is an increasing empirical base for person-centred nursing, as yet little research has been undertaken to determine its outcomes for patients and nurses. The framework developed can be described as a mid-range theory. Further testing of the framework through empirical research is required to establish its utility for nursing practice and research. (Source: PubMed)


PURPOSE: This study concerns one component of the ability to provide person-centered care: the cognitive skill of perceiving others in relatively complex terms. This study tested the effectiveness of a social motivation for increasing the number of psychological constructs used to describe an unfamiliar senior citizen. DESIGN AND METHODS: Forty-four certified nurse aide students participated. Students were mostly 30-year-old (M = 31) females (86%) with a high school education (72%). A quasi-experimental design was used. Early in training, participants completed the Role Category Questionnaire (RCQ), which measured their interpersonal cognitive complexity. On the basis of their RCQ scores, participants were matched and assigned to the experimental or control condition. Five weeks later, participants viewed a 15-min videotaped biography of an unfamiliar
senior citizen--Mitch. Participants in both conditions were told they would be asked to describe Mitch as a person after watching the video. Only participants in the experimental condition were additionally asked to imagine that they would be having a personal conversation with him afterward. RESULTS: As hypothesized, participants in the experimental condition (M = 14.6) used more constructs to describe Mitch than did participants in the control condition (M = 11.8): F(1, 41) = 4.03, p < .05. Participants' RCQ scores were significantly correlated with the complexity of their descriptions of Mitch. IMPLICATIONS: The findings suggest that new training materials should be created that include experienced certified nurse aides' modeling how biographical and personal information can be used in caregiving tasks to gain residents' cooperation. (Source: PubMed)


Nurses working on an orthopedic surgery and rheumatology unit in a large teaching hospital in Canada participated in a 24-month research project to evaluate what happens when nurses are provided 20% of their time for the purpose of learning and self-development. Half of the teaching-learning was aligned with the commitment of the organization to advance patient-centered care, and in particular patient-centered care guided by the nursing theory, human becoming. The other half was self-directed by nurse participants according to their learning interests and self-development priorities. The purpose of this column is to describe the teaching-learning and mentoring processes in which the nurses were engaged and to highlight the subsequent changes in nursing practice that have happened on the unit from the perspectives of nurse participants. (Source: PubMed)


Ideal Micro Practices are capable of delivering patient-centered collaborative care. With respect to comparable adult patients in "usual"
care settings, twice as many patients who use Ideal Micro Practices report they receive care that is "exactly what they want and need exactly when and how they want and need it" (68% vs 35%). Compared to usual care, these very small, low-overhead practices are more likely to have patients report very high levels of continuity (98% vs 88%), efficiency (95% vs 73%), and access (72% vs 53%). Patient ratings of very good information (83% vs 67%) and clinician awareness of pain or emotional problem are also higher (87% vs 69%). However, only a slim majority of patients using Ideal Micro Practices report that they are confident in their ability to manage and control their health problems or concerns. Ideal Micro Practices are sharing new tools and approaches to better understand their patients' needs and increase patients' confidence in their ability to manage conditions. In addition, these practices are working collaboratively to standardize their approaches and make the essential elements of Ideal Micro Practice replicable. (Source: PubMed)


This article, the fifth of six in a series on roles for family members in family-centered care, focuses on the role of parents as educators of clinicians in the health care system. Two interviews highlight this role. The director of family services at a pediatric hospital, a parent of a child who suffered with a chronic illness, offers suggestions for institutions wanting to further develop this key role. This includes involving patient and family advisors at the "front end" of any initiative or new project; identifying champions (clinical staff, administrators, and patients/family members) for these roles within the institution; preparing family members for the educator role; following-up with thanks and feedback; and tracking successes of projects in which patient and family advisors participate. The father interviewed in this article describes the sense of fulfillment he experiences from teaching health care providers about child and family needs and the emotional side of care. He urges all parents to recognize the
important education they can offer professionals when they both ask questions and share about their own child and family. (Source: PubMed)


