Exploring the Person-centred Care Practice Patterns of Mental Health Nurses: A Concurrent Mixed Methods Study

Chantille Irene Isler

Faculty of Nursing, Memorial University of Newfoundland

A dissertation submitted to the School of Graduate Studies in partial fulfillment for the degree of Doctor of Philosophy Faculty of Nursing

March 2024

Abstract

Aim: To understand the person-centred care practice patterns of mental health nurses in one Atlantic Canadian province.

Background: There is emphasis on person-centred care within mental health services, yet, person-centred care is often poorly understood and operationalized by health care professionals. Mental health nurses' person-centred practices remain unclear, as there is limited research on their practices.

Design: The Person-centred Practice Framework (McCormack & McCance, 2016), comprising of 17 constructs spanning three domains essential for implementing person-centred care, was the theoretical framework for this concurrent mixed methods study. The quantitative portion of the study was a descriptive cross-sectional design and both interviews and participant observation comprised the qualitative portion. Interpretive description, a nursing methodology, guided the qualitative components of the study. In the integration phase, the analytic technique of merging established the alignment among complementary data within the three sets of study findings.

Methods: Seventy Registered Nurses across one Atlantic Canadian province completed the survey package consisting of: 1) the person-centred practice inventory (Slater et al., 2017), 2) the person-centred climate questionnaire (Edvardsson et al. 2010), and 3) 13 demographic and work-related questions. Interviews occurred with eight individuals who had received recent inpatient mental health care in the province. Thirty-six hours of participant observation were conducted on three adult inpatient mental health units. The Pillar Integration Process, a four-stage procedure designed to integrate qualitative and quantitative data using joint display tables, guided the integration.

Results: Three patterns were developed from the integrated data that described how nurses conduct and navigate their practice within the care environment: 1) mental health nurses maintain a separation from patients and often deliver nursing care from a distance, 2) mental health nurses practice in an organizational culture that supports the status quo, which is not person-centred care, and 3) when mental health nurses and individuals co-engage in person-centred moments, the results are inspiring and foster hope. The results of each component of the study are presented throughout the dissertation.

Conclusion: Nurses face organizational and personal barriers in their delivery of person-centred care. Although person-centred moments were infrequent, they are valued by those who receive care. Advancing beyond discrete moments of person-centred care requires a sustained commitment from both health care professionals and the organization within which they work. Organizations should evaluate current practices and structures to ensure nurses are optimally positioned to provide person-centred care.

Acknowledgements

I would like to thank my family and friends for all of their encouragement and support since I began this academic journey. I would especially like to thank my husband, Bursin, for his unwavering love and support as well as my son Sawyer for his unconditional love.

I would like to wholeheartedly thank my PhD supervisor, Dr Joy Maddigan, who has been a constant source of knowledge, encouragement, and guidance. I would also like to acknowledge and thank my PhD committee members, Dr. Alice Gaudine and Dr. Robin Burry, for their insight, encouragement, and commitment. I would also like to thank my classmate, Daisy Baldwin, who has been consistently supportive and encouraging throughout the PhD program.

I would like to thank others who helped in the research process. I would like to thank Dr. Donna Moralejo for her significant contribution to the quantitative data analysis. I would like to thank my research assistant, Ahmad Deeb, for his assistance with reviewing the quantitative analysis and results. I would also like to thank my research assistant, Rebecca Druken, for her assistance in collecting participant observation data. I would also like to acknowledge Michelle Swab at the Memorial University Health Sciences Library for her assistance throughout the PhD program.

Finally, I will be forever grateful to those who agreed to participate in this dissertation research. I am also thankful to the community agency and its member who formed the experience-expert advisory group for the study. Their input was valuable to study development.

Table of Contents

List of Appendices

Chapter 1: Literature Review and Overview of the Study

Chapter 1 summarizes the narrative literature review conducted on the topic of person-centred mental health nursing care. An overview of the mixed methods research study is provided, along with a description of the manuscripts that follow in this dissertation.

Exploring the Person-centred Care Practice Patterns of Mental Health Nurses: A Concurrent Mixed Methods Study

Person-centred care (PCC) is a global phenomenon that underpins both national and international health care policy (McCormack et al., 2015; Phelan et al., 2020; World Health Organization (WHO) (WHO, 2015). Since 2009, the WHO has committed to putting people at the centre of health care (WHO, 2015). Person-centred health services are described as "…an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in humane and holistic ways" (WHO, 2015, p. 7). PCC is endorsed by many health care organizations in Canada, including the Canadian Nursing Association (CNA) (CNA, 2011). In essence, PCC is the humanising of health care delivery by prioritizing the needs and preferences of individuals and families rather than the needs of health care professionals, the tasks of care, or the disease (McCormack et al., 2015; Morgan & Yoder, 2012; Phelan et al., 2020; WHO, 2015).

PCC is a central pillar of high-quality health care (Institute of Medicine, 2001). It has distinct measurement approaches (van Diepen et al., 2020) and has been linked to improved patient outcomes (Ballard et al., 2018; Ekman et al., 2012; Fors et al., 2015; Olsson et al., 2014; Wynia et al., 2018), satisfaction of care (Allerby et al., 2020; Kuipers et al., 2019; Rossom et al., 2016), as well as job satisfaction for nurses (den Boer et al., 2017; van Diepen et al., 2020; Lehuluante et al., 2012). However, issues such as traditional practices and structure, professional attitudes, and time constraints of staff can limit the operationalization of PCC in some health care settings (Moore et al., 2017). Further, stigma, marginalization, social disconnection, disempowerment, and restrictions in exercising human rights can impact those receiving mental

health care and creates additional challenges in moving PCC from rhetoric to reality (Smith & Williams, 2016). Therefore, the operationalization of PCC in mental health care settings has been challenging and limited (Choy-Brown et al., 2020; Hsiao et al., 2019).

Despite the obstacles to delivering PCC, many health organizations report both supporting and providing PCC (Montague et al., 2017; Canadian Medical Association and Canadian Nurses Association (CMA & CNA), 2011). However, the state of person-centred mental health nursing care in Canada is not well established. There was no existing literature located detailing the extent to which nurses working with mental health clients are engaging in PCC in Canada. There is a need to address this gap and produce quality information on the delivery of PCC in mental health settings. Therefore, the purpose of this study is to examine the nature and extent of PCC practices demonstrated by mental health nurses in one Atlantic Canadian province.

Background

PCC is a health care priority for patients, families, and health systems (Montague et al., 2017). In an online self-report survey conducted to determine PCC practices and indicators operationalized within Canadian health care systems, 92% reported practicing PCC and the remaining organizations reported valuing PCC with plans of working towards it (Doktorchick et al., 2018). The health organization that was the primary setting for this study reported that PCC occurs systemically throughout the organization (Doktorchick et al., 2018). While somewhat encouraging, the survey did not provide clear evidence of the PCC practices of mental health nurses in that province.

Those living with mental illness face disempowerment, forms of coercion, questions regarding decisional capacity, and other unique challenges that have the potential to impact their

person-centred health care experiences (Beitinger et al. 2014; Morant et al., 2015). For health care professionals working with those with a mental illness, upholding person-centred principles, such as working with each person's beliefs and values and sharing decision-making, may be challenging (Smith & Williams, 2016). Mental health nurses, for example, navigate the conflicting responsibility of protecting the patient and the community from harm, while continuing to empower individuals through support for the dignity of risk and the right to fail (Deegan, 1996). There is a growing belief in the mental health community that individuals availing of mental health services have the right to make their own decisions and take their own risks (Davidson et al., 2015). Consequently, it has then been argued that nurses and other health professionals should only use their authority when the evidence compellingly indicates the person or community is at risk (Davidson et al., 2015). Despite widespread support for shared decision-making between mental health nurses and individuals in their care (Beitinger et al., 2014; Hamann & Heres, 2014; Puschner et al., 2016), implementation remains challenging and limited (Farrelly et al., 2015; The Schizophrenia Commission, 2012) with routine clinical practices prevailing (Morant et al., 2015; Royal College of Psychiatrists, 2014).

Effective mental health nursing care is underpinned by a person-centred and recovery-oriented approach focused on collaborative interpersonal relationships as well as working holistically and with patient beliefs and values (Gabrielsson et al., 2016; Tofthagen et al., 2014). PCC is increasingly being regarded as a core component of the recovery movement in mental health care (Hummelvoll et al., 2015; Slade et al.,2014). Developing sustainable person-centred practices requires a comprehensive approach that extends beyond individual interactions; it requires sustained commitment from entire health care organizations (Edgar et al., 2020). Without an organisational commitment to person-centred practices, tension is likely to arise

between organizational policies and the ideals of health care professionals (Edgar et al., 2020; Parley, 2001). Organizational commitment to the cultivation of person-centred cultures is required for sustained PCC (McCormack et al., 2018). A person-centred culture is exemplified by a practice environment that promotes the following seven characteristics: i) effective coordination of patient and family care, ii) strong clinical leadership, iii) facilitation, iv) effective teamwork, v) knowledgeable and skilled health care professionals, vi) a flexible model of care, and vii) a systemic person-centred vision (McCance et al., 2013).

Despite Canadian reports stating that PCC occurs systemically throughout the health system, there was limited information regarding specific efforts to implement or maintain this significant cultural shift within Mental Health & Addictions services on one Atlantic Canadian Province. This includes a review of studies and documents that address recovery-oriented care, as the research team acknowledges that recovery-oriented practice incorporates PCC as a clear and distinctive feature (Hummelvoll et al., 2015; Slade et al., 2014). The lack of implementation evidence suggests that person-centred mental health nursing care is not yet operationalized locally.

Nurses are the health care professionals who spend the most time with patients (Molina-Mula et al., 2017) and they use themselves as therapeutic tools through nurse–patient relationships (Oh & Nam, 2018). In order to advance person-centred mental health nursing care within this Atlantic Canadian province, more information is needed on the PCC practices that currently exist. This study will begin to address this gap in knowledge.

Organization of Dissertation

This is a five-chapter, paper-based, mixed methods dissertation. This chapter, Chapter 1, contains a comprehensive literature review highlighting the gap in research, outlines the research

questions and study framework, and provides an overview of the full mixed methods study. Chapters 2, 3 and 4 are yet-to-be published manuscripts that report on the quantitative descriptive cross-sectional component, the qualitative interview component, and the integration analysis component respectively. The second qualitative method used in the study, participant observation, will be developed as a publishable manuscript upon completion of the dissertation. The results are presented in this dissertation in Chapter 1 and further summarized in Chapter 4 as they were included in the integration and assisted to inform study recommendations. The final chapter, Chapter 5, summarizes the entirety of the mixed methods study and describes potential future opportunities in education, practice, research, and policy.

Literature Review

Search Strategy

To more fully explore person-centred nursing care, a narrative literature review that appraised the quality and strength of the evidence was developed. The search strategy included four databases, CINAHL, PubMed, Psych INFO, and Cochrane Library and included the following search terms: ‘person-centred care’ OR ‘patient-centred care’ OR ‘family-centred care’ and ‘nurs*’. The search timeframe was from inception to August 2023 to capture the relevant history of PCC. Only academic publications were considered; opinion papers, dissertations, commentary articles, and letters to editor were excluded. Only articles that could be retrieved in full text from the university library were considered. Non-English-language publications were also excluded. The reference lists of included articles were hand searched for additional studies. Quantitative studies included in the review were critically appraised using the Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit (PHAC, 2014). Qualitative

studies included in the review were critically appraised using the Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Qualitative Research (Lockwood et al., 2015).

Person-centred Care

PCC is an evolving concept with a long history and tradition in health care (Morgan & Yoder, 2012; Santana et al., 2018). The following sections outline the history, existing definitions, and defining attributes of PCC.

History

It could be argued that the origins of PCC, in a nursing context, trace back to Florence Nightingale (1860) when she differentiated nursing from medicine with the emphasis on the individual rather than the disease (Lauver et al., 2002). However, the term *patient-centred medicine* was first coined by physician, Edith Balint, in the 1960s, who placed emphasis on understanding the patient as a unique human being (Balint, 1968). In the late 1980's, *The Picker-Commonwealth Program for Patient-Centred Care*, a private research foundation in the US, began to promote PCC as a way of delivering health services that focused on patients' individual needs (Beatrice et al., 1998). Studies conducted by the research foundation identified that patient preferences were too often ignored or overlooked. Consequently, these findings resulted in the development of seven, patient-identified, priority dimensions of care: 1) respect for patients' preferences; 2) coordination of care; 3) information and education about their health issues; 4) physical comfort; 5) emotional support; 6) involvement of friends and family; and 7) continuity of care and transition to home needs (Beatrice et al., 1998). The foundation was also the first to highlight the significance of organizational involvement in PCC (Morgan & Yoder, 2012). In the 1990's the importance of interpersonal relationship between the care provider and those receiving care was highlights (Peplau, 1997; Stewart et al., 1995).

With the 2000s came literature that further clarified the dimensions of PCC. Mead and Bower (2000) developed a PCC conceptual framework that provided initial insights on how to operationalize PCC within medicine. The framework had two measurement approaches and five dimensions of care: i) biopsychosocial perspective, ii) patient as person, iii) shared power and responsibility, iv) therapeutic alliance, and v) doctor as person. The Institute of Medicine (IOM) (IOM, 2001) "Crossing the Quality Chasm" report contributed to the surge in publications focused on PCC (Morgan & Yoder, 2012). PCC was identified as a critical element to address America's fragmented and impersonal health care system (IOM, 2001). At the same time Brendan McCormack, a British nurse, started publishing research about PCC of the elderly (McCormack, 2001, 2003, 2004). He published a PCC conceptual framework in gerontological nursing (McCormack, 2003) before working with a colleague to developing the *Framework for Person-centred Nursing* (McCormack & McCance, 2006). The title was later revised to the *Person-centred Practice Framework* to establish its relevancy to other health care providers as well as nurses (McCormack & McCance 2016). Although the Person-centred Practice Framework appears to dominate the PCC literature, other existing frameworks also provide insight (Jayadevappa & Chhatre, 2011; McKay et al., 2020; Santana et al., 2018). For example, *RAISe* (Relationship, Agency, Information, Safe environment), a conceptual framework, was developed to assist health care professionals in applying PCC within coercive mental health care environments (McKay et al, 2020).

Several concept analyses of PCC have been published in the nursing literature and also contributed to its development. For example, Slater (2006) identified four antecedents (dignity, autonomy, respect, and therapeutic relationship), three attributes (individuality, respecting values, and empowerment), and two consequences (improved health outcomes and perceived

improved relationships) of PCC. In a later concept analysis, Hobbs (2009) highlighted therapeutic engagement as the main attribute and process with effective care, less suffering, and resolved needs as the consequences of PCC. Since that time, several other PCC concept analyses have been published (Lusk & Fater, 2013; Ogden et al., 2017), one of which focused on PCC in the context of inpatient psychiatric nursing (Gabrielsson et al., 2015). In this analysis, Gabrielsson et al. (2015) described PCC in inpatient psychiatry as cultural, relational, and recovery-oriented. They described the intersection between the principles of PCC and the concepts underpinning recovery and interpersonal nursing and concluded that future PCC work should consider the contexts at both conceptual and praxis levels (Gabrielsson et al., 2015).

Definitions

PCC is a multidimensional, yet nebulous concept, which creates difficulty in articulating a clear, shared definition (McCance et al., 2011; Morgan & Yoder, 2012). There is no universally accepted definition of PCC in the literature which is problematic because the way PCC is defined often influences how it is measured (de Silva., 2014). For example, the IOM (2001) defined PCC as "care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (p. 49). Since that time there has been further development and clarification of the meaning of PCC. McCormack (2003) defined PCC as "the formation of a therapeutic narrative between professional and patient that is built on mutual trust, understanding and a sharing of collective knowledge" (p. 203). Providing a similar but more detailed definition Drach-Zahavy (2009) defined PCC as "understanding the personal meaning of the illness for the patient by eliciting their concerns, ideas, expectations, needs, feelings and functioning; promoting the understanding of the patient within their unique psychosocial context; sharing power and responsibility, and developing common therapeutic

goals that are concordant with the patient's values" (p. 1465). McCormack et al. (2013) then shifted their definition of PCC by placing a significance on person-centred cultures. Their definition best aligns with the framework of this study:

> An approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development (McCormack et al., 2013, p. 193).

Defining Attributes

Despite the absence of a shared definition, six common attributes have been identified across many definitions of PCC. These attributes are core features of the phenomenon and provide a sound foundation for PCC research and practice. The attributes are: 1) establishing a therapeutic relationship; 2) shared power and responsibility; 3) getting to know the person; 4) facilitating personal empowerment; 5) trust and respect; and 6) communication (Sharma et al., 2015).

Therapeutic engagement takes place when nurses engage with individuals by actively listening, comprehending, and responding to their needs, all the while nurturing emotional and personal growth (McAllister et al., 2021). The importance of establishing a therapeutic relationship between the health care provider and person receiving care was a commonly described attribute of PCC (Hobbs, 2009; Holmström & Röing, 2010; Kitson et al., 2013; McCormack & McCance, 2016; National Aging Research Institute (NARI), 2006; Pelzang, 2010; Robinson et al., 2008).

Several studies identified the importance of persons being active participants in their care (Holmström & Röing, 2010; McCormack & McCance, 2016; Morgan & Yoder, 2012; NARI, 2006; Pelzang, 2010; Robinson et al., 2008). One review stated that it is central to the role of health care professionals to provide persons with support to make decisions about their health based on what is best for them (Pelzang, 2010). When persons are involved in decision-making, the care provided is based on the patient's self-identified needs, wishes, and values (Morgan & Yoder, 2012; NARI, 2006; Pelzang, 2010; Robinson et al., 2008). In order to do this, health care professionals must look past the illness and learn more about the care recipient (NARI, 2006; Pelzang, 2010; McCormack & McCance, 2016). Therefore, trust and respect are also integral to PCC (Holmström & Röing, 2010; McCormack & McCance, 2016; Morgan & Yoder, 2012; NARI, 2006; Pelzang, 2010; Slater, 2006) as they are required in order to understand each person as a unique individual with their own values, needs, and lived experiences (Pelzang, 2010; Slater, 2006). To understand each person as an individual, nurses must spend time getting to know their patients. This requires an established connection between the person, their family, and health professionals (Holmström & Röing, 2010; Pelzang, 2010). It involves providing the person, and those close to them, with clear and accurate information about their care (Holmström & Röing, 2010; Pelzang, 2010) as well as understanding what is important to them.

Operationalizing Person-centred Care

Nurses are in a strategic position to provide PCC as they are the core of comprehensive care delivery in a variety of health care settings (Cusack et al., 2017). Further, many PCC attributes align with the Code of Ethics for Registered Nurses (CNA, 2017). Commonalities include the importance of therapeutic relationships, trust, respect, power differentials, and therapeutic communication. This cohesion suggests PCC is a safe and ethical nursing practice

(Sharma et al., 2015), a notion supported by nursing scholars. Dr. Sally Thorne, a Canadian nurse, positioned PCC as a core element of nursing. In fact, she places it at the centre, stating that PCC, "is so fundamental to nursing's theoretical, ethical, and philosophical core that, arguably, it constitutes the central idea from which nursing has distinguished itself from all other health care professions over time" (Thorne & Stajduhar, 2017, p. 24). However, Thorne and Stajduhar (2017) pointed out that embedding PCC into practice is challenging for many reasons, one being that the current health care system is resistant to change. The next sections will focus on the operationalization of PCC, including prevalence, barriers, and impact of PCC.

Prevalence

There is very limited literature describing the prevalence of PCC in mental health settings. Further, the WHO (2015) indicated that there is no universally accepted way to measure progress in establishing PCC. Therefore, the prevalence of PCC delivered by mental health nurses remains unclear. In one survey of 704 acute care registered nurses from the United Kingdom working in diverse areas, including psychiatry, high levels of PCC were reported (Slater et al., 2015). Similarly, American health service users of a supportive housing agency indicated a moderate to high mean score for PCC (Hamovitch et al., 2018). Livingston et al. (2012) also found characteristics of PCC were present in varying degrees within a Canadian forensic hospital.

Participants in other studies indicated that PCC is not being operationalized in mental health. For example, family-centred care was reported to be inadequate by family caregivers in Taiwan (Hsiao et al. 2019). Similarly, American health care professionals working in the community demonstrated low levels of competency in person-centred care planning (PCCP) and also lacked the training and support needed to implement PCC consistently (Choy-Brow et al.

2020). In another American study only 15% of community mental health staff rated themselves as high PCCP implementers (Matthews et al., 2018).

Barriers

Moore et al. (2017) identified barriers to the implementation of PCC through interviews with 18 Swedish researchers who had conducted seven different PCC intervention studies. Common barriers included: 1) traditional practices and structure, 2) time constraints, and 3) professional attitudes (Moore et al., 2017). Participants indicated that traditional care pathways often restrict health care professionals from navigating away from 'usual care' to use new and different strategies (Moore et al., 2017). In addition, existing power structures that place physicians at the top of the power hierarchy were problematic in implementing PCC (Moore et al., 2017). Similarly, The Registered Nurses Association of Ontario (RNAO) indicated that lack of autonomy for nurses within an organization is a barrier to their ability to deliver PCC (RNAO, 2015). The NARI and the RNAO advocate that health care organizations establish policies and procedures that promote the autonomy of nurses to practice PCC (NARI, 2006: RNAO, 2015). The physical structure of care spaces can also impact PCC. Environmental constraints, such as lack of space for private conversations, was identified as a barrier to PCC on acute inpatient units in Australia (Lloyd et al., 2018).

Developing person-centred partnerships as well as staff training and education are important, but time consuming, activities required for the implementation of PCC (Moore et al., 2018). Several researchers interviewed by Moore et al. (2017) indicated that time constraints negatively impacted PCC. High staff workloads and time pressures were also barriers to PCC for health care professionals in Australia (Lloyd et al., 2018). Staff shortages and associated large caseloads result in insufficient time spent with the individuals receiving care and inconsistent

patient assignments (Foster et al., 2010; NARI, 2006; Pelzang, 2010). For example, nurses working in China indicated that large caseloads made it difficult to find adequate time to engage patients and families (Wong et al., 2014). For PCC to be possible, health care organizations require a model of care that improves patients' access to nurses and encourages them to spend more time discussing care (RNAO, 2015).

Many studies indicate that professional attitudes can be a barrier to PCC (Lloyd et al. 2018; Moore et al., 2017). For example, managers in an Australian hospital identified unsupportive staff attitudes, including cynical views towards family-centred care, inflexible decision-making, and little interest towards change, as barriers to family-centred care (Lloyd et al., 2018). In a discussion of barriers to PCC in Ontario, Canada, informants indicated that PCC becomes 'the luck of the draw' for service users in terms of receiving a health care provider who has the personal will to work around the heavy constraints of the health care system and make a concerted effort to provide PCC (Kuluski et al., 2013; Kuluski et al., 2016). Maintaining a PCC approach requires a conscious effort on behalf of care providers (Moore et al., 2017). After learning to provide care using a PCC approach, staff have been reported to often fall back into the practice of 'usual care,' perhaps because of a lack of interest, sufficient knowledge, or commitment (Moore et al., 2017).

Impact

PCC has several potential benefits including improved health outcomes for individuals and families, satisfaction with the care received, and increased job satisfaction for nurses. In non-psychiatric settings, associations between PCC and improved patient outcomes have been widely documented (Allerby et al., 2020). Shorter hospital stays and better functional performance are also common findings in the PCC literature (Ballard et al., 2018; Ekman et al., 2012; Fors et al.,

2015; Olsson et al., 2014; Wynia et al., 2018). However, relatively few studies have examined PCC and patient outcomes in mental health settings (Allerby et al., 2020). In one Canadian study, an electronic care planning system aimed at improving PCC in acute care mental health settings was found to decrease symptoms of aggressive behavior, depression, withdrawal, and psychosis in those with schizophrenia and concurrent disorders (Doran, 2010). Similarly, PCC significantly reduced the use of seclusion ($p = 0.04$) and restraints ($p = 0.05$) on acute care psychiatric units in an American study (Wale et al., 2011). Another American study used a randomized-controlled design to examine the impact of PCCP and collaborative documentation on medication adherence in the community setting; medication adherence increased ($p < 0.01$) in the experimental group (Stanhope et al., 2013).

There is limited research focused on the association between PCC and patient satisfaction in psychiatric settings. Allerby et al. (2020) used a before and after study design to test the effects of a PCC educational intervention on Swedish hospital staff caring for those with psychosis; patient satisfaction was significantly higher in the post-implementation group ($p = 0.041$). Similarly, researchers found that all measures of patient centredness were positively associated with good-to-excellent care ratings from clients suffering from depression remission in an American study (Rossom et al., 2016). Finally, findings from a Danish study with participants diagnosed with two or more chronic conditions include that PCC was positively associated patients' satisfaction with care; however, the conditions were not necessarily psychiatric (Kuipers et al., 2019).

The care environment is an integral aspect of PCC (McCormack & McCance, 2016). Therefore, it is important to acknowledge the relationship between person-centredness and nurses' job satisfaction. No studies were found that addressed job satisfaction among mental

health nurses. However, a positive association between PCC and two outcomes, job satisfaction and work-related health, among health care professionals was reported in several studies included in one scoping review (van Diepen et al., 2020). For example, significant positive association between PCC and job satisfaction ($p < 0.001$) as well as PCC and well-being ($p < 0.001$) (den Boer et al., 2017) was reported in a Dutch cross-sectional study with community health registered nurses included in the review. A Swedish cross-sectional study of registered nurses working in acute care found similar results (Lehuluante et al., 2012).

Measuring Person-centred Care

Nine cross-sectional studies were included from the literature search that measured PCC either within mental health care settings or in a population where psychiatry was explicitly represented. One additional study was selected from the literature search that measured PCC in general hospital settings (Tiainen et al., 2020); it was unclear if psychiatry was involved. Tiainen et al.'s study was included in this literature review because they used the *Person-centred Practice Inventory-Staff (PCPI-S)* (Tiainen et al., 2020), a questionnaire used in the dissertation. Four of the ten studies were conducted in the United States (Choy-Brown et al., 2020; Matthews et al., 2018; Rossom et al., 2016; Slater et al. 2015), two in Canada (Durand & Fleury, 2021; Livingston et al., 2012), one in the Netherlands (Boer et al., 2017), one in the United Kingdom (Slater et al., 2015), one in Finland (Tiainen et al., 2020) and one in Taiwan (Hsiao et al., 2019). Five studies were conducted in the community (Boer et al., 2017; Choy-Brown et al., 2020; Hamovitch et al., 2018; Rosssom et al., 2016, Matthews et al., 2018) and four were conducted in the hospital (Hsiao et al., 2019; Livingston et al., 2012; Slater et al., 2015; Tiainen et al., 2020), and one study spanned inpatient and outpatient settings (Durand & Fleury, 2021). Data collection involved a chart review (Choy-Brown et al., 2020), surveys to health care professionals (Boer et

al., 2017; Durand & Fleury, 2021; Matthews et al., 2018; Slater et al., 2015; Tiainen et al., 2020), surveys to service users (Rossom et al., 2016), and surveys to both health care professionals and service users or caregivers (Hamovitch et al., 2018; Hsiao et al., 2019; Livingston et al., 2012).

Outcome Measures

Seven of the ten cross-sectional studies described above identified PCC as an outcome measure (Boer et al., 2017; Choy-Brown et al., 2020; Hamovitch et al. 2018; Hsiao et al., 2019; Matthews et al. 2018; Slater et al., 2015; Tiainen et al., 2020). Of those that measured PCC directly, two used the PCPI-S (Slater et al., 2015; Tiainen et al., 2020), three used the *Patient-Centred Care Questionnaire* (Boer et al., 2017; Hamovitch et al, 2018; Matthews et al., 2018), and one used the *Patient Centred Care Planning (PCCP) Assessment Measure* (Choy-Brown et al., 2020) for a chart review. Finally, Hsiao et al. (2019) measured quality of family-centred care using the *Measure of Process of Care for Adults*, a questionnaire that was designed to assess the extent to which family caregivers perceived quality of family-centred care from health care professionals. The remaining three studies each used a variety of different outcome measures and measurement tools to evaluate PCC (Durand & Fleury, 2021; Livingston et al., 2012; Rossom et al., 2016).

Significant Findings

Based on the findings from the ten cross-sectional studies included in the review, it remains difficult to determine the extent to which PCC is practiced in mental health settings. Matthews et al. (2018) reported only 15% of community mental health staff rated themselves as high PCCP implementers where a high implementer was defined as someone who selected “agree” or “strongly agree” to all items on the Person-centred Care Questionnaire. Similarly, family-centred care in the presence of schizophrenia was found to be inadequate in another study

(Hsiao et al., 2019). When 160 charts of community mental health clients were reviewed it was found that providers demonstrated low levels of competency in PCCP. However, service users in a different study reported high PCC with a mean survey score of 117.08 where the possible range of scores was 32 to 160 (Hamovitch et al., 2018). Similarly, high levels of PCC were reported in acute care settings, including psychiatry (Slater et al., 2015) where the subscales of the PCPI-S were scored positively by registered nurses. Nurses in another study completed the PCPI-S and had similar results (Tiainen et al., 2020). Characteristics of PCC were found to be present in varying degrees within a Canadian forensic hospital (Livingston et al., 2012). Finally, three patient-centred aspects of care were found to be closely associated with depression improvement in one study: 1) asking for ideas and preferences regarding treatment, 2) asking about patient concerns or questions, 3) providing a treatment plan for daily life, 4) screening for depression, and 5) asking about suicide risk (Rossom et al., 2016).

Critical Appraisal

The PHAC (2014) critical appraisal toolkit was used to evaluate the 10 cross-sectional studies described above; the critical appraisal tool for descriptive studies was used. Overall, the quality of the studies was rated as medium to high. Common issues among the studies were low response rates (Slater et al., 2015; Rossom et al., 2016), potential information bias (Boer et al., 2017; Durand & Fleury, 2021; Livingston et al., 2012; Matthews et al., 2018; Slater et al., 2015), and neglecting to control for confounding variables (Livingston et al., 2012; Rossom et al., 2016; Slater at al., 2015).

Promoting Person-centred Care

Only seven interventional studies were identified in the literature search that aimed to enhance person-centred mental health nursing care. Three studies were conducted in Sweden

(Alexiou et al. 2018; Alexiou et al. 2016; Allerby et al. 2020), two in the United States (Stanhope et al. 2013; Stanhope & Matthews, 2019), and two in Southeast Asia (Lee et al. 2016; Wong et al. 2014). Designs included randomized-control trials (Lee et al. 2016; Stanhope et al. 2013), uncontrolled before and after (Alexiou et al. 2018; Alexiou et al. 2016), mixed methods (Stanhope & Matthews, 2019; Wong et al. 2014), and controlled before and after studies (Allerby et al. 2020). Two studies took place in the community (Stanhope et al. 2013; Stanhope & Matthews, 2019), one study was situated in both the community and hospital (Wong et al. 2014), and four studies took place in inpatient settings (Alexiou et al. 2018; Alexiou et al. 2016; Allerby et al. 2020; Lee et al. 2016). In three studies patients were the participants (Alexiou et al. 2016; Allerby et al. 2020; Stanhope et al. 2013), in three studies health care professionals were the participants (Alexiou et al. 2018; Stanhope & Matthews, 2019; Wong et al. 2014), and in one study caregivers of those with bipolar disorder were participants (Lee et al. 2016). Stanhope & Matthews (2019) also reviewed 300 charts at five community mental health clinics.

The interventions implemented in the seven studies varied. In two studies the intervention was the transition to a more patient-centred forensics facility (Alexiou et al. 2018; Alexiou et al. 2016) and in four studies PCC educational interventions for staff was implemented (Allerby et al. 2020; Stanhope et al. 2013; Stanhope & Matthews, 2019; Wong et al. 2014). A family-centred care program delivered to the families of those admitted to hospital with bipolar disorder was the intervention in the final study (Lee et al. 2016).

Outcome Measures

Interestingly, common outcome measures and data collection instruments were only found in two of the seven studies described above (Alexiou et al. 2018; Alexiou et al. 2016). Both used the *Person-centred Climate Questionnaire* to assess the unit environment. As an

additional measure Alexiou et al. 2018 used the *PCC Assessment Tool* to assess PCC and Alexiou et al. 2016 used the *Quality in Psychiatry Questionnaire* to assess quality of care. The four studies that evaluated the effects of PCC educational interventions for staff had differing outcome measures and data collection instruments. Allerby et al. (2020) measured empowerment with the *Empowerment Scale* and customer satisfaction with the *UKU-ConSat Rating Scale*. Stanhope et al. (2013) measured medication adherence and service engagement by collecting data on outcomes from health care providers and collecting data from health care centres on appointment no-shows. Stanhope & Matthews (2019) used the *PCCP Assessment Measure* to evaluate PCCP fidelity; they also used focus groups, interviews, consultations to better understand the PCCP implementation process. Wong et al. (2014) measured nurses' experience of their relationship with families using the *Family Nursing Practice Scale*. Finally, Lee et al. (2016), who evaluated the effects of a family-centred care program for families, used the *Family Function Scale* to measure family function and the *Caregiver Burden Inventory* to measure caregivers' perceived health status and caregivers' burden.

Summary of Findings

This section presents relevant findings from the seven studies described above. Two of the seven studies examined the impact of relocating psychiatric forensics hospitals in the United Kingdom (Alexiou et al., 2016; Alexiou et al., 2018); the move resulted in improved feelings of a secure environment ($p = 0.03$) in one study (Alexiou et a., 2016) and in a significant ($p < 0.02$) improvement on all three domains of the PCC Climate Questionnaire taken by staff (safety, everydayness, and community) in the other study (Alexiou et al., 2018). PCC education was the intervention in four of the seven studies, and resulted in: improved satisfaction among health care professionals ($p < 0.05$) (Allerby et al., 2020); enhanced service engagement ($p = 0.001$)

(Stanhope et al., 2013); improved medication adherence ($p < 0.01$) (Stanhope et al., 2013); improved PCCP fidelity ($p < 0.05$) (Stanhope & Matthews, 2019); and improved confidence, satisfaction, knowledge, and skills and comfort in working with families among nurses (Wong et al., 2014). Finally, one of the seven studies evaluated the effects of a family-centred care program for families found significant improvements in family function ($p = 0.03$) in the intervention group (Lee et al., 2016).

Critical Appraisal

The PHAC (2014) critical appraisal toolkit was used to evaluate the seven PCC intervention studies; the critical appraisal tool for analytical studies was used. Study designs were noted to be dichotomised as either weak or strong. The quality of the studies was categorized as either medium or high. Common issues among the studies included: high dropout rates (Alexiou et al., 2016; Alexiou et al., 2018), potential information bias (Alexiou et al., 2016; Alexiou et al., 2018; Lee et al., 2016), no random sampling (Allerby et al., 2020; Alexiou et al., 2016; Alexiou et al., 2018; Lee et al., 2016; Stanhope et al., 2013) not controlling for confounding (Alexiou et al., 2016; Alexiou et al., 2018). In addition, Lee et al. (2016) was noted to have a small sample size ($N = 47$), which is small for the methodology, and randomized-controlled trial, but nevertheless, produced statistically significant results.

Gaps in the Literature

There are several gaps in the person-centred mental health care literature. First, it remains unclear to what extent PCC is being practiced in mental health settings. The existing literature is conflicting and evaluation tools varied. Longitudinal studies, using consistent evaluation tool(s), are necessary to better understand the extent of PCC practices in mental health environments. Strategies to enhance PCC within mental health practice settings have been implemented in some

research studies, however, only a few studies with methodological weaknesses have evaluated PCC outcomes. Little is known about the perspective of mental health nurses in relation to PCC or that of service users. Future intervention studies to promote PCC, such as staff education, should use repeated measures with consistent evaluation tools to determine true effectiveness. Future studies should also address existing methodological issues such as retention and control for confounding variables. Finally, only three prevalence and intervention studies included in the review were conducted in Canada. The extent to which PCC is operationalized in Canadian mental health care settings remains unclear.

Research Problem

PCC is an approach to nursing that places the person, in their context, above the disease and at the centre of care (WHO, 2015). Operationalizing PCC has been challenging in many practice areas (Moore et al., 2017). Mental health settings have compounding obstacles in delivering PCC due to the, sometimes, coercive nature of the care provided (Smith & Williams, 2016). Nevertheless, many Canadian health care systems, report both supporting and providing PCC (Montague et al., 2017; CMA & CNA, 2011). One reason for this is the value that is placed on PCC by patients and families (Montague et al., 2017). A culture of PCC can result in improved patient satisfaction (Allerby et al., 2020; Kuipers et al., 2019; Rossom et al., 2016) and better patient-outcomes, such as, shorter hospital stays and better functional performance (Ballard et al., 2018; Ekman et al., 2012; Fors et al., 2015; Olsson et al., 2014; Wynia et al., 2018). However, minimal information exists to demonstrate the extent of PCC at the mental health program level. To advance person-centred mental health nursing care within the province of focus for this study, more evidence is needed regarding current PCC practices.