Effective methods for teaching patient-centred interviewing skills are resource intensive. Providing students the opportunity to work in small groups with simulated patients is highly valued and has demonstrable long-term benefits. Expanding cohorts of medical students and diminishing faculty resources led to the implementation of a peer assisted learning (PAL) project in patient-centred interviewing skills. The paper reports the evaluation of a PAL project on student tutors. The methodology included direct and indirect measures of student tutors' skills in facilitation and patient-centred interviewing. The self-report evaluations strongly suggest that participating in a PAL project has substantial benefits for student tutors that included both interviewing and facilitation skills. Objective measures revealed no change in patient-centred interviewing skills after participating in the project. The study concludes that formalizing PAL may tap a valuable resource within the medical school and provide benefits for student tutors. Careful consideration needs to be given to ways in which student tutors are supported before, during and after the project. (Source: PubMed)


Schools of Nursing face the challenge of providing students with experiences to use evidence-based consumer centric care information tools. To facilitate this challenge, a unique partnership was forged between a school of nursing and a leading clinical information systems corporation. This strategic partnership was created to advance the field of nursing informatics through the sharing of intellectual capital. Through this sharing, the goal is to study how technology can promote patient safety, support
evidence-based care and facilitate consumer involvement in health care decisions. This paper describes the design, development and testing of a multimedia product that can be used by schools of nursing. This product can be integrated into a nursing curriculum to promote the use of informatics tools as an integral practice component. The multimedia product embraces the core competencies advocated by the Institute of Medicine's Health Professions Education Report. (Source: PubMed)

Paley, J. (2006). Evidence and expertise. *Nursing inquiry, 13*(2), 82-93. This paper evaluates attempts to defend established concepts of expertise and clinical judgement against the incursions of evidence-based practice. Two related arguments are considered. The first suggests that standard accounts of evidence-based practice imply an overly narrow view of 'evidence', and that a more inclusive concept, incorporating 'patterns of knowing' not recognised by the familiar evidence hierarchies, should be adopted. The second suggests that statistical generalisations cannot be applied non-problematically to individual patients in specific contexts, and points out that this is why we need clinical judgement. In evaluating the first argument, I propose a criterion for what counts as evidence. It is a minimalist criterion but the 'patterns of knowing', referred to in the literature, still fail to meet it. In evaluating the second argument, I will outline the powerful empirical reasons we have for thinking that decisions based on research evidence are usually better than decisions based on clinical judgement; and show that current efforts to rehabilitate clinical judgement seriously underestimate the strength of these reasons. By way of conclusion, I will sketch the ways in which the concept of expertise will have to be modified if we accept evidence-based practice as a template for health-care. (Source: PubMed)


This handbook prepared by the Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson Foundation provides a
comprehensive summary of important patient safety and quality improvement concepts for frontline nurses. Experts in each topic area reviewed the latest published evidence to assemble sections on providing patient-centered care, nurses' working conditions and work environment, critical opportunities for improving quality and safety, and practical tools for implementing patient safety interventions for practicing nurses.

(Source: Publisher)


A patient-centered model of care has profound implications for the way that care is planned, delivered, and evaluated. Although most leaders in healthcare organizations today embrace the basic tenets of a patient-centered philosophy, they often find that moving toward a patient-centered model requires an unanticipated level of commitment and significant adjustments in organizational structures. In this article, the authors describe how patients and families have been integrated into the care delivery model by involving them in planning, decision-making, and improvement processes at all levels of the organization. (Source: PubMed)


The concept of “knowing the patient” refers to the therapeutic decision making that enables nurses to individualize patient care. It is a product of experience in a nursing specialty, the time spent as a nurse, and the experience acquired in forming relationships with patients. Research has shown that nurses make clinical decisions more easily when they “know patients.” An innovative approach to care delivery that teams RNs and PCTs 1:1 promotes effective nurse-patient rounds and fosters RN and PCT teamwork. This care delivery model gives nurses a means to form important connections with patients as well as other caregivers to bring about more effective priority setting and decision making. A model of care
to support knowing patients has potential for improving patient outcomes. (Source: QSEN Team)

This article explores the philosophy of person-centred care. Person-centred care developed in response to the need for a more patient-sensitive healthcare service and is based on a rich understanding of the patient, his or her circumstances and needs. (Source: PubMed)