Worldview

A worldview often embraced by mixed methods scholars, the transformative paradigm (Mertens, 2003), merges the philosophy of inquiry with social justice research (Creswell & Plano Clark, 2018). Using both quantitative and qualitative methodologies "provide a mechanism for addressing the complexities of research in culturally complex settings that can provide a basis for social change" (Mertens, 2007, p. 212). Aligning with this paradigm, I, the primary investigator, believe that knowledge is reflective of power and social relationships; knowledge construction improves society (Creswell & Plano Clark, 2018). Those suffering from enduring mental illness are a group at risk of being "pushed to the margins of society" (Mertens, 2009). To highlight the importance of recognizing those receiving mental health care as individual persons, I will refer to "patients" as "individuals" throughout the dissertation whenever possible. However, there are some instances when the word "patient" is used for increased clarity for the reader. In conducting this study, we, the research team, acknowledge our position as educated, white-settler, Canadian women. Prior to the start of the study a small number of individuals with lived-experience of mental illness were invited to form a lived-experience expert advisory group. Details about this group are provided in the coming section titled, *Experience-expert Advisory Group*.

Theoretical Framework

The guiding framework for this study will be the *Person-centred Practice Framework* (Figure 1.1) (McCormack & McCance, 2016). Philosophical underpinnings of the framework are rooted in the concepts of *caring* and *personhood* (McCormack & McCance, 2006; McCormack & McCance, 2016) with parallels to human science principles, such as those described by Watson (1985): human freedom, choice and responsibility, holism, ways of knowing, relationships, and the importance of time and space. It was derived from two conceptual

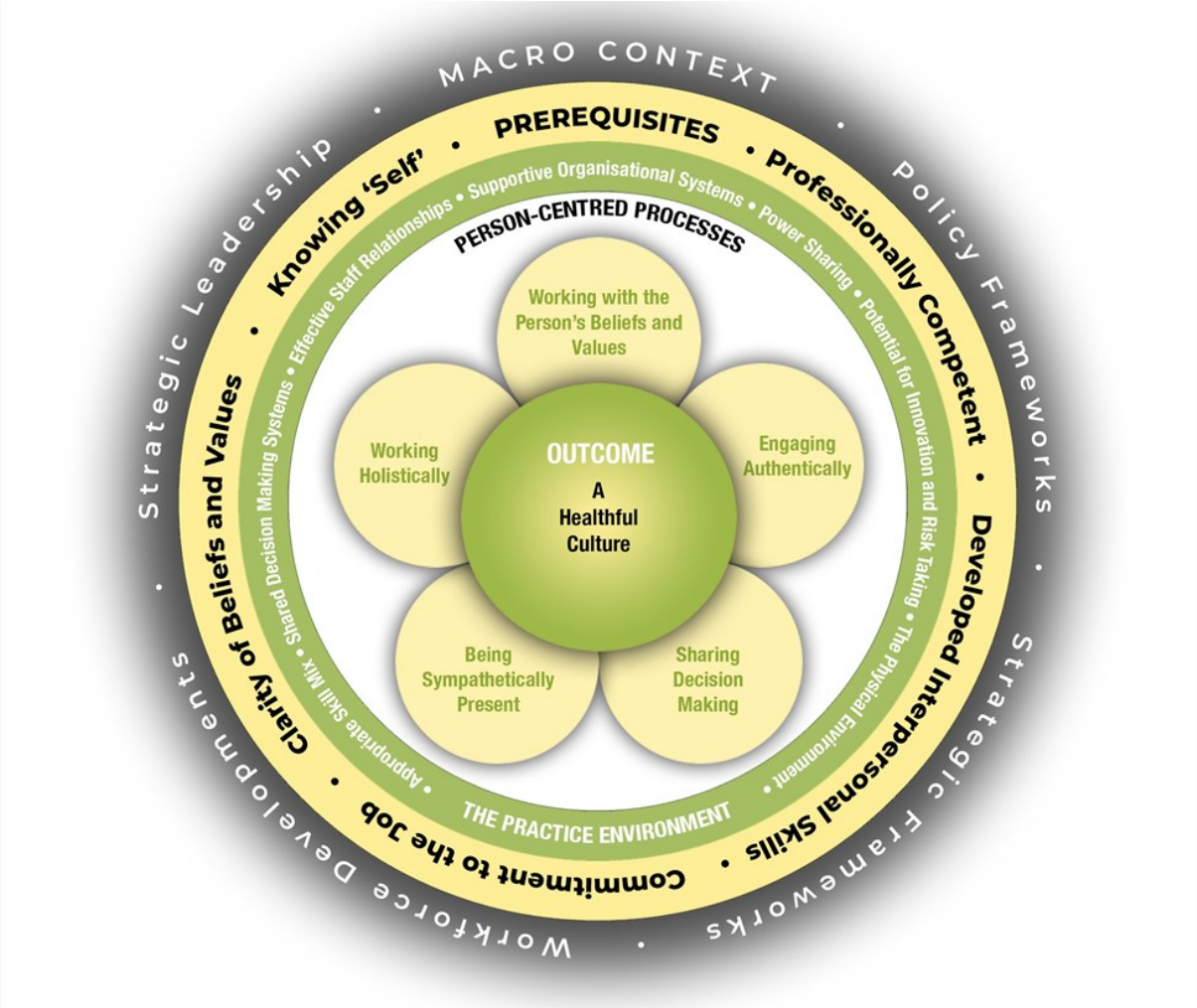
frameworks, one that focused on PCC of older adults and the other that focused on patients' and nurses' experiences of caring in nursing (McCormack & McCance, 2006).

The framework assists health organizations and the professionals who work within them to better understand how PCC can be operationalized (McCormack & McCance, 2016). Three domains within the framework that speak to the operationalization of PCC: prerequisites, the care environment, the care process. (McCormack & McCance, 2016). The framework is organized in such a way that external domains need to be considered and strengthened to bolster the subsequent inner layer. (McCormack & McCance, 2016; Slater et al., 2017). Each domain is further described by several, more concrete, constructs that are listed below.

The framework outlines the key attributes of nurses that facilitate the delivery of PCC and environmental characteristics that are conducive to person-centred ways of working. A person-centred nurse, who can manage the challenges of a constantly evolving care environment, must possess a combination of the following: professional competence, interpersonal skills, job commitment, clear beliefs and values, and self-awareness (McCormack & McCance, 2016). According to McCormack and McCance (2016), the care environment must be person-centred for the true potential of nurses to be realized. The care environment greatly impacts the operationalization of PCC, potentially limiting or enhancing the facilitation of the person-centred processes (McCormack & McCance, 2016). There are seven impactful characteristics of the care environment: appropriate skill mix, shared decision-making systems, power sharing, effective staff relationships, supportive organisational systems, potential for innovation and risk taking; and the physical environment (McCormack & McCance, 2016, p. 47- 48).

Figure 1.1

The Person-centred Practice Framework [Reproduced with permission from the person-centred practice international community of practice (2023)]



The person-centred process is the component of the framework that focuses on the patient in their context via a range of activities that operationalize person-centred practice (McCormack & McCance, 2016). Such activities include: 1) working with patients' beliefs and values, 2) engaging authentically, 3) being sympathetically present, 4) sharing decision-making, and 5) providing holistic care (McCormack & McCance, 2016). Finally, person-centred outcomes are at

the centre of the framework and demonstrate the results expected from effective PCC (McCormack & McCance, 2016). Possible outcomes may be: 1) a good experience of care, 2) involvement in care, 3) feeling of well-being, and 4) existence of a healthful culture (McCormack & McCance, 2016).

Experience-expert Advisory Group

Through partnering with a social centre for those living in the community with mental illness, an experience expert advisory group was formed. The centre is a space for members to socialize through structured activities, allowing them to build social skills and feel they are a part of a community. This centre was chosen as a partner because the members have lived-experience of mental illness and receiving mental health care within the study province. Seven members of centre met at four different points in time to discuss the study. They were first provided with patient-oriented research-patient-partner training as well as education on the study. The remaining meetings focused on: 1) clarity and appropriateness of interview questions, 2) observational data collection methods, 3) interview recruitment, and 4) reviewing interview findings. The seven experience experts were able to provide a valuable perspective regarding these aspects of the study.

Study Overview

Research Questions

The purpose of this concurrent mixed methods study is to better understand the PCC practice patterns of mental health nurses. The main research question is: What are the PCC practice patterns exemplified by mental health nurses in one Atlantic Canadian province? The six sub-questions are:

1) What are the self-reported PCC practices of mental health nurses?

2) To what extent is the practice environment associated with the delivery of PCC?
3) What occupational, environmental, and demographic factors predict nurses' delivery of PCC?
4) What are the occupational and demographic factors that predict a PCC environment?
5) What is the nature of the tertiary inpatient care culture as demonstrated by unit observations?
6) What are the PCC perspectives of individuals who have received mental health nursing care in the past year?

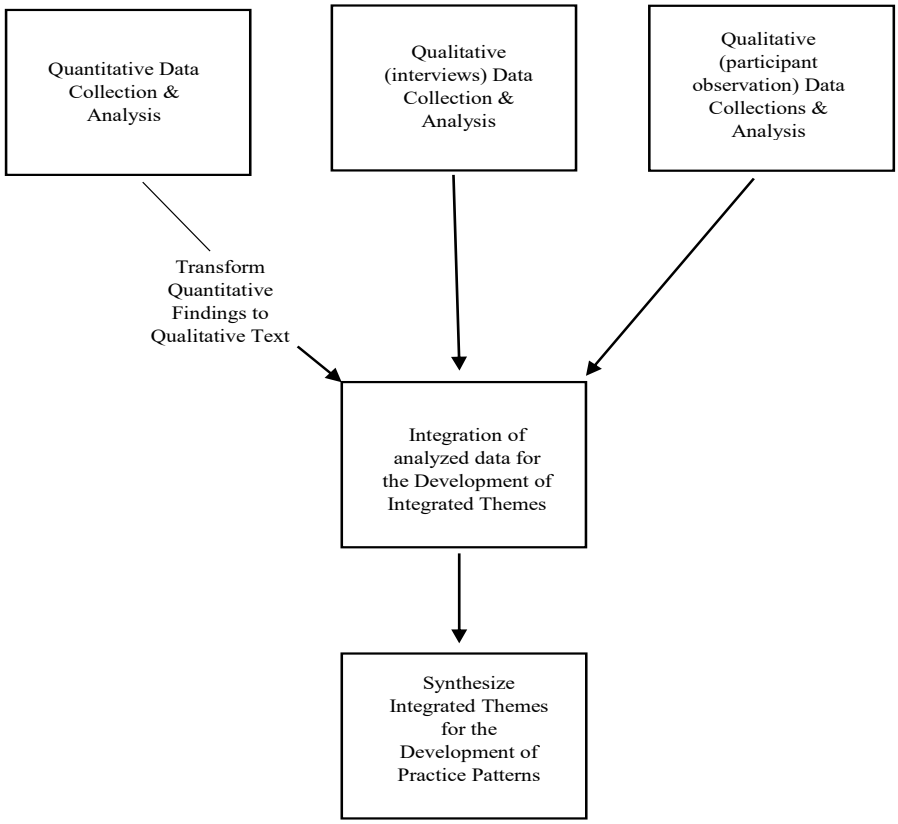
Design

The researchers took the philosophical perspective that the search for knowledge should use all strategies available and value both subjective and objective knowledge (Creswell & Plano Clark, 2018). As there is no 'best measure' that uncovers all aspects of PCC, a range of methods and tools was necessary to provide a robust picture of person-centred mental health nursing care (Silva, 2014). A concurrent mixed methods design (Creswell & Plano Clark, 2018) was chosen for the study to examine person-centred mental health nursing care from three distinct viewpoints. Figure 1.2 depicts the concurrent design and highlights the parallel but separate nature of the data collection as well as the data analysis of each component. The quantitative cross-sectional component of the investigation was a descriptive, cross-sectional study. Quantitative findings addressed the first four research sub-questions. Quantitative data was collected via a survey package completed by mental health and addictions (MH & A) nurses in one Atlantic province. Both qualitative components were guided by a nursing methodology, interpretive description (Thorne, 2016). Qualitative findings address the last two research sub-

questions. Data was collected via participant observation on three acute care inpatient units as well as via interviews with those who have availed of inpatient mental health services for a persistent mental illness. Integration of all analyzed data assisted to clarify understanding of person-centred mental health nursing care in the province. Tashakkori and Teddlie's (2008) five criteria for interpretive rigor was used to ensure quality at the data integration stage of the study.

Figure 1.2

Concurrent Mixed Methods Study Design



Summary of Methods and Findings

Due to the complex nature of the Person-centred Practice Framework and how it aligns with each study component, a summary of the methods and findings from each study component is provided below. With the exception of the participant observation component of the study, all

other study components are explained in detail in the remaining chapters. As a result, a more detailed description of the participant observation methods and results are provided here.

Quantitative Component

A short summary of the quantitative methods and findings are presented below; more details can be found in Chapter 2.

Methods

All MH & A Registered Nurses working in one Atlantic province were the target population for the quantitative phase of the study. Consequently, approximately 400 MH & A nurses in the province received an invitation to participate using a number of strategies including an email invitation sent through both the provincial nursing regulatory body and the employer organization. The online survey package included three questionnaires: 1) Person-centred Practice Inventory – Staff (PCPI-S) (Appendix A), 2) Person-centred Climate Questionnaire – Staff (PCCQ-S) (Appendix B), and 3) 13 demographic and work-related questions (Appendix C). Descriptive and inferential statistics were used to address the four quantitative research questions. Histograms and the Shapiro-Wilk test were used to test for normality of variables. The significance level for the study was set at $p \leq 0.05$.

Findings

Seventy registered nurses completed the survey resulting in a response rate of approximately 17.5%. Once analyzed, their data was used to answer research questions one through four:

1) What are the self-reported PCC practices of mental health nurses?
2) To what extent is the practice environment associated with the delivery of PCC?

3) What occupational, environmental, and demographic factors predict nurses' delivery of PCC?

4) What are the occupational and demographic factors that predict a PCC environment?

Research Question One. Each domain of the PCPI-S was scored high by nurses. When construct scores were summed, the mean score for the prerequisite domain was 75.73 (SD = 9.4; maximum possible mean score = 90) while the mean score for the care environment was 91.97 (SD = 16.91; maximum possible mean score = 125) and the mean score for the care process was 68.91 (SD = 9.01; maximum possible mean score = 80).

Research Question Two. There was a moderate, positive, statistically significant ($r_s = 0.45$, $p < 0.001$) association between the care environment of the PCPI-S and the care process, which was the measure of delivery of PCC. This association suggests that as the care environment improves, so does the delivery of PCC. Total scores from the PCCQ-S were also used to assess the association between the environment and PCC. However, no significant relationship was found ($r_s = 0.24$, $p = 0.05$).

Research Question Three. When using the care process domain of the PCPI-S as the outcome variable for delivery of PCC, the final occupational and demographic predictor variables in the model were: 1) the prerequisites domain score on the PCPI-S, 2) the environment domain score of the PCPI-S, and 3) relationship with manager. The R^2 of 0.761 indicated that the regression model explains 76.1% of the variance observed in the PCPI-S (care process) score.

Research Question Four. When using the environment domain score of the PCPI-S as the outcome variable, the final occupational or demographic predictor variables in the model were: 1) the prerequisites domain score on the PCPI-S, 2) the care process domain score of the

PCPI-S, 3) relationship with manager, and 4) role satisfaction. The R^2 of .718 indicates that the regression model explains 71.8% of the variance observed in the PCPI-S (environment) score. There were two measures for environment. The previous model with PCPI-S (environment) as the outcome showed that there were four significant predictors, include role satisfaction. However, when using PCCQ-S the only significant occupational or demographic predictor variable was role satisfaction. The R^2 of .205 reveals that the regression model explains 20.5% of the variance observed in the PCCQ score.

Qualitative Participant Observation Component

Qualitative participant observation methods were used to address the fifth research questions. Interpretive description methodology (Thorne, 2008) was used in this study phase. A summary of the methods and findings are presented below. This study component will be reported in a manuscript to be written after completion of this dissertation.

Methods

The Workplace Culture Critical Analysis Tool Revised (WCCAT^R) (Appendix D) guided data collection on the PCC culture of three mental health inpatient units (Wilson et al., 2020). The tool is explicitly linked to the Person-centred Practice Framework (Wilson et al., 2020), and allowed the research team to capture data related to the culture in which nurses practice. Participant observation provided a unique perspective on the current practices of inpatient mental health nurses and highlighted their cultural implications. A research assistant (RA) familiar with the hospital and unit staff collected the observations. The RA was master's student and a registered nurse in the psychiatric hospital where the observations took place. Prior to beginning data collection, the RA and the principal investigator piloted the tool on one unit. Both researchers made independent observations for two hours and then compared both sets of

data for congruency. No issues were identified during piloting, and so the research assistant began data collection on the first unit in summer 2022 . She collected data on each unit twice during the morning (0900-1100), afternoon (1300-1500), and evening (1900-2100). Data was collected on six different occasions on each unit, resulting in 18 data collection times. The researcher spent two hours on the unit at each data collection time, resulting in 36 hours of unit observation. During data collection periods, study notification posters were accessible in the nursing station and on the unit for nurses and patients to read regarding the study (Appendix E).

The activity on the care environments was observed and while that did include observing the nursing care that was provided, no specific nurse or patient was identified. Observations took place in the dining room, TV room, hallway, and other common areas on the units. The research assistant did not accompany nurses/patients into interview rooms, bathrooms, or bedrooms, as the purpose of the observations was to gain a sense of the PCC culture at the unit and program level. While on the unit, the observer made every effort to blend quietly with the unit atmosphere.

The constant comparative method was used to analyze observational data. Initially observational data analysis was guided by the WCCAT^{R}. The primary investigator and another member of the research team independently read and re-read observational data to prepare for the analysis (Lincoln & Guba, 1985). The two researchers then independently assigned meaning units to the appropriate construct within the WCCAT^{R} and labelled them with initial codes. The researchers came together to confirm placement of the data within the tool and the initial codes. Sub-themes and themes were then developed from the grouped data, however, they continually changed as the data was constantly being compared. A decision trail of analytic choices was documented to enhance rigor.

Findings

Seven themes were developed from the observational data (Table 1.1). Three themes aligned with the prerequisites domain, three themes aligned with the care environment domain, and one theme aligned with the care process domain.

Table 1.1

Participant Observation Themes

Framework Domain	Themes
I Prerequisites	1.1 Unstable foundations for PCC
	1.2 The nature of the care delivered
	1.3 Interpersonal skills varied
II Care environment	2.1 Lack of organizational guidance for implementation of PCC
	2.2 Supportive teamwork
	2.3 A care environment of diminished personhood
III Care processes	3.1 Person-centred practices, inspiring but fleeting

Five constructs of The Person-centre Practice Framework illustrate the nature of the prerequisites domain: 1) knowing self, 2) developed interpersonal skills, 3) competent care, 4) commitment to the job, and 5) clarity of beliefs and values. The three themes derived from the prerequisites observational data suggested that the required attributes for effective PCC may not always be exhibited in the daily behaviors and actions of mental health nurses. The theme *unstable foundations for PCC* represents nurses', often, weak clarity of person-centred beliefs and values as well as commitment to the job present in the observational data. The theme *the nature of the care delivered* was developed to highlight lack of mental health care being received by individuals who often had to seek out their nurse for care. The theme *interpersonal skills*

varied was developed because while many nurses exhibited developed interpersonal skills, there were also several examples of poor nurse-patient interactions.

Within the Person-centred Practice Framework the care environment refers to the context in which care is delivered. Themes associated with the care environment represent the backdrop of care is delivered. The environment is represented by seven constructs that can either facilitate or hinder the delivery of PCC and require careful consideration during implementation. Elements such as effective staff relationships, power-sharing, and systems for shared decision-making reflect the effectiveness of team collaboration in supporting patient care. Two factors, supportive organizational systems and a culture of innovation and risk-taking, serve as indicators of the larger organization's commitment to PCC delivery, emphasizing the necessity for a comprehensive organizational shift to achieve PCC. The final two factors, skill mix and the physical setting, underscore the importance of ample resources to maintain a therapeutic environment that supports individuals in their recovery. Observations pertaining to the seven environmental constructs yielded three themes. Two themes identify barriers to the development of both a PCC approach and an organizational culture that encourages and supports mental health nurses in adopting new and innovative approaches to their practice.

The Care Process Domain involves delivering care to individuals through a variety of activities and behaviors outlined by the final five constructs: working with individuals' beliefs and values, authentic engagement, sympathetic presence, shared decision-making, and offering holistic care. Nursing actions or behaviors that aligned with these five constructs were infrequent and, when they did occur, the interactions were brief but appreciated by patients. As a result, a singular theme was developed, primarily addressing the notable absence of PCC delivery.

Qualitative Interview Component

Qualitative interviews were used to address the sixth research questions. Interpretive description methodology (Thorne, 2008) was used in this study phase. A full report of this study component is found in Chapter 3.

Methods

Adults who received care on an inpatient mental health unit in the previous year were invited participate in the interview component of the study. Participants were recruited through posters (Appendix F) in community agencies and snowball sampling. Participants had the choice of in-person, online, or a telephone interview. Interviews were audio recorded and transcribed verbatim upon completion by a transcriptionist. The primary investigator conducted the interviews and took field notes. Interviews lasted approximately 45 minutes. A developed interview guide (Appendix G) was used to better understand the experiences of mental health patients in receiving PCC. Constant comparative method was used to analyze the data for this study.

Findings

Three themes were developed that captured participants' experiences of inpatient person-centred mental health nursing care (Table 1.2). The first theme, *rare moments of PCC*, represents the overall lack of PCC experienced by individuals receiving services on an inpatient mental health unit. The majority of care received by participants was not individualized and their self-identified needs were not given priority. Although there was some evidence of PCC identified by participants, these person-centred moments were scarce and scattered among routine nursing care. The second theme, *the relationship with my nurse: A fluctuating connection*, characterized the nurse-patient relationship; it was changeable and shaped by the

feelings that participants had towards the nurses who cared for them. Some participants described positive relationships with their nurses, which helped them feel safe, protected and, ultimately, well cared for. Other participants identified nurse-patient interactions that were negative, leaving them to feel that they were not in control of decisions made about their care and treatment. This resulted in two sub-themes: 1) *In good hands*, and 2) *Limited control*.

Table 1.2

Interview Themes and Sub-themes

Theme	Sub-Theme
1) Rare moments of PCC	
2) The relationship with my nurse: A fluctuating connection	2.1 In good hands
	2.2 Limited control
3) The care environment as an uncertain space	3.1 Perils of an unknown environment
	3.2 Pearls of the care environment

The third theme, *the care environment as an uncertain space*, was developed to address the impact of the care environment on patients' well-being. There were contrasting perspectives about the care environment from participants, suggesting a sense of uncertainty and fear. Theme three has two sub-themes: 1) *Perils of an unknown environment* and 2) *Pearls of the care environment*. Several participants described feeling that they were left alone to navigate serious issues, including their own safety. Lack of personal space was also affected participants' recovery. The first sub-theme was developed to capture this data. However, some individuals who were hospitalized for a longer period or had repeat admissions, perceived the unit as feeling familiar. Further, multiple participants spoke of the positive impact that unit activities had on their recovery. The second sub-theme was developed to capture this data.

Integration Component

The Pillar Integration Process (PIP) was chosen as the methodology for the integration phase of the study (Fekonja et al., 2022; Johnson et al. 2019; Richards et al., 2022). PIP is a four-stage technique designed to integrate qualitative and quantitative data using joint display tables (Johnson et al. 2019). For the purpose of this study, an additional step was implemented to further integrate themes developed from the integrated data and develop the PCC practice patterns of mental health nurses. Additional details on the integration analysis and results are outlined in Chapter 4.

Methods

Prior to beginning the first stage of integration, the quantitative survey data was transformed into qualitative text. As survey scores were clustered around the maximum score, there was minimal variation in the data. Our strategy was to maximize the existing variation by grouping constructs into high, moderate, and low agreement categories based on their mean scores. By optimizing the limited amount of variation in the nurses' data, a richer, more robust integration was possible.

Listing the mixed methods study findings was the first activity in the integration process. Raw data (e.g., mean scores, selected quotes) and grouped data (e.g., mean scores transformed into qualitative categories, interview themes) that informed the research question were listed in a pillar joint display table. Next, during matching, researchers horizontally aligned similar data, and refined and organized the categories and themes. In the third stage of PIP, checking, all data in the six columns were crosschecked to ensure appropriate data matching in all rows of the table. During the fourth and final pillar building stage, a pillar was constructed within the joint display. To then develop the pillar, researchers compared and contrasted the findings relevant to

the constructs that were included in each of the three PCC domains across rows, connecting and integrating the findings for each of the 17 constructs. Seventeen integrated themes were developed based on the content and fit of the three sets of findings (survey, interview, and observation) for each construct. The integrated themes were again integrated leading to the development of three meta-themes to represent the PCC practice patterns demonstrated by nurses working in mental health services.

Findings

PIP data integration resulted in 17 themes located in the pillar of each data integration table, one for each construct of the Person-centred Practice Framework. The data integration table for the care process domain can be found in Appendix H and contains five integrated themes.

A description of the integrated themes that aligned with the five prerequisite constructs are outlined below (Table 1.3). Some nurses demonstrated developed interpersonal skills, competent care, and commitment to the job; however, there was inconsistencies in the data that reflected theses constructs. Nurses did not always interact with patients in a calm, warm, or respectful way and individuals often had to seek out their nurse with care requests. However, when nurses did use a therapeutic approach, patients were more at ease.

Table 1.3

Integrative Themes from the Prerequisite Domain

Prerequisite Domain Construct	**Integrative Theme**
Developed Inter personal Skills	Nurses were inconsistent in their communication with individuals. Most nurses reported effective interpersonal skills but, from the patients' perspective, these skills were used selectivity. Although nurses and patients spent limited time together, individuals appreciated the positive interactions they had with nurses.
Competent Care	Nurses had the competencies to assist individuals with activities of daily living and were responsive to their physical health needs. They were less likely to implement activities or interventions that were supportive of the individuals' mental health.
Commitment to the Job	Individuals noticed when nurses did small things that were important to them. When nurses spent time explaining or provided help, individuals were grateful.

Prerequisite Domain Construct	Integrative Theme
Knowing Self	When nurses interacted with a calm, but warm approach, individuals become more comfortable and trusting.
Clarity of Beliefs and Values	Nurses did not always respect the dignity and beliefs of the individuals they cared for. Their interactions with patients were mostly by request, that is, the person had to come to the nursing station to ask for the care that they needed.

The care environment is comprised of seven constructs and Table 1.4 outlines the integrated themes developed to align with each construct. It is clear that nurses work well together and with other members of the health care team. However, they still work in a hierarchical system where power sharing is not evident. Further, nurses are working within an organization that does not support them in the provision of PCC and their capacity for innovation and risk taking is very limited. Although adequate staffing levels and skill mix were commonly noted throughout the data, nurses remained primarily behind the nursing station with each other.

Table 1.4

Integrative Themes from the Care Environment Domain

Care Environment Construct	Integrative Theme
Effective staff relationships	Nurses are members of collegial teams. Health care teams effectively worked together in the provision of patient care.
Shared decision-making systems	Nurses are included and contribute to care decision in the provision of patient care.
Power sharing	Although nurses are members of collegial teams, they are not equal teammates. They work within a hierarchical system where final decisions about care rest with the doctor.
Skill mix	Adequate staffing levels and skill mix do not change how care is provided. Nurses situate themselves behind the nursing station, separated from patients who have to seek them out continuously.
Physical space	The environment is an unsupportive physical space for PCC. The lack of space was challenging and disruptive to individuals' recovery.
Supportive organizational systems	Mental health nurses practice in an organization that does not promote person-centred care. No information or resources were accessible to nurses.
Innovation and Risk taking	Nurses are constrained in their capacity to practice innovation and risk taking.

Five constructs align with the prerequisite domain of the framework; Table 1.5 presents the themes that aligned with each construct. Nurses infrequently engaged in person-centred

practices, however, when they did, it was positively received by those for which they provided care.

Table 1.5:

Integrative Themes from the Care Process Domain

Care Process Construct	Integrative Theme
Holistic Care	When mental health professionals took an individualized approach with their patients, it was experienced by the individual as helpful and affirming. It also provided new knowledge to support the individual's recovery.
Sympathetic Presence	When mental health nurses spent time getting to know their patients, patients felt cared for and accepted.
Authentic Engagement	Authentic engagement between the nurse and patient went beyond social interaction and came to rest in a space that was meaningful to the individual. It was an opportunity for growth.
Working with person's beliefs and values	When nurses understand patients' concerns and wishes, they provided helpful responses that are positively received.
Shared decision-making	Mental health nurses made few attempts at shared decision making with individuals (patients). They did pass patient requests on to the physician and speak with family members about the patient's plan of care.

Integrated Practice Patterns

Based on the 17 integrated themes produced from the PIP, three meta-themes were developed to describe the how nurses conduct and navigate their practice within the care environment.

Practice Pattern One: Mental health nurses maintain a separation from patients and often deliver nursing care from a distance. There is a clear division between nurses and the individuals on inpatient units. Nurses often congregate together in the nursing station and patients remain standing on the outside, frequently making requests for care that nurses address from within the station. Consequently, opportunities for individuals to engage with their nurse is limited and precious. Nurses demonstrated competence in assisting patients with daily activities and attending to their physical needs, but they were less inclined to provide-mental health care.

Often, the nursing care did not require spending time "with" the person; it was task-oriented and frequently provided to an individual while they were standing in the corridor.

Practice Pattern Two: Mental health nurses practice in an organizational culture that supports the status quo, which is not person-centred care. The importance of building relationships and fostering therapeutic engagement between patients and nurses is not prioritized or valued in the care environment. Patient involvement in care decisions is limited and shared decision making between nurses and those receiving care is almost nonexistent. Many nurses exhibit a lack of clarity regarding their beliefs, values, and commitment to their profession. This uncertainty is attributed, in part, to the organizational culture within which they work, which seems to neither nurture these personal attributes nor enable nurses to engage effectively in shared decision-making with individuals. Despite working in collegial teams and participating in care decisions, nurses function within a hierarchical system and evidence of power sharing is minimal.

Practice Pattern Three: When mental health nurses and individuals co-engage in person-centred moments, the results are inspiring and foster hope. While evidence of shared decision-making was limited, nurses engaged in other person-centered practices. Some connections between nurses and patients extended beyond social interactions, and transcended into meaningful spaces that were essential for growth. Nurses also exhibited a sympathetic presence when they dedicated time to understanding their patients. Additionally, when nurses took a personalized approach with individuals, the experience was perceived as beneficial and affirming. Lastly, when nurses invested time into understanding individuals' concerns and priorities, they provided helpful responses that were well-received.

Conclusion

This chapter included a narrative literature review of PCC with an emphasis on literature pertaining to person-centred mental health nursing care. A brief description of the full mixed methods study comprising the methodology and findings of the three sub-studies was also presented. The following two chapters (Chapters 2 and 3) contain full reports of two of the three sub-studies, the cross-sectional survey and the qualitative interview study. The participant observation study, the third sub-study, is completed and will be developed as a separate manuscript upon completion of my doctoral program. The fourth chapter of this dissertation describes the integration phase and how new findings were developed and the final chapter is focused on the major implications of this study.

References

Alexiou, E., Degl' Innocenti, A., Kullgren, A., & Wijk, H. (2016). The impact of facility relocation on patients' perceptions of ward atmosphere and quality of received forensic psychiatric care. *Journal of Forensic and Legal Medicine*, *42*, 1–7. https://doi.org/10.1016/j.jflm.2016.04.014

Alexiou, E., Wijk, H., Ahlquist, G., Kullgren, A., & Degl' Innocenti, A. (2018). Sustainability of a person-centered ward atmosphere and possibility to provide person-centered forensic psychiatric care after facility relocation. *Journal of Forensic and Legal Medicine*, *56*, 108–113. https://doi.org/10.1016/j.jflm.2018.04.006

Allerby, K., Goulding, A., Ali, L., & Waern, M. (2020). Striving for a more person-centered psychosis care: results of a hospital-based multi-professional educational intervention. *BMC Psychiatry*, *20*(1), 523–523. https://doi.org/10.1186/s12888-020-02871-y

Balint, E. (1968). *The possibilities of patient-centered medicine*. Paper presented at the symposium conducted at the American Psychiatric Association, New Orleans, LA.

Ballard, C., Corbett, A., Orrell, M., Williams, G., Moniz-Cook, E., Romeo, R., Woods, B., Garrod, L., Testad, I., Woodward-Carlton, B., Wenborn, J., Knapp, M., & Fossey, J. (2018). Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *PLoS Medicine*, *15*(2), e1002500–. https://doi.org/10.1371/journal.pmed.1002500

Beatrice, D., Thomas, C. P., & Biles, B. (1998). Grant making with an impact: The Picker/Commonwealth Patient-Centered Care Program. *Health Affairs (Millwood, Va.)*, *17*(1), 236–244. https://doi.org/10.1377/hlthaff.17.1.236

Beitinger, R., Kissling, W., & Hamann, J. (2014). Trends and perspectives of shared decision-making in schizophrenia and related disorders. *Current Opinion in Psychiatry*, *27*(3), 222–229. https://doi.org/10.1097/YCO.0000000000000057

Boer, J., Nieboer, A. P., & Cramm, J. M. (2017). A cross-sectional study investigating patient-centred care, co-creation of care, well-being and job satisfaction among nurses. *Journal of Nursing Management*, *25*(7), 577–584. https://doi.org/10.1111/jonm.12496

Canadian Medical Association (CMA) and Canadian Nurses Association (CNA) (2011). *Principles to Guide Health Care Transformation in Canada*. https://www.cna-aiic.ca/~/media/cna/files/en/guiding_principles_hc_e.pdf.

Canadian Nurses Association. *Code of Ethics for Registered Nurses*. https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/Code_of_Ethics_2017_Edition_Secure_Interactive.pdf

Choy-Brown, M., Stanhope, V., Williams, N., & Bond, L. (2020). Delivering Person-Centered Care in Community Mental Health Programs. *Research on Social Work Practice*, *30*(8), 907–917. https://doi.org/10.1177/1049731520944568

Creswell, J. W., & Piano Clark, V. L. (2018). *Designing and Conducting Mixed Methods Research.* Sage.

Cusack, E., Killoury, F., & Nugent, L. E. (2017). The professional psychiatric/mental health nurse: skills, competencies and supports required to adopt recovery-orientated policy in

practice. *Journal of Psychiatric and Mental Health Nursing*, *24*(2-3), 93-104. https://doi.org/10.1111/jpm.12347

Davidson. L., Tondora, J., Miller, R., & O'Connell, J. (2015). Person centred care. In P.W. Corrigan (Ed.), Person-centred care for mental illness (pp. 81-102). American Psychological Association.

Deegan. (1996). Recovery as A Journey of the Heart. *Psychiatric Rehabilitation Journal*, *19*(3), 91–97. https://doi.org/10.1037/h0101301

Doktorchik, C., Manalili, K., Jolley, R., Gibbons, E., Lu, M., Quan, H., & Santana, M. J. (2018). Identifying Canadian patient-centred care measurement practices and quality indicators: a survey. *CMAJ Open*, *6*(4), E643–E650. https://doi.org/10.9778/cmajo.20170143

Doran, D., Paterson, J., Clark, C., Srivastava, R., Goering, P. N., Kushniruk, A. W., Bajnok, I., Nagle, L., Almost, J., & Carryer, J. (2010). A Pilot Study of an Electronic Interprofessional Evidence-Based Care Planning Tool for Clients with Mental Health Problems and Addictions. *Worldviews on Evidence-Based Nursing*, *7*(3), 174–184. https://doi.org/10.1111/j.1741-6787.2010.00191.x

Drach-Zahavy, A. (2009). Patient-centred care and nurses' health: the role of nurses' caring orientation. *Journal of Advanced Nursing*, *65*(7), 1463–1474. https://doi.org/10.1111/j.1365-2648.2009.05016.x

Durand, F., & Fleury, M.-J. (2021). A multilevel study of patient-centered care perceptions in mental health teams. *BMC Health Services Research*, *21*(1), 44-44. https://doi.org/10.1186/s12913-020-06054-z

Edgar, D., Wilson, V., & Moroney, T. (2020). Which is it, person-centred culture, practice or care? It matters. *International Practice Development Journal*, *10*(1), 1-17. https://doi.org/10.19043/ipdj.101.008

Edvardsson, D., Kock, S., & Nay, R. (2010). Psychometric evaluation of the English language Person-centred Climate Questionnaire - staff version. *Journal of Nursing Management*, *18*(1), 54–60. https://doi.org/10.1111/j.1365-2834.2009.01038.x

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I.-L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L.-E., Rosén, H., Rydmark, M., & Sunnerhagen, K. S. (2011). Person-centered care — Ready for prime time. *European Journal of Cardiovascular Nursing : Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*, *10*(4), 248–251. https://doi.org/10.1016/j.ejcnurse.2011.06.008

Farrelly, S., Lester, H., Rose, D., Birchwood, M., Marshall, M., Waheed, W., Henderson, R. C., Szmukler, G., & Thornicroft, G. (2015). Barriers to shared decision making in mental health care: qualitative study of the Joint Crisis Plan for psychosis. *Health Expectations: an International Journal of Public Participation in Health Care and Health Policy*, *19*(2), 448–458. https://doi.org/10.1111/hex.12368

Fors, A., Taft, C., Ulin, K., & Ekman, I. (2016). Person-centred care improves self-efficacy to control symptoms after acute coronary syndrome: a randomized controlled trial. *European Journal of Cardiovascular Nursing : Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*, *15*(2), 186–194. https://doi.org/10.1177/1474515115623437

Foster, M., Whitehead, L., & Maybee, P. (2010). Parents' and health professionals' perceptions of family centred care for children in hospital, in developed and developing countries: A review of the literature. *International Journal of Nursing Studies, 47*(9), 1184–1193. https://doi.org/10.1016/j.ijnurstu.2010.05.005

Gabrielsson, S., Sävenstedt, S., & Zingmark, K. (2015). Person-centred care: clarifying the concept in the context of inpatient psychiatry. *Scandinavian Journal of Caring Sciences*, *29*(3), 555-562. https://doi.org/10.1111/scs.12189

Hamann, J., & Heres, S. (2014). Adapting shared decision making for individuals with severe mental illness. *Psychiatric Services (Washington, D.C.)*, *65*(12), 1483–1486. https://doi.org/10.1176/appi.ps.201400307

Hamann, J., Mendel, R., Cohen, R., Heres, S., Ziegler, M., Bühner, M., & Kissling, W. (2009). Psychiatrists' Use of Shared Decision Making in the Treatment of Schizophrenia: Patient Characteristics and Decision Topics. *Psychiatric Services (Washington, D.C.)*, *60*(8), 1107–1112. https://doi.org/10.1176/ps.2009.60.8.1107

Hamovitch, E. K., Choy-Brown, M., & Stanhope, V. (2018). Person-centered care and the therapeutic alliance. *Community Mental Health Journal*, *54*(7), 951-958. https://doi.org/10.1007/s10597-018-0295-z

Hobbs, J. H. (2009). A dimensional analysis of patient-centered care. *Nursing Research, 58*, 52-62. https://doi.org/10.1097/NNR.0b013e31818c3e79

Hsiao, C., Lu, H., & Tsai, Y. (2019). Factors Associated With Primary Family Caregivers' Perceptions on Quality of Family-Centered Care in Mental Health Practice. *Journal of Nursing Scholarship*, *51*(6), 680–688. https://doi.org/10.1111/jnu.12526

Hummelvoll, J., Karlsson, B., & Borg, M. (2015). Recovery and person-centredness in mental health services: roots of the concepts and implications for practice. *International Practice Development Journal, 5* (Suppl 7); Special Issue September. https://doi.org/10.19043/ipdj.5SP.009

Institute of Medicine. (2001). *Crossing the quality chasm: a new health system for the 21st century.* National Academy Press.

Jayadevappa, R., & Chhatre, S. (2011). Patient-centered care – A conceptual model and review of the state of the art. *The Open Health Services and Policy Journal, 4*, 15-25. https://doi.org/.10.2174/1874924001104010015

Kitson, A., Marshall, A., Bassett, K., & Zeitz, K. (2013). What are the core elements of patient-centred care? A narrative review and synthesis of the literature from health policy, medicine and nursing. *Journal of Advanced Nursing*, *69*(1), 4–15. https://doi.org/10.1111/j.1365-2648.2012.06064.x

Kuipers, S., Cramm, J., & Nieboer, A. (2019). The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BMC Health Services Research*, *19*(1), 1–9. https://doi.org/10.1186/s12913-018-3818-y

Kuluski, K., Peckham, A., Williams, A. P., & Upshur, R. E. . (2016). What gets in the way of person-centred care for people with multimorbidity? Lessons from Ontario, Canada. *Healthcare Quarterly*, *19*(2), 17–23. https://doi.org/10.12927/hcq.2016.24694

Kuluski, K., Hoang, S. N., Schaink, A. K., Alvaro, C., Lyons, R. F., Tobias, R., & Bensimon, C. M. (2013). The care delivery experience of hospitalized patients with complex chronic

disease. *Health Expectations : an International Journal of Public Participation in Health Care and Health Policy*, *16*(4), e111–e123. https://doi.org/10.1111/hex.12085

Lauver, D. R., Ward, S. E., Heidrich, S. M., Keller, M. L., Bowers, B. J., Brennan, P. F., Kirchhoff, K. T., & Wells, T. J. (2002). Patient-centered interventions. *Research in Nursing & Health, 25*(4), 246–255. https://doi.org/10.1002/nur.10044

Lee, H., Lin, E. C., Chen, M., Su, T., & Chiang, L. (2018). Randomized, controlled trial of a brief family-centred care programme for hospitalized patients with bipolar disorder and their family caregivers. *International Journal of Mental Health Nursing*, *27*(1), 61–71. https://doi.org/10.1111/inm.12294

Lehuluante, A., Nilsson, A., & Edvardsson, D. (2012). The influence of a person-centred psychosocial unit climate on satisfaction with care and work. *Journal of Nursing Management*, *20*(3), 319–325. https://doi.org/10.1111/j.1365-2834.2011.01286.x

Lincoln, Y. S. & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *Naturalistic Evaluation, 30,* 73-84. https://onlinelibrary.wiley.com/ doi/abs/10.1002/ev.1427

Livingston, J.D., Nijdam-Jones, A., & Brink, J. (2012). A tale of two cultures: examining patient-centered care in a forensic mental health hospital. *The Journal of Forensic Psychiatry & Psychology*, *23*(3), 345–360. https://doi.org/10.1080/14789949.2012.668214

Lloyd, B., Elkins, M., & Innes, L. (2018). Barriers and enablers of patient and family centred care in an Australian acute care hospital: Perspectives of health managers. *Patient Experience Journal, 5*, 55-64. https://doi.org/10.35680/2372-0247.1270

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *International Journal of Evidence Based Healthcare, 13*(3),179–187. https://doi.org/10.1097/XEB.0000000000000062

Lusk, J., & Fater, K. (2013). A Concept Analysis of Patient-Centered Care. *Nursing Forum (Hillsdale)*, *48*(2), 89–98. https://doi.org/10.1111/nuf.12019

Matthews, E., Stanhope, V., Choy-Brown, M., & Doherty, M. (2018). Do providers know what they do not know? A correlational study of knowledge acquisition and person-centered care. *Community Mental Health Journal*, *54*(5), 514–520. https://doi.org/10.1007/s10597-017-0216-6

McAllister, S., Simpson, A., Tsianakas, V., & Robert, G. (2021). "What matters to me": A multi-method qualitative study exploring service users', carers' and clinicians' needs and experiences of therapeutic engagement on acute mental health wards. *International Journal of Mental Health Nursing*, *30*(3), 703-714. https://doi.org/10.1111/inm.12835

McCance, T., Gribben, B., McCormack, B., & Laird, E. A. (2013). Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme. *International Practice Development Journal*, *3*(1).

McCance, T., McCormack, B., & Dewing, J. (2011). An exploration of person-centredness in practice. *Online Journal of Issues in Nursing*, *16*(2), 1-10. https://doi.org/10.3912/OJIN.Vol16No02Man01

McCormack B. (2001) Negotiating Partnerships with Older People: A Person-centred Approach. Ashgate, Basingstoke.

McCormack, B. (2003). A conceptual framework for person-centred practice with older people. *International Journal of Nursing Practice*, *9*(3), 202-209. https://doi.org/10.1046/j.1440-172X.2003.00423.x

McCormack, B. (2004). Person-centredness in gerontological nursing: an overview of the literature. *Journal of Clinical Nursing*, *13*(s1), 31-38. https://doi.org/10.1111/j.1365-2702.2004.00924.x

McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T.E., Porock, D., van Lieshout, F., & Wilson, V. (2015) Person-centredness – the 'state' of the art. *International Practice Development Journal*, 5(1), 1-15. https://doi.org/10.19043/ipdj.5SP.003.

McCormack, B., Manley, A., & Titchen, A. (2013). *Practice development in nursing*. Wiley-Blackwell.

McCormack, B., Dickson, C., Smith, T., Ford, H., Ludwig, S., Moyes, R., Lee, L., Adam, E., Paton, T., Lydon, B., & Spiller, J. (2018). 'It's a nice place, a nice place to be'. The story of a practice development programme to further develop person-centred cultures in palliative and end-of-life care. *International Practice Development Journal*, *8*(1), 1-23. https://doi.org/10.19043/ipdj81.002

McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing*, *56*(5), 472-479. https://doi.org/10.1111/j.1365-2648.2006.04042.x

McCormack, B., & McCance, T. (Eds.). (2016). *Person-centred practice in nursing and health care: Theory and practice*. ProQuest Ebook

McKay, K., Ariss, J., & Rudnick, A. (2020). RAISe-ing awareness: Person-centred care in coercive mental health care environments—A scoping review and framework development. *Journal of Psychiatric and Mental Health Nursing*, *28*(2), 251-260. https://doi.org/10.1111/jpm.12671

Mead, N., & Bower, P. (2000). Patient-centeredness: A conceptual framework and review of the empirical literature. *Social Science & Medicine, 51,* 1087-1110. https://doi.org/10.1016/S0277-9536(00)00098-8

Mertens, D. (2003). Mixed methods and the politics of human research: The transformative-emancipatory perspective. In A. Tashakkori & C. Teddle (Eds.), Handbook of mixed methods in social & behavioral research (pp. 135-164). Sage.

Mertens, D. M. (2007). Transformative Paradigm: Mixed Methods and Social Justice. *Journal of Mixed Methods Research, 1*(3), 212–225. https://doi.org/10.1177/1558689807302811

Mertens, D. (2009). *Transformative research and evaluation*. Guilford Press.

Molina-Mula, J., Gallo-Estrada, J., & Perello´-Campaner, C. (2017). Impact of Interprofessional Relationships from Nurses' Perspective on the Decision-Making Capacity of Patients in a Clinical Setting. *International Journal of Environmental Research and Public Health, 15*(1), 49. https://doi.org/10.3390/ijerph15010049

Montague, T., Gogovor, A., Aylen, J., Ashley, L., Ahmed, S., Martin, L., Cochrane, B., Adams, O., & Nemis-White, J. (2017). Patient-Centred Care in Canada: Key Components and the Path Forward. *Healthcare Quarterly*, *20*(1), 50–56. https://doi.org/10.12927/hcq.2017.25136

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare

contexts. *Scandinavian Journal of Caring Sciences*, *31*(4), 662–673. https://doi.org/10.1111/scs.12376

Morant, N., Kaminskiy, E., & Ramon, S. (2015). Shared decision making for psychiatric medication management: beyond the micro-social. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *19*(5), 1002-1014. https://doi.org/10.1111/hex.12392

Morgan, S., & Yoder, L. (2012). A concept analysis of person-centered care. *Journal of Holistic Nursing, 30*(1), 6-15. https://doi.org/10.1177/0898010111412189

National Ageing Research Institute. (2006). What is person-centred health care? A literature review. http://www.mednwh.unimelb.edu.au/pchc/downloads/PCHC_literature_review.pdf

Nightingale, F. (1860). *Notes on nursing what it is, and what it is not*. D. Appleton.

Ogden, K., Barr, J., & Greenfield, D. (2017). Determining requirements for patient-centred care: a participatory concept mapping study. *BMC Health Services Research*, *17*(1), 780-780. https://doi.org/10.1186/s12913-017-2741-y

Oh, I. O., & Nam, K. A. (2018). An exploration of essentials of psychiatric and mental health nursing. *Journal of Korean Academic Psychiatry and Mental Health Nursing, 27*(4), 415–426. https://doi.org/10.12934/jkpmhn.2018.27.4.415

Olsson, L., Jakobsson Ung, E., Swedberg, K., & Ekman, I. (2013). Efficacy of person-centred care as an intervention in controlled trials – a systematic review. *Journal of Clinical Nursing*, *22*(3-4), 456–465. https://doi.org/10.1111/jocn.12039

Parley, F. F. (2001) Person-centred outcomes: are outcomes improved where a person-centred model is used? *Journal of Learning Disabilities, 5*(4), 299-308. https://doi.org/10.1177%2F146900470100500402

Pelzang, R. (2010). Time to learn: Understanding patient-centred care. *British Journal of Nursing, 19*(14), 912–917. https://doi.org/10.12968/bjon.2010.19.14.49050

Peplau, H. (1997). Peplau's theory of interpersonal relations. *Nursing Science Quarterly, 10*(4), 162-167. https://doi.org/10.1177/089431849701000407

Phelan, A., McCormack, B., Dewing, J., Brown, D., Cardiff, S., Cook, N., Dickson, C., Kmete, S., Lorber, M., Magowan, R., McCance, T., Skovdahl, K., Štiglic, G., & van Lieshout, F. (2020). Review of developments in person-centred healthcare. *International Practice Development Journal*, *10*(Suppl2), 1-29. https://doi.org/10.19043/ipdj.10Suppl2.003

Public Health Agency of Canada. (2014). Critical Appraisal Toolkit. https://publications.gc.ca/collections/collection_2014/aspc-phac/HP40-119-2014-eng.pdf

Puschner, B., Becker, T., Mayer, B., Jordan, H., Maj, M., Fiorillo, A., Égerházi, A., Ivánka, T., Munk-Jørgensen, P., Krogsgaard Bording, M., Rössler, W., Kawohl, W., & Slade, M. (2016). Clinical decision making and outcome in the routine care of people with severe mental illness across Europe (CEDAR). *Epidemiology and Psychiatric Sciences*, *25*(1), 69–79. https://doi.org/10.1017/S204579601400078X

Registered Nurses Association of Ontario. Person- and Family-Centred Care. https://rnao.ca/sites/rnao-ca/files/FINAL_Web_Version_0.pdf

Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal of the American*

Academy of Nurse Practitioners, 20(12), 600–607. https://doi.org/10.1111/j.1745-7599.2008.00360.x

Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners*, *20*(12), 600-607. https://doi.org/10.1111/j.1745-7599.2008.00360.x

Royal College of Psychiatrists (2014). Report of the second round of the National Audit of Schizophrenia (NAS2). London: HWUIP and the Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/national-audit-of-schizophrenia-document-library/nas_round-2-report.pdf?sfvrsn=6356a4b0_4

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *21*(2), 429-440. https://doi.org/10.1111/hex.12640

Sharma, T., Bamford, M., & Dodman, D. (2015). Person-centred care: an overview of reviews. *Contemporary Nurse : a Journal for the Australian Nursing Profession*, *51*(2-3), 107–120. https://doi.org/10.1080/10376178.2016.1150192

Silva, D. (2014). *Helping measure person-centred care.* The Health Foundation. https://www.health.org.uk/publications/helping-measure-person-centred-care

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: Implementing

recovery-oriented practices in mental health systems. *World Psychiatry, 13*, 12–20. https://doi.org/10.1002/wps.20084

Slater, L. (2006). Person-centredness: A concept analysis. *Contemporary Nurse, 23*, 135-144. https://doi.org/10.5172/conu.2006.23.1.135

Slater, P., McCance, T., & McCormack, B. (2015). Exploring person-centred practice within acute hospital settings. *International Practice Development Journal*, *5*(Suppl), 1-8. https://doi.org/10.19043/ipdj.5SP.011

Slater, P., McCance, T., & McCormack, B. (2017). The development and testing of the Person-centred Practice Inventory – Staff (PCPI-S). *International Journal for Quality in Health Care*, *29*(4), 541-547. https://doi.org/10.1093/intqhc/mzx066

Smith, G. P., & Williams, T. M. (2016). From providing a service to being of service: advances in person-centred care in mental health. *Current Opinion in Psychiatry*, *29*(5), 292-297. https://doi.org/10.1097/YCO.0000000000000264

Stanhope, V., Ingoglia, C., Schmelter, B., & Marcus, S. C. (2013). Impact of person-centered planning and collaborative documentation on treatment adherence. *Psychiatric Services*, *64*(1), 76–79. https://doi.org/10.1176/appi.ps.201100489

Stanhope, V., & Matthews, E. B. (2019). Delivering person-centered care with an electronic health record. *BMC Medical Informatics and Decision Making*, *19*(1), 168–168. https://doi.org/10.1186/s12911-019-0897-6

Stewart, M., Brown, J. B., Weston, W., McWhinney, I., McWilliam, C., & Freeman, T. (1995). *Patient-centered medicine: Transforming the clinical method.* London, England: Sage.

Tashakkori, A. & Teddlie, C. (2009). Integrating qualitative and quantitative approaches to research. In *The SAGE handbook of applied social research methods* (pp. 283-317). SAGE Publications, Inc.

The Schizophrenia Commission (2012). The abandoned illness: a report from the Schizophrenia Commission. London. https://www.rethink.org/media/2637/the-abandoned-illness-final.pdf

Thorne, S. E. (2008). *Interpretive description*. Left Coast Press.

Thorne, S. (2016). *Interpretive description qualitative research for applied practice* (2nd ed). Routledge.

Thorne, S., & Stajduhar K. (2017). Rebuilding the roots of patient-centred care. *Special Focus on Nursing Leadership in Home and Community Care, 30*(1), 23-29. https://doi.org/10.12927/cjnl.2017.25109

Tiainen, M., Suominen, T., & Koivula, M. (2021). Nursing professionals' experiences of person-centred practices in hospital settings. *Scandinavian Journal of Caring Sciences*, *35*(4), 1104-1113. https://doi.org/10.1111/scs.12925

Tofthagen, R., Talseth, A.-G., & Fagerstrom, L. (2014). Mental health nurses' experiences of caring for patients suffering from self-harm. Nursing Research and Practice, 2014, 1–10. https://doi.org/10.1155/2014/905741

Van Diepen, C. (2020). Association between person-centred care and healthcare providers' job satisfaction and work-related health: A scoping review. *BMJ Open*, *12*(12), p.e042658-e042658. https://doi.org/10.1136/bmjopen-2020-042658

Wale, J., Belkin, G. S., & Moon, R. (2011). Reducing the use of seclusion and restraint in psychiatric emergency and adult inpatient services- improving patient-centered care. *Permanente Journal*, *15*(2), 57–62. https://doi.org/10.7812/TPP/10-159

Watson, J. (1985) Nursing: Human science and human care, a theory of nursing. National League for Nursing, New York.

Wong. O., (2014). Contextual Barriers to the Successful Implementation of Family-Centered Practice in Mental Health Care: A Hong Kong Study. *Archives of Psychiatric Nursing*, *28*(3), 212–219. https://doi.org/10.1016/j.apnu.2014.02.001

World Health Organization. (2015). *WHO global strategy on people-centred and integrated health services: Interim report.* https://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_SDS_2015.6_eng.pdf

Wilson, V., Dewing, J., Cardiff, S., Mekki, T. E., Øye, C., & McCance, T. (2020). A person-centred observational tool: devising the Workplace Culture Critical Analysis Tool. *International Practice Development Journal*, *10*(1), 1-15. https://doi.org/10.19043/ipdj.101.003

Wynia, K., Spoorenberg, S. L. W., Uittenbroek, R. J., Jager, M., Kremer, H. P. H., & Reijneveld, S. A. (2018). Long-term advantages of person-centred and integrated care: results of a longitudinal study on Embrace. *International Journal of Integrated Care*, *18*(S2), 362–. https://doi.org/10.5334/ijic.s2362

Chapter 2: Person-centred Care Among Mental Health Nurses: A Cross-sectional Study

Chantille Isler PhD(c), RN

Joy Maddigan PhD, RN

Alice Gaudine PhD, RN, FCAN

Robin Burry PhD, RN

Introductory Statement

Chapter 2 contains a manuscript that presents the quantitative results from the mixed methods research. The target audiences for this manuscript are mental health nurses and health organizations. This manuscript was written with the intention for submission the Canadian Journal of Nursing Research, however, excess details will be removed for publication to meet the required word limit.

Authorship Statement:

Chantille Isler (the primary investigator) and Dr. Maddigan contributed to the conception and research design. With guidance from Dr. Maddigan, Chantille Isler contributed to data collection, analysis, and interpretation and wrote the manuscript. Dr. Maddigan, Dr. Gaudine, and Dr. Burry reviewed the manuscript and revisions were made by Chantille Isler based on feedback. Dr. Maddigan, Dr. Gaudine, and Dr. Burry reviewed the revised manuscript and gave final approval.

Key Words:

Person-centred care, cross-sectional, nursing, mental health

Abstract

Background: Person-centred care can result in improved patient satisfaction and health outcomes, however, operationalization of person-centred care has been challenging in mental health settings. To advance person-centred mental health nursing care more evidence is needed regarding the PCC practices that currently exist.

Purpose: The purpose of this study was to describe person-centred mental health nursing practice as well as associated factors.

Methods: This study is the descriptive cross-sectional quantitative portion of a mixed methods study conducted to understand the person-centred practice patterns of mental health nurses working in a province in Atlantic Canada. All mental health and addictions nurses in the province (N = approximately 400) were invited to complete an online survey including three questionnaires: 1) Person-centred Practice Inventory – Staff (PCPI-S) (Slater et al., 2017), 2) Person-centred Climate Questionnaire – Staff (Edvardsson et al. 2010), and 3) 13 demographic and work-related questions developed for the study.

Results: A response rate of approximately 17.5% was achieved (n = 70). All three domains of the PCPI-S were scored high by nurses: prerequisites domain mean score 75.73 (SD = 9.4; maximum possible score = 90), the care environment mean score was 91.97 (SD = 16.91; maximum possible score = 125), care process mean score was 68.91 (SD = 9.01; maximum possible score = 80). There was a moderate, positive, statistically significant ($r_s = 0.451$, $p < 0.001$) association between the care environment domain score of the PCPI-S and the care process domain score of the PCPI-S, which was the measure of delivery of PCC. A regression model explained 76.1% of the variance in the care process domain score of the Person-centred Practice Inventory-Staff score and had three significant predictors: 1) the prerequisites domain

score of the PCPI-S, 2) the environment domain score of the PCPI-S, and 3) relationship with manager.

Conclusions: Findings from this study align with other person-centred care studies that surveyed nurses.

Person-Centred Care Among Mental Health Nurses: A Cross-sectional Study

Person-centred care (PCC) has been endorsed by many national and international health care organizations, including the Canadian Nursing Association (CNA, 2011) and the World Health Organization (WHO, 2015). In essence, PCC is the humanizing of health care delivery, prioritizing the needs and preferences of individuals and families rather than the tasks of care or the disease (McCormack et al., 2015; Morgan & Yoder, 2012; Phelan et al., 2020; WHO 2015). Nurses and other health professionals who practice within a person-centred framework strive to understand and work with the narratives of those receiving care through the co-creation and monitoring of a health plan (Britten et al., 2020; Coulter et al., 2015; McCormack & McCance, 2016). Thereby, individuals assume increased responsibility for their care, resulting in increased self-efficacy (Fors et al., 2015; Olsson et al., 2014; Pirhonen et al., 2017).

With a focus on the person, PCC is a fundamental element of nursing practice (Parse, 2019; Nightingale, 1860; Thorne & Stajduhar, 2017). The importance of relationships with those cared for has historically been emphasized in models of nursing care (Boykin & Schoenhofer 1993; Peplau 1952; Watson 1999). Similarly, the relationship between nurses, those for whom they care and their loved ones, is central to PCC (McCormack & McCance 2016). Although true for all areas of nursing, the significance of relationships is mental health nursing is paramount (Barker, 2001; van Dusseldorp et al., 2023; Gunasekara et al., 2014; Wills, 2010) and the recovery movement within the mental health community has further reinforced these person-centred principles (Shepherde et al, 2008).

PCC is a central pillar of high-quality health care (Institute of Medicine, 2001). It has been linked to improved patient outcomes (Ballard et al., 2018; Ekman et al., 2012; Fors et al., 2015; Olsson et al., 2014; Wynia et al., 2018), satisfaction of care (Allerby et al., 2020; Kuipers

et al., 2019; Rossom et al., 2016), as well as job satisfaction for nurses (den Boer, Nieboer, & Cramm, 2017; Diepen et al., 2020; Lehuluante et al., 2012). Despite the benefits of PCC, operationalization has been a persistent issue in many health care settings (Moore et al., 20217), including mental health (Choy-Brown et al., 2020; Gask & Coventry, 2012; Hennessey et al. 2023; Hsiao, Lu, & Tsai, 2019; McKay et al., 2021; Slater et al., 2017; Tully et al., 2023; Wykes et al., 2018). Issues such as traditional practices and structure, professional attitudes, and time constraints of staff can make implementation challenging (Moore et al., 2017). In addition, issues specific to mental health care increase the complexity of operationalization. Potential social stigma, discrimination, lack of insight, altered cognition, disempowerment, marginalization, and restrictions in exercising human rights create compounding challenges in operationalization of PPC in mental health settings (Smith & Williams, 2016). It is not surprising then that implementation of the recovery model used in psychiatry, within which PCC is a key component, has faced similar operationalization challenges (Biran-Ovadia et al., 2023; Ørjasæter & Almvik, 2022).

PCC cannot be effectively provided to individuals by simply relying on the motivation of nurses and other health care professionals; it also requires sustained organizational commitment to cultivate and support person-centred cultures (McCormack et al., 2011; McCormack & McCance, 2016; Phelan et al., 2020). A person-centred culture is a practice environment that upholds conditions such as effective coordination of patient and family care, strong clinical leadership, facilitation, effective teamwork, knowledgeable and skilled health care professionals, a flexible model of care, and a systemic person-centred vision (Edgar et al., 2020; McCance et al., 2013). Organizations with a true commitment to developing person-centred cultures ensure that it is embedded in everyday practices at every organizational level (McCormack 2020).

In order for organizations to operationalize PCC and cultivate person-centred cultures, the adoption of a PCC framework is required. McCormack and McCance (2016) developed *The Person-centred Practice Framework* (Figure 1.1) to facilitate the development and operationalization of person-centred health cultures. Using the framework as a guide, organizations can effectively translate the principles of person-centredness into practice (Tiainen et al. 2021). The purpose of this study is to determine the PCC practices of mental health nurses and the factors that impact PCC.

This study is the quantitative portion of a provincial mixed methods study conducted to better understand the PCC practice patterns of mental health nurses working in an Atlantic Canadian province. In the spirit of self-reflexivity, the research team acknowledges their standpoint as educated, white-settler, Canadian woman. The primary investigator has a strong commitment to social justice and aligns with Donna Merten's Transformative Paradigm (Mertens, 2007), which is described in chapter 1.

Theoretical Framework for the Study

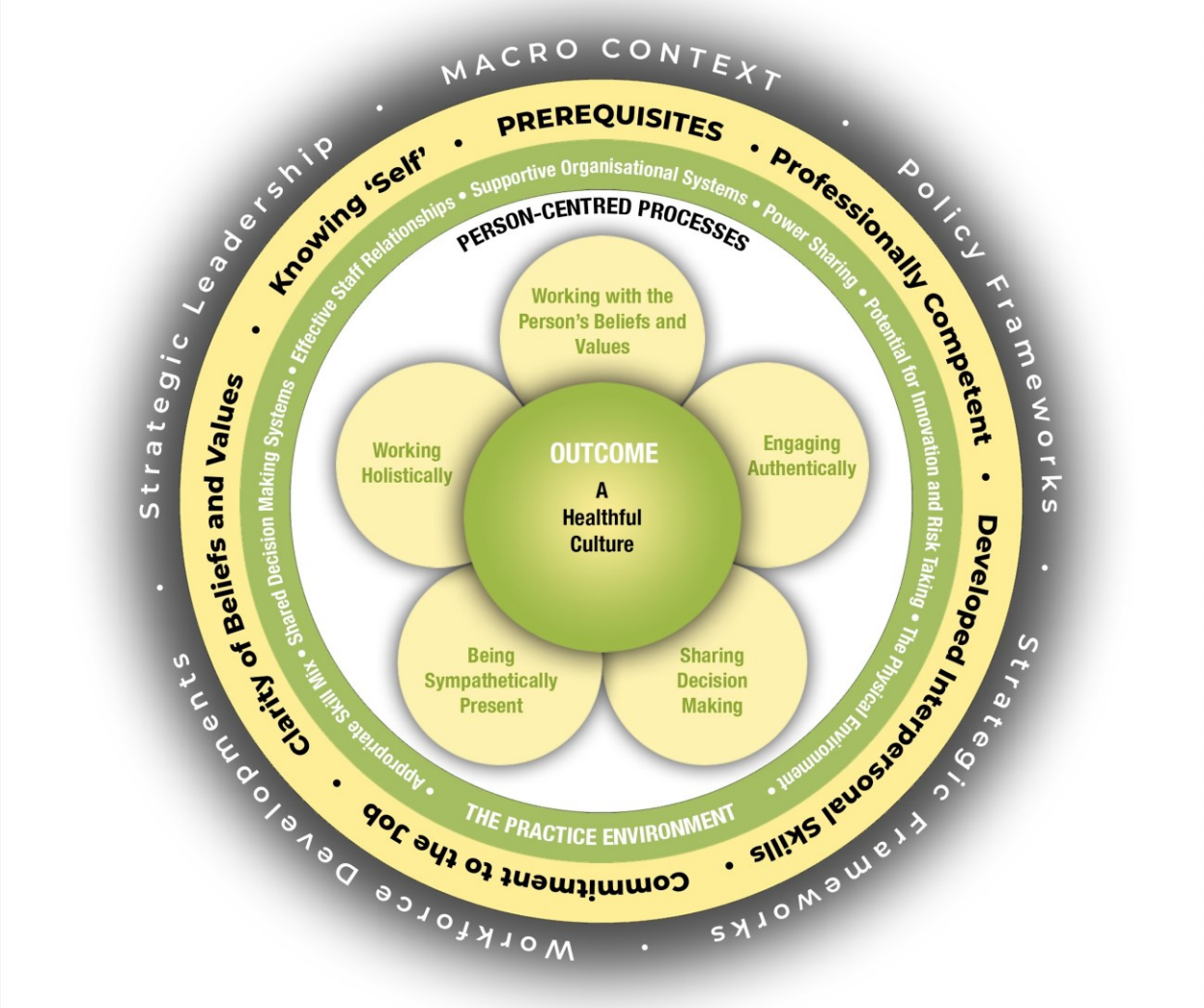
This study is underpinned by The Person-centred Practice Framework (Figure 1.1) (McCormack & McCance, 2016). The framework is rooted in concepts of caring and personhood (McCormack & McCance, 2006; McCormack & McCance, 2016) and was originally developed as a framework for nursing practice. Overtime, it has been refined to include all health disciplines (McCormack & McCance, 2016). The framework assists health care teams to understand PCC and how components of PCC can be operationalized (McCormack & McCance, 2016). The definition of PCC used in this study aligns with the person-centred practice framework:

> *An approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development* (McCormack et al., 2013, p 193).

The person-centred practice framework has four domains: prerequisites, the care environment, the care process, and person-centred outcomes (McCormack & McCance, 2016). To help further describe each domain, several, more concrete, constructs are included in the framework (Slater et al., 2017). The domains of the framework are structured in such a way that the outer domains should be considered and enhanced to strengthen the next inner layer. That is, strengthening health care professionals is a prerequisite to improving the care environment, which is required to deliver care through the person-centred processes (McCormack & McMCane, 2016; Slater et al., 2017). Through this process, person-centred outcomes are attained which is at the centre of the framework.

Figure 2.1

The Person-centred Practice Framework [Reproduced with permission from the person-centred practice international community of practice (2023)].



Methods

Design

This quantitative, descriptive, cross-sectional study is part of a larger mixed methods study designed to address the following research questions:

1) What are the self-reported PCC practices of mental health nurses?
2) To what extent is the practice environment associated with the delivery of PCC?
3) What occupational, environmental, and demographic factors predict nurses' delivery of PCC?
4) What are the occupational and demographic factors that predict a PCC environment?

Population and Recruitment

All RNs currently working in mental health and addictions (MH & A) services throughout the province were the target population for this study. According to the nursing regulatory body of the province, approximately 400 registered nurses (RNs) worked in either the community or inpatient mental health settings and read and understood English and, therefore, were eligible to participate in this study. Approximately 260 RNs, working in mental health who agreed to be contacted for research purposes, were invited by the provincial nursing regulatory body to participate in the study via email invitation (Appendix I). In addition, all RNs working in the provincial MH & A program were invited to participate via email sent through their employer. Further, the employers circulated invitation posters to RNs across the province both via email and through signage in the workplace (Appendix J). The emails and poster contained a link to the survey. It is assumed that all 400 RNs received an invitation from their employer as MH&A senior management in all health regions agreed to facilitate survey distribution through posters and email.

Data Collection

The online survey package was delivered through Qualtrics^{XM}, a software program for creating and delivering surveys. The online survey package began with an information letter

summarizing the study and stating the participant's rights (Appendix K). It made clear that participation was voluntary and completing the survey implied consent.

In total, 100 responses were received (25% approximated response rate) however, only 70 responses were included for data analysis due to missing data (17.5% approximated response rate). Although all RNs working in MH & A were contacted to participate, the actual response rate cannot be determined as the exact number of RNs working in the provincial MH & A Program in not known. Survey submissions with greater than 10% of data missing were removed from the study. Submissions with missing data of less than 10% were included and a zero was used to replace any missing value, as to not inflate results (Dong & Peng, 2013).

Outcomes and Measures

The survey package included: 1) the person-centred practice inventory- staff (PCPI-S) (Slater et al., 2017) (Appendix A), 2) the person-centred climate questionnaire-staff version (PCCQ-S) (Edvardsson et al. 2010) (Appendix B), and 3) 13 work-related and demographic questions (Appendix C) developed for this study. Table 2.1 lists the measures used for each key study outcome.

Table 2.1

Measures for key study outcomes

Outcomes	**Measure**
Practice Environment	1) The practice environment domain score of the PCPI-S 2) The PCCQ-S total score
Delivery of PCC	1) The care process domain score of the PCPI-S

The Person-centred Practice Inventory-Staff. The PCPI-S (Slater et al., 2017) (Appendix A) is a self-report tool designed for health care professionals in all health care settings. It was developed in alignment with McCormack and McCance's (2016) Person-centred Practice Framework and examines how staff perceive person-centred practice (Slater et al., 2017). The questionnaire has 59 items, each with a 5-point Likert-type scale ranging from 1 = strongly disagree to 5 = strongly agree. The maximum score for each domain is as follows: prerequisites (90), the care environment (125), and the care process (80). The tool measures 17 constructs that align with one of three major domains of The Person-centred Practice Framework: prerequisites, the care environment, and the care process. The prerequisites domain considers attributes of the nurse, the care environment domain focuses on the context within which the care is delivered, and the care process domain represents the delivery of PCC to individuals (Slater et al., 2017).

The tool was found to be valid when tested on nurses working in a range of acute care settings, including mental health (Slater et al., 2017). In the confirmatory factor analysis, all factor loadings were statistically significant ($p \leq 0.05$) and ranged from 0.417 to 0.921 (Slater et al., 2017). Permission to use the instrument was granted by the tool developers. No study has been located that tests the reliability of the tool, therefore, it was assessed as part of this dissertation research study; the Cronbach's alpha for PCPI-S was 0.97. For each domain, the Cronbach's alpha was as follows: Prerequisites = 0.87; Care Environment = 0.91; Care Process = 0.93. This means that the internal consistency for tool and the three subscales was good.

The Person-centred Climate Questionnaire – Staff Version. This self-report tool (Appendix B) was developed to evaluate to extent to which staff perceive the climate of health care settings as person-centred (Edvardsson et al., 2010). The PCCQ-S includes four subscales:

1) a climate of safety, 2) a climate of everydayness, 3) a climate of community, and 4) a climate of comprehensibility. A climate of safety referred to a place that was welcoming and where one could be themselves. A climate of everydayness referred to a place that felt homely and was clean, nice to look at, and peaceful. A climate of community referred to a place where one could get unpleasant thoughts out of there head as well as contact loved ones and have them visit with relative ease. Finally, a climate of comprehensibility refers to a place where people are safe and in good hands, as well as where people have staff available to talk with who use understandable language. The questionnaire has 14 items, each rated on a six-point Likert-type scale ranging from 1 = "No, I very strongly disagree," to 6 = "Yes, I very strongly agree." When summed, scores can range from 14, indicating a climate that is not person-centred, to 84, indicating a climate that is very person-centred (Edvardsson et al., 2010).