Promoting cultural competency in health care was examined from the Canadian perspective, and explored practice environments and educational programs for future health professionals that foster cultural awareness and support culturally sensitive care. Many of the issues raised are generic and likely to occur whenever patients' health practices and beliefs differ from conventional Western care. The main theme that emerged with respect to the practice environment was the use of a participatory action approach to foster collaboration with patients, traditional healers and the community. Successful collaboration is likely to result in a blend of ideas and perspectives from traditional health practices and conventional Western health care. With respect to education, programs need to focus on providing opportunities both in the classroom and in the clinical arena for students to work in interprofessional teams. These teams should not only comprise partners from medicine, nursing, physical therapy and other health professions but also include aboriginal paraprofessionals. Pedagogical initiatives also need to incorporate case-based formats and interactive sessions with patients and families. The principles underlying this approach: openness, mutual respect, inclusiveness, responsiveness and understanding one's roles should be fundamental to the delivery of culturally competent health care to all ethnic communities. (Source: PubMed)

**PURPOSE:** To examine relationships between patients' demographic characteristics and patients' reports of patient-centered care. **DESIGN:** Secondary analysis of data (N = 423) from a study in the northeastern United States focused on the psychometric properties of the Oncology Patients' Perceptions of the Quality of Nursing Care Scale (OPPQNCS). **METHODS:** The quality of four interpersonal nursing interventions, representing patient-centered nursing care, was measured with the OPPQNCS subscales. Patients' characteristics included race (White or non-White), sex, age, education, income, and hospitalization for cancer. Four separate ordinary least squares regression models were constructed. **FINDINGS:** Hospitalization was inversely related to intervention quality in each model. Income was the only statistically significant characteristic for nonhospitalized patients, and only in the coordination model. For hospitalized patients, education was statistically significant in the coordination model, and income in the proficiency model. An interaction term for education and income was statistically significant in the responsiveness model, and a term for gender and education in the individualization model. **CONCLUSIONS:** Hospitalized patients' exposure to nursing care may indicate a wider range of care quality than for nonhospitalized patients, possibly accounting for the inverse relationship between hospitalization and patient-centered care. Groups identified at risk for lower quality care--minorities, women, elders, and people in low-income groups--did not report a lower level of patient-centered nursing care. Nurses' contributions to patient-centered care and care equity are important components of care quality, particularly for hospitalized cancer patients. (Source: PubMed)

BACKGROUND: Experts continue to decry the lack of progress made in decreasing the alarming frequency of medical errors in health care organizations. At the same time, other experts are concerned about the lack of job satisfaction and turnover among nurses. Research and theory suggest that a work environment that facilitates patient-centered care should increase patient safety and nurse satisfaction. PURPOSES: The present study began with a conceptual model that specifies how work environment variables should be related to both nurse and patient outcomes. Specifically, we proposed that health care work units with climates for patient-centered care should have nurses who are more satisfied with their jobs. Such units should also have higher levels of patient safety, with fewer medication errors. METHODOLOGY/APPROACH: We examined perceptions of nurses from three acute care hospitals in the eastern United States. FINDINGS: Nurses who perceived their work units as more patient centered were significantly more satisfied with their jobs than were those whose units were perceived as less patient centered. Those whose work units were more patient centered reported that medication errors occurred less frequently in their units and said that they felt more comfortable reporting errors and near-misses than those in less patient-centered units. PRACTICE IMPLICATIONS: Patients and quality leaders continue to call for delivery of patient-centered care. If climates that facilitate such care are also related to improved patient safety and nurse satisfaction, proactive, patient-centered management of the work environment could result in improved patient, employee, and organizational outcomes. (Source: PubMed)

Redman, R. W., & Lynn, M. R. (2004). Advancing patient-centred care through knowledge development. The Canadian journal of nursing research = Revue canadienne de recherche en sciences infirmieres, 36(3), 116-129. The call for health-care services that are patient-centred raises the need for knowledge development in both the conceptual and empirical domains. The definitions and operational elements of patient-centred care present a
variety of conceptual issues. A common element in all definitions is accommodation of patient wants, preferences, and expectations. In the research domain, intervention studies face both design and measurement challenges. These include the development of interventions that are patient-centred or tailored for both patient characteristics and the environment in which they will be delivered. By addressing these critical issues, nursing can play a key role in advancing intervention science and knowledge development in the domain of patient-centred care. (Source: PubMed)


Understanding power and learning how to use it is critical if nurses' efforts to shape their practice and work environments are to be successful. As part of our efforts to develop a Fast-Track BSN-to-PhD nursing program, we met with nurse leaders from six organizations to explore what power means, how nurses acquire it, and how they demonstrate it in their practice. Through these discussions, we identified eight characteristics of powerful nursing practice that, together, form a framework that can guide nurses' efforts to develop a powerful practice and shape the health care delivery settings and academic institutions in which they work. In this article we review recent studies of organizational power and share discussions which helped us better understand nursing power and the ways in which it is manifested. We also reflect on what power means for individual nurses and the profession and discuss how our insights influenced our Fast-Track program. (Source: PubMed)


Healthcare's increasing focus on quality and safety seem like a "natural" for nursing. The profession has prided itself in being the patient's advocate and the keeper of quality and safety. While nursing has clearly provided
consistent and committed leadership in these arenas, it is also possible that exclusive professional ownership of quality and safety may actually work against the best interest of both nursing and patients. This editorial challenges nursing to reconsider its role in and approach to quality and safety improvement. Building on the important perspectives presented in this issue of Nursing Outlook, the author identifies the need for nursing to advance its own professional contributions through building on the shared values and commitments common to health professions. Establishing common ground and extending the concept of care teams to incorporate others beyond direct-care providers are explored as a fundamental component of nursing's work in quality and safety improvement. (Source: PubMed)

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)


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)

This article is about a teaching strategy that operationalizes an aspect of the National League for Nurses' position statement "Transforming Nursing Education" and the Institute of Medicine's report "Crossing the Quality Chasm." Engaging students with patients' first-person experiences related to health and illness and their experiences with health care can help students learn about the multiplicity of views on experience, help them focus on the patient as an individual, and heed the call for more patient-centered care. This article describes how an interpretive research group can be used to develop these skills by teaching undergraduate nursing students, in a caring, open environment, what life is like from the patient's perspective. (Source: PubMed)

Health care delivery settings are redesigning in the wake of staggering reports of severe quality and safety issues. Sweeping changes underway in health care to address quality and safety outcomes lend urgency to the call to transform nursing curricula so new graduate competencies more closely match practice needs. Emerging views of quality and safety and related competencies as applied in practice have corresponding implications for the redesign of nursing education programs. Nurse executives and nurse educators are called to address the need for faculty development through
strategic partnerships. (Source: PubMed)


**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)

practice expectations and created a mandate for change in the preparation of health care professionals. The Quality and Safety Education for Nurses project team conducted a survey to assess current levels of integration of quality and safety content in pre-licensure nursing curricula. Views of 195 nursing program leaders are presented, including information about satisfaction with faculty expertise and student competency development related to 6 domains that define quality and safety content: patient-centered care, teamwork and collaboration, evidence-based practice, quality improvement, safety, and informatics. With competency definitions as the sole reference point, survey respondents indicated that quality and safety content was embedded in current curricula, and they were generally satisfied that students were developing the desired competencies. These data are contrasted with work reported elsewhere in this issue of Nursing Outlook and readers are invited to consider a variety of interpretations of the differences. (Source:PubMed)