Evidence for the tool's reliability was found when tested with Australian health care professionals working in a hospital caring for those receiving planned services, such as short-stay elective surgery and diagnostic procedures (Evardsson et al., 2010). In that study, the Cronbach's alpha coefficient was satisfactory for the total scale (0.89) and for the four subscales: 0.87, 0.79, 0.82 and 0.69. In addition, when test–retest reliability was conducted there were no statistically significant differences found between the mean scores of the questionnaire at the times of test and retest. Principal component analyses were used to assess construct validity; all items showed good to excellent factor loadings with minor cross-loadings (Edvardsson et al., 2010). Dividing the items into four categories explained 71.8% of the total variance, indicating that the items measure the same underlying construct (Edvardsson et al., 2010). The sample used by Edvardsson et al. (2010) to test the reliability and validity of the tool was similar to the population in our study in that they were both health care professionals. However, the health care

professionals in the study by Edvardsson et al. (2010) were caring for those in hospital receiving planned services and the population in our study were mental health nurses. The Cronbach's alpha for the PCCQ was calculated for this study and was found to be 0.89 (A Climate of Safety = 0.90; A Climate of Everydayness = 0.79; A Climate of Community = 0.67, A climate of Comprehensibility = 0.75). This means that the internal consistency for all sub-scales was good, except "A Climate of Community," which was still acceptable at 0.67. Permission to use the instrument was granted by the tool developers.

Participant Characteristics: Thirteen participant characteristics were also collected for the study (Appendix C), including: 1) age in years, 2) populations cared for, 3) practice setting, 4) number of years as an RN, 5) number of years as a mental health nurse, 6) highest level of education, 7) sex, 8) practice region, 9) certification as a psychiatric mental health nurse from the Canadian Nurses Association, 10) nursing role, 11) job satisfaction, 12) turnover intention, and 13) relationship with manager.

Ethical Considerations

Ethics approval was received for this study by the provincial research ethics board (application # 20222135). Required approvals were also granted by all participating institutions and health authorities. Nurses were not remunerated to participate in the study. There were no obvious or immediate risks or benefits to nurses participating in the study. Nurses were provided with a list of resources at the end of the survey should they feel the questions affected their mental health.

Data Analysis

The statistical software package SPSS version 28 (IMB Corp, 2021) was used to analyze the data for this study. Histograms and the Shapiro-Wilk test were used to test for normality of

variables. One variable was positively skewed, many were negatively skewed, and others had a normal distribution. Significance level for the study was set at $p \leq 0.05$.

For descriptive analyses of participants' personal and professional characteristics, frequencies and percentages were generated for categorical variables. Means (SD) and medians (IQR) were calculated for continuous variables.

To address the first research question, to determine the self-reported PCC practices of mental health nurses, the 59 individual items of the PCPI-Staff were summed as per the accompanying manual, resulting in 17 sub scores containing between 3 to 5 items. Means and standard deviations (SD) were reported for all 17 sub scores. The 17 sub scores were then further categorized to the three major overarching domains of person-centred practices: prerequisites, care environment, care process. Both means (SD) and medians [interquartile range (IQR)] were reported for all three as not all data were normally distributed. For the remaining research questions the care process domain score was used as a measure for delivery of person-centred care in the study.

To address the second research question, to determine the association between practice environment and the delivery of PCC, a Spearman's rho (R_s) was used. This test was chosen because the data from the care process domain of the PCPI-S, which is the measure for the delivery of PCC, was negatively skewed. In this study there were two measures for environment: 1) The score for the practice environment domain of the PCPI-S, and 2) the total score of the PCCQ. Although there is some overlap between the measures, items pertaining to each largely addressed differing aspects of the care environment. Therefore, two Spearman's rho tests were run, one testing the association between the care process domain and the care environment

domain of the PCPI-S and one testing the association between the care process domain of the PCPI-S and the PCCQ.

The final two research questions were addressed using multiple linear regression. Research question three was: What occupational, environmental, and demographic factors predict nurses' delivery of PCC? The delivery of PCC was the outcome variable, measured by the care process domain score. Variables assessed were: 1) relationship with manager, 2) the prerequisites score on the PCPI-S, 3) the care environment score of the PCPI-S 4) age, 5) number of years as an RN, 6) number of years as a mental health RN, 7) PCCQ score, 8) sex, 9) practice setting, 10) population cared for, 11) highest level of education, 12) practice region, 13) nursing role, 14) role satisfaction, and 15) turnover intention. Research question number four was: what are the occupational and demographic factors that predict a PCC environment? For research this research question two models were created. In the first, the care environment score from the PCPI-S was the outcome variable and in the second model the total PCCQ-S score was the outcome variable. The predictor variables for each model were: 1) age, 2) number of years as an RN, 3) number of years as a mental health RN, 4) sex, 5) practice setting, 6) population cared for, 7) highest level of education, 8) practice region, 9) nursing role, 10) role satisfaction, 11) turnover intention, 12) relationship with manager, 13) the prerequisites score on the PCPI-S, and 14) the care process domain score on the PCPI-S.

The predictors were chosen if they were either deemed important in the literature or found to be significant in the bivariate analysis. For the bivariate analysis for continuous variables (e.g., age, the delivery of PCC), Spearman's rho was used to test for a relationship unless all variables were normally distributed and then Pearson's r (r) was used. For categorical variables (e.g., relationship with manager with categories good, fair, poor), the Kruskal-Wallis

test was used to test the difference of means unless the continuous variable assessed with the categorical variable was normally distributed and then ANVOA was used. Due to concerns about normality with the outcome variable in the third research question, the care process domain of the PCPI-S, spearman's rho and Kruskal-Wallis were used to identify potential predictor variables for the model.

Dummy variables were created for all categorical variables with more than two categories (Stommel & Dontje, 2014). Modeling was conducted by comparing models one at a time, dropping one variable at a time and determining if the R-squared (R^2) change was significant ($p \leq 0.05$) using an F- test. The F-test is was used to compare the two models and determine if there is a significant difference between them, therefore indicating that the variable being tested is significant in the model. If it was significant, the variable stayed in the model. If it was not significant, it was assessed as to whether it was a confounder before dropping it. When the final model was established, effect modification was assessed by comparing the model with all interaction terms included to a model without the interaction terms, using the R^2 change and F - test. A centered variable was used in the final model when interaction terms were significant to facilitate interpretation or address multicollinearity. Lastly, all assumptions of multiple linear regression were checked using the final model and found to be met (Stommel & Dontje, 2014). Although there was an outlier in the data, it was found not to be an influential outlier. This was determined by comparing the predicted probability plots of the standardized residuals when the outlier was included and excluded. They were similar, indicating the outlier was not influential.

Results

In this section, the findings related to the research questions are explained. Seventy nurses completed the questionnaire. It was not possible to calculate an exact response rate as the

actual number of MH & A nurses is unknown. Assuming there were approximately 400 MH&A nurses in the province, the response rate is 17.5%.

Participant Characteristics

Participant characteristics are presented in Table 2.2 and Table 2.3. Nurses completed the survey in all four health regions of the province with the majority of responses from the Eastern region (n = 45; 63.4%), which has the densest population. Females were the primary participants (n= 66; 94.3%) and the mean age of participants was 44.23 years. The average work experience of nurses was 18.76 years with an average of 14.08 years as a mental health nurse. The majority of participants worked in either inpatient (n = 21; 30%) or community (n = 33; 47.1%) mental health nursing care providing direct care (n = 48; 68.6%) to an adult population (n = 54; 77.1%). Only 10% (n = 7) of participants held a master's degree; for (n = 44; 62.9%) of participants, the highest level of education was an undergraduate degree. Thirty percent of participants held a certification in psychiatric mental health nursing from the Canadian Nurses Association. Eighty percent (n= 56) of participants were very satisfied or satisfied with their current nursing role, while the other (n = 14; 20%) were not satisfied. Just less the half (n = 32; 45.7%) of participants either intended to leave their role (n = 17; 24.3%) or were undecided (n = 15; 21.4%). The majority of participants (n = 47; 67.1%) had a good relationship with their manager while others described the relationship as fair (n = 18; 25.7%) or poor (n = 5; 7.1%).

Table 2.2

Participant Characteristics (continuous variables)

	N	Mean	SD	Median	IQR
Age in years	65	44.2	10.6	42.0	35.0-54.0
# of years as an RN	67	18.8	10.7	16.0	10.0-30.0
# of years as MH Nurse	67	14.1	10.2	11.0	6.0-20.0

Table 2.3

Participant Characteristics (Categorical variables)

Characteristic	**Variable**	**% (n)[1]**
Sex (n=70)	Female	94.3 (66)
	Male	4.3 (3)
	Rather not to say	1.4 (1)
Practicing setting (n=70)	Community	47.1 (33)
	Inpatient	30.0 (21)
	Emergency Services	18.6 (13)
	Other	4.3 (3)
Population under care (n=70)	Adult mental health	77.1 (54)
	Geriatric mental health	5.7 (4)
	Child/youth mental health	1.4 (1)
	Adult addictions	11.4 (8)
	Forensic	1.4 (1)
	Other	2.9 (2)
Highest level of nursing education (n=69)	Diploma	25.7 (18)
	Undergraduate	62.9 (44)
	Master's	10.0 (7)
Health authority (n=70)	Eastern	64.3 (45)
	Central	15.7 (11)
	Western	18.6 (13)
	Labrador-Grenfell	1.4 (1)
Certificate in psychiatric mental health (n=70)	Yes	30.0 (21)
	No	70.0 (49)
The nursing role (n=70)	Direct care nurse	68.6 (48)
	Nurse practitioner	4.3 (3)
	Patient care facilitator	8.6 (6)

Characteristic	Variable	% (n)[1]
	Management	7.1 (5)
	Clinical nurse specialist	2.9 (2)
	Other	8.6 (6)
Satisfaction with the nursing position (n=70)	Not satisfied	20.0 (14)
	Satisfied	50.0 (35)
	Very satisfied	30.0 (21)
Intention to leave current position (n=70)	Yes	24.3 (17)
	No	54.3 (38)
	Undecided	21.4 (15)
Relationship with the immediate manager (n=70)	Poor	7.1 (5)
	Fair	25.7 (18)
	Good	67.1 (47)

[1]% (n) is the proportion and number of participants in who had the identified characteristics

PCC Practices of Mental Health Nurses

When items were summed, the mean score for the prerequisite domain was 75.7 (SD = 9.4; maximum possible mean score = 90) while the mean score for the care environment was 92.0 (SD = 16.9; maximum possible mean score = 125) and the mean score for the care process was 68.9 (SD = 9.0; maximum possible mean score = 80) (Table 2.4). Mean scores for the 17 constructs of the PCPI-S can be found in Table 2.5. Mean scores of the three domains were also scored out of five in Table 2.5 so that they could be more easily compared to each other. Overall, all three domains were score high by nurses (i.e. 3.8 out of 5, or higher).

The highest scored prerequisites were ‘developed interpersonal skills’ (M = 4.3, SD = 0.6) and ‘being committed to the job’ (M = 4.4, SD = 0.6). The lowest prerequisite was ‘clarity of beliefs and values’ (M = 3.8, SD = 0.7). The care environment had the lowest scores over all, compared to scores of the prerequisites and care process. ‘Shared decision-making systems’ was scored the highest (M = 4.3, SD = 0.7) and ‘supportive organizational systems’ was scored the lowest (M = 3.1, SD = 1.0). ‘Supportive organizational systems’ was the lowest scored area when comparing all seventeen constructs measuring person-centred practice. The highest scored constructs of the care process were ‘providing holistic care’ (M = 4.4, SD = 0.7) and

'sympathetic presence' (mean = 4.4, SD = 0.6), while the lowest score construct was 'shared decision making' (M = 3.7, SD = 0.8).

Table 2.4:

Mean and median scores for the 3 domains of the PCPI-S

	Mean	SD	Median	IQR
Prerequisites (18)	75.7	9.4	76.0	71.8-83.0
The Care Environment (25)	92.0	16.9	93.5	84.8-100.5
Care Process (16)	68.9	9.0	68.0	64.0-76.0

Table 2.5

PCPI-S Mean Sub-Scores

	Mean	**SD**
Prerequisites (18)[1]	4.2	0.5
Developed interpersonal skills (4)	4.3	0.6
Professionally competent (3)	4.3	0.8
Knowing self (3)	4.1	0.6
Clarity of beliefs and Values (3)	3.8	0.7
Commitment to the job (5)	4.4	0.6
The Care Environment (25)[2]	3.9	0.6
Skill mix (3)	4.1	0.6
Effective staff relationship (3)	4.0	0.8
Power sharing (4)	3.6	0.9
The physical environment (3)	4.0	0.7
Shared decision-making systems (4)	4.3	0.7
Potential for innovation and risk taking (3)	3.7	0.8
Supportive organizational systems (5)	3.1	1.0
Care Process (16)[3]	4.2	0.6
Providing holistic care (3)	4.4	0.7
Sympathetic presence (3)	4.4	0.6
Engagement (3)	4.4	0.6
Shared decision making (3)	3.7	0.8
Working with patients' beliefs and values (4)	4.1	0.6

[1]The prerequisites domain is made up five constructs and 18 questions from the PCPI-S. The number of questions that make up each construct are listed in the table.

[2] The environment domain is made up seven constructs and 25 questions from the PCPI-S. The number of questions that make up each construct are listed in the table.
[3] The care process domain is made up five constructs and 16 questions from the PCPI-S. The number of questions that make up each construct are listed in the table.

Association Between Practice Environment and Delivery of Person-centred Care

There was a moderate, positive, statistically significant ($r_s = 0.451$, $p < 0.001$) association between the care environment of the PCPI-S and the care process, which was the measure of delivery of PCC. This association suggests that as the care environment improves, so does the delivery of PCC. Total scores from the PCCQ-S were also used to assess the association between the environment and PCC; however, no significant relationship was found ($r_s = 0.235$, $p = 0.05$).

Predictors of Delivery of Person-centred Care

When using the care process domain of the PCPI-S as the outcome variable for delivery of PCC, the final predictor variables were: 1) the prerequisites domain score on the PCPI-S, 2) the environment domain score of the PCPI-S, and 3) relationship with manager. There was a significant interaction found between the environment score and relationship with manager. This means that there was a difference in the care process score depending on the relationship with manager for those with the same environment score when prerequisite score was controlled for. The final model contained the interaction terms. Each of the dummy terms for the variable for relationship with manager had its own interaction term with environment. The environment variable was centred to reduce the issue of multicollinearity and also to facilitate interpretation of the final model. Using a centered variable allows us to compare individuals with the average environment score rather than specifying the change in care process score for every one-unit change in environment score. Table 2.6 provides the model coefficients.

When controlling for prerequisites and using the mean environment score (M= 92.0) and mean prerequisites score (M= 75.7), the calculations of the predicted outcome score for those

with a good relationship with manager is shown below. The dummy variable for good relationship with manager (RMgood) was coded as 1 and the dummy variable for fair relationship with manager (RMfair) and poor relationship with manager (RMpoor) were coded as 0. The predicted score was calculated by adding the relevant coefficients as shown below.

> Predicted score = b0 + b1(RMgood X mean_env_score) + b2 (RMfair X mean_env_score) + b3 (mean_env_score) + b4 (mean_prerequisite score) + b5 (RMgood) + b6 (RMfair).
>
> Predicted score = b0 + b1(1 x mean_env_score) + b2(0 x mean_env_score) + b3(mean_env_score) + b4(mean_prerequisite score) + b5 (1) +b6 (0)
>
> Predicted score = b0 + b1 (mean_env_score) + 0 + b3 (mean_env_score) + b4 (prerequisite score) + b5 + 0
>
> Predicted score = b0 + b1 (mean_env_score) + b3 (mean_env_score) + b4 (mean_prerequisite score) + b5
>
> Predicted score = 20.27 + 0.405 (92) + -0.178(92) + .586(75.7) + 2.276
>
> Predicted score = 20.27 + 37.26 + -16.38 + 44.6 + 2.28
>
> Predicted score = 88.03

Using the same calculations, the predicted score for those with a poor relationship with manager is b0, which is 48.25. The predicted score for those with a fair relationship with manager is 68.43.

For those with a good relationship with their manager and the average environment score (M = 92.0) compared to those with a poor relationship with their manager and average environment score, their predicted care process score differed by 88.03 - 48.25 = 39.78 when prerequisite is held constant. For those with a fair relationship with their manager, compared to those with a poor relationship with their manager, their predicted care process score differed by 68.43 - 48.25 = 20.18, when prerequisite was held constant.

Table 2.6

Predictor of PCPI-S Care Process Domain Score[1]

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	20.27	8.839		2.29	.025
Relationship with Manager = Good X PCPI-S_Environment (Centred)	.405	.240	.588	1.69	.097
Relationship with Manager = Fair X PCPI-S_Environment (Centred)	.150	.249	.123	.60	.549
PCPI-S_Environment (Centred)	-.178	.235	-.334	-.76	.453
PCPI-S_Prerequisites	.586	.089	.611	6.55	<.001
Relationship with Manager = Good	2.276	5.811	.120	.39	.697
Relationship with Manager = Fair	6.135	5.905	.300	1.04	.303

[1]PCPI-S Care Process Score is a measure for delivery of PCC

The R^2 of .761 (Table 2.7) indicated that the regression model explains .761 of the variance observed in the PCPI-S (care process) score. Although this number is high, there may still be a few other factors that are impacting the outcome that we do not understand at this time.

Table 2.7

Model Summary for the delivery of PCC

				Change Statistics				
R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
.872[1]	.761	.738	4.60673	.761	33.460	6	63	<.001

[1]Predictors: (Constant), Relationship with Manager = Good X PCPI-S_Environment (Centred), Relationship with Manager = Fair X PCPI-S_Environment (Centred), PCPI-S_Environment (Centred), PCPI-S_Prerequisites, Relationship with Manager = Good, Relationship with Manager=Fair

Predictors of a Person-centred Care Environment

In this study, there were two measures for environment, PCPI (environment) score and the total PCPQ-S score**.** When using the environment domain score of the PCPI-S as the outcome variable, the significant occupational or demographic predictor variables were: 1) the prerequisites domain score on the PCPI-S, 2) the care process domain score of the PCPI-S, 3) relationship with manager, and 4) role satisfaction. There was no interaction found. Table 2.8 provides the model coefficients.

Table 2.8

Predictors of PCPI-S Environment Domain Score[1]

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	-20.840	9.959		-2.093	.040
PCPI-S_Prerequisites	.556	.226	.309	2.461	.017
PCPI-S_Care Process	.675	.234	.359	2.887	.005
Relationship with Manager = Good[2]	19.293	4.688	.539	4.115	<.001
Relationship with Manager = Fair[2]	9.641	4.795	.251	2.011	.049
Role Satisfaction = Satisfied[3]	10.694	3.087	.318	3.464	<.001
Role Satisfaction = Very satisfied[3]	11.358	3.629	.310	3.130	.003

[1]Outcome variable was care environment score of the PCPI-S
[2]Relationship with manager was categorized as good, fair, and poor
[3]Role satisfaction was categorized as very satisfied, satisfied, not satisfied

First, the model (Table 2.8) indicates that when all other variables were controlled for, each one-unit change in prerequisite score was associated an increase of 0.56 in PCPI-S (environment) score. The model also indicates that, when all other variables were controlled for, each one-unit change in the care process score was associated with an increase of 0.68 in PCPI-S (environment) score.

Second, the model (Table 2.8) also indicates that when all other variables were controlled for, having a good relationship with the manager was associated with an increase of 19.29 in PCPI-S (environment) score compared to having a poor relationship with the manager. Similarly, having a good relationship with the manager was associated with an increase of 9.64 in PCPI-S (environment) score compared to having a poor relationship with the manager

Third, the model (Table 2.8) indicates that when all other variables were controlled for, being very satisfied with one's role was associated with an increase of 11.36 in PCPI (environment) score compared to not being satisfied with one's role. Similarly, being satisfied with ones' role was associated with an increase of 10.7 in PCPI (environment) score compared to not being satisfied with one's role.

Table 2.9

Model Summary for outcome variable PCPI-S(environment)

				Change Statistics				
R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
.847[1]	.718	.691	9.40653	.718	26.705	6	63	< .001

[1]Predictors: (Constant), Relationship with manager=Good, Relationship with manager=fair PCPI-S (Care Process), Role Satisfaction=Satisfied, Role Satisfaction=Very satisfied, PCPI-S (Prerequisites)

The R^2 of .718 (Table 2.9) indicates the regression model explains .718 of the variance observed in the PCPI-S(environment) score. Although this number is high, there may still be a few other factors that are impacting the outcome that we do not understand at this time.

The previous model with PCPI-S (environment) as the outcome variable showed there were four significant predictors, including role satisfaction, as previously discussed and shown in Table 2.8. However, when using the PCCQ-S score as the outcome variable the only significant occupational or demographic predictor variable was role satisfaction (Table 2.10).

Table 2.10

Predictors of PCCQ-S Score[1]

	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	t	Sig.
(Constant)	52.071	2.527		20.608	< .001
Role Satisfaction =Satisfied[2]	9.386	2.990	.452	3.139	.003
Role Satisfaction =Very satisfied[2]	13.405	3.262	.592	4.109	< .001

[1]Outcome variable was the PCCQ-S
[2]Role satisfaction was categorized as very satisfied, satisfied, not satisfied

The model indicates that, being satisfied in one's role was associated with an increase of 9.24 in PCCQ-S score compared being unsatisfied with one's role. The model also indicates that, being very satisfied in one's role was associated with an increase of 13.41 in PCCQ-S score compared being unsatisfied with one's role.

The R^2 of .205 (Table 2.11) reveals that the regression model explains 20.5% of the variance observed in the PCCQ score. This low percentage indicates other factors are impacting the outcome that we do not understand at this time and further exploration of other variables is needed.

Table 2.11

Model Summary for outcome variable PCCQ

R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	F Change	df1	df2	Sig. F Change
.452[1]	.205	.181	9.45441	.205	8.620	2	67	< .001

[1]Predictors: (Constant), Role Satisfaction=Satisfied, Role Satisfaction=Very satisfied

Discussion

In this study, nurses' person-centred practices were examined through the three domains of the Person-centred Practice Framework: 1) prerequisites, 2) the care environment, and 3) the care processes. The results of this study indicate that mental health nurses self-report high scores (3.9 or higher on a scale of 1 to 5) in each of the three domains, suggesting that nurses align with person-centred principles and want to practice person-centred care. Regarding prerequisites to PCC (i.e. nurses' attributes), nurses scored themselves particularly high in three of five areas: 1) professional competence, 2) developed interpersonal skills, and 3) commitment to the job. This suggests that nurses believe that they have the knowledge, skills, and attitudes required to provide PCC (McCormak & McCance, 2016; Slater et al., 2015; Slater et al., 2017). Clarity of beliefs and values was the lowest scored prerequisite construct in this study and perhaps an area to address in the development of a person-centred culture. Health care professionals that contribute to an effective workplace culture have shared values such as person-centredness, continuing education, and being led by high challenge/high support, that are obtained through a shared vision (Manley et al. 2011; McCormack & McCance, 2016).

Regardless of the prerequisite skills and characteristics nurses possess, their ability to provide person-centred care will diminish if supportive care environments are not in place (McCormack & McCane, 2016). Under the care environment domain, nurses scored particularly high in two areas: 1) skill mix and 2) shared decision-making. However, overall, nurses scored the care environment domain lower than prerequisites or the care process domains. 'Supportive organizational systems' was not only the lowest scored care environment construct but also the lowest scored of all 17 constructs. Magnet Hospitals are known for empowering nurse initiative and creativity; they invest in the professional development of nurses (McCaughey et al., 2020). They are awarded the "Magnet" designation by maintaining both exceptional patient care and nursing practice environment (McCaughey et al. 2020). Such supportive organizational systems are underpinned by a shared governance framework that prioritizes culture, communication, professional autonomy, and accountability (McCormack & McCance, 2016: Speroni et al., 2021). Studies indicate that RN job satisfaction (Speroni et al., 2021) and patient satisfaction (McCaughey et al., 2020) are higher in hospitals with magnet designation.

The care process domain represents care activities that operationalize person-centered practice (McCormakc & McCance, 2016). In this study, the care process domain scores represent the delivery of person-centred care. Nurses scored themselves particularly high for the following three person-centred process constructs: 1) providing holistic care, 2) sympathetic presence, and 3) engaging authentically. Nurses scored lowest on their ability to engage patients in shared decision-making. Facilitating shared-decision making is particularly important in psychiatry, where patient autonomy is often diminished (Smith & Williams, 2016). It is the role of the nurse to offer support and expertise, while enabling the patient to choose their own path, in their own way (McCormack & McCance, 2016).

Findings from this study are similar to Tiainen et al. (2021) who used the PCPI-S to evaluate the person-centred practices of nurses in a large Finish hospital. They too reported high scores for all three domains (Tiainen et al., 2021). It is important to interpret such findings with caution as nurses can overestimate the extent to which they practice PCC (Bolster & Manias, 2010). One Australian study that examined person-centred interactions between patients and nurses found inconsistencies between how nurses say they practice and how they actually practice (Bolster & Manias, 2010). Nurses perceived they were practicing in a person-centred way; however, observational data revealed interactions were often centred on the nurses' perceptions of patient priorities rather than the patients' priorities themselves (Bolster & Mania, 2010).

Association Between the Practice Environment and Delivery of Person-centred Care

Results from this study supported a positive association between the care environment and the delivery of PCC. This is an expected result, as McCormack and McCance (2016) indicated that the care environment directly impacts person-centred practice. Several other studies have also shown the importance of environment in improving health care delivery and quality of care (Kieft et al., 2014; Naseri et al., 2022; Ta'an et al., 2020). In their cross-sectional study, Rutten et al. (2021) found that work environment characteristics such as teamwork, social support from managers, and staff development opportunities were associated with self-reported PCC. Using structural equation modeling, Balqis-Ali et al. (2022) also found a significant relationship between the care environment and the delivery of PCC; they too used the person-centred process domain of the Person-centred Practice Framework to quantify the delivery of PCC. Finally, a significant positive relationship between leadership and person-centred care was found in one Swedish study (Backman et al. 2021). Health care professionals who identified that

their leaders coached, gave feedback, were open to innovative ideas, and allowed staff space to handle conflicts constructively also reported delivering a higher degree of PCC (Backman et al., 2021).

Predictors of Delivery of Person-centred Care

In this study there were three significant predictors to the delivery of PCC. Two predictors are from the Person-centred Practice Framework: prerequisites to PCC and the care environment. This is an expected finding as McCormack and McCance (2016) stress the importance of both in the delivery of PCC. Prerequisites refer to the qualities of the nurse: professional competence, developed interpersonal skills, commitment to the job, knowing self, and clarity of belief and values (McCormack & McCance, 2016). Ahn and Yi (2022) also found that moral sensitivity and professional qualifications were predictors to the provision of PCC by mental health nurses. In the Person-centred Practice Framework (McComack & McCance, 2016), the care environment refers to the following characteristics: appropriate skill mix, shared decision making and power sharing among practitioners, effective staff relationships, supportive organizational system, potential for innovation and risk taking, the physical environment. Findings from a British ethnographic study guided by the Person-centred Practice Framework also supported the importance of the care environment in the delivery of PCC (Kelly & Brown, 2021). The significant relationship between prerequisites, the care environment, and the care process was also highlighted by Balqis-Ali et al. (2022); their structural equation model depicted a unidirectional relationship between prerequisites and care process as well as care environment and care process. They also found that care environment played a partial mediating role in the relationship between prerequisites and care processes (Balqis-Ali et al. 2022).

The third predictor of delivery of PCC in this study was nurses' relationship with their manager. Similarly, in a Norwegian cross-sectional study, Ree (2020) found that transformational leadership was a predictor of person-centred care. The results of several other studies supported a transformational leadership style as the key to enabling the use of PCC (Poels et al., 2020; Rutten et al., 2021; Smit et al., 2017). Transformational leadership can be characterized by a manager who communicates of a vision for improvement, places importance on developing staff competence, provides staff support, empowers and motivates staff, and shows understanding (Ree, 2020). Similarly, a systematic review exploring the influence of managers' leadership on the delivery of PCC highlighted the impact of effective management in the provision of PCC (Moenke et al. 2023).

Predictors of a Person-centred Care Environment

Findings from this study indicate that nurses' role satisfaction and relationship with their manager are predictors of a person-centred environment; the prerequisites domain and the care process domain of The Person-centred Practice Framework were also predictors. Other researchers have found a significant positive association between job satisfaction and PCC (van der Meer et al., 2018; Vassbø et al., 2019; Wallin et al., 2012; Willemse et al., 2015). Researchers who conducted a systematic review exploring the influence of managers' leadership on the delivery of PCC found that positive managerial qualities are: 1) valuing and recognizing staffs' work, 2) providing feedback to staff, 3) promoting a positive work environment and culture, and 4) involving staff in organizational changes (Moenke et al., 2023). Some leadership barriers to PCC were staff shortages, limited collaboration between managers and staff, and limited education (Moenke et al., 2023). Many of these barriers and facilitators are likened to the qualities of a person-centred environment outlined in the Person-centred Practice Framework

(McCormack & McCance, 2016), supporting the notion that feeling positive about one's manager supports a person-centred environment.

According to the McCormack and McCance's (2016) Person-centred Practice Framework, prerequisites are a precursor to a person-centred care environment and, therefore, an expected predictor in a model with care environment as the outcome. This finding is also supported by Balqis-Ali et al. (2022) who found a unidirectional relationship between prerequisites and the care environment using structural equation modeling. Our study also found that the care process was a predictor of the care environment; however, Balqis-Ali et al. (2022)'s findings only support a unidirectional relationship between the care environment and care process, where the care environment leads to or supports the care process.

Implications

Although RNs rated all aspects of person-centred practice positively, the care environment domain of the PCPI-S was rated the lowest of the three domains. This domain represents the context within which care takes place (McCormack & McCance, 2016). The care environment construct, supportive organizational systems, was rated the lowest of all 17 constructs in the PCPI-S. Manley (2000) described work culture as the culture of units experienced daily by patients and staff. Characteristics of unit cultures go beyond what we see such as language, technology, and how people interact to include what is unseen (Manley, 2000). In the case of person-centred cultures that may include shared values, team effectiveness, a commitment to continuous learning and improvement, and transformational leadership (McCormack et al., 2011). Although person-centred cultures are the ideal, what healthcare providers usually experience is 'person-centred moments'; that is specific person-centred interactions between one nurse and one patient at a particular point in time (McCormack et al.,

2011). Developing person-centred cultures require persistent effort and commitment from both individual health care professionals, leaders, and the larger organization (McCormack et al., 2011). Emancipatory practice development is a research methodology used to develop person-centred cultures at the unit level (Manley et al., 2008; McCormack et al., 2011). It is as a means to motivate staff to adopt PCC values and attributes using sustained and continuous quality improvement, where the focus is on staff learning and the freedom to work differently (Manley et al., 2008; McCormack et al. 2011). However, only when this effort is combined with a commitment to support person-centred culture from the organizational level will PCC be realized.

Strengths and Limitations

Although the sample size of this study was small**,** one major strength of this study was the diversity of the sample. A provincial sample was obtained with representation from across the province. MH & A nurse participants worked in a variety of settings such as inpatient units, community programs, and emergency departments. They cared for a variety of populations including adult, geriatric, and pediatric populations. This diverse sample supports the generalizability of the study findings to MH & A nurses working in other provinces. To our knowledge, this is the first study that investigated the person-centred practices of MH & A nurses in this Atlantic Canadian province. The study provides new knowledge on the person-centred practices of MH & A nurses and can be used to inform practices changes and future research.

There are some limitations to this study that may have impacted the conclusions drawn regarding associations. The nature of a cross-sectional design is descriptive. Although it can be used to identify associations between variables, cross-sectional designs provide weak evidence

for a causal association. Stronger research design, such as a cohort study design, are needed to address this limitation. In addition, self-report data used in this study may not be reflective of reality as it is a person's perception of their own ability (Bolster & Mania, 2010). Although both two data collection tools were found to be valid, they still measured nurses perception of PCC. Further, some variables such as relationship with manager, role satisfaction, and turnover intention were measured using one item on the survey; content validity of those constructs is a limitation of this study. This limitation should be addressed if this study is repeated by using an existing valid measure for the variables. Finally, inability to determine an exact response rate is a limitation of this study. However, it has little effect on conclusions drawn as all MH & A RNs in the province were invited to participate through their employer and/or professional regulator.

In spite of study limitations, our findings provide a valuable contribution to mental health nursing research and PCC research. New knowledge from this study includes the positive association between environmental factors and delivery of person-centred mental health nursing care as well as significant predictors of PCC in the mental health setting. Study findings also provide directions for future research, such as addressing organizational issues that may hinder person-centred culture development.

Conclusion

MH & A RNs in this study believe that they have the ability to implement PCC. Further findings from this study support the Person-centred Practice framework in two ways: 1) the positive association between the care environment domain and the care process domain, and 2) the prerequisite domain and the environment domain were found to be predictors to the care process domain. MH & A RNs rated some care environment constructs among the lowest of the 17 constructs (e.g. such as supportive organizational systems and power sharing). Future

research should focus on the context within which care takes place. In order for person-centred cultures to be fully realized, both nurses and organizations need to be committed to person-centred practice.

Acknowledgement

The authors would like to acknowledge Dr. Donna Moralejo, Dr. Hensley Mariathas, and Ahmed Deeb PhD (candidate) for their assistance with data analysis for this study.

References

Ahn, S., & Yi, Y. (2022). Factors influencing mental health nurses in providing person-centered care. *Nursing Ethics*, *29*(6), 1491-1502. https://doi.org/10.1177/09697330221089076

Backman, A., Sjögren, K., Lövheim, H., Lindkvist, M., & Edvardsson, D. (2021). The influence of nursing home managers' leadership on person-centred care and stress of conscience: A cross-sectional study. *BMC Nursing*, *20*(1), 1-200. https://doi.org/10.1186/s12912-021-00718-9

Balqis-Ali1. (2022). Healthcare provider person-centred practice: relationships between prerequisites, care environment and care processes using structural equation modelling. *BMC Health Services Research*, *22*(1), 576. https://doi.org/10.1186/s12913-022-07917-3

Barker, P. (2001). The tidal model: Developing an empowering, person-centred approach to recovery within psychiatric and mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, *8*(3), 233-240. https://doi.org/10.1046/j.1365-2850.2001.00391.x

Biran-Ovadia, A., Strous, R. D., Bart, O., & Lipskaya-Velikovsky, L. (2023). Study of recovery model implementation in psychiatric hospitals: Clients and multidisciplinary staff perspective. *International Journal of Mental Health Nursing*, *32*(2), 603–614. https://doi.org/10.1111/inm.13106

Bolster, D., & Manias, E. (2010). Person-centred interactions between nurses and patients during medication activities in an acute hospital setting: Qualitative observation and interview study. *International Journal of Nursing Studies*, *47*(2), 154-165. https://doi.org/10.1016/j.ijnurstu.2009.05.021

Boykin, A. & Schoenhofer, S. (1993) *Nursing as caring: A model for transforming practice*. National League for Nursing Press.

Britten, N., Ekman, I., Naldemirci, Ö., Javinger, M., Hedman, H., & Wolf, A. (2020). Learning from Gothenburg model of person centred healthcare. *BMJ, 370*, 1-6. https://doi.org/10.1136/bmj.m2738

Coulter, A., Entwistle, V. A., Eccles, A., Ryan, S., Shepperd, S., & Perera, R. (2015). Personalised care planning for adults with chronic or long-term health conditions. *Cochrane Database of Systematic Reviews, 2013*(5), Article CD0010523. https://doi.org/10.1002/14651 858. CD010523

Dong, Y., & Peng, C. Y. (2013). Principled missing data methods for researchers. *SpringerPlus, 2*(1), 222. https://doi.org/10.1186/2193-1801-2-222

Edgar, D., Wilson, V., & Moroney, T. (2020). Which is it, person-centred culture, practice or care? It matters. *International Practice Development Journal*, *10*(1), 1-17. https://doi.org/10.19043/ipdj.101.008

Edvardsson, D., Koch, S., & Nay, R. (2010). Psychometric evaluation of the English language Person-centred Climate Questionnaire - staff version. *Journal of Nursing Management*, *18*(1), 54-60. https://doi.org/10.1111/j.1365-2834.2009.01038.x

Fors, A., Ekman, I., Taft, C., Björkelund, C., Frid, K., Larsson, M. E. H., Thorn, J., Ulin, K., Wolf, A., & Swedberg, K. (2015). Person- centred care after acute coronary syndrome, from hospital to primary care— A randomised controlled trial. *International Journal of Cardiology, 187*(1), 693– 699. https://doi.org/10.1016/j.ijcard.2015.03.336

Gask, L., & Coventry, P. (2012). Person-centred mental health care: The challenge of implementation. *Epidemiology and Psychiatric Sciences*, *21*(2), 139-144. https://doi.org/10.1017/S2045796012000078

Gunasekara, I., Pentland, T., Rodgers, T., & Patterson, S. (2014). What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use: What makes an excellent mental health nurse? *International Journal of Mental Health Nursing*, *23*(2), 101-109. https://doi.org/10.1111/inm.12027

Hennessy, B., Hunter, A., & Grealish, A. (2023). A qualitative synthesis of patients' experiences of re-traumatization in acute mental health inpatient settings. *Journal of Psychiatric and Mental Health Nursing, 30*(3), 398-434. https://doi.org/10.1111/jpm.12889

IBM Corp. Released 2021. IBM SPSS Statistics for Windows, Version 28.0. Armonk, NY: IBM Corp

Kelly, R., & Brown, D. N. (2021). 'Owning the space'— person- centred practice in a 100% singleroom acute- care environment: An ethnographic study. *Journal of Clinical Nursing*, *31*(19/20), 2921-2934. https://doi.org/10.1111/jocn.16119

Kieft, R. A. M. M., Brouwer, B. J. M., Francke, A. L., & Delnoij, D. (2014). How nurses and their work environment affect patient experiences of the quality of care: A qualitative study. *BMC Health Services Research*, *14*(1), 249-249. https://doi.org/10.1186/1472-6963-14-249

Manley, K. (2000). Organisational culture and consultant nurse outcomes: Part 1 organisational culture. *Nursing Standard, 14*, 34-38. https://doi.org/10.7748/ns2000.05.14.36.34.c2840

Manley, K., McCormack, B., Wilson, V. (Eds) (2008) International Practice Development in Nursing and Healthcare. Oxford: Blackwell.

Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: the attributes, enabling factors and consequences of a new concept. *International Practice Development Journal*, *1*(2).

McCance, T., Gribben, B., McCormack, B., & Laird, E. A. (2013). Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme. *International Practice Development Journal*, *3*(1).

McCaughey, D., McGhan, G. E., Rathert, C., Williams, J. H., & Hearld, K. R. (2020). Magnetic work environments: Patient experience outcomes in Magnet versus non-Magnet hospitals. *Health Care Management Review*, *45*(1), 21-31. https://doi.org/10.1097/HMR.0000000000000198

McCormack, B., Angie, T., & Kim, M. (2013). *Practice development in nursing*. Wiley-Blackwell.

McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T.E., Porock, D., van Lieshout, F. & Wilson, V. (2015) Person-centredness – the 'state' of the art. *International Practice Development Journal, 5*(1), 1-15. https://doi.org/10.19043/ipdj.5SP.003.

McCormack, B., Dewing, J., & McCance, T. (2011). Developing person-centred care: addressing contextual challenges through practice development. *Online Journal of Issues in Nursing*, *16*(2), 3-3. https://doi.org/10.3912/OJIN.Vol16No02Man03

McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing*, *56*(5), 472-479. https://doi.org/10.1111/j.1365-2648.2006.04042.x

McCormack, B., & McCance, T. (2016). *Person-centred practice in nursing and health care : Theory and practice (2nd ed.)*. Wiley.

McKay, K., Ariss, J., & Rudnick, A. (2021). RAISe-ing awareness: Person-centred care in coercive mental health care environments—A scoping review and framework

development. *Journal of Psychiatric and Mental Health Nursing*, *28*(2), 251-260. https://doi.org/10.1111/jpm.12671

Mertens, D. M. (2007). Transformative paradigm: Mixed methods and social justice. *Journal of Mixed Methods Research*, *1*(3), 212-225. https://doi.org/10.1177/1558689807302811

Moenke, L., Handley, M., & Goodman, C. (2023). The influence of care home managers' leadership on the delivery of person-centred care for people living with dementia: A systematic review. *Journal of Nursing Management*, *2023*, 1–12. https://doi.org/10.1155/2023/9872272

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, *31*(4), 662-673. https://doi.org/10.1111/scs.12376

Naseri, S., Ghafourifard, M., & Ghahramanian, A. (2022). The impact of work environment on nurses' compassion: A multicenter cross-sectional study. *SAGE Open Nursing*, *8*, 23779608221119124. https://doi.org/10.1177/23779608221119124

Nightingale, F. (1860). *Notes on nursing: What it is and what it is not.* Dover

Olsson, L.- E., Karlsson, J., Berg, U., Kärrholm, J., & Hansson, E. (2014). Person- centred care compared with standardized care for patients undergoing total hip arthroplasty— A quasi-experimental study. *Journal of Orthopaedic Surgery and Research, 9*(1), Article 95. https://doi.org/10.1186/s13018014-0095-2

Open Resources. (2023). Person-centred practice international community of practice. Retrieved November 14, 2023, from https://www.pcp-icop.org/membership-benefits

Ørjasæter, K. B., & Almvik, A. (2022). Challenges in adopting recovery-oriented practices in specialized mental health care : "How far should self-determination go; Should one be allowed to perish?" *Journal of Psychosocial Rehabilitation and Mental Health, 9*, 395–407. https://doi.org/10.1007/s40737-022-00276-6

Peplau, H. E. (1952). *Interpersonal relations in nursing.* Putnam & Sons.

Phelan, A., McCormack, B., Dewing, J., Brown, D., Cardiff, S., Cook, N., Dickson, C., Kmete, S., Lorber, M., Magowan, R., McCance, T., Skovdahl, K., Štiglic, G., & van Lieshout, F. (2020). Review of developments in person-centred healthcare. *International Practice Development Journal*, *10*(Suppl2), 1-29. https://doi.org/10.19043/ipdj.10Suppl2.003

Pirhonen, L., Hansson- Olofsson, E., Fors, A., Ekman, I., & Bolin, K. (2017). Effects of person-centred care on health outcomes— A randomized controlled trial in patients with acute coronary syndrome. *Health Policy, 121*, 169– 179. https://doi.org/10.9758/cpn.2017.15.2.126

Poels, J., Verschueren, M., Milisen, K., & Vlaeyen, E. (2020). Leadership styles and leadership outcomes in nursing homes: a cross-sectional analysis. *BioMedical Centre Health Services Research, 20*(1), 1009. https://doi.org/10.1186/s12913-020-05854-7

Ree, E. (2020). What is the role of transformational leadership, work environment and patient safety culture for person-centred care? A cross-sectional study in Norwegian nursing homes and home care services. *Nursing Open, 7*(6), 1988–1996. https://doi.org/10.1002/nop2.592

Rutten, J., Backhaus R, Tan, F., Prins, M., van der Roest, H., Heijkants, C., Hamers, J., & Verbeek, H. (2021). Work environment and person-centred dementia care in nursing

homes - a cross-sectional study. *Journal of Nursing Management, 29,* 2314–2322. https://doi.org/10.1111/jonm.13386

Slater, P., McCance, T., & McCormack, B. (2015). Exploring person-centred practice within acute hospital settings. *International Practice Development Journal*, *5*(Suppl), 1-8. https://doi.org/10.19043/ipdj.5SP.011

Slater, P., McCance, T., & McCormack, B. (2017). The development and testing of the Person-centred Practice Inventory – Staff (PCPI-S). *International Journal for Quality in Health Care*, *29*(4), 541-547. https://doi.org/10.1093/intqhc/mzx066

Smit, D., de Lange, J., Willemse, B., & Pot, A. Predictors of activity involvement in dementia care homes: A cross-sectional study. *BioMedical Centre Geriatrics, 17*(1), 175. https://doi.org/10.1186/s12877-017-0564-7

Smith, G. P., & Williams, T. M. (2016). From providing a service to being of service: Advances in person-centred care in mental health. *Current Opinion in Psychiatry*, *29*(5), 292-297. https://doi.org/10.1097/YCO.0000000000000264

Speroni, K. G., Wisner, K., Ober, M., Haines, F., Walters, C., & Budhathoki, C. (2021). Effect of shared governance on nurse-sensitive indicator and satisfaction outcomes by Magnet® recognition status. *The Journal of Nursing Administration*, *51*(7/8), 379-388. https://doi.org/10.1097/NNA.0000000000001033

Stommel, M., & Dontje, K. J. (2014*). Statistics for advanced practice nurses and health professionals.* Springer.

Ta'an, W. F., Alhurani, J., Alhalal, E., Al-Dwaikat, T. N., & Al-Faouri, I. (2020). Nursing Empowerment: How job performance is affected by a structurally empowered work

Environment. *The Journal of Nursing Administration, 50*(12), 635–641. https://doi.org/10.1097/NNA.0000000000000951

Thorne, S., & Stajduhar, K. (2017). Rebuilding the roots of patient-centred care. *Nursing Leadership)*, *30*(1), 23–29. https://doi.org/10.12927/cjnl.2017.25109

Tiainen, M., Suominen, T., & Koivula, M. (2021). Nursing professionals' experiences of person-centred practices in hospital settings. *Scandinavian Journal of Caring Sciences*, *35*(4), 1104-1113. https://doi.org/10.1111/scs.12925

Tully, S. M., Bucci, S., & Berry, K. (2023). "My life isn't my life, it's the systems": A qualitative exploration of women's experiences of day-to-day restrictive practices as inpatients. *Journal of Psychiatric and Mental Health Nursing, 30*(1), 110-122. https://doi.org/10.1111/jpm.12855

van der Meer, L., Nieboer, A. P., Finkenflügel, H., & Cramm, J. M. (2018). The importance of person-centred care and co-creation of care for the well-being and job satisfaction of professionals working with people with intellectual disabilities. *Scandinavian Journal of Caring Sciences, 32*(1), 76–81. https://doi.org/10.1111/scs.12431

Van Diepen, C. (2020). Association between person-centred care and healthcare providers' job satisfaction and work-related health: A scoping review. *BMJ Open*, *12*(12), p.e042658-e042658. https://doi.org/10.1136/bmjopen-2020-042658

van Dusseldorp, L., Groot, M., van Vught, A., Goossens, P., Hulshof, H., & Peters, J. (2023). How patients with severe mental illness experience care provided by psychiatric mental health nurse practitioners. *Journal of the American Association of Nurse Practitioners*, *35*(5), 281–290. https://doi.org/10.1097/JXX.0000000000000867

Vassbø, T. K., Kirkevold, M., Edvardsson, D., Sjögrenm, K., Lood, Q., Sandman, P. O., & Berglan A. (2019). Associations between job satisfaction, person-centredness, and ethically difficult situations in nursing homes-A cross-sectional study. *Journal of Advanced Nursing, 75,* 979–988. https://doi.org/10.1111/jan.13890

Wallin, A. O., Jakobsson, U., & Edberg, A. K. (2012). Job satisfaction and associated variables among nurse assistants working in residential care. *International Psychogeriatrics, 24*, 1904–1918. https://doi.org/10.1017/S1041610212001159

Watson, J. (1999). *Nursing: Human science and human care – A theory of nursing*. National League of Nursing Press.

Willemse, B. M., De Jonge, J., Smit, D., Visser, Q., Depla, M., & Pot, A. M. (2015). Staff's person-centredness in dementia care in relation to job characteristics and job-related well-being: A cross-sectional survey in nursing homes. *Journal of Advanced Nursing, 71*, 404–416. https://doi.org/10.1111/jan.12505

Wills, C. E. (2010). Sharing decisions with patients: Moving beyond patient-centered care. *Journal of psychosocial nursing and mental health services*, *48*(3), 4-5. https://doi.org/10.3928/02793695-20100202-03

Wykes, T., Csipke, E., Williams, P., Koeser, L., Nash, S., Rose, D., Craig, T., & McCrone, P. (2018). Improving patient experiences of mental health inpatient care: A randomised controlled trial. *Psychological Medicine*, *48*(3), 488-497. https://doi.org/10.1017/S003329171700188X

Chapter 3: "It's a Mixed Bag": An Interpretive Description Study of Individuals' Perspectives Regarding Person-centred Nursing Care Received on Inpatient Psychiatric Units

Chantille Isler PhD (c), RN

Joy Maddigan PhD, RN

Robin Burry PhD, RN

Alice Gaudine PhD, RN, FCAN

Introductory Statement

Chapter 3 contains a manuscript that presents qualitative interview results from the mixed methods research study. The target audience for this manuscript is mental health nurses, other members of the health care team, as well as health administrators. This manuscript was written with the intention for submission to the Journal of Psychiatric and Mental Health Nursing, however, some information may be removed or condensed to meet publisher requirements.

Authorship Statement:

Chantille Isler (the primary investigator) and Dr. Maddigan contributed to the conception and research design. With guidance from Dr. Maddigan, Chantille Isler contributed to data collection, analysis, and interpretation and wrote the manuscript. Dr. Burry worked with Chantille to conduct the data analysis. Dr. Maddigan, Dr. Gaudine, and Dr. Burry reviewed the manuscript and revisions were made by Chantille Isler based on feedback. Dr. Maddigan, Dr. Gaudine, and Dr. Burry reviewed the revised manuscript and gave final approval.

Key Words:

Person-centred care, interpretive description, nursing, mental health, inpatient psychiatric care

Abstract

Aim: The aim of this study was to explore individuals' perspectives of the nursing care they recently received on an inpatient mental health unit, as it relates to person-centred care.

Methods: Interpretive description methodology was used to understand the person-centred care experiences of eight individuals who had an inpatient mental health admission in the past 12 months.

Results: Three themes were developed from the data: 1) rare moments of person-centred care, 2) the relationship with my nurse: a fluctuating connection, and 3) the care environment as an uncertain space.

Discussion: Participants reported that person-centred care was rare, inconsistent, and unpredictable. These findings are not surprising considering the difficulty in operationalizing person-centred care reported in the literature.

Implications for Mental Health Nursing: PCC is currently not at the centre of mental health nursing practice, despite the stated values of many health care organizations, professional associations, and professionals. Workforce development initiatives are needed to motivate and empower nurses to adopt person-centred ways of working. However, only when this effort is combined with an actionable commitment to support person-centred cultures at the organizational level will a more consistent delivery of person-centred care be possible.

"It's a Mixed Bag": An Interpretive Description Study of Individuals' Perspectives Regarding Person-centred Nursing Care Received on Inpatient Psychiatric Units

In Canada, one in seven people use mental health services annually (Government of Canada, 2020). Over 250, 000 people are discharged from a Canadian hospital for an issue related to mental health and/or substance use disorder (Canadian Institute for Health Information, 2023). When an individual is admitted to a facility for inpatient mental health care, support and guidance regarding social relationships, self-management, personal autonomy, social participation, personal recovery, physical health and other therapeutic care can be provided by mental health nurses (Hurley et al., 2022).

The therapeutic role of nurses on inpatient mental health wards is of particular importance as patients interact with nurses more than any other health professional; nurses are consistently present on the unit and available at any time (Hopkins et al., 2009; McAndrew et al., 2014). Furthermore, patients perceive the therapeutic relationship with their nurse is associated with the quality of care received (Coffey et al., 2019). Good mental health nursing care is underpinned by a person-centred and recovery-oriented approach focused on collaborative interpersonal relationships as well as working holistically and with patient beliefs and values (Gabrielsson et al., 2016; Tofthagen et al., 2014). Person-centred care (PCC) is increasingly being regarded as a core component of the recovery movement in mental health care (Hummelvoll et al., 2015; Slade et al.,2014).

Internationally, there is continued advocacy for person-centred health care (WHO, 2015; 2016). PCC is viewed as a healthcare strategy, designed to humanize and centralize individuals as well as support the health care provider and the larger health organization in engaging with the person (McCormack et al., 2015; Morgan & Yoder, 2012; Phelan et al., 2020; WHO 2015). This

study is framed by the following definition of PCC: “an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development” (McCormack & McCance, 2016, p. 20).

In Canada, nurses are expected to practice PCC and partner with those engaging in health services (CNA, 2015). However, despite much attention from both health care policy and health organizations, PCC is still criticized for its unclear conceptualization and, consequently, limited operationalization (Byrne et al., 2020). Traditional practices and structure, professional attitudes, and time constraints of staff make operationalizing PCC difficult in many healthcare settings (Moore et al., 2017). However, a key issue hinges on the difficulty health care providers have to fully embrace the principles of PCC (Smith & Williams, 2016).

Distinguishing features of inpatient mental health environments, such as involuntary admissions and potentially coercive care (Hem et al., 2018; Landeweer et al, 2011), add further complexity to the operationalization of PCC (Gabrielsson et al., 2014; Smith & Williams, 2016). Coercive mental care refers to mental health care that is primarily pharmacological, rather than psychological, and provided to individuals who are considered involuntary service users (McKay et al., 2020; Monahan et al., 1995). Coercive care also includes physical restraint and isolation rooms (Hirsch et al., 2019). PCC is underpinned by patient autonomy, that is, self-determination (McCormack & McCance, 2016; Phelan et al. 2020). Given PCC is the recognized gold standard of care, it is important for health care organizations and providers to revisit coercive mental

healthcare approaches and retain only those practices that align with the values that underpin PCC while also prioritizing safety of patients and staff (McKay et al., 2020).

The focus on this study is on PCC in the context of inpatient mental health nursing care. PCC is most often discussed in relation to health care in general (Phalen et al., 2020) rather than in relation to mental health care in particular. Research on person-centered inpatient mental health nursing care that examines the patient's perspective is sparse (Laitila et al., 2018; Vennedey et a., 2020). Although studies have been published from the perspectives of mental health patients on good care (Ahn & Shin, 2023; Gunasekara et al., 2014; Johansson & Eklund, 2003) or recovery-oriented care (Waldemar et al., 2018), research on the delivery of PCC in mental health inpatient settings have mostly been investigated from a professional perspective, for example mental health nurses (Ahn & Yi, 2023; O'Donovan, 2007). This is concerning as the premise of PCC is that the patient should be placed at the centre of care (Robinson et al., 2008). One Dutch study examined PCC in the context of mental health by interviewing service users; however, they were focused solely on the outpatient perspective (Maassen, et al., 2016). Similarly, a German study sought service-users perspectives on the barriers and facilitators of person-centred mental health nursing care (Vennedey et al., 2020). In this study, inpatient experiences were discussed, however, it was not the focus of the study (Vennedey et a., 2020). A recent Finish study did examine inpatients' views regarding their involvement in care, however, all aspect of PCC were not explored (Laitila et al., 2018). It is essential that patients' experiences are heard to better understand the current state of person-centred mental health nursing practice within the Canadian inpatient mental health setting. The purpose of this study is to explore the perspectives of individuals about the nursing care they recently received on an inpatient mental health unit, as it relates to PCC.

Methods and Materials

This qualitative study was conducted as part of a larger provincial mixed methods study designed to better understand the PCC practice patterns of mental health nurses working in an Atlantic Canadian province. The conceptual framework for the study was The Person-centred Practice Framework (McCormack & McCance, 2016). The framework highlights the importance of health care professional's personal attributes as well as environmental factors as necessary building blocks to the delivery of PCC (McCormack & McCance, 2016). For this study, the framework informed the developed of a semi-structured interview guide (Appendix G) as well as the data analysis.

Researchers' Reflexivity

This study arose, in part, due to the professional concerns of the principal investigator [CI]. After years of practice as an inpatient mental health nurse I wished to better understand the person-centred practices of mental health nurses. Knowing that part of understanding nurses' practices included the patient perspective, I designed the study, and collected and analyzed the data described herein with guidance and assistance from the research team. I have a strong commitment to social justice and align with Donna Merten's Transformative Paradigm (Mertens 2007). Firmly rooted in a human rights agenda, the Transformative Paradigm bring the voices of marginalized groups, like those living with mental illness, into the world of research for enhanced social justice (Mertens et al., 2010). The research team acknowledges their positionality as educated, white-settler, Canadian women. Three members of the research team [CI, JM, AG] have mental health nursing clinical experience.

Design

Interpretive description methodology (Thorne, 2008) was used to understand the care experiences of those with recent mental health inpatient admissions. Interpretive description is a qualitative methodology that challenges the researcher to not only describe and interpret a phenomenon, but also consider the meaning of related behaviors and relevance to clinical practice (Thorne, 2008). This is the most appropriate methodology to answer the research question as we are seeking to better understand a complex clinical issue through a critical examination of the lived experiences of participants.

Recruitment

The study was conducted in a province in Atlantic Canada. English speaking adults, 18 years of age or older, who had received care on an inpatient mental health unit in the province in the previous year was eligible to participate in the study. Participants were recruited through posters (Appendix F) in community agencies and snowball sampling. Those who were interested in participating contacted the principal investigator directly. Those interested were provided with more details about the study, emailed or given a hard copy of the consent form (Appendix L), and a consent form was reviewed. Depending on each individual's request, review of the consent form took place either over the phone, online, or in-person. If the individual was still interested in participating, they signed the consent before being interviewed. Those who agreed to participate were given a $100 honorarium for their time.

Data Collection

Semi-structured interviews were conducted by the primary investigator in summer 2022. Participants had the choice of being interviewed in-person, online, or over the telephone. Interviews were audio recorded and transcribed verbatim upon completion. Field notes were also

taken. Interviews lasted approximately 45 minutes. A semi-structured interview guide (Appendix G) was developed by the principle investigator to collect data to better understand the experiences of mental health clients in receiving PCC. Development was guided by the Person-centred Practice Framework. The interview guide was reviewed for clarity and relevance by an experience-expert advisory group formed to guide the study. The opening question of the interview was, 'Can you describe your experience of receiving mental health nursing care as an inpatient?' The interview covered topics such as: describing one's favorite nurse, aspects of the inpatient environment that were helpful to one's recovery, suggestions for change, and how one's ideas were incorporated into their care. As this study attempted to obtain an in-depth understanding of patient experiences in receiving mental health nursing care, aspects of care that hinder person-centeredness were also explored. For example, participants were asked to describe aspects of the inpatient environment and experiences with their nurses they found unhelpful to their recovery.

Analysis

Constant comparative method was used to analyze participant interviews and accompanying field notes collected. According to Thorne et al. (2004) and Thorne (2016), the constant comparative method is an appropriate approach to analysis for interpretive description. Other interpretive description researchers have also used constant comparative method to analyze their data (Nath et al., 2016).

Thorne (2016) indicated that when using an interpretive descriptive methodology, researchers should avoid precision in the early stages of coding. The inductive analytical process began with the primary investigator and another member of the research team independently reading and re-reading the interview transcripts (Lincoln & Guba, 1985). The two researchers

independently broke data down into meaning units and gave the meaning units an initial code. Then the researchers came together to both confirm initial codes and consider the meaning of related behaviors; in doing so, researchers were able to better understand the actions of nurses within the context of the inpatient mental health setting (Thorne, 2008). Next researchers grouped codes into sub-themes (Lincoln & Guba, 1985). Sub-themes constantly changed as initial codes were compared with each other and researchers engaged in interpretive thinking (Thorne, 2016). Through this process a greater understanding of the relationships between components of the sub-themes was reached. Lastly, sub-themes were then grouped into themes. Themes continued to evolve as the data was constantly compared, until a consensus was reached. Themes developed from the data were compared and their relationships were explored. Researchers made notes of their analytic decisions to enhance transparency and rigor.

Rigor

Thorne (2016) outlined four principles that provide evaluation standards in interpretive description. Table 3.1 highlights Thorne's (2016) four principles used to ensure rigor and credibility for interpretive description studies along with specific techniques for rigor used in this study.

Table 3.1:

Techniques Used to Enhance Rigor

Principle	Definition	Relevant techniques used in this study
Epistemological Integrity	"a defensible line of reasoning from the assumptions made about the nature of knowledge through to the methodological rules by which decisions about the research process are explained." (Thorne, 2016, p. 233).	1) Team members trained in qualitative research 2) Co-authors provided guidance and feedback 3) Exploration of different qualitative methods, before selecting ID 4) Study will be defended by first author in doctoral defense
Representative Credibility	Conclusions align with the population sampled and are not expanded beyond (Thorne, 2016).	1) Sample included participants of varying gender, age, and place of admission. 2) Use of participant quotes to support findings
Analytic logic	Ensure the reasoning behind the decision-making is clear in the report (Thorne, 2016).	1) Audit trail recorded in journal during data collection and analysis
Interpretive Authority	"Assurance that a researcher's interpretations are trustworthy, that they fairly illustrate or reveal some truth external to his or her own bias or experience (Thorne, 2016, p. 235)	1) Reflexive process used during data collection and analysis, including journal 2) Transcripts professionally transcribed, and verified by the researcher 3) Discussed data analysis and interpretation frequently with co-authors 4) Two researchers independently analyzed the transcripts. 5) Audit trail

Ethics

The study was approved by the Health Research Ethics Board for the province (application # 20222135). All participants were informed of their rights in terms of anonymity and the option to withdraw from the study at any time. They received an informed consent form to review and sign along with a copy to keep before being interviewed. Participants were also told that their choice to participate, or not, in the study would have no impact on any current or future health treatment.

Results

Eight individuals living in the community, who experienced a recent inpatient psychiatric admission, were interviewed. Five of the individuals interviewed identified as female and three individuals identified as male. Five individuals were between 20 and 30, two were between 30 and 40, and one was between 60 and 70. Of the eight individuals interviewed only two were currently employed.

The three themes and four subthemes comprised the findings that are listed in Table 3.2. The themes include: 1) rare moments of PCC, 2) the relationship with my nurse: a fluctuating connection, 3) the care environment as an uncertain space. An example of the coding framework can be found below (Figure 3.1).

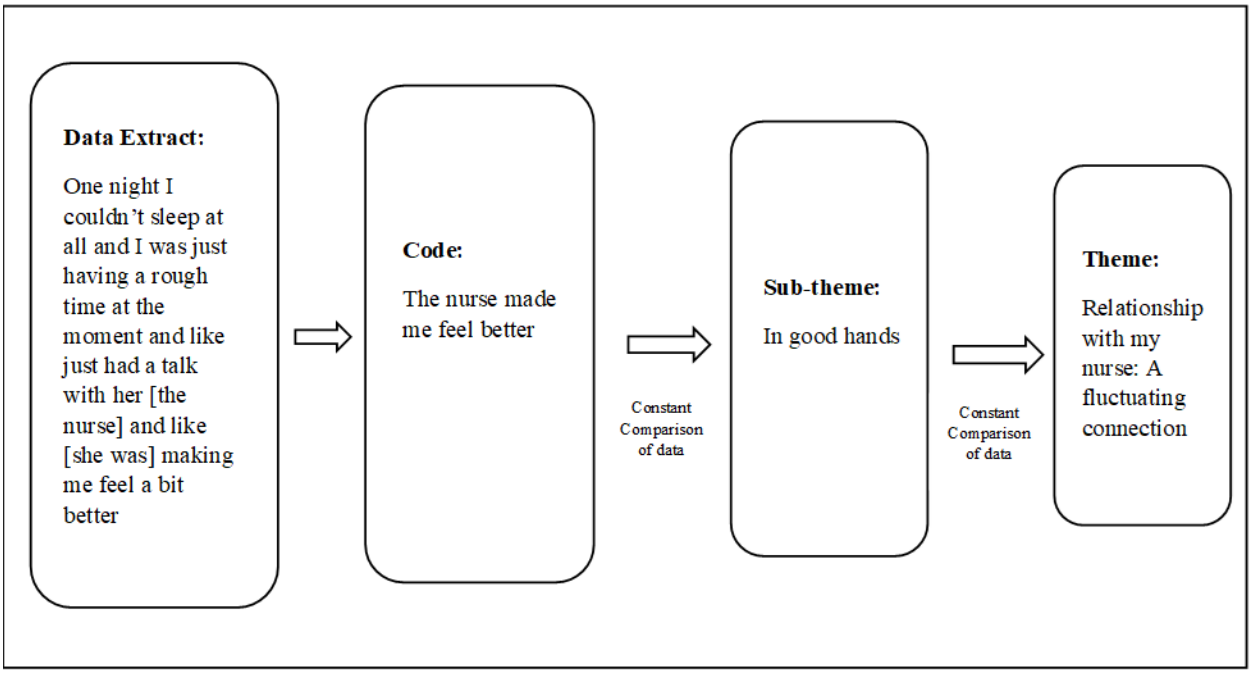
Table 3.2

Themes and Sub-Theme

Theme	Sub-Theme
1) Rare moments of PCC	
2) The relationship with my nurse: A fluctuating connection	2.1 In good hands
	2.2 Limited control
3) The care environment as an uncertain space	3.1 Perils of an unknown environment
	3.2 Pearls of the care environment

Figure 3.1

Example of Analysis Steps



Theme 1: Rare Moments of PCC

The first theme was developed to reflect what was missing from the descriptions of participants when highlighting the nature of the care they had received during a recent inpatient stay. Little evidence of PCC was identified or discussed by individuals when they recounted their inpatient experience. Participants did identify nurses who were helpful and competent but limited examples were found of care that was individualized or led by them. The vast majority of care was focused on daily routines and unit practices, and while these interactions were appreciated by participants, they were not of a person-centred nature.

Good nursing care often met the expectations of individuals, but it was not unique to them or their preferences. One participant described a positive discharge experience:

> [A nurse] *walked me down to my car with all my bags of clothes and helped me load up my trunk. He gave me the name of this place to go to take my car to get it checked out.* (P1)

Although this was an important unit practice, it did not integrate the key features of person centred-care. Similarly, another participant spoke about appreciating the nurses who took the time to explain things, especially new medication:

> *Two nurses specifically, who kind of like took the time to explain things to me [like] why they were giving me the meds.* (P2)

This level of care is what is expected of a safety-conscious, competent nurse. However, it is also routine care that could and should be delivered to all individuals when appropriate.

In spite of its rarity, PCC experiences or moments were identified by some participants. One person felt involved in decisions about medication times:

> *If I wanted to take my medication a little bit earlier one night, I could say to the nurse, you know, what do you think if I tried this, and they'd say, well, it would be better if you did it this way or it would be better if you tried it this way. Maybe we can switch it to the morning. Let me talk to the doctor. They were really open to anything I had to say.* (P1)

The nurse engaged with the individual in shared-decision making and, therefore, the individual felt comfortable in voicing her preferences.

Another participant described an instance where she felt her nurse understood her as an individual:

> *She seemed to really care. You know like she would come in and ask how I was and she seemed to be able to anticipate my moods. Just by talking to me and you know, I appreciated that so much.* (P8)

PCC goes beyond routine nursing care and truly places the individual at the center of the care experience. PCC interactions are remembered and appreciated by those who experience them.

Theme 2: The Relationship with my Nurses: Fluctuating Connections

Individuals' connections with their mental health nurses were time sensitive as patient-nurse assignments changed frequently over the course of one admission. Individuals had many different nurses; some they liked and others they did not. Their perspective on the nursing care they received was often influenced by the feelings they had about individual nurses who cared for them. Participants described positive relationships with some nurses, resulting in a sense of safety and wellbeing. However, they also noted interactions with their nurses that had negative outcomes which left them feeling as if they had no control of the decisions made about their care and treatment. Participants consistently identified that their experiences differed between nurses:

> *It's kind of a mixed bag as to whether or not you're going to get like very empathetic treatment for whatever it is you're experiencing. So, I find it can be a bit of a toss-up.* (P6)

This inconsistency reduced the level of trust between individuals and their nurses and may have been compounded by participants' awareness of the level of stress that nurses were . One participant observed:

> *.... that they [nurses] were stressed out, too; just the amount of work they had to do and the amount of people who were in there at the time.* (P2)

Availability of the nurse was another factor that may have influenced the relationship individuals had with their nurses. Some individuals noted that they usually found a nurse to turn to when needed, even if it wasn't their assigned nurse. However, others felt their nurse was never available; they were either with another patient, off the unit, or in the nursing station. This was

distressing for some participants. To this point, some participants had anxious feelings while waiting to know which nurse they were assigned that day. As individuals did not have a say in choosing their nurse, some were fearful about the quality of care they might receive. They were uncertain if they would be able to have a positive connection with their assigned nurse. One individual described it this way:

> *Whenever I knew that she [a nurse] was on that day I would be anxious waiting for them to write the name of my nurse for the day on the board, hoping that it would be her. And if it was her, I was happy but if it wasn't it was almost like I'd have that bit of disappointment because I knew that if I have any problems that day or if anything happens then I know that at least I will have somebody there that I can go to.* (P3)

When participants expressed ideas for improving the inpatient stay, they often referred to the importance of building better relationships between patients and nurses. Participants indicated that mental health nurses should have strong therapeutic communication skills and tailor their communication to the individual person. One participant said,

> *Being able to communicate well [is important] in those [acute] situations that should be fairly tense. Nurses who are capable of de-escalating those situations without having to call security and stuff* (P6).

Ultimately, participants want to be supported and cared for in a way they made them feel like a person. Two sub-themes further illustrate the dimensions of the theme: 1) in good hands and 2) I had limited control over my care.

In Good Hands

Many participants recalled positive experiences with their nurse that promoted their recovery. Participants described situations during their hospital admission when they felt their

nurse was able to help them, supported them and/or was looking out for their best interest. One participant noted:

> *One night I couldn't sleep at all and I was just having a rough time at the moment and like, I just had a talk with her [the nurse] and like [she was] making me feel a bit better.* (P4)

They talked about feeling comfortable with their nurse. One participant stated:

> *He [nurse] was just very calm, cool, collected, very comforting* (P2)

Another said:

> *I knew that I was in a safe place and that they [nurses] were looking out for me*. (P2)

Positive descriptions of a care relationship are expected in all health settings, but are of particular importance in mental health settings. When discussing affirmative experiences with their nurses, individuals spoke of being happy with the care they received in these particular situations. However, while constructive, the affirmative experiences that participants described were not fully representative of a PCC relationship. There was limited discussion of nurses getting to know individuals and, then, using that knowledge as part of engagement and care. One participant did describe a positive but unique experience:

> *[One nurse] took an interest in getting to know me. Like he noticed my tattoo and he talked to me about a show that I liked and he watched and that sort of thing. A personal connection but not unprofessional, just knew that would calm me down and so he started talking about something while he had to do what he was doing.* (P2)

This level of engagement reflects PCC but it was a rare find in the day-to-day routines of the mental health unit. The sub-theme, *in good* hands, indicates that while many individuals expressed satisfaction with the quality of competent nursing care, they were still figuratively 'in'

the nurse's hands rather than 'holding' the nurse's hands as an equal partner in care. Little opportunity was evident for individuals to fully participate in care decisions.

Limited Control

Not all relationships between patients and nurses were perceived positively. As a result of negative experiences, some participants felt they had little control over their care. They perceived nurses as exercising authority over them. Two participants provided particularly jarring accounts. One individual explained:

> *I am a larger male. Me expressing discomfort towards somebody or raising my voice at all could be grounds for them* [nurses] *to call security or just try not to deal with me. So, I find it difficult to express discomfort sometimes.* (P6)

A second participant related this experience:

> *She [the nurse] should have been the one to walk away. She should have been the one to leave, not me, the patient, because there is nowhere for me to go. Like, she was my nurse. She would have to give me my pills and I had to crawl back to her and ask for my medication.* (P1)

Others expressed dissatisfaction with the lack of care they received including difficult encounters with their nurse. One participant revealed:

> *I've had nurses get mad at me for having panic attacks. I've had nurses roll their eyes at me and tell me there is nothing they can do for me when I've self-harmed while in the hospital.* (P7)

When suffering from anxiety and thoughts of self-harm, the same participant described the following interaction with a nurse:

> [The nurse said] *What do you expect us to do? And I said, I don't know what my options are. And she said, well don't expect us to put you in a room with someone. Don't expect someone to sit with you because that's not going to happen and don't expect us to check on you more.* (P7)

When receiving care for an eating disorder, another participant felt a nurse wasn't taking the opportunity to therapeutically engage with her during a supervised meal time.

> *Sometimes I was the one who would try to get a conversation going and the thing is it would be me at the table with the staff member that was supposed to be sitting there with me during that hour for any support that I required.* (P3)

The above encounters resulted in participants feeling diminished, defeated and knowing that they had little control over their care decisions. This is contrary to a PCC environment.