OBJECTIVE: To determine the effect of intensive patient-centered management (PCM) on service utilization and survival. STUDY DESIGN: Prospective cohort study of 756 patients in California who had a life-limiting diagnosis with multiple comorbid conditions (75% were oncology patients) and who were covered by a large commercial health maintenance organization from February 2003 through December 2004. METHODS: Group membership determined assignment to the PCM cohort versus the usual-management cohort after blindly screening for clinical complexity. Both cohorts accessed the same delivery system, utilization management practices, and benefits. Intervention was intensive PCM, involving education, home visits, frequent contact, and goal-oriented care plans. RESULTS: Roughly half (358) of the 756 patients received PCM. Fewer PCM oncology patients elected either chemotherapy or radiation (42% increase over usual-management oncology patients). PCM patients had reductions in
inpatient diagnoses indicative of uncoordinated care: nausea (-44%),
anemia (-33%), and dehydration (-17%). PCM patients had utilization
reductions: -38% inpatient admissions (95% confidence interval [CI] =
-37%, -38%), -36% inpatient hospital days (95% CI = -35%, -37%), and
-30% emergency department visits (95% CI = -29%, -31%). PCM patients
had utilization increases: 22% more home care days (95% CI = 20%,
23%) and 62% more hospice days (95% CI = 56%, 67%). Overall costs
were reduced by 26% (95% CI = 25%, 27%). Patients' lives were not
shortened (26% of PCM patients died vs 28% of patients who received
usual management) (P = .80). CONCLUSION: Comprehensive PCM can
sharply reduce utilization and costs over usual management without
shortening life. (Source: PubMed)

Tarini, B. A., Christakis, D. A., & Lozano, P. (2007). Toward family-
centered inpatient medical care: the role of parents as participants in
medical decisions. The Journal of pediatrics, 151(6), 690-5, 695.e1.
OBJECTIVES: To determine parental participation in medical decision-
making (MDM) during hospitalization and its association with parental self-
efficacy and to explore other factors associated with participation. STUDY
DESIGN: We surveyed parents of children admitted to a pediatric medical
unit to measure parental report of participation in MDM during
hospitalization and self-efficacy with physician interactions (categorized
into tertiles). We performed multivariate logistic regression to evaluate the
association between self-efficacy and parental participation, controlling for
potential confounders. RESULTS: One hundred thirty of 278 eligible parents
completed surveys and 86% reported participating in MDM about their
child’s care. After adjusting for covariates, parents with scores in the
middle and highest self-efficacy tertiles had higher odds of participating in
MDM compared with parents in the lowest tertile. Younger parents and
parents of previously hospitalized children were also more likely to
participate although parents with a high school education or less were less
likely. CONCLUSIONS: Self-efficacy was significantly associated with
parental participation in MDM during hospitalization after adjusting for
confounding factors. Interventions to increase self-efficacy may also improve parental participation in MDM. (Source: PubMed)

Thornton, L. (2005). The model of whole-person caring: Creating and sustaining a healing environment. *Holistic nursing practice, 19*(3), 106-115. At Three Rivers Community Hospital, Grants Pass, Oregon, the theoretical Model of Whole-Person Caring has resulted in quantifiable and sustainable results in the areas of increased patient and employee satisfaction and decreased nursing turnover, and serves as the foundation for a comprehensive healing environment. The model is a useful framework for healthcare education and its utilization as the theoretical construct for The New England School of Whole-Health Education illustrates its congruency in an educational setting. (Source: PubMed)


**PURPOSE:** Patient-centredness should be at the heart of medical education. This longitudinal study aimed to assess possible attitude changes towards patient-centredness in a medical students' cohort as they progressed through the clinical curriculum. It also investigated the possible impact of socio-demographic factors on students' attitudes.

**METHODS:** The same student cohort was tested on 2 occasions: during their initial exposure to clinical curricula (year 4) and after 2 years, at the end of the clerkship (year 6). Students completed a questionnaire including demographics and the 18-item Patient-Practitioner Orientation Scale (PPOS). PPOS differentiates between patient-centred versus doctor-centred or disease-centred orientation, measuring attitudes along 2 dimensions: 'sharing' and 'caring'.

**RESULTS:** A total of 483 fully completed questionnaires was returned (response rate 83%). The cohort's attitudes were significantly more doctor-centred at the end of their studies compared to the beginning of their clinical curricula ($P < 0.001$). However, regarding the caring part of their relationship with patients, they maintained a satisfactory level of
patient-centredness. Concerning sharing information, female students were significantly more patient-centred at year 4, with their mean score decreasing at the end of their clerkship. Furthermore, among only female students, having a looser relationship with religion was associated with more patient-centred attitudes. CONCLUSIONS: Increased authoritarianism in graduating students' attitudes emphasises clearly the need for future research and redesigning communication curricula. Furthermore, the influence of gender and relationship with religion on attitudes towards the doctor-patient relationship should be explored further, in order to eliminate disparities in the provision of patient-centred medical care. (Source: PubMed)