Theme 3: The Care Environment as an Uncertain Space

The final theme addresses the impact of the care environment on participants' well-being. Participants discussed the mental health environment and how it influenced their hospital experience. Individuals often identified both positive and negative features of the setting, indicating its unpredictability. Several participants described times when they were left on their own to navigate serious issues, including their own safety. Others identified positive aspects of the care environment such as access to activities. Two sub-themes: 1) *perils of an unknown environment,* and 2) *pearls of the care environment*, highlight the contrasting aspects of the care environment

Perils of an Unknown Environment

Select features of the care environment had a negative impact on participants' recovery and well-being. Participants had little to no control over some issues and were often left to

manage them without support. One common experience was the feeling that they were unsafe and at risk of harm while on the unit. The source of the potential harm came from the behavior and agitation of other individuals who were also patients on the unit. One participant summed it up:

> *The dynamics within the unit weren't the greatest and some of the people were kind of intimidating and scary at times.* (P2)

This was verified by another participant who stated:

> *I mean there were plenty of times where patients were aggressive; [I was] just generally uncomfortable with their language.* (P6)

A more specific account was provided another individual:

> *There was one incident where there was another patient who was really sick and they ended up sedating him and they put him in the TQ room. The room that I was in was right next to that room and when the sedation that they gave him wore off, he started banging on the doors and on the walls in that room. It went on all that evening and the entire night all I could hear was this patient screaming and calling out and threatening a lot of awful things that everyone on the unit was listening to all night long. It was at the point where we were afraid what was going to happen when they let him out.* (P3)

Participants' recovery was not only negatively impacted by the illness behaviors of other individuals on the unit but also by the physical space in which they were confined. The majority of those interviewed indicated the units on which they were admitted did not have enough room for the number of patients on the unit, with several stating they slept in rooms with seven other patients. Participants also expressed they did not have anywhere to go when they needed time alone. One participant said:

> *I prefer to have less people in a group bedroom. There have been times where there was wall to wall, multiple, like 8 beds in one room. We can't really reduce beds but it would be nice to have some sort of separation or some sort of privacy.* (P6)

Another participant recalled a time during their admission when they had a particularly difficult day. The lack of space on the unit compounded their struggle:

> *All I wanted to do was get out. I just wanted space. I just needed like space. There's not much space.* (P1)

Participants also encountered uncertainty when attempting to follow the unit rules. They reported that information given by one nurse was often inconsistent with information given by another. This caused frustration for some individuals:

> *There is a lot of miscommunications between the nurses. Like I would ask to shower and then the morning staff would tell me that I had to do it in the evening and the evening staff would tell me that I had to do it in the morning.* (P7)

Further, some participants found that they were often left without knowing who their nurse was on any given day. One participant said:

> *I didn't know who the nurses were. So, it was like, what do I do to get their attention? Who do I ask if I need any assistance?* (P2)

Other participants knew to look on either a message board in their room or on a white board in a common area for their nurses name.

Pearls of the Care Environment

Ensuring individuals feel safe and have the space they need to journey through the recovery process are essential aspects of the care environment. Although these features were lacking for many, participants did talk about aspects of the environment that positively affected

their care experience. Individuals who were hospitalized for a longer period or had repeat admissions, perceived the unit as feeling familiar, which put them at greater ease. As one participant stated:

> *I got really comfortable there. Really familiar with it.* (P1)

These participants often felt as though they knew the unit routines as well as the nurses. This created a sense of comfort and belonging. In some cases, this was encouraged by nursing staff. One participant said:

> *…they [the nurses] started to make me feel more comfortable and get involved with all the stuff that was there.* (P2)

In addition, some participants felt they had continuity of care in the nurse they were assigned. Although infrequent, some individuals were assigned the same nurse for more than one shift. One participant stated:

> *Some days you might get the same nurse two or three days in a row depending on the scheduling. If the same nurse was working for three days, then they would try to keep that bit of consistency*. (P1)

Finally, the majority of participants spoke of the positive impact that unit activities had on their recovery. This included both structured activities, such as health professional-led group sessions, and unstructured activities, such as coloring in a common area with others. For example, one participant enjoyed unstructured activities stating:

> *When there are specifically like activities that we can do and not necessarily Bingo and stuff but like things that we can play like chess or putting puzzles together and that sort of stuff, having open access to art and anything in that case is very helpful or games and stuff.* (P6)

Structured unit activities often included engaging with other patients and organized activities were typically initiated by therapeutic recreation or occupational therapy specialists. At times participants were taken off the unit by these professionals for activities such as bus rides or going to the gym. One participant said:

> *I did the gym every day, Monday to Friday. In the morning 8:15 and there are two days during the week that they do it in the evening. My God we used to go down and if I could get a couple of people to go down with me we'd play soccer or we'd play basketball. I went on all the walks and stuff that I could. I really like the OT program.* (P1)

Although participants emphasized that unit activities were helpful to their recovery, there was no evidence of nurses engaging with individuals in these types of activities.

Participants' positive experiences related to continuity of care, unit activities, and feelings of familiarity on the unit supported the sub-theme, pearls of the care environment. The sub-theme is phrased to highlight the positivity expressed by participants about the care environment. The word pearl is used to signify that these positive experiences were not common and were peppered among negative environmental experiences such as safety and lack of space. It highlights that more work is needed to elevate inpatient programming and a sense of community among the inpatient units to foster a more person-centered climate and environment.

Discussion

Based on the findings of this study, the experiences of those receiving inpatient mental health care do not fully reflect PCC (McCormack & McCance, 2016; Phelan et al., 2020). Participants reported that care was inconsistent and unpredictable, with care experiences differing depending on the nurse providing care. Within the same interview, participants spoke about care that aligned, and also clearly did not align, with person-centred principles

(McCormack & McCance, 2016; Phelan et al., 2020). Participants reported differing experiences regarding the approach to care as well as their perceived relationship with their nurse(s). Such inconsistencies are not surprising considering the historic difficulty in operationalizing PCC (Smith & Williams, 2016). In a Swedish study that explored everyday life in psychiatric inpatient care, participants reported differing experiences regarding interactions with nurses; some participants described trustful nurse-patient interactions, whereas others described obstructive or absent interactions (Molin et al., 2016). Patient participants in a Finnish study called for additional training of health professionals on how to involve service users in their care (Laitila et al., 2018). One PCC review also found that shared decision-making and self-directed care remains low among mental health populations (Smith & Williams, 2016).

A qualitative study examining good mental health nursing care found that patients perceive care as good when they were treated like individuals and encouraged to share their history, narratives, and goals (Ahn & Shin, 2023). Although limited, participants in our study did describe times when they engaged in shared-decision making and when their nurse took the time to get to know their interests and preferences. Participants in our study also described feeling comfortable with their nurse, feeling like nurses were helped when needed, the care environment feeling familiar, and the positive impact of access to activities, which are all important building blocks of PCC (McCormack & McCance, 2016; Phelan et al., 2020). Participants in Ahn & Shin (2023) also highlighted the role of nurses in their adaption to the unfamiliar mental health setting. Further, a nurse who provided guidance about the environment, introduced them to other patients, and encouraged participation in ward programs was deemed helpful in familiarizing new patients with the unit (Ahn & Shin, 2023). Participants in an Australian study examining what makes an excellent mental health nurse indicated that nurses should be sensitive to both the

mood of patients and the ward; they should also be skilled at anticipating service user's needs and where possible, try to meet them (Gunasekara et al., 2014). The needs referred to were of a routine nature, such as acknowledging a patients presence at the nursing station (Gunasekara et al., 2014). Similar to the results of our study, participants in a Swedish study exploring the everyday life in psychiatric inpatient care also found that patients found activities beneficial (Molin et al., 2016).

During their admission, participants in our study also expressed receiving routine nursing care, in other words, care was done 'to' or 'for' them, rather than 'with' them. Further, some patients felt nurses held a position of power over them, they didn't get the care they needed or wanted, and, in some cases, that were rude to them. Inconsistencies in the availability of nurses and lack of awareness of who was caring for them were often verbalized by participants. These findings were similar to those reported in Molin et al. (2016), a Swedish study exploring the everyday life in psychiatric inpatient care. Participants felt uninvolved in making decisions about their care and, at times, as though they were treated like children (Molin et al., 2016). They also commented on nurses' availability, indicating that nurses were often in the nursing station or nowhere to be seen; nurses were perceived as difficult to reach (Molin et al., 2016). Similarly, participants in a quality improvement study in Australia examining what makes an excellent mental health nurse reported that patients were ignored by nurses at the nursing station (Gunasekara et al., 2014). Participants in that study indicated that they would like nurses to introduce themselves at the beginning of each shift and explain their role (Gunasekara et al., 2014). Participants also wanted a nurse who was attentive and highlighted how frustrating it is when apparently simple needs went unmet (Gunasekara et al., 2014). Aligning with our study, power differences were also highlighted by participants in Morline et al. (2016) who spoke of

abuse of power by staff and use of coercive measures. There were accounts of staff using unkind words, losing their temper, and using force rather than attempting to verbally communicate (Molin et al., 2016). Similarly, in a qualitative exploration of women's experiences as inpatients, participants felt powerless and, at times, as though they were being punished by staff (Tully et al., 2023).

Another concerning finding from our study was participants' impressions of the care environment. The care environment included both the physical surroundings and the structure of care received. Several participants expressed that the lack of space impacted their recovery, Further, many participants felt unsafe during their admission and, at times, did not ask for care due to observing the increased stress and workload of nurses assigned to their care. These findings align with Vennedey et al. (2019), a German study that examined facilitators and barriers to PCC from the patient perspective. Participants in that study also perceived a high responsibility and workload among staff and the negative impact of increased workload on the provider's ability to provide PCC (Vennedey et al., 2020). In the same study, participants also reported that confined spaces negatively impacted their perception of patient-centredness and that rooms with three patients or less facilitate PCC (Vennedey et al., 2020). These feelings were echoed by forensics psychiatric patients in Sweden who indicated that updated and improved physical space enhanced their perception of a patient-centred environment (Alexiou et al., 2018). Participants in our study often spoke of safety concerns in reference to other patients on the unit, for example, feeling intimidated by others. This finding aligns with one systematic review of violence on inpatient mental health settings that reported a pooled prevalence for physical violence at 43.2% (95% CI 0.37 to 0.49) and a pooled prevalence for verbal aggression at 57.4% (95% CI 0.34 to 0.81) among the 364 studies (Thibaut et al., 2019). However, participants in

other qualitative studies conducted in Canada and Sweden primarily discussed safety in terms of the physical space (Livingston et al., 2012; Olausson et al., 2019). For example, participants in a Swedish forensic mental health study indicated that having a place, like their room, to feel safe and in control was essential to them (Olausson et al., 2019).

Thorne (2008), highlights the importance of considering the meaning of related behaviors when examining clinical problems. The results of this of this study indicate that those admitted to inpatient mental health units engage in rare person-centred moments with their nurses; PCC is not consistent or reliable. However, it may be that nurses aren't given the power to fully embrace person-centred ways of working (Byrne et al., 2020). Nurses may be working within environments with unsupportive workplace culture, high workload, and restrictive policies and practices (Byrne et al., 2020). That is, they may be working within an organization that does not support nurses in the provision of PCC. Health care organizations must create space for nurses 'to be' with those they are caring for and allow for opportunities to increase connections and shared-decision making (McCormack, 2020).

Existing research on person-centred mental health nursing care from the perspective of patients is very limited. Findings from our study contribute to this gap in the research as well as contribute to the research on the general experiences of those who receive inpatient mental health nursing care. One strength of this study is that the open nature of the interviews encouraged interviewees to express various positive and negative care experiences, resulting in a rich data. Further, the participant sample was appropriate for the study's methodology and was large enough to capture a variety of views and experiences about inpatient mental health nursing care. One important issue in qualitative research is transferability. In this study, all participants lived in one Atlantic province and had used the inpatient mental health services there. Thus,

transferability of the findings to other mental health settings and in other Canadian provinces or countries requires caution.

Implications for Practice

Despite the support for PCC in practice, research, and health policy as well as the recognition of PCC as an essential component of recovery-orientated practice, this study confirms that the operationalization of PCC in mental health inpatient settings remains limited. Embracing PCC requires a change in clinical mindset from the notion doing 'for' or 'to' the patient to working 'with' the person, building their capacity to take control of their own wellness (Smith & Williams, 2016). Findings from this study may stimulated mental health nurses to reflect on their own practice and make personal changes in their ways of working. However, only when this effort is combined with an actionable commitment to support person-centred cultures at the organizational level will we see more consistent delivery of PCC. In part, this includes policy changes that allows inpatient nurses more autonomy in their practice and provides nurses with the resources to practice PCC. Workforce development initiatives are also needed to empower nurses to adopt person-centred ways of working. Future research could explore transformational practice development as an approach to cultivating person-centred practices among nurses (Manley et al., 2008; McCormack et al., 2011).

Conclusion

Based on study findings, person-centred mental health nursing care is inconsistent. Participants who received inpatient treatment within this Canadian province experienced person-centred moments, that is specific person-centred interactions between one nurse and one patient at a particular point in time (McCormack et al., 2011). However, these instances were infrequent and most descriptions of nursing care were of a routine nature. It is important to note that it is not

realistic to expect every interaction between a nurse and patient to be person-centred. Routine practices are a necessary aspect of nursing care; however, results of this study revealed few moments of PCC with missed opportunities to engage in a person-centred way.

References

Ahn, S., & Shin, S. (2023). 'I felt alive': A qualitative study of inpatients' perspectives on good mental health nursing in South Korea. *International Journal of Mental Health Nursing*, *32*(3), 791-800. https://doi.org/10.1111/inm.13122

Ahn, S., & Yi, Y. (2022). Factors influencing mental health nurses in providing person-centered care. *Nursing Ethics*, *29*(6), 1491-1502. https://doi.org/10.1177/09697330221089076

Byrne, A.-L., Baldwin, A., & Harvey, C. (2020). Whose centre is it anyway? Defining person-centred care in nursing: An integrative review. *Plos One*, *15*(3), e0229923-e0229923. https://doi.org/10.1371/journal.pone.0229923

Canadian Nurses Association. (2015). Framework for the practice of registered nurses in Canada. https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/rn-practice-framework2

Canadian Institute for Health Information. *Mental Health and Substance Use Disorder Discharges.* Accessed October 1, 2023.

Coffey, M., Hannigan, B., Barlow, S., Cartwright, M., Cohen, R., Faulkner, A., Simpson, A. (2019). Recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings: a cross national comparative mixed methods study. *BMC Psychiatry, 19*(1), 115. https://doi.org/10.1186/s12888-019-2094-7

Gabrielsson, S., Savenstedt, S., & Olsson, M. (2016). Taking personal responsibility: Nurses' experiences of good nursing practice in inpatient psychiatry. *International Journal of Mental Health Nursing, 25*(5), 434–443. https://doi.org/10.1111/inm.12230

Gabrielsson, S., Sävenstedt, S., & Zingmark, K. (2015). Person-centred care: clarifying the concept in the context of inpatient psychiatry. *Scandinavian Journal of Caring Sciences*, *29*(3), 555-562. https://doi.org/10.1111/scs.12189

Government of Canada (2020). Data Blog. Retrieved from: https://health-infobase.canada.ca/datalab/mental-illness-blog.html

Gunasekara, I., Pentland, T., Rodgers, T., & Patterson, S. (2014). What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use: What makes an excellent mental health nurse? *International Journal of Mental Health Nursing*, *23*(2), 101-109. https://doi.org/10.1111/inm.12027

Hennessy, B., Hunter, A., & Grealish, A. (2023). A qualitative synthesis of patients' experiences of re-traumatization in acute mental health inpatient settings. *Journal of Psychiatric and Mental Health Nursing*, *30*(3), 398-434. https://doi.org/10.1111/jpm.12889

Hem, M. H., Gjerberg, E., Husum, T. L., & Pedersen, R. (2018). Ethical challenges when using coercion in mental healthcare: A systematic literature review. *Nursing Ethics, 25*(1), 92–110. https://doi.org/10.1177/0969733016629770

Hirsch, S., & Steinert, T. (2019). Measures to Avoid Coercion in Psychiatry and Their Efficacy. *Deutsches Arzteblatt International, 116*(19), 336–343. https://doi.org/10.3238/arztebl.2019.0336

Hopkins, J. E., Loeb S. J., & Fick D. M. (2009). Beyond satisfaction, what service users expect of inpatient mental health care: a literature review. *Journal of Psychiatric Mental Health Nursing, 16*(10), 927–937. https://doi.org/10.1111/j.1365-2850.2009.01501.x

Hummelvoll, J., Karlsson, B., & Borg, M. (2015). Recovery and person-centredness in mental health services: roots of the concepts and implications for practice. *International Practice Development Journal, 5* (Suppl 7); Special Issue September. https://doi.org/10.19043/ipdj.5SP.009

Hurley, J., Lakeman, R., Linsley, P., Ramsay, M., & McKenna-Lawson, S. (2022). Utilizing the mental health nursing workforce: A scoping review of mental health nursing clinical roles and identities. *International Journal of Mental Health Nursing*, *31*(4), 796-822. https://doi.org/10.1111/inm.12983

Johansson, H., & Eklund, M. (2003). Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Science, 17,* 339–46. https://doi.org/10.1046/j.0283-9318.2003.00233.x

Landeweer, E. G. M., Amba, T. A., & Widdershoven, G. A. M. (2011). Moral margins concerning the use of coercion in psychiatry. *Nursing Ethics, 18*(3), 304–316. https://doi.org/10.1177/09697 33011 400301

Laitila, M., Nummelin, J., Kortteisto, T., & Pitkänen, A. (2018). Service users' views regarding user involvement in mental health services: A qualitative study. *Archives of Psychiatric Nursing*, *32*(5), 695-701. https://doi.org/10.1016/j.apnu.2018.03.009

Livingston, J. D., Nijdam-Jones, A., & Brink, J. (2012). A tale of two cultures: examining patient-centered care in a forensic mental health hospital. *The Journal of Forensic Psychiatry & Psychology, 23*(3), 345–360. https://doi.org/10.1080 /14789949 .2012.668214

Manley, K., McCormack, B., & Wilson, V. (2008). Introduction. In K. Manley, B. McCormack, & V. Wilson (eds.), Practice Development in Nursing: International Perspectives (p. 1-16). Oxford: Blackwell Publishing.

McAndrew, S., Chambers, M., Nolan, F., Thomas, B., & Watts, P. (2014). Measuring the evidence: reviewing the literature of the measurement of therapeutic engagement in acute

mental health inpatient wards. *International Journal Mental Health Nursing, 23*(3), 212–220. https://doi.org/10.1111/inm.12044

McCormack, B., Borg, M., Cardiff, S., Dewing, J., Jacobs, G., Janes, N., Karlsson, B., McCance, T., Mekki, T.E., Porock, D., van Lieshout, F., &Wilson, V. (2015) Person-centredness – the 'state' of the art. *International Practice Development Journal, 5*(1), 1-15. https://doi.org/10.19043/ipdj.5SP.003

McCormack, B., Dewing, J., & McCance, T. (2011). Developing person-centred care: addressing contextual challenges through practice development. *Online journal of Issues in Nursing*, *16*(2), 3-3. https://doi.org/10.3912/OJIN.Vol16No02Man03

McCormack, B., & McCance, T. (2016). *Person-centred practice in nursing and health care : Theory and practice (2nd ed.)*. Wiley.

McKay, K., Ariss, J., & Rudnick, A. (2020). RAISe-ing awareness: Person-centred care in coercive mental health care environments: A scoping review and framework development. *Journal of Psychiatric and Mental Health Nursing*, *28*(2), 251-260. https://doi.org/10.1111/jpm.12671

Mertens, D. M. (2007). Transformative Paradigm: Mixed Methods and Social Justice. *Journal of Mixed Methods Research*, *1*(3), 212-225. https://doi.org/10.1177/1558689807302811

Mertens, D., Bledsoe, K., Sullivan, M. & Wilson, A. (2010). Utilization of mixed methods for transformative purposes. In C. Teddlie & A. Tashakorri (Eds.), *Handbook of mixed methods research* (2nd ed.). Sage.

Molin, J., Graneheim, U. H., & Lindgren, B.-M. (2016). Quality of interactions influences everyday life in psychiatric inpatient care-patients' perspectives. *International Journal of*

Qualitative Studies on Health and Well-being, *11*(1), 29897-29811. https://doi.org/10.3402/qhw.v11.29897

Monahan, J., Hoge, S. K., Lidz, C., Roth, L. H., Bennett, N., Gardner, W., & Mulvey, E. (1995). coercion and commitment: Understanding involuntary mental hospital admission. *International Journal of Law and Psychiatry, 18*(3), 249–263. https://doi.org/10.1016/0160-2527(95)00010

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, *31*(4), 662-673. https://doi.org/10.1111/scs.12376

Morgan, S., & Yoder, L. (2012). A concept analysis of person-centered care. *Journal of Holistic Nursing, 30*(1), 6-15. https://doi.org/10.1177/0898010111412189

O'Donovan, A. (2007). Patient-centred care in acute psychiatric admission units: reality or rhetoric? *Journal of Psychiatric and Mental Health Nursing*, *14*(6), 542-548. https://doi.org/10.1111/j.1365-2850.2007.01125.x

Olausson, S., Danielson, E., Beglund Johansson, I., & Wijk, H. (2019). The meanings of place and space in forensic psychiatric care-a qualitative study reflecting patients' point of view. *International Journal of Mental Health Nursing, 28*(2), 516–526. https://doi.org/10.1111/inm.12557

Phelan, A., McCormack, B., Dewing, J., Brown, D., Cardiff, S., Cook, N., Dickson, C., Kmete, S., Lorber, M., Magowan, R., McCance, T., Skovdahl, K., Štiglic, G., & van Lieshout, F. (2020). Review of developments in person-centred healthcare. *International Practice Development Journal*, *10*(Suppl2), 1-29. https://doi.org/10.19043/ipdj.10Suppl2.003

Robinson, J. H., Callister, L. C., Berry, J. A., & Dearing, K. A. (2008). Patient-centered care and adherence: Definitions and applications to improve outcomes. *Journal of the American Academy of Nurse Practitioners*, *20*(12), 600-607. https://doi.org/10.1111/j.1745-7599.2008.00360.x

Shin, S., & Ahn, S. (2023). Experience of adolescents in mental health inpatient units: A metasynthesis of qualitative evidence. *Journal of Psychiatric and Mental Health Nursing*, *30*(1), 8-20. https://doi.org/10.1111/jpm.12836

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., Perkins, R., Shepherd, G., Tse, S., & Whitley, R. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry, 13*(1), 12–20. https://doi.org/10.1002/wps.20084

Smith, G. P., & Williams, T. M. (2016). From providing a service to being of service: advances in person-centred care in mental health. *Current Opinion in Psychiatry*, *29*(5), 292-297. https://doi.org/10.1097/YCO.0000000000000264

Thorne, S. E. (2008). *Interpretive description*. Left Coast Press.

Thorne, S. (2016). *Interpretive description qualitative research for applied practice* (2nd ed). Routledge.

Thorne, S., Kirkham, S. R., & O'Flynn-Magee, K. (2004). The Analytic Challenge in Interpretive Description. *International Journal of Qualitative Methods*, *3*(1), 1-11. https://doi.org/10.1177/160940690400300101

Tofthagen, R., Talseth, A.-G., & Fagerstrom, L. (2014). Mental health nurses' experiences of caring for patients suffering from self-harm. *Nursing Research and Practice, 2014*, 1–10. https://doi.org/10.1155/2014/905741

Tully, S. M., Bucci, S., & Berry, K. (2023). “My life isn't my life, it's the systems”: A qualitative exploration of women's experiences of day-to-day restrictive practices as inpatients. *Journal of Psychiatric and Mental Health Nursing*, *30*(1), 110-122. https://doi.org/10.1111/jpm.12855

Vennedey, V., Hower, K. I., Hillen, H., Ansmann, L., Kuntz, L., & Stock, S. (2020). Patients’ perspectives of facilitators and barriers to patient-centred care: insights from qualitative patient interviews. *BMJ Open*, *10*(5), e033449-e033449. https://doi.org/10.1136/bmjopen-2019-033449

Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L., & Arnfred, S. (2018). Recovery orientation in mental health inpatient settings: Inpatient experiences? *International Journal of Mental Health Nursing*, *27*(3), 1177-1187. https://doi.org/10.1111/inm.12434

World Health Organization. (2015). *WHO global strategy on people-centred and integrated health services: Interim report.* https://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_SDS_2015.6_eng.pdf

World Health Organization. (2016). *Framework on integrated, people centred health services.* https://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_39-en.pdf

Younas, A., Inayat, S., & Masih, S. (2023). Nurses’ perceived barriers to the delivery of person-centred care to complex patients: A qualitative study using theoretical domains framework. *Journal of Clinical Nursing*, *32*(3-4), 368-381. https://doi.org/10.1111/jocn.16245

Chapter 4: The Person-centred Care Practice Patterns of Mental Health Nurses: Results of the Integration Phase of a Concurrent Mixed Methods Study

Chantille Isler PhD (c), RN

Joy Maddigan PhD, RN

Robin Burry PhD, RN

Alice Gaudine PhD, RN, FCAN

Introductory Statement

Chapter 4 contains a manuscript that presents the integrated findings of the mixed methods study. The target audiences for this manuscript are mental health nurses and health organizations. This manuscript was written with the intention for submission to the Journal of Clinical Nursing, however, some information may be removed or condensed to meet the requirements for publication.

Authorship Statement

Chantille Isler (the primary investigator) and Dr. Maddigan contributed to the conception and research design. With guidance from Dr. Maddigan, Chantille Isler contributed to data collection, analysis, and interpretation and wrote the manuscript. Dr. Maddigan and Chantille Isler conducted the study integration. Dr. Maddigan, Dr. Gaudine, and Dr. Burry reviewed the manuscript and revisions were made by Chantille Isler based on feedback. Dr. Maddigan, Dr. Gaudine, and Dr. Burry reviewed the revised manuscript and gave final approval.

Key Words:

Person-centred care, mixed methods, nursing, mental health

‘

Abstract

Aim: To identify the person-centred care practice patterns exemplified by mental health nurses through the integration of relevant findings from a concurrent mixed methods study.

Background: The integration phase of this mixed methods study is based on the findings from three sub-studies: i) a survey of 70 mental health nurses, ii) eight interviews with individuals who had a recent mental health inpatient experience and, iii) 36 hours of participant observation on three mental health inpatient units.

Design: Based on the research design of the full concurrent mixed methods study, the analytic technique of merging was used in the integration analysis to establish the level of concordance and alignment among complementary data within the three sets of findings. The Person-centred Practice Framework comprised of 17 constructs spanning three domains essential for operationalizing person-centred care, guided the integration analysis.

Methods: The Pillar Integration Process, a four-stage procedure designed to integrate qualitative and quantitative data using joint display tables, was used for integration. The Pillar procedure resulted in the development of integrated themes based on the merging of the quantitative and qualitative findings. An additional step in the analysis was taken to further integrate the Pillar themes to develop meta-themes that illustrate the person-centred care practice patterns of mental health nurses.

Results: Three practice patterns were developed from the further integration of 17 integrated themes that described how nurses work and navigate their practice within the mental health care environment, including: 1) Mental health nurses maintain a separation from patients and often deliver nursing care from a distance, 2) Mental health nurses practice in an organizational culture

that supports the status quo, which is not person-centred care, and 3) When mental health nurses and individuals co-engage in person-centred moments, the results are inspiring and foster hope.

Conclusion: Nurses face organizational, professional, and personal barriers that constrain their ability to deliver person-centred care. While person-centred moments were infrequent, they are valued by both the individual and the nurse who experience them.

Relevance for Clinical Practice: Advancing beyond discrete occasional moments of PCC requires a sustained commitment from both health care professionals and their organization. Organizational strategies are needed to ensure that practices and structures (i.e. the care culture) are developed to promote the delivery of person-centred care including the preparation and commitment of nurses and other health care professionals.

Keywords: Person-centred care, mixed methods, nursing, mental health

The Person-centred Care Practice Patterns of Mental Health Nurses: Results of the Integration Phase of a Concurrent Mixed Methods Study

Within current mental health services, there is a growing focus on individualized recovery and person-centred care (PCC) (Allikmets et al. 2020; Brophy et al. 2016; Waldemar et al., 2018). PCC is a core component of recovery (Biran-Ovadia et al., 2023; Ørjasæter & Almvik, 2022) and is an expression of the ethical, humanistic, and holistic foundations of nursing care (Edvardsson et al., 2017). That is, person-centeredness is the "operationalizing of personhood" (Anker-Hansen et al., 2020, p. 130). Nurses who practice PCC respect the beliefs, decisions, and preferences of individuals (McCormack & McCance, 2016) and involve them in collaborative decision-making through a therapeutic connection (Byrne et al., 2020).

PCC is a core component of high-quality health care (Langberg et al., 2019; Santana et al., 2017). It is associated improved patient outcomes (Ballard et al., 2018; Ekman et al., 2012; Fors et al., 2015; Olsson et al, 2014; Wynia et al., 2018), satisfaction of care (Allerby et al., 2020; Kuipers et al., 2019; Rossom et al., 2016), as well as job satisfaction for nurses (den Boer et al., 2017; van Diepen et al., 2020; Lehuluante et al., 2012). However, PCC is poorly understood and operationalized by health care professional (Hakansson Eklund et al., 2019).

Although professional attitudes, time constraints, and traditional practices and structure can limit the operationalization of PCC in any health setting (Moore et al., 2017), contextual aspects of psychiatric care settings can present additional constraints (Bass et al., 2014; Cromar-Hayes & Chandley, 2015; Oh & Nam, 2018; Wyder et al., 2017). Mental health nurses have an enhanced responsibility to balance patient preferences in conjunction with community, legal, and professional accountabilities (Meehan et al., 2008). Engaging in shared decision-making, a fundamental person-centred practice (McCormack & McCance, 2016), may have to be

implemented in a way that corresponds with the individual's recovery. Additionally, health care organizations are typically risk-adverse, which negatively impacts nurses' ability to foster patient autonomy (Bass et al., 2014; Cromar-Hayes & Chandley, 2015). As a result, an emphasis on biomedical practices such as medication, psychiatric diagnoses, and containment of individuals often prevail (Chester et al., 2016; Waldemar et al., 2018; Wand et al., 2022), leaving those receiving care dissatisfied (Rose et al., 2015; Waldemar et al., 2018).

Background

Persons living with serious and persistent mental illness are a vulnerable population who often encounter obstacles exercising their political, civil, and social rights (Ventura et al., 2021; WHO, 2010). They experience social stigma, discrimination, marginalization, disempowerment, and disconnectedness (Beitinger et al. 2014; Morant et al., 2015; WHO, 2010). Further, their insight, autonomy, cognition, may also be impacted by their illness (Moore et al., 2017). As a result, nurses practicing in mental health settings must use their most important and complex therapeutic tool, themselves (Tierney, 2020), to work with individuals' beliefs and values and engage them in in shared-decision making (McCormack & McCance, 2016). As such, the nurse-patient relationship is essential to person-centred mental health nursing care (Oh & Nam, 2018; Wand et al., 2022).

Therapeutic engagement occurs when nurses interact with individuals through active listening, understanding, and responsiveness to their needs, all while fostering emotional and personal development (McAllister et al., 2019). However, nurses can face challenges in implementing therapeutic engagement that results in disappointing client care (McAllister & McCrae 2017; McKeown, 2015). While individuals receiving care expect respectful, personalized, and empowering treatment (Moreno- Poyato et al., 2016), they may experience

poor care, for example, disrespect, inadequate details about their treatment, insufficient involvement in decision making, and lack of formal and informal conversations with those caring for them (Cutcliffe et al., 2015; Sommerstad et al., 2021). Studies examining person-centred principles, for example, shared decision-making, reported those receiving mental health care are often invited to express their beliefs and preferences; however, health professionals ultimately remain in charge of care decisions (Reid et al., 2018; Waldemar et al., 2019).

Few studies have directly examined mental health nurses' person-centred practices (O'Donohue et al., 2023; Slater et al., 2015). While nurses' experiences of delivering mental health care (Lindgren et al., 2021; Wyder et al., 2017) and patients' experiences of receiving mental health care (Molin et al., 2016; Schmidt & Uman, 2019; Waldemar et al., 2018; van Dusseldorp et al., 2023) have been examined, little evidence exists as to mental health nurses' PCC practices. Patients' experiences of receiving PCC from general health care practitioners has been explored in a systematic review of ten studies (Havana et al., 2023). To our knowledge, there have been no mixed methods studies examining person-centred mental health nursing care. In one study participant observation was used to examine recovery-oriented practices (Waldemar et al., 2019**)** but no studies were located where participant observation was used to examine person-centred mental health nursing care.

This component of the mixed methods study is the integration phase. The purpose is to merge the findings from the three study components (survey, observations, and interviews) to better understand the person-centred practice patterns of mental health nurses in one Atlantic Canadian province.

Study Framework

This study is underpinned by The Person-centred Practice Framework (McCormack & McCance, 2016). The framework assists health organizations and health professionals to understand how PCC can be effectively operationalized (McCormack & McCance, 2016). Three domains in the framework address the operationalization of PCC, including: the prerequisites, the care environment, and the care process (McCormack & McCance, 2016). A detailed description of the Person-centred Practice Framework is in Chapter 1 of this document.

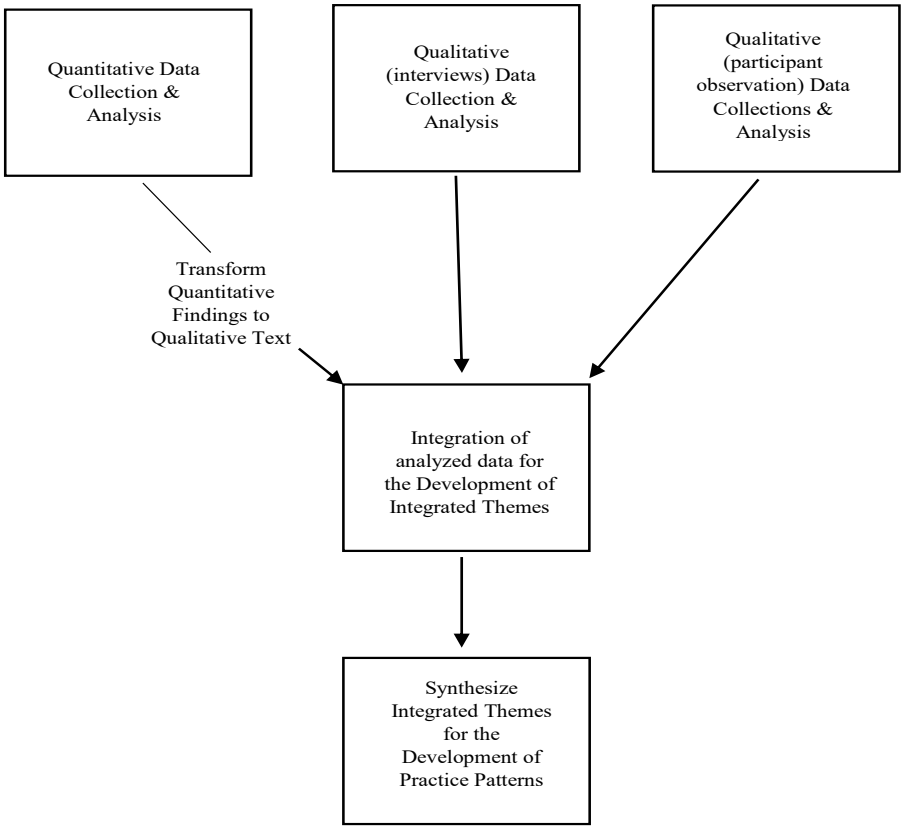
Methods

Design

A concurrent mixed methods design was chosen for the study (Creswell & Plano Clark, 2018). This study has one quantitative component, two qualitative components, and an integration phase. Figure 4.1 depicts the concurrent design and highlights the parallel but separate nature of the data collection and data analysis of each component. Integration begins with the merging of the findings from each component (Creswell & Plano Clark, 2018). The integration phase of the study is the focus of this paper.

Figure 4.1

Concurrent Mixed Methods Study Design



Overview of the Three Study Components

Below is a brief description of the methods and findings from the survey, participant observation, and interview components of the mixed methods study.

Quantitative Component

An online survey package was distributed to all mental health and addictions registered nurses (RNs) working in one Atlantic Canadian province regarding their person-centred practices (approximately 400 nurses). Included was the questionnaire, the Person-centred Practice

Inventory-Staff (PCPI-S) (Appendix A), which measured nurses' PCC practices for this study (Slater et al., 2017). The Likert-type scale consists of 59 items that measures 17 constructs essential to PCC. Seventy mental health nurses completed the online questionnaire. The descriptive results for the 17 constructs are the quantitative data used in the integration phase of the study.

Survey Results Relevant to the Integration Phase. Seventy RNs completed the survey. The 17 constructs of the PCPI-S provide important information about how nurses believe they are delivering PCC. The majority of nurses rated their PCC practices highly. For 12 of the 17 constructs, nurses scored their practices between 4.0 and 4.4 out of 5. These high ratings indicate that nurses perceive that they are providing many aspects of PCC to individuals receiving mental health services. The remaining five constructs received a mean score between 3.1 and 3.8 out of a possible 5. The ratings of these constructs suggested that nurses believe that they provide some aspects of PCC less commonly than others.

Qualitative Components

Participant Observation Study Methods. Participant observation was conducted on three adult mental health inpatient units using the Workplace Culture Critical Analysis Tool-Revised (Wilson et al., 2020) (Appendix D). This tool aligned with the Person-centered Practice Framework and included the 17 constructs measured in the nurses' PCC survey. Structured data collection took place six times on each unit for two hours each time, resulting in 18 data collection periods and 36 hours of unit observation. Observations in the care environments focused on the everyday activities of the units at three different time-periods, morning, afternoon and evening. The observation tool was designed to identify regular unit routines and actions that, when analysed, provide information about the culture ('the way we do things around here') on

the units and in the larger organization. The constant comparative method was used to analyze observational data.