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)


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)
Collaborative Care refers to a partnership between healthcare professionals and patients who feel confident to manage their health conditions. Using an Internet-based assessment of health needs and healthcare quality, we surveyed 24,609 adult Americans aged 19 to 69 who had common chronic diseases or significant dysfunction. In these patients, we examined the association of Collaborative Care with specific measures for treatment effect, disease control, prevention, and economic impacts. These measures were adjusted for respondents' demographic characteristics, burden of illness, health behaviors, and overall quality of healthcare. Only 21% of respondents participated in good Collaborative Care, 36% attained fair Collaborative Care, and 43% experienced poor Collaborative Care. Regardless of overall care quality or the respondents' personal characteristics, burden of illness, or health behaviors, good Collaborative Care was associated with better control of blood pressure, blood glucose level, serum cholesterol level, and treatment effectiveness for pain and emotional problems. Some preventive actions were better, and some adverse economic impacts of illness were mitigated. (Source: PubMed)

Wayman, K. I., Yaeger, K. A., Sharek, P. J., Trotter, S., Wise, L., Flora, J. A., et al. (2007). Simulation-based medical error disclosure training for pediatric healthcare professionals. *Journal for healthcare quality: Official publication of the National Association for Healthcare Quality, 29*(4), 12-19. Ethical and regulatory guidelines recommend disclosure of medical errors to patients and families. Yet few studies examine how to effectively train healthcare professionals to deliver communications about adverse events to family members of affected pediatric patients. This pilot study uses a preintervention-postintervention study design to investigate the effects of medical error disclosure training in a simulated setting for pediatric oncology nurses (N=16). The results of a paired t test showed statistically
significant increases in nurses' communication self-efficacy to carry out medical disclosure ($t = 6.68$, $p < .001$). Ratings of setting "realism" and simulation effectiveness were high (21 out of 25 composite score). Findings provide preliminary support for further research on simulation-based disclosure training for healthcare professionals. (Source: PubMed)

An innovative approach was employed to help undergraduate student nurses prepare for a practice placement working with older people. The method involved the use of life histories as a means of gaining insight into the unique experiences of individuals and how those experiences help shape the person. This narrative approach is valuable in assessing need and in ensuring that the care provided is of a high standard. Research suggests that it can also help boost the quality of life of older people and the self-esteem of the staff involved. To contextualise this subject, a brief overview of the relevant demographics of this client group is offered to help set the scene of the care environments in which the students were to be placed. (Source: PubMed)

Throughout the country, use of electronic health records continues to increase. For successful implementation of an electronic health record system in an acute care setting, it is vital to educate and address the patient's perceptions about the use of technology when caring for the patient. This article describes the development of an educational sensitivity tool designed to enhance clinicians' simultaneous interactions with patients and computers in a midsize community hospital. The Patient First tool brings attention to the thoughts and perceptions a patient may have in various situations, promoting alternative solutions for staff to properly address the patient's concerns. A committee was developed to address concerns regarding the impact a computer at the bedside would have on
patient and clinician interactions. One primary educational tool developed was the Patient First sensitivity presentation that cautioned and guided clinicians to be aware of patient perceptions. (Source: PubMed)


As patient populations become increasingly diverse, health care organizations are looking for innovative ways to communicate effectively across cultures, languages, and health literacy levels. This study identified eight hospitals from across the country that have demonstrated a commitment to providing patient-centered communication with vulnerable patient populations. Through site visits and focus group discussions, the authors draw out “promising practices” from the hospital’s efforts to lower language barriers and ensure safe, clear, and effective health care interactions. The promising practices include: having passionate champions to advocate for communication programs; collecting information on patient needs; engaging communities; developing a diverse and skilled workforce; involving patients; spreading awareness of cultural diversity; providing effective language assistance services; addressing low health literacy; and tracking performance over time. Hospital and health system leaders can use these practices as starting points to encourage patient-centered communication in their own organizations. (Source: Publisher)