Participant Observation Results. The participant observation component of the study included seven themes, each pertaining to one of the three domains of the Person-centred Practice Framework (see Table 4.1 below). Themes developed from the analysis of the structured observations highlighted interactions and unit characteristics that aligned with the 17 PCC constructs. The observational findings were used in the integration phase of this study

Prerequisite Domain. Themes that focused on the prerequisite domain addressed the observations that related to the five prerequisite constructs. This domain reflects the attributes needed by practitioners to build a PCC relational practice with individuals living with mental illness. It requires mental health nurses to have broad knowledge of one's self, including the beliefs and values that they hold and a self-awareness that promotes interest in and acceptance of others. Essential prerequisites include a commitment to the work, demonstrated by the nurse's ability to respond competently and attentively to individuals' needs and concerns using therapeutic interpersonal skills to promote connection and healing. The three themes that developed from the prerequisite observational data indicate that the required attributes for PCC are not always evident in the day-to-day behaviors and actions taking place on a mental health unit or by mental health nurses.

Table 4.1

Themes Developed from Participant Observation

Framework Domain	Themes
I Prerequisites	1.1 Unstable foundations for PCC
	1.2 The nature of the care delivered
	1.3 Interpersonal skills varied
II Care environment	2.1 Lack of organizational guidance for implementation of PCC
	2.2 Supportive teamwork
	2.3 A care environment of diminished personhood
III Care processes	3.1 Person-centred practices, inspiring but fleeting

The Care Environment Domain. Themes related to the care environment represent the context of care delivery. As a broad domain, the environment considers seven factors (constructs) that influence the provision of PCC. These factors are facilitative or prohibitive and need consideration when implementing PCC. The seven constructs also illustrate the types of issues that can arise on any unit, many of which are the nurses' responsibility to manage. Matters such as, effective staff relationships, power-sharing and shared decision-making systems reflect how well teams work together in support of the individuals receiving care. Two factors, supportive organizational systems, and innovation and risk taking, provide evidence of commitment by the larger organization for the delivery of PCC. They indicate the need for a 'whole organization' effort to achieve PCC. The two final factors, skill mix and the physical setting, highlight the value of adequate resources to maintain a therapeutic space and milieu that supports individuals in their recovery. Observations related to the seven environment constructs produced three main themes that are contextual in nature. Two of the three themes identify

barriers to the development of both a PCC approach and an organizational culture that guides and supports mental health nurses to new and unique ways of being and practicing.

The Care Process Domain. The Care Process Domain refers to the provision of care to individuals through a range of activities and behaviors represented by the remaining five constructs: working with patients' beliefs and values, engaging authentically, sympathetic presence, shared decision-making, and providing holistic care. Observations that corresponded with the five constructs were scarce. Moments of person-centred nursing care were rarely identified and, when they were, the interactions between the individual and nurse were very brief. Consequently, one theme was developed that spoke primarily to the absence of PCC delivery.

Qualitative Interview Study Methods. Semi-structured interviews were conducted with eight individuals living in the community who had received inpatient mental health nursing care in the previous year. Participants were interviewed, either in-person or by phone, for approximately 45 minutes. An interview guide was used to better understand individuals' experiences of receiving inpatient mental health nursing care. Interviews were audio recorded and transcribed verbatim upon completion. Constant comparative method was used to analyze the interview data.

Qualitative Interview Results. Three themes captured participants' experiences of inpatient mental health nursing care (see Table 4.2). The first theme, *rare moments of PCC*, was developed in response to the absence of PCC for individuals receiving care on inpatient mental health units; most of the care received by participants lacked personalization and their self-identified needs were not prioritized. While some instances of PCC were noted by participants,

these person-centered moments were infrequent and dispersed within what would typically be considered routine nursing care.

The second theme delineated the dynamics of the nurse-patient relationship; it was changeable and influenced by the feelings participants had towards the nurses who cared for them. Some participants recounted positive connections with their nurses, fostering feelings of safety, protection, and ultimately, being well cared for. In contrast, other participants highlighted negative nurse-patient interactions, leading them to perceive a lack of control over decisions regarding their care and treatment. Two sub-themes were developed to illustrate these dimensions of the theme: 1) *In good hands* and 2) *Limited control*.

Table 4.2

Interview Themes and Sub-themes

Theme	Sub-Theme
2) Rare moments of PCC	
2) The relationship with my nurse: A fluctuating connection	2.1 In good hands
	2.2 Limited control
3) The care environment as an uncertain space	3.2 Perils of an unknown environment
	3.2 Pearls of the care environment

The final theme was developed to explore the impact of the care environment on patients' well-being. Participants presented divergent perspectives on the care environment, indicating a sense of unpredictability and apprehension. Some participants expressed a feeling of being left alone to grapple with significant issues, including concerns about their own safety. The subtheme, *perils of an unknown environment*, was developed to encapsulate this data. Individuals felt that they were unsafe and vulnerable to harm from co-patients while on the unit. They also reported challenges related to limited physical space, nurse availability, awareness of their assigned nurse was, and inconsistency regarding the communication of unit rules. Despite

numerous concerns, participants did acknowledge positive aspects of the care environment. Although limited, the subtheme, *pearls of the care environment*, was developed to represent this data. Individuals who had longer hospitalizations or multiple admissions perceived the unit as feeling familiar, contributing to a greater sense of ease. Participants felt acquainted with unit routines, as well as with nurses and fellow patients. Additionally, several participants spoke positively about the beneficial effects of unit activities on their recovery.

Study Integration Phase

The mixed methods research question answered by the integration of the study findings is: What are the person-centred care practice patterns of mental health nurses in one Atlantic Canadian province?

The integrated findings provide a baseline measure of the nature and quality of the PCC delivered to individuals accessing mental health services. The Pillar Integration Process (PIP) was chosen as the methodology for the integration phase of the study (Fekonja et al., 2022; Johnson et al. 2019; Richards et al., 2022). PIP is a four-stage technique designed to integrate qualitative and quantitative data using joint display tables (Johnson et al. 2019). The approach evolved from traditional mixed methods matrices and joint displays (Creswell, 2003; Miles & Huberman, 1994; O'Cathain et al., 2010) and is suitable for most mixed methods study designs (Johnson et al. 2019).

Thee first two authors of the manuscript conducted data integration, which involved working through four 'pillar' stages of the PIP: listing, matching, checking, and integrated theme development (Johnson et al. 2019). For the purpose of this study, an additional step was implemented to further integrate the 17 integrated themes and develop the PCC practice patterns of mental health nurses.

Quantitative Data Transformation

Prior to beginning the first stage of integration, the quantitative survey data was transformed into qualitative text. As survey scores were clustered around the maximum score, there was minimal variation in the data. Our strategy was to maximize the existing variation by grouping constructs into high, moderate, and low agreement categories based on their mean scores. The mean score for each construct was examined, ranked, and grouped into three categories (see Table 4.3, Column 1). Constructs with the highest mean scores, that is, scores of 4.3 and 4.4 were grouped as 'PCC practices for which nurses have the highest agreement'. Constructs with mean scores of 4.0 and 4.1 were categorized as 'PCC practices for which nurses have moderate agreement. The final category comprised the constructs with the lowest mean scores, that is, mean scores between 3.1 and 3.8. Those constructs were grouped as 'PCC practices for which nurses have the lowest agreement'. By optimizing the limited amount of variation in the nurses' data, a richer, more robust integration was possible.

Table 4.3

Qualitizing the Survey Findings into High, Moderate and Low Agreement Categories

1. PCC Constructs Grouped by Level of Agreement	Mean	2. PCC Constructs Grouped by Domain	Mean
PCC Practices with the highest agreement		**Domain 1: Prerequisites**	
1. Holistic care (CP)*	4.4	Developed interpersonal skills	4.3
2. Authentic engagement (CP)	4.4	Professionally competent	4.3
3. Sympathetic presence (CP)	4.4	Knowing self	4.1
4. Commitment to the job (P) **	4.4	Clarity of beliefs and Values	3.8
5. Professional competence (P)	4.3	Commitment to the job	4.4
6. Developed interpersonal skills (P)	4.3	**Domain 2: The Care Environment**	
7. Shared decision-making systems (CE)***	4.3	Skill mix	4.1
PCC Practices with moderate agreement		Effective staff relationship	4.0
8. Working with patients' beliefs and values (CP)	4.1	Power sharing	3.6
9. Knowing self (P)	4.1	The physical environment	4.0
10. Skill mix (CE)	4.1	Shared decision-making systems	4.3
11. Effective staff relationships (CE)	4.0	Potential for innovation and risk taking	3.7
12. Physical environment (CE)Knowing self (P)	4.0	Supportive organizational systems	3.1
PCC Practices with the lowest agreement		**Domain 3: Care Process**	
13. Clarity of beliefs and values (P)	3.8	Providing holistic care	4.4
14. Shared decision-making (CP)	3.7	Sympathetic presence	4.4
15. Innovation and risk (CE)	3.7	Authentic Engagement	4.4
16. Power sharing (CE)	3.6	Shared decision making	3.7
17. Supportive organizational systems (CE)	3.1	Working with patients' beliefs and values	4.1

*CP: Care Process Domain **P: Prerequisite Domain; ***CE: Care Environment Domain;

When the categories were created by highest, moderate and lowest agreements, each category contained a mix of constructs covering the three domains. While the constructs with the highest agreement were mostly under the Prerequisite (P) and Care Process (CP) Domains, both of these domains contained constructs that had moderate and lowest agreements (Table 4.3, Column 2). Constructs related to the Care Environment (CE) had had lower mean scores with only one construct, shared decision-making systems reaching the highest agreement.

The Pillar Integration Process

Stages of Integration. Listing the mixed methods study findings was the first activity in the integration. Raw data (e.g., mean scores, selected quotes) and grouped data (e.g., mean scores transformed into qualitative categories / text, themes) that informed the research question were

listed in a pillar joint display table. Raw and grouped data were sorted under the appropriate columns, labeled either QUANT DATA and QUANT CATEGORIES or QUAL CODES and QUAL THEMES. There were two QUAL CODES and QUAL THEMES columns to account for the two types of qualitative data, interview and participant observation. Appendix H contains the joint display table for the care processes.

The matching stage is the second major procedure of PIP. This procedure requires the researchers to horizontally align similar data, and refine and organize the categories and themes. Raw data and themes/categories were compared across rows of the joint display so that the qualitative items reflected the quantitative items of the same construct. When there were constructs that did not appear to have data representation from one or more of the three data sources, the section remained blank. This allowed the researchers to identify any gaps in the matched data. The third stage of PIP involved implementation of quality assurance activities. All data in the six columns were crosschecked to ensure appropriate data matching in all rows of the table. Any identified blanks in the joint display were rechecked to ensure that no data could provide an appropriate match.

During the fourth and final pillar building stage, a pillar was constructed within the joint display. To develop the pillar, researchers compared and contrasted the findings relevant to the constructs that were included in each of the three PCC domains across rows, connecting and integrating the findings for each of the 17 constructs. Integrated themes were developed based on the content and fit of the three sets of findings (survey, interview, and observation) for each construct. The integrated themes were organized and positioned in the pillar column to correspond with relevant data from the three data sources. These new themes in the PILLAR column were then examined as a whole to develop new insights and build additional inferences

from the integrated data. The integrated themes were again integrated leading to the development of three PCC practice patterns demonstrated by mental health nurses working in mental health services.

Integrated findings

PIP data integration resulted in 17 themes located in the pillar of each data integration table, one for each construct of the Person-centred Practice Framework. Integrative themes captured the essence of the mixed data that were merged for each construct.

Prerequisites

A description of the integrated themes that aligned with the five prerequisite constructs are contained in Table 4.4 below.

Table 4.4

Integrative Themes from the Prerequisite Domain

Prerequisite Domain Construct	Integrative Theme
Developed Inter personal Skills	Nurses were inconsistent in their communication with individuals. Most nurses reported effective interpersonal skills but, from the patients' perspective, these skills were used selectivity. Although nurses and patients spent limited time together, individuals appreciated the positive interactions they had with nurses.
Competent Care	Nurses had the competencies to assist individuals with activities of daily living and were responsive to their physical health needs. They were less likely to implement activities or interventions that were supportive of the individuals' mental health.
Commitment to the Job	Individuals noticed when nurses did small things that were important to them. When nurses spent time explaining or provided help, individuals were grateful.
Knowing Self	When nurses interacted with a calm, but warm approach, individuals become more comfortable and trusting.
Clarity of Beliefs and Values	Nurses did not always respect the dignity and beliefs of the individuals they cared for. Their interactions with patients were mostly by request, that is, the person had to come to the nursing station to ask for the care that they needed.

Nurses expressed high agreement with survey questions that addressed their interpersonal skills. However, data from interview and participant observation provided mixed accounts. Qualitative data revealed that some, but not all, nurses formed meaningful connections with those in their care. Observations captured several interactions between nurses and individuals

they cared for where nurses exemplified developed interpersonal skills. Some interview participants also felt that nurses took the time to get to know them and their families. They reported feeling comfortable with their nurse. However, there were also many examples where nurses did not engage with individuals they cared for appropriately, missed opportunities for engagement, and, in some cases, were simply rude.

Nurses reported high agreement on statements regarding their professional competence. Evident in the observation and interview data are also many occurrences of competent nursing care. Most of this care, however, focused on routine nursing practices and attention to physical health issues. Information about competent mental health care was missing from the three sets of findings. Survey questions were not specific to mental health nursing and both sets of qualitative data lacked evidence of competent mental health care. One exception was psychiatric medication administration.

Nurses self-reported a high commitment to the job, but this was not fully substantiated by the qualitative data. Study participants who were interviewed emphasized that the care they received was dependent on the nurse they were assigned. They provided accounts of nurses demonstrating commitment to the job such as providing patient education and going above and beyond in little ways. Observations identified nurses doing small tasks for patients that made their inpatient stay more comfortable. There was, however, consistent qualitative evidence that nurses were not making themselves available to individuals (patients) when needed.

Nurses were assessed to have weak clarity of beliefs and values. Nurses rated this construct in the lowest agreement category. In addition, observations and interview data both provided confirming evidence that nurses were not clear about their own beliefs and values. Similarly, nurses reported low agreement on survey questions about the construct, knowing self.

There was limited observation and interview data about this construct, however, it was noted that when nurses used a calm and warm approach, individuals they cared for became more comfortable and trusting.

Care Environment

Seven constructs comprise the Care Environment Domain of the Framework. The three data sets contributed evidence for the integrative themes as described in Table 4.5.

Table 4.5

Integrative themes that align with the care environment domain

Care Environment Construct	Integrative Theme
Effective staff relationships	Nurses are members of collegial teams. Health care teams effectively worked together in the provision of patient care.
Shared decision-making systems	Nurses are included and contribute to care decision in the provision of patient care.
Power sharing	Although nurses are members of collegial teams, they are not equal teammates. They work within a hierarchical system where final decisions about care rest with the doctor.
Skill mix	Adequate staffing levels and skill mix do not change how care is provided. Nurses situate themselves behind the nursing station, separated from patients who have to seek them out continuously.
Physical space	The environment is an unsupportive physical space for PCC. The lack of space was challenging and disruptive to individuals' recovery.
Supportive organizational systems	Mental health nurses practice in an organization that does not promote person-centred care. No information or resources were accessible to nurses.
Innovation and Risk taking	Nurses are constrained in their capacity to practice innovation and risk taking.

Concordance was evident within three constructs: effective staff relationships, shared decision-making systems, and power sharing. Both the observational data and the survey data supported the notion that health care teams effectively worked together in the provision of patient care. Nurses scored survey questions pertaining to shared decision-making systems with particularly high agreement and they scored effective staff relationships with moderate agreement. Observational data supported the survey findings for these two constructs. Although

data on power sharing was also concordant, unlike the previous two constructs, data collectively indicated that power sharing with limited. Nurses reported low agreement with survey questions regarding this construct and there was no interview or observational data that exemplified power sharing.

Nurses reported moderate agreement with survey questions regarding skill mix. Observational data revealed that there was often appropriate staffing levels and skill mix for the number of patients and acuity of the unit. Discordantly, interviewees perceived that nurses had a high workload and stress level. Participant observation and interview data revealed many instances when nurses were situated behind the nursing desk, divided from patients. Those interviewed reported that this made them feel as though their nurse wasn't available to them. Several interview participants recalled instances where they had to try to get their nurses attention from outside the nursing station.

There was expansion among the data describing the physical environment; data sets, when combined, painted a clear picture of the physical environment. Nurses reported moderate agreement with statements regarding working in a person-centred physical environment. Interviews highlighted concerns with the physical environment, particularly around space. Participants reported overcrowding and lack of privacy. The observational data also contributed to the description of the physical environment and confirmed that some aspects the physical environment were not person-centred. For example, limited patient activities, aggressive messages written by co-patients on the walls in common areas, and plexiglass barriers around the nursing station.

There was concordance within the constructs, supportive organizational systems and potential for innovation and risk-taking as demonstrated by a low agreement of nurses on survey

questions and limited observational and interview data. These two constructs are related in that innovation and risk-taking can only happen when nurses are given autonomy in their practice. In a culture where PCC is not evident, nurses' capacity for innovation and risk-taking practices also may be hindered.

Care Process

Five constructs align with the prerequisite domain of the framework. Table 4.6 presents the themes that aligned with each construct.

Table 4.6:

Integrative themes that align with the care process domain

Care Process Construct	Integrative Theme
Holistic care	When mental health professionals took an individualized approach with their patients, it was experienced by the individual as helpful and affirming. It also provided new knowledge to support the individual's recovery.
Sympathetic presence	When mental health nurses spent time getting to know their patients, patients felt cared for and accepted.
Authentic engagement	Authentic engagement between the nurse and patient went beyond social interaction and came to rest in a space that was meaningful to the individual. It was an opportunity for growth.
Working with person's beliefs and values	When nurses understand patients' concerns and wishes, they provided helpful responses that are positively received.
Shared decision-making	Mental health nurses made few attempts at shared decision making with individuals (patients). They did pass patient requests on to the physician and speak with family members about the patient's plan of care.

When surveyed, nurses identified their highest agreement with providing holistic care. However, evidence of this way of working was rare in both the interview and participant observation data. When mental health professionals did take an individualized approach with their patients, it was experienced by the individual as helpful and affirming. It also provided new knowledge to support the individual's recovery.

Two PCC constructs, engaging authentically and being sympathetically present, were also highly supported by nurses. Interview and observational data, although limited, did suggest

mental health nurses demonstrated these ways of working more commonly; when they did, the results were positive. The construct, working with person's beliefs and values, had moderate agreement ratings by nurses. Although there was limited interview and observational data to support this construct, the existing data were inspiring and hopeful. When nurses took the time to understand patients' concerns and wishes, they provided helpful responses that are positively received.

The remaining PCC construct, shared decision-making, had lower agreement ratings among nurses surveyed. There was concordance among the three types of data, as interview and observational data revealed very little evidence of this way of working. There was no observed shared decision-making between an individual and their nurse. Concordantly, interview findings revealed only one instance of shared decision-making between a nurse and an individual receiving care.

Integrated Practice Patterns

Based on the integrated themes produced from the Pillar Integration Process, three patterns were developed to describe the how nurses conduct and navigate their practice within the care environment. These patterns captured the complex interrelatedness of the prerequisites, care environment, and care process domains of the Person-centred Practice Framework.

Practice Pattern One: Mental health nurses maintain a separation from patients and often deliver nursing care from a distance.

On inpatient units, there is a clear separation between nurses and the individuals in their care. Nurses often stayed together in the nursing station, which had Plexiglas protection on two units. Individuals remained on the outside and, often, nurses responded to their requests for care from inside the nursing station. Individuals tended to mingle around the nursing station waiting

to catch the attention of a nurse, but the opportunities to spend time with their nurse were infrequent. Even when they sought out their nurse at the nursing station, interactions were short, primarily transactional and experienced from a standing position.

Adequate staffing levels and skill mix did not change these practices. Individuals receiving care described insufficient communication with nurses and a lack of knowledge about their care plan. Given the few, brief interactions patients have with their nurses, this is a natural but unfortunate consequence. Although most nurses reported exhibiting effective interpersonal skills, patient accounts indicate that nurses use these skills inconsistently. Furthermore, nurses demonstrated behaviors that, at times, did not respect the dignity of the individuals in their care. Individuals waited varying lengths of time to be acknowledged by a nurse but some requests made at the nursing station did not get a response.

Although nurses were noted to deliver competent care, the care was primarily of a routine nature and did not focus on mental health needs. The majority of the care provided did not require the nurse to spend time "with" the person and was task-based. Nurses were competent in assisting patients in moving through the day and were responsive to their physical needs. However, they were less likely to implement interventions or activities that were supportive of the individuals' mental health. Nurses did not initiate programming or other therapeutic activities on inpatient units and there was little evidence of nurses spending one-on-one time with patients to discuss their mental health concerns. In spite of the limited time that nurses and patients had together, individuals expressed appreciation for the positive interactions they had with nurses.

Practice Pattern Two: Mental health nurses practice in an organizational culture that supports the status quo, which is not person-centred care.

Mental health nursing practice no longer has a strong relational foundation to support individuals receiving mental health services. Practice has become primarily transactional, with tasks completed upon request. Relationship building and therapeutic engagement between the patient and nurse are not promoted or valued in the care environment. Patients and nurses spend little time together. Given that person-centred and recovery-focused care have been a national policy priority for almost two decades, current clinical mental health practices suggest that the shift has stalled and the status quo prevails.

Nurses do not facilitate decision-making directly with individuals in their care. Patient participation in care decisions is weak and advocacy related to patient rights was absent. The only significant experience of shared decision-making involved patient participation in interdisciplinary rounds, which was the practice on one unit only. However, the extent of the individual's participation in rounds is unknown.

Many nurses do not have a strong clarity regarding their beliefs and values or a strong commitment to the job. However, nurses are working in an organizational cultural that does not promote these personal attributes and no resources were identified that would build nurses' capacity to engage in PCC with individuals. Not surprisingly, nurses also demonstrated little capacity to practice innovation and risk taking, which also suggests that nurses are working in a risk-adverse environment with reduced autonomy to provide PCC. It was also evident that although nurses worked within collegial teams and were included in care decisions, they continue to work in a hierarchical system with little evidence of power sharing. Mental health

nurses were active members of interprofessional teams, but ultimately, they were not equal partners in care.

Practice Pattern Three: When mental health nurses and individuals co-engage in person-centred moments, the results are inspiring and foster hope

Although there was scant evidence of shared decision-making in the practices of mental health nurses, there were instances of nurses implementing other person-centred practices. The evidence revealed that nurses had the professional knowledge and skills to engage therapeutically with individuals and families and co-create trusting relationships. Inspiring connections were made between nurses and patients that went beyond social interaction, were meaningful to the individual and provided opportunity for growth. When nurses took the time to get to know and understand their patients, individuals felt accepted and supported. Working with patients as valued individuals elicited new knowledge about the patients' concerns and needs and was helpful to their recovery. It also enabled nurses to provide more individualized responses that were positively received by those receiving care.

Pattern Summary

Mental health nurses in this study respond to individuals' requests for routine care but are not proactive in anticipating their needs. Patient requests are typically fulfilled with the individual standing in the hall, separated from the nurse by an enclosed nursing station barrier. The time spent with nurses consists primarily of brief interactions between individuals and their nurse that take place while standing outside the nursing station. There was limited evidence of care that focused on the individual's mental health needs or care that included an understanding of the individual's beliefs and values. The nursing care was not relationship-based. In addition, there was little evidence to support shared-decision making between nurses and their patients.

These practice patterns are the norm and they reflect an organizational culture that has not made the shift to PCC. No policies or education were identified that promoted person-centred practices, which suggests that it is not an organizational priority. In some instances, however, intrinsically motivated nurses and those they cared for did engage in person-centred moments. These moments were valued by both the nurse and the individual and resulted in memories that stayed with the individual long after discharge.

Discussion

In this study we aimed to describe the person-centred practice patterns of mental health nurses. The Person-centred Practice Framework describes the interconnectedness of staff attributes, the care environment, and the delivery of PCC (McCormack & McCance, 2016). The three patterns that were developed from the integrated data are reflective of this interdependence. In weaving each pattern, multiple constructs within the framework were considered and addressed.

The first pattern revealed that mental health nurses often deliver care from a distance, creating a gap between the patient and their nurse. This result was also reported in other studies examining inpatient mental health care. For example, those receiving care in Denmark noticed mental health care professionals were often positioned in their office, away from patients (Waldemar et al., 2018). They felt health care professionals observed and assessed them from their office, where they were separated by glass (Waldemar et al., 2018). As in our study, this created a sense of distance from the health care provider and made participants feel as though they, “were standing on ‘the other side’ looking in, but not seen” (Waldemar et al., 2018, p. 1182). As a result, these participants also felt opportunities to share their feelings and experiences with care providers were limited, making some feel isolated (Waldemar et al., 2018).

Integrated findings from our study revealed that patients often had to request care from nurses. An integrative literature review of individuals' experiences of acute mental health care (Schmidt & Uman, 2020) and a participant observation study examining interactions between health care professionals and those they care for on inpatient mental health units (Waldemar et al., 2019) had similar findings. Waldemar et al. (2019) reported that individuals were required to make requests to staff as they were restricted by unit rules, leaving the impression they had to plead for favors. For example, they had to rely on staff to access their belongings. Waldemar et al. (2019) also reported times when health care professionals would talk to patients in a condescending manner, such as telling them to go to their room as a parent would tell a child. Similarly, in our study, there were instances when nurses did not respect the dignity of patients, such as when they provided disrespectful responses. Schmidt and Uman (2020) reported that individuals had to seek out care and often experienced a number of staff-related barriers to accessing care such as feeling dismissed, intimidated, and disliked by nurses (Schmidt & Uman, 2020). Interview participants from one study in Schmidt & Uman (2020)'s review suggested the implementation of dedicated time for conversations between patients and their health care professionals as a way to improve engagement (Kalagi et al., 2018).

The second developed pattern described the impact of organizational culture on nurses' ability to deliver PCC. As in our study, Waldemar et al. (2019) and Waldemar et al. (2018) also reported lack of shared decision-making between health care professionals and those receiving care. Waldemar et al. (2019) described practices that initially appear to be shared-decision making, such as asking patient preferences; however, care planning decisions were ultimately in the hands of health care professionals. Further, health care professionals in this study often referred to unit rules when responding to patients' needs or requests. Similarly, Waldemar et al.

(2018) reported that individuals' involvement in care decisions was limited. Those interviewed reported that their involvement extended no further then accepting or declining suggested medicine changes and reporting side effects (Waldemar et al., 2018). Other studies have also identified system-related issues, such as a biomedical model, outdated practices, and entrenched workplace cultures, as constraining progress towards a more collaborative approach to care (Isobel et al. 2021; Wand et al., 2022). For example, two studies (Wand et al., 2022; Wyder et al., 2017) reported an unsupportive organizational culture where nurses' administrative load left them with insufficient time to practice in a person-centred way. Findings from one narrative synthesis (Wyder et al., 2017) indicated that even when nurses found the time to engage in shared-decision making, for example regarding discharge planning, it was not uncommon for plans to be changed by medical staff. As in our study, this speaks to nurses' lack of power and low-level position on the health care hierarchy. Further, Wyder et al. (2017) and one other study (Rio et al., 2021) reported nurses were left to balance patient preferences with organizational risk management policies.

When nurses did engage individuals in person-centred moments, the results were inspiring and hopeful. This third and final pattern was developed from integrated data that supported nurses' delivery of PCC. In our study, nurses more frequently engaged in person-centred practices showcased by how they behaved when interacting with those they cared for. This finding aligned with Ahn and Shin (2023) who found that participants experienced good mental health nursing when it was perceived that mental health nurses genuinely wanted to spend time with individuals and get to know them. When nurses conveyed empathy and listening, those receiving care felt comfortable to express how they were feeling (Ahn & Shin, 2023). As in our study, participants in Ahn and Shin (2023) favoured care that respected their individual values

and beliefs. Further, participants felt free to seek help if their nurse conveyed understanding for their personal difficulties and provided practical advice (Ahn & Shin, 2023). In other studies, empathy and listening were identified as importing building blocks in the nurse-patient relationship that, when delivered, also encouraged individuals to share their personal difficulties (Horgan et al., 2021; Moreno-Poyato et al., 2021). In one international study examining the desirable qualities of a mental health nurse, it was found that empathy and compassion were highly valued by those receiving care (Horgan et al., 2021). As in our study, participants in Horgan et al. (2021) were looking for skilled nurses who demonstrated caring behaviours, sensitivity, and compassion. Further, they too sought nurses who were accessible, available, and were willing to dedicate time to connect (Horgan et al., 2021).

In summary, not all moments between an individual and their nurse can be person-centred. Everyday routine practices, especially on an inpatient unit are required and expected. However, integrated findings revealed that person-centred moments were the exception, conducted by a small number of intrinsically motivated nurses. When these moments did occur, they were valued by patients. Although person-centred moments were rare, even more rare were person-centred moments of shared decision-making. Individuals receiving care were not equal partners in the care process.

Strengths and Limitations of the Work

This study is one of only a few studies that specifically examined person-centre mental health nursing care and it is the first study where person-centred mental health nursing care is examined using multiple methodologies. In this study, person-centred mental health nursing care is examined from three viewpoints: nurses, patients, and participant observation. Together, these three perspectives create a novel, multidimensional understanding of person-centered mental

health nursing care. Examined in isolation, each viewpoint would only provide a partial assessment of PCC. Combining multiple methodologies allows a broader, more complete picture of person-centred mental health nursing care. Finally, the chosen integration method for this study, the PILLAR method, is an established integration method that provided specific directions on how to conduct the integration. Following this method, 17 themes were developed. In this study an additional step was taken in the integration; the 17 themes were analysed and re-integrated to create three meta-themes. This is an adaption of the established PILLAR method that can be considered by future researchers.

There are limitations to the study findings. First, data were collected in one Canadian province and the results may not be generalizable or transferable to other provinces or countries. However, the samples were varied and included people of different genders, ages, diagnoses, and professional roles. Second, participant observation was conducted by a research assistant who was also a mental health nurse working within the hospital where the observations took place. Although the research assistant made every effort to remain unbiased, it is possible that her recorded observations were impacted by her familiarity with the setting and the staff.

Recommendations for Further Research

It is recommended that future research focus on identifying facilitators of PCC and develop intervention studies to provoke culture change and practice change. This includes involving people with lived experience to contribute to solving practice issues and improving care experiences. Strategies to reduce or eliminate the barriers to PCC identified in this study should be explored. Emancipatory practice development research has the potential to strengthen the capacity in mental health nurses to take ownership of their practice and deliver PCC. Other intervention studies aimed at fostering person-centred principles among nurses could help

improve nurses' engagement in PCC. Further, the impact of COVID-19 on nurse-patient engagement as it relates to PCC remains unknown and should also be explored in future research. Finally, how nurse burnout impacts PCC is another important avenue to explore in future.

Implications for Policy and Practice

Study findings revealed fragmented and under-practiced PCC in mental health, underscoring the need for a fundamental shift in the approach of healthcare professionals and organizations. The significant gaps in PCC indicate that merely implementing isolated, one-time change events is insufficient to bring about lasting improvements in person-centred mental health care and the development of person-centred cultures. To foster a more consistent person-centred practice, a sustained commitment from health care professionals and health organizations is essential (Edgar et al., 2020). Creating person-centred cultures requires a comprehensive and ongoing transformation of attitudes, policies, and practices within the healthcare system. Nurses should be provided with regular education and training that supports and fosters person-centred principles. This involves not only training on the clinical advancements of mental health nursing, but also refining therapeutic communication skills, clinical leadership, critical thinking, conflict resolution, and shared-decision making with patients. Embedding such person-centred principles into the fabric of practice development would empower nurses to consistently deliver PCC. Further, organizations play a pivotal role in the formation of person-centred cultures through the prioritization and incentivization of person-centered approaches. This includes revising policies and procedures to align with PCC principles. In part, this would include moving away from risk-averse care environments. Allocating resources for ongoing training and mentorship programs are also crucial steps. Further, creating environments that encourage collaboration and power-

sharing both among healthcare providers and between health care providers and patients is also important. Until the organization makes steps to empower nurses to take ownership and power of their practice, give nurses more autonomy to engage in shared-decision making with patients, and positions them as equals within the health care team, their ability to practice PCC will continue to be diminished.

Conclusion

In this study we examined the person-centred practice patterns of mental health nurses. Three themes were developed from the integrated findings that revealed the interconnectedness of constructs within the person-centred practice framework. When nurses practiced in a person-centred way, it was valued by those receiving care. However, person-centred mental health care was found to be limited as a result of staff attributes and organizational practices, policies, and structures.

References

Ahn, S., & Shin, S. (2023). 'I felt alive': A qualitative study of inpatients' perspectives on good mental health nursing in South Korea. *International Journal of Mental Health Nursing*, *32*(3), 791-800. https://doi.org/10.1111/inm.13122

Allerby, K., Goulding, A., Ali, L., & Waern, M. (2020). Striving for a more person-centered psychosis care: results of a hospital-based multi-professional educational intervention. *BMC Psychiatry*, *20*(1), 523–523. https://doi.org/10.1186/s12888-020-02871-y

Allikmets, S., Marshall, C., Murad, O. & Gupta, K. (2020). Seclusion: A patient perspective. *Issues in Mental Health Nursing, 41*(8), 723–735. https://doi.org/10.1080/01612840.2019.1710005

Anker-Hansen, C., Skovdahl, K., McCormack, B., & Tønnessen, S. (2020). Collaboration between home care staff, leaders and care partners of older people with mental health problems: a focus on personhood. *Scandinavian Journal of Caring Sciences*, *34*(1), 128-138. https://doi.org/10.1111/scs.12714

Ballard, Corbett, A., Orrell, M., Williams, G., Moniz-Cook, E., Romeo, R., Woods, B., Garrod, L., Testad, I., Woodward-Carlton, B., Wenborn, J., Knapp, M., & Fossey, J. (2018). Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *PLoS Medicine*, *15*(2), e1002500–. https://doi.org/10.1371/journal.pmed.1002500

Bass, H., Tickle, A., & Lewis, N. (2014). The recovery-orientation of three mental health units. *Mental Health Review Journal, 19*, 163-175. https://doi.org/10.1108/MHRJ-11-2013-0036

Biran-Ovadia, A., Strous R. D., Bart, O., & Lipskaya-Velikovsky, L. (2021). Study of recovery model implementation in psychiatric hospitals: Clients and multidisciplinary staff perspective. *International Journal of Mental Health Nursing, 32*(2), 603-614. https://doi.org/10.1111/inm.13106

Beitinger, Kissling, W., & Hamann, J. (2014). Trends and perspectives of shared decision-making in schizophrenia and related disorders. *Current Opinion in Psychiatry*, *27*(3), 222–229. https://doi.org/10.1097/YCO.0000000000000057

Brophy, L. M., Roper, C. E., Hamilton, B. E., Tellez, J. J., & McSherry, B. M. (2016). Consumers and their supporters' perspectives on poor practice and the use of seclusion and restraint in mental health settings: results from Australian focus groups. *International Journal of Mental Health Systems, 10*(1). https://doi.org/10.1186/s13033-016-0038-x

Byrne, A. -L., Baldwin, A., & Harvey, C. (2020). Whose centre is it anyway? Defining person-centred care in nursing: An integrative review. *PloS one*, *15*(3), e0229923-e0229923. https://doi.org/10.1371/journal.pone.0229923

Boer, J., Nieboer, A. P., & Cramm, J. M. (2017). A cross-sectional study investigating patient-centred care, co-creation of care, well-being and job satisfaction among nurses. *Journal of Nursing Management, 25*(7), 577–584. https://doi.org/10.1111/jonm.12496

Chester, P., Ehrlich, C., Warburton, L., Baker, D., Kendall, E., & Crompton, D. (2016). "What is the work of Recovery Oriented Practice? A systematic literature review." *International Journal of Mental Health Nursing*, *25*(4), 270–285. https://doi.org/10.1111/inm.12241

Creswell, J. W. (2003). Research design: Qualitative, quantitative and mixed methods approaches (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Piano Clark, V. L. (2018). *Designing and Conducting Mixed Methods Research.* Sage.

Cromar-Hayes, M., & Chandley, M. (2015). Recovery in a high secure hospital in England: Working towards a hopeful future with service users in a custodial setting is fraught with difficulty. Maxine Cromar-Hayes and Mark Chandley discuss how reflective practice helped to explore the principles involved. *Mental Health Practice*, *18*, 32–37. https://doi.org/10.7748/mhp.18.8.32.e972

Cutcliffe, J. R., Santos, J. C., Kozel, B., Taylor, P. & Lees, D. (2015). Raiders of the lost art: A review of published evaluations of inpatient mental health care experiences emanating from the United Kingdom, Portugal, Canada, Switzerland, Germany and Australia. *International Journal of Mental Health Nursing, 24*(5), 375– 385. https://doi.org/10.1111/inm.12159

Edgar, D., Wilson, V., & Moroney, T. (2020). Which is it, person-centred culture, practice or care? It matters. *International Practice Development Journal*, *10*(1), 1-17. https://doi.org/10.19043/ipdj.101.008

Fors, A., Taft, C., Ulin, K., & Ekman, I. (2016). Person-centred care improves self-efficacy to control symptoms after acute coronary syndrome: a randomized controlled trial. *European Journal of Cardiovascular Nursing : Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*, *15*(2), 186–194. https://doi.org/10.1177/1474515115623437

Edvardsson, D., Watt, E., & Pearce, F. (2017). Patient experiences of caring and person-centredness are associated with perceived nursing care quality. *Journal of Advanced Nursing, 73*(1), 217–227. https://doi.org/10.1111/jan.13105

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I.-L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L.-E., Rosén, H., Rydmark, M., & Sunnerhagen, K. S. (2011). Person-centered care — Ready for prime time. *European Journal of Cardiovascular Nursing : Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*, *10*(4), 248–251. https://doi.org/10.1016/j.ejcnurse.2011.06.008

Fekonja, U., Strnad, M., & Fekonja, Z. (2022). Association between triage nurses' job satisfaction and professional capability: Results of a mixed-method study. *Journal of Nursing Management.*, *30*(8), 4364–4377. https://doi.org/10.1111/jonm.13860

Håkansson Eklund, J., Holmström, I. K., Kumlin, T., Kaminsky, E., Skoglund, K., Höglander, J., Sundler, A. J., Condén, E., & Summer Meranius, M. (2019). "Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient Education and Counseling*, *102*(1), 3–11. https://doi.org/10.1016/j.pec.2018.08.029

Havana, T., Kuha, S., Laukka, E., & Kanste, O. (2023). Patients' experiences of patient-centred care in hospital setting: A systematic review of qualitative studies. *Scandinavian Journal of Caring Sciences*, *37*(4), 1001–1015. https://doi.org/10.1111/scs.13174

Horgan, A., O Donovan, M., Manning, F., Doody, R., Savage, E., Dorrity, C., O'Sullivan, H., Goodwin, J., Greaney, S., Biering, P., Bjornsson, E., Bocking, J., Russell, S., Griffin, M., MacGabhann, L., Vaart, K. J., Allon, J., Granerud, A., Hals, E., . . . Happell, B. (2021). 'Meet Me Where I Am': Mental health service users' perspectives on the desirable

qualities of a mental health nurse. *International Journal of Mental Health Nursing*, *30*(1), 136-147. https://doi.org/10.1111/inm.12768

Isobel, S., Wilson, A., Gill, K., Schelling, K. & Howe, D. (2021). What is needed for Trauma Informed Mental Health Services in Australia? Perspectives of clinicians and managers. *International Journal of Mental Health Nursing, 30*,72–82. https://doi.org/10.1111/inm.12811

Johnson, R. E., Grove, A. L., & Clarke, A. (2019). Pillar integration process: a joint display technique to integrate data in mixed methods research. *Journal of Mixed Methods Research, 13*, 301–320. https://doi.org/10.1177/1558689817743108

Kalagi, J., Otte, I., Vollmann, J., Juckel, G., & Gather, J. (2018). Requirements for the implementation of open door policies in acute psychiatry from a mental health professionals' and patients' view: a qualitative interview study. *BMC Psychiatry, 18*(1), 304–304. https://doi.org/10.1186/s12888-018-1866-9

Kuipers, S., Cramm, J., & Nieboer, A. (2019). The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BMC Health Services Research*, *19*(1), 1–9. https://doi.org/10.1186/s12913-018-3818-y

Langberg, E. M., Dyhr, L., & Davidsen, A. S. (2019). Development of the concept of patient-centredness - a systematic review. *Patient Education and Counseling, 102*, 1228–36. https://doi.org/10.1016/j.pec.2019.02.023

Lehuluante, A., Nilsson, A., & Edvardsson, D. (2012). The influence of a person-centred psychosocial unit climate on satisfaction with care and work. *Journal of Nursing Management*, *20*(3), 319–325. https://doi.org/10.1111/j.1365-2834.2011.01286.x

Lindgren, B. M., Molin, J., & Graneheim, U. H. (2021). Balancing between a person-centred and a common staff approach: Nursing staff's experiences of good nursing practice for patients who self-harm. *Issues in Mental Health Nursing*, *42*(6), 564-572. https://doi.org/10.1080/01612840.2020.1817206

McAllister, S. & McCrae, N. (2017). The therapeutic role of mental health nurses in psychiatric intensive care: A mixed-methods investigation in an inner-city mental health service. *The Journal of Psychiatric and Mental Health Nursing, 24* (7), 491–502. https://doi.org/10.1111/jpm.12389

McAllister, S., Robert, G., Tsianakas, V. & McCrae, N. (2019). Conceptualising nurse-patient therapeutic engagement on acute mental health wards: An integrative review. *International Journal of Nursing Studies, 93*, 106– 118. https://doi.org/10.1016/j.ijnurstu.2019.02.013

McCance, T., McCormack, B., Slater, D., McConnell, D. (2021). Examining the theoretical relationship between constructs in the Person-centred Practice Framework: A structural equation model. Int. *Journal of Environmental Research and Public Health 18*, 13138. https://doi.org/10.3390/ijerph182413138

McCormack, B., & McCance, T. (2016). *Person-centred practice in nursing and health care : Theory and practice (2nd ed.)*. Wiley.

McKeown, M. (2015). The future of mental health nursing: are we barking up the wrong tree? *Journal of Psychiatric and Mental Health Nursing, 22*, 724–730. https://doi.org/10.1111/jpm.12247

Meehan, T. J., King, R. J., Beavis, P. H., & Robinson, J. D. (2008). Recovery-based practice: do we know what we mean or mean what we know? *Australian and New Zealand Journal of Psychiatry*, *42*(3), 177–182. https://doi.org/10.1080/00048670701827234

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis: An expanded sourcebook. London, England: Sage

Molin, J., Graneheim, U. H., & Lindgren, B.-M. (2016). Quality of interactions influences everyday life in psychiatric inpatient care-patients' perspectives. *International Journal of Qualitative Studies on Health and Well-Being*, *11*(1), 29897-29811. https://doi.org/10.3402/qhw.v11.29897

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, *31*(4), 662–673. https://doi.org/10.1111/scs.12376

Morant, N., Kaminskiy, E., & Ramon, S. (2015). Shared decision making for psychiatric medication management: beyond the micro-social. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *19*(5), 1002-1014. https://doi.org/10.1111/hex.12392

Moreno-Poyato, A. R., Montesó-Curto, P., Delgado-Hito, P., Suárez-Pérez, R., Aceña-Domínguez, R., Carreras-Salvador, R., Leyva-Moral, J. M., Lluch-Canut, T., & Roldán-Merino, J. F. (2016). The Therapeutic Relationship in Inpatient Psychiatric Care: A Narrative Review of the Perspective of Nurses and Patients. *Archives of Psychiatric Nursing*, *30*(6), 782–787. https://doi.org/10.1016/j.apnu.2016.03.001

Moreno-Poyato, A. R., El Abidi, K., Rodríguez-Nogueira, Ó., Lluch-Canut, T., & Puig-Llobet, M. (2021). A qualitative study exploring the patients' perspective from the 'Reserved Therapeutic Space' nursing intervention in acute mental health units. *International Journal of Mental Health Nursing*, *30*(3), 783-797. https://doi.org/10.1111/inm.12848

O'Cathain, A., Murphy, E., & Nicholl, J. (2010). Three techniques for integrating data in mixed methods studies. *British Medical Journal, 341*, 87. https://doi.org/10.1136/bmj.c4587

O'Donohue, E., Aguey-Zinsou, M., Yule, E., Fairhurst, I., & Debaets, M. (2023). Mental health consumer perspectives of a person-centred multidisciplinary care planning meeting on a rehabilitation inpatient unit. *International Journal of Mental Health Nursing*, 32(6), 1701-1712. https://doi.org/10.1111/inm.13192

Oh, I. O., & Nam, K. A. (2018). An exploration of essentials of psychiatric and mental health nursing. *Journal of Korean Academic Psychiatry and Mental Health Nursing, 27*(4), 415–426. https://doi.org/10.12934/jkpmhn.2018.27.4.415

Olsson, L., Jakobsson Ung, E., Swedberg, K., & Ekman, I. (2013). Efficacy of person-centred care as an intervention in controlled trials – a systematic review. *Journal of Clinical Nursing*, *22*(3-4), 456–465. https://doi.org/10.1111/jocn.12039

Ørjasæter, K. B., & Almvik, A. (2022). Challenges in Adopting Recovery-oriented Practices in Specialized Mental Health Care : "How Far Should Self-Determination Go ; Should One be Allowed to Perish?". *Journal of Psychosocial Rehabilitation and Mental Health, 9*, 395–407. https://doi.org/10.1007/s40737-022-00276-6

Reid, R., Escott, P., & Isobel, S. (2018). Collaboration as a process and an outcome: Consumer experiences of collaborating with nurses in care planning in an acute inpatient mental

health unit. *International Journal of Mental Health Nursing*, *27*(4), 1204–1211. https://doi.org/10.1111/inm.12463

Richards, H. L., Eustace, J., O' Dwyer, A., Wormald, A., Curtin, Y., & Fortune, D. G. (2022). Healthcare workers use of psychological support resources during COVID-19; a mixed methods approach utilising Pillar Integration Analysis. *PloS one, 17*(4), e0267458. https://doi.org/10.1371/journal.pone.0267458

Rio, J. H., Fuller, J., Taylor, K. & Muir-Cochrane, E. (2021). The impact of workplace culture on the accountability of mental health nurses to involve consumers in care planning: A focused ethnography. *Nursing & Health Sciences, 23*(1), 255–262. https://doi.org/10.1111/nhs.12807

Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings: Experiences and perceptions of service users and nurses. *Epidemiology and Psychiatric Sciences, 24*(1), 90– 96. https://doi.org/10.1017/S2045796013000693

Rossom, R. C., Solberg, L. I., Vazquez-Benitez, G., Crain, A. L., Beck, A., Whitebird, R., & Glasgow, R. E. (2016). The effects of patient-centered depression care on patient satisfaction and depression remission. *Family Practice*, *33*(6), 649–655. https://doi.org/10.1093/fampra/cmw068

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *21*(2), 429-440. https://doi.org/10.1111/hex.12640

Schmidt, M., & Uman, T. (2020). Experiences of acute care by persons with mental health problems: An integrative literature review. *Journal of Psychiatric and Mental Health Nursing*, *27*(6), 789–806. https://doi.org/10.1111/jpm.12624

Slater, P., McCance, T., & McCormack, B. (2015). Exploring person-centred practice within acute hospital settings. *International Practice Development Journal*, *5*(Suppl), 1-8. https://doi.org/10.19043/ipdj.5SP.011

Slater, P., McCance, T., & McCormack, B. (2017). The development and testing of the Person-centred Practice Inventory – Staff (PCPI-S). *International Journal for Quality in Health care*, *29*(4), 541-547. https://doi.org/10.1093/intqhc/mzx066

Sommerstad, H. S., Kildahl, A. N., Munkhaugen, E. K., Karlsen, K. & Bakken, T. L. (2021) Experiences of ward atmosphere in inpatients with intellectual disability and mental illness: Clinical implications for mental health nursing. *International Journal of Developmental Disabilities, 67*(5), 339– 348. https://doi.org/10.1080/20473869.2021.1900507

Tierney, M. (2020). Psychiatric-mental health nurses: Revolutionizing access to person-centered care. *Journal of the American Psychiatric Nurses Association*, *26*(6), 595-597. https://doi.org/10.1177/1078390320965245

van Dusseldorp, L., Groot, M., van Vught, A., Goossens, P., Hulshof, H., & Peters, J. (2023). How patients with severe mental illness experience care provided by psychiatric mental health nurse practitioners. *Journal of the American Association of Nurse Practitioners*, *35*(5), 281–290. https://doi.org/10.1097/JXX.0000000000000867

van Diepen, C., Fors, A., Ekman, I., & Hensing, G. (2020). Association between person-centred care and healthcare providers' job satisfaction and work-related health: a scoping

review. *BMJ Open*, *10*(12), e042658–e042658. https://doi.org/10.1136/bmjopen-2020-042658

Ventura, C. A. A., Austin, W., Carrara, B. S., & de Brito, E. S. (2021). Nursing care in mental health: Human rights and ethical issues. *Nursing Ethics*, *28*(4), 463-480. https://doi.org/10.1177/0969733020952102

Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L., & Arnfred, S. (2018). Recovery orientation in mental health inpatient settings: Inpatient experiences? *International Journal of Mental Health Nursing*, *27*(3), 1177-1187. https://doi.org/10.1111/inm.12434

Waldemar, A. K., Esbensen, B. A., Korsbek, L., Petersen, L., & Arnfred, S. (2019). Recovery-oriented practice: Participant observations of the interactions between patients and health professionals in mental health inpatient settings. *International Journal of Mental Health Nursing*, *28*(1), 318–329. https://doi.org/10.1111/inm.12537

Wand, T., Glover, S., & Paul, D. (2022). What should be the future focus of mental health nursing? Exploring the perspectives of mental health nurses, consumers, and allied health staff. *International Journal of Mental Health Nursing*, *31*(1), 179-188. https://doi.org/10.1111/inm.12947

Wilson, V., Dewing, J., Cardiff, S., Mekki, T. E., Øye, C., & McCance, T. (2020). A person-centred observational tool: devising the Workplace Culture Critical Analysis Tool. *International Practice Development Journal*, *10*(1), 1-15.

WHO (2010). Mental Health and Development. http://apps.who.int/iris/bitstream/10665/44257/1/9789241563949_ eng.pdf

Wyder, M., Ehrlich, C., Crompton, D., McArthur, L., Delaforce, C., Dziopa, F., Ramon, S., & Powell, E. (2017). Nurses experiences of delivering care in acute inpatient mental health

settings: A narrative synthesis of the literature. *International Journal of Mental Health Nursing*, *26*(6), 527–540. https://doi.org/10.1111/inm.12315

Wynia, K., Spoorenberg, S. L. W., Uittenbroek, R. J., Jager, M., Kremer, H. P. H., & Reijneveld, S. A. (2018). Long-term advantages of person-centred and integrated care: Results of a longitudinal study on embrace. *International Journal of Integrated Care*, *18*(S2), 362–. https://doi.org/10.5334/ijic.s2362

Chapter 5: Conclusion

Chapter 5 is the conclusion chapter and provides an overview of the mixed methods study including key findings from each study phase. Recommendations for education, practice, policy and future research are provided.

This concurrent mixed methods study makes a significant contribution to the existing person-centred care (PCC) literature, as person-centred mental health nursing care is understudied (Jang et al., 2022; World Health Organization (WHO), 2021). Specifically, study findings bring new insights and understanding of person-centred mental health nursing practices in one Atlantic Canadian province. This is the first Canadian study to examine person-centred mental health nursing care using three distinct methods: 1) survey of nurses, 2) interviews with patients, and 3) participant observation of the inpatient setting. It is the first to explore person-centred mental health nursing care using observations in combination with qualitative interviews with individuals who had recently received inpatient mental health care. As well, the quantitative survey, the Person-centred Practice Inventory, has rarely been used with mental health nurses and thus provides new information on their perspective of PCC. In full, the findings offer a broader, more complete understanding of person-centred mental health nursing practice and the culture in which nurses practice. The study findings can serve as a baseline from which a provincial mental health workforce that embraces PCC as the model of care and supportive organizational culture can be developed.

PCC is an approach to nursing that prioritizes the person as a unique individual (WHO, 2015). It has been associated with enhanced patient satisfaction (Allerby et al., 2020; Kuipers et al., 2019; Rossom et al., 2016) and improved health outcomes, including shorter hospital stays and enhanced functional performance (Ballard et al., 2018; Ekman et al., 2012; Fors et al., 2015; Olsson et al., 2014; Wynia et al., 2018). Although PCC is regarded a core component of high-quality health care (Langberg et al., 2019; Santana et al., 2017), implementation remains challenging in many care areas for reasons such as professional attitudes, time constraints, and traditional practices and structures (Moore et al., 2017). Operationalizing PCC in mental health

settings can be particularly challenging as patient insight, autonomy, and cognition may be impacted as a result of their illness (Moore et al., 2017). Although Canadian healthcare systems report both endorsing and delivering PCC (Montague et al., 2017; Canadian Medical Association (CMA) & Canadian Nurses Association (CNA), 2011), the state of person-centred mental health nursing care in at least one Atlantic Canadian province remained unclear. This research study aimed to explore the PCC practice patterns of mental health nurses in one Atlantic Canadian province.

The overarching mixed methods research question was: What are the PCC practice patterns exemplified by mental health nurses in one Atlantic Canadian province? This study had three different data collection methods that were conducted concurrently and used to answer six research questions:

1) What are the self-reported PCC practices of mental health nurses?
2) To what extent is the practice environment associated with the delivery of PCC?
3) What occupational, environmental, and demographic factors predict nurses' delivery of PCC?
4) What are the occupational and demographic factors that predict a PCC environment?
5) What is the nature of the tertiary inpatient care culture as demonstrated by unit observations?
6) What are the PCC perspectives of individuals who have received mental health nursing care in the past year?

The study results were presented in three separate chapters. The quantitative descriptive, cross-sectional sub-study results were presented in Chapter 2 and the qualitative interview results

were presented in Chapter 3. The participant observation results were summarized in Chapter 1 and Chapter 4, however, additional details regarding this method will be developed as a publishable manuscript upon completion of this dissertation. The integration results were presented in Chapter 4. Chapter 5 continues with a synopsis of the key findings, followed by recommendations for education, practice, research, and policy.

Key Results

The results of each phase of the study are briefly outlined below.

Quantitative Phase

Seventy nurses completed the online survey that included three questionnaires, resulting in a response rate of approximately 17.5%. Once analyzed, their data were used to answer research questions one through four. Each domain of the Person-centred Practice Inventory-Staff (PCPI-S) was scored high by nurses. For example, the mean score for the prerequisite domain was 75.73 (SD = 9.4; maximum possible mean score = 90) while the mean score for the care environment was 91.97 (SD = 16.91; maximum possible mean score = 125) and the mean score for the care process was 68.91 (SD = 9.01; maximum possible mean score = 80).

A positive, statistically significant ($r_s = 0.45$, $p < 0.001$) association was found between the care environment of the PCPI-S and the care process; the measure of delivery of PCC. This association suggested that as the care environment improves, so does the delivery of PCC.

To determine the occupational, environmental, and demographic factors that predict nurses' perception of the delivery of PCC, the care process domain score of the PCPI-S was used as the outcome variable. The final occupational and demographic predictor variables in the model were: 1) the prerequisites domain score on the PCPI-S, 2) the environment domain score

of the PCPI-S, and 3) relationship with manager. The model explained 76.1% of the variance observed in the PCPI-S (care process) score.

To determine the occupational and demographic factors that predict a PCC environment two different models were developed; one model with the care environment domain score of the PCPI-S as the outcome variable and one with the PCCQ-S total score as the outcome variable. When using the care environment domain score of the PCPI-S as the outcome variable, the final occupational or demographic predictor variables in the model were: 1) the prerequisites domain score on the PCPI-S, 2) the care process domain score of the PCPI-S, 3) relationship with manager, and 4) role satisfaction. The model explained 71.8% of the variance observed in the PCPI-S (environment) score. However, when using PCCQ-S total score the only significant occupational or demographic predictor variable was role satisfaction. The model explained 20.5% of the variance observed in the PCCQ-S score.

Qualitative Participant Observation Phase

Seven themes were developed from the observational data, each aligning with a domain of The Person-centred Practice Framework. Three themes aligned with the prerequisites domain, three themes aligned with the care environment domain, and one theme aligned with the care process domain.

The three themes aligning with the prerequisites domain suggested that the required attributes for effective PCC may not always be exhibited in the daily behaviors and actions of mental health nurses. The theme *unstable foundations for PCC* represented the, often, weak clarity of person-centred beliefs and values as well as commitment to the job present in the observational data. The theme *the nature of the care delivered* was developed to highlight lack of mental health care being received by individuals who often had to seek out their nurse for care.

The theme *interpersonal skills varied* was developed to because many nurses exhibited developed interpersonal skills, however, there were also several examples of poor nurse-patient interactions.

Themes aligning with the care environment domain represent the backdrop on which care was delivered. Observations pertaining to the seven environmental constructs yielded three themes. Barriers to the development of a PCC were represented in two themes: 1) *lack of organizational guidance for implementation of PCC* and 2) *a care environment of diminished personhood*. The final theme, *supportive team work*, was developed to capture the many observed examples of nurses working well with each other, and with other members of the health care team.

The care process domain of the Person-centred Practice Framework is represented by five constructs: working with individuals' beliefs and values, authentic engagement, sympathetic presence, shared decision-making, and offering holistic care. Nursing actions and behaviors that aligned with these five constructs were infrequent in the interview and observational data. However, when they did occur, the interactions were appreciated by patients. A singular theme was developed to represent this data: *person-centred practices, inspiring but fleeting.*

Qualitative Interview Phase

Three themes were developed that captured participants' experiences of inpatient person-centred mental health nursing care, as it pertained to PCC. The first theme, *rare moments of PCC*, represented the lack of PCC experienced by individuals receiving services on an inpatient mental health unit; the majority of care received by participants was not individualized and their self-identified needs were not given priority.

The second theme was, *the relationship with my nurse: a fluctuating connection*. It was developed to characterized the nurse-patient relationship; it was changeable and shaped by the feelings that participants had towards the nurses who cared for them. Some participants described positive relationships with their nurses, which helped them feel safe, protected and ultimately, well cared for. Other participants identified nurse-patient interactions that were negative, leaving them to feel that they were not in control of decisions made about their care and treatment. As a results two sub-themes were developed: *in good hands* and *limited control*.

The final theme, *the care environment as an uncertain space*, was developed to address contrasting perspectives about the care environment, which suggested uncertainty and fear. Several participants described feeling that they were left on their own to navigate serious issues, including their own safety. The subtheme, *perils of an unknown environment*, was developed to represent this data. Others who were hospitalized for a longer period or had repeat admissions, perceived the unit as feeling familiar, which put them at greater ease. Further, multiple participants spoke of the positive impact that unit activities had on their recovery. The subtheme, *pearls of the care environment*, was developed to represent this data.

Integration Phase

The Pillar Integration Process (PIP) was used to integrate the data and resulted in 17 themes, one for each construct of the Person-centred Practice Framework. Based on the integrated themes, three patterns were developed to describe the how nurses conduct and navigate their practice within the care environment. These patterns captured the complex interrelatedness of the prerequisites, care environment, and care process domains of the Person-centred Practice Framework.

The first pattern was, *mental health nurses maintain a separation from patients and often deliver nursing care from a distance*. In inpatient settings, there was a division between nurses and the individuals in their care, as nurses were primarily situated in the nursing station. From outside, individuals made requests for care that nurses often addressed without leaving the nursing station; opportunities for individuals to spend time with their nurse was limited. Although nurses reported that they possess effective interpersonal skills, patient accounts revealed that nurses inconsistently applied these skills. Nurses demonstrated competence in assisting patients with daily activities and attending to their physical needs, but there was little evidence to indicate that they were providing mental health care; for example, there was limited data obtained to indicate that nurses spent individualized time with patients to discuss their mental health concerns. Further, nurses did not take the initiative to provide patient programming or therapeutic activities on inpatient units.

The second practice pattern was, *mental health nurses practice in an organizational culture that supports the status quo, which is not PCC*. Relationship building between patients and nurses was not emphasized or valued in the care environment. Further, patient involvement in care decisions was limited and shared decision making was uncommon. Many nurses lacked clarity regarding their beliefs and values or a commitment to their profession. This may be attributed to the organizational culture within which they work, that appeared to neither foster these personal attributes nor enable nurses to engage effectively in shared decision-making with individuals. Despite working in collegial teams and contributing to care decisions, nurses appeared to function within a hierarchical system with minimal evidence of power sharing. While they were active members of collegial teams, they were not equal teammates.

The third practice pattern was, *when mental health nurses and individuals co-engage in person-centred moments, the results are inspiring and foster hope*. Nurses possessed the professional knowledge and skills necessary to establish therapeutic connections with individuals and families, fostering trusting relationships. Some interactions between nurses and patients transcended beyond social interaction, into meaningful spaces that were essential for growth. When nurses invested time into understanding patient concerns and priorities, they provided helpful responses that were well-received. Moreover, when nurses showed a sympathetic presence while learning patient concerns and priorities, patients felt cared for and accepted. Finally, when nurses used this information and took an individualized approach to care, the experience was perceived as beneficial and affirming.

Strengths and Limitations

There are several study strengths to highlight. The Person-centred Practice Framework was the theoretical framework for the study and it guided the study from development to the interpretation of the result. The use of this established framework connected all aspects of the study. In addition, person-centred mental health nursing was examined using three different methods: 1) survey of nurses; 2) interviews with patients; and 3) participant observation of the inpatient setting. Data collection resulted in three distinct data sets that were combined for a more complete understanding of the current state of mental health nursing care in the province. The existing literature on person-centred mental health nursing care from the viewpoint of nurses, patients, and participant observation was either very limited or nonexistent. Further, this was a provincial study with participants from all regions, also contributing to a more accurate picture of the state of mental health nursing care. Finally, the PIP method is an established integration method that provided specific directions on how to conduct the integration. The

developed integration tables (Appendix H) show clearly the steps taken to developed integrative themes. However, we built on the existing methods by adding an additional step; we re-analyzed the 17 themes to create three meta-themes. There are additional strengths for each phase of the research study that were described in chapter 2, 3, and 4.

There are some study limitations that must be presented. Although the three data sets provided a more complete picture of PCC, the three data sets were collected during the period between January 2022 and August 2022. Although changes or variations in PCC that took place over this short period of time were likely captured, long-term potential fluctuations in PCC were not captured. In addition, this study was conducted in one Atlantic Canadian province. As a result, findings may not be generalizable to other provinces in Canada or other countries.

Recommendations

Outcomes of this study include recommendations for nursing education, practice, research, and health care policy. These would be of particular interest to nurse educators, health care administrators, nurse researchers, as well as government officials involved in policy development and decision making.

Education

It is recommended that PCC competencies be emphasized during undergraduate nursing education as it is important nursing students understand the many factors that contribute to person-centred practice, including the required attributes of nurses. Learning ought to extend beyond theory and into clinical practice settings so that nurses can understand the practical implications of PCC. It is important for clinical instructors to model person-centred behaviors and discuss with students how to independently practice PCC, even in instances when their co-workers or the organization have not fully embraced person-centred practice. Critical thinking

and problem-solving skills must be fostered, allowing students to navigate challenges in the provision of PCC. Further, it is important for students to engage in self-assessment and reflection on their person-centred practice. Constructive feedback from faculty is also vital to their development, providing a means to refine and enhance their PCC skills. To provide guidance, faculty themselves must also understand and embrace person-centred ways of working; PCC education for faculty may be required

Practice

Complex challenges require complex solutions; the solution to operationalizing PCC is multifaceted. The development of person-centred cultures must be continuous, collaborative, participatory, and driven by health care providers and those receiving care. To change a health culture is a significant undertaking that requires commitment from both staff and the organization. One-off change events are ineffective for sustained cultural change; continuous approaches to operationalizing PCC are supported in the literature (McCance et al., 2013). Further, fostering reflective practice is important as nurses in this study primarily reported that they provide PCC, which was not supported by results of the interviews conducted with individuals who recently received inpatient care or participant observations.

Emancipatory practice development is one way to engage nurses in cultural change and empower them practice in a person-centred way; it is a recommended strategy to action PCC (McCance et al., 2013). It gives nurses the power to make group practice changes that will support PCC. Practice development is characterized as a continuous method for enhancing quality of practice, prioritizing learning, and allowing flexibility in the implementation of different care and work practices to promote effective PCC (Manley et al., 2008). Key to this approach is transformational leaders and skilled facilitators, the capacity for learning within the

context of practice, and the utilization of a systematic and rigorous change process (Manley et al., 2011).

It is also important for the role of mental health nurses to be reconsidered within the health care organization. A deconstruction of current practices is required to facilitate alignment and focus on PCC and nurses' professional identity. It is important for mental health nurses to prioritize spending time with patients, including conducting unit programming, rather than medication administration and unit management. There is an opportunity to leverage nurses' skills and abilities to be clinical nurse leaders in the health care setting by providing mentorship, acting as change agents, and coordinating care between patients, families, and the health care team. Clinical supervision may be another way to support nurses in the provision of PCC. Finally, managerial support for nurses is important; managers who are responsive and enable effective workplace cultures and collective leadership are necessary to foster a culture of PCC.

Research

It is recommended the focus of future PCC research extend beyond nurses and examine health care organizations. In order for PCC to be fully operationalized, mental health nurses must have the autonomy to place the patient at the center of care and care decisions. In future, researchers need to examine the organizational changes required for mental health nurses to fully adopt person-centred practices. This ought to include how nurses are positioned in the health care team and larger organization. In an organization that upholds person-centred principles, as seen in magnet hospitals, nurses engage in clinical leadership and participate in shared governance and organizational decision-making (McCaughey et al., 2020). They are valued members of the health care team who do not work within a hierarchical structure. Future research must highlight how organizations can alter practice structures to create space for and empower

mental health nurses to practice PCC. Interventional studies to promote the operationalization of PCC in mental health settings are limited. Determining the most effective interventions to enhance person-centred practice among mental health nurses is a recommended research priority.

Policy

Review of policies that guide mental health nursing practice is important for PCC to be fully operationalized. In order for individuals to guide their own care, mental health nurses need the flexibility to make decisions with those receiving care. Therefore, a review of policies to ensure they support autonomy among mental health nurses are recommended. Further, although mental health nurses have the skills to conduct risk assessments, it is recommended that organizational policies be reviewed to ensure they are non-punitive in the event that a patient self-harms or completes suicide unexpectedly. Often, in inpatient settings, many policies support a one-size-fits-all approach to care. As a result, regardless of ones level of risk, nurses are bound by the same safety policies as every patient in their care. This contributes to a risk-adverse system that does not support PCC.

Conclusion

We now know that person-centred mental health nursing care is not fully operationalized within one Atlantic Canadian Province. Some nurses possess the attributes required for PCC, however, often routine practice prevailed. Interview participants and participant observations indicated that nurses do not regularly practice in a person-centred way, however, when they do it is noticed and appreciated my individuals receiving care. There may be organizational barriers that are resulting in diminished person-centred practice. A multifaceted approach including strategies such as clinical supervision, emancipatory practice development, and policy

development, is required to make a successful cultural shift to one that upholds person-centered principles and fosters person-centred nursing practice.

References

Allerby, K., Goulding, A., Ali, L., & Waern, M. (2020). Striving for a more person-centered psychosis care: results of a hospital-based multi-professional educational intervention. *BMC Psychiatry*, *20*(1), 523–523. https://doi.org/10.1186/s12888-020-02871-y

Ballard, Corbett, A., Orrell, M., Williams, G., Moniz-Cook, E., Romeo, R., Woods, B., Garrod, L., Testad, I., Woodward-Carlton, B., Wenborn, J., Knapp, M., & Fossey, J. (2018). Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *PLoS Medicine*, *15*(2), e1002500–. https://doi.org/10.1371/journal.pmed.1002500

Canadian Medical Association (CMA) and Canadian Nurses Association (CNA) (2011). *Principles to Guide Health Care Transformation in Canada*. https://www.cna-aiic.ca/~/media/cna/files/en/guiding_principles_hc_e.pdf.

Ekman, I., Swedberg, K., Taft, C., Lindseth, A., Norberg, A., Brink, E., Carlsson, J., Dahlin-Ivanoff, S., Johansson, I. -L., Kjellgren, K., Lidén, E., Öhlén, J., Olsson, L. -E., Rosén, H., Rydmark, M., & Sunnerhagen, K. S. (2011). Person-centered care — Ready for prime time. *European Journal of Cardiovascular Nursing : Journal of the Working Group on Cardiovascular Nursing of the European Society of Cardiology*, *10*(4), 248–251. https://doi.org/10.1016/j.ejcnurse.2011.06.008

Fors, A., Taft, C., Ulin, K., & Ekman, I. (2016). Person-centred care improves self-efficacy to control symptoms after acute coronary syndrome: a randomized controlled trial. *European Journal of Cardiovascular Nursing : Journal of the Working Group on*

Cardiovascular Nursing of the European Society of Cardiology, *15*(2), 186–194. https://doi.org/10.1177/1474515115623437

Jang, S. J., Sun Joo., Kim, E. H., & Lee, H. (2022). Moral sensitivity and person-centred care among mental health nurses in South Korea: A cross-sectional study. *Journal of Nursing Management*, *30*(7), 2227-2235. https://doi.org/10.1111/jonm.13554

Kuipers, S., Cramm, J., & Nieboer, A. (2019). The importance of patient-centered care and co-creation of care for satisfaction with care and physical and social well-being of patients with multi-morbidity in the primary care setting. *BMC Health Services Research*, *19*(1), 1–9. https://doi.org/10.1186/s12913-018-3818-y

Langberg, E. M., Dyhr, L., & Davidsen, A. S. (2019). Development of the concept of patient-centredness - a systematic review. *Patient Education and Counseling, 102*, 1228–36. https://doi.org/10.1016/j.pec.2019.02.023

McCaughey, D., McGhan, G. E., Rathert, C., Williams, J. H., & Hearld, K. R. (2020). Magnetic work environments: Patient experience outcomes in Magnet versus non-Magnet hospitals. *Health Care Management Review*, *45*(1), 21-31. https://doi.org/10.1097/HMR.0000000000000198

Manley, K., McCormack, B., Wilson, V. (Eds) (2008) International Practice Development in Nursing and Healthcare. Oxford: Blackwell.

Manley, K., Sanders, K., Cardiff, S., & Webster, J. (2011). Effective workplace culture: The attributes, enabling factors and consequences of a new concept. *International Practice Development Journal*, *1*(2).

McCance, T., Gribben, B., McCormack, B., & Laird, E. A. (2013). Promoting person-centred practice within acute care: the impact of culture and context on a facilitated practice development programme. *International Practice Development Journal*, *3*(1).

Montague, T., Gogovor, A., Aylen, J., Ashley, L., Ahmed, S., Martin, L., Cochrane, B., Adams, O., & Nemis-White, J. (2017). Patient-centred care in Canada: Key components and the path forward. *Healthcare Quarterly*, *20*(1), 50–56. https://doi.org/10.12927/hcq.2017.25136

Moore, L., Britten, N., Lydahl, D., Naldemirci, Ö., Elam, M., & Wolf, A. (2017). Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, *31*(4), 662–673. https://doi.org/10.1111/scs.12376

Olsson, L., Jakobsson Ung, E., Swedberg, K., & Ekman, I. (2013). Efficacy of person-centred care as an intervention in controlled trials – a systematic review. *Journal of Clinical Nursing*, *22*(3-4), 456–465. https://doi.org/10.1111/jocn.12039

Rossom, R. C., Solberg, L. I., Vazquez-Benitez, G., Crain, A. L., Beck, A., Whitebird, R., & Glasgow, R. E. (2016). The effects of patient-centered depression care on patient satisfaction and depression remission. *Family Practice*, *33*(6), 649–655. https://doi.org/10.1093/fampra/cmw068

Santana, M. J., Manalili, K., Jolley, R. J., Zelinsky, S., Quan, H., & Lu, M. (2018). How to practice person-centred care: A conceptual framework. *Health Expectations : An International Journal of Public Participation in Health Care and Health Policy*, *21*(2), 429-440. https://doi.org/10.1111/hex.12640

World Health Organization. (2015). *WHO global strategy on people-centred and integrated health services: Interim report.* https://apps.who.int/iris/bitstream/handle/10665/155002/WHO_HIS_SDS_2015.6_eng.pdf

World Health Organization. (2022). *Mental health crisis services: Promoting person-centred and rights-based approaches*. World Health Organization.

Wynia, K., Spoorenberg, S. L. W., Uittenbroek, R. J., Jager, M., Kremer, H. P. H., & Reijneveld, S. A. (2018). Long-term advantages of person-centred and integrated care: results of a longitudinal study on Embrace. *International Journal of Integrated Care*, *18*(S2), 362–. https://doi.org/10.5334/ijic.s2362

APPENDICES

Appendix A

The Person-centred Practice Inventory-Staff

Please indicate how much you agree or disagree with each of the following statements:

		Strongly Disagree	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1.	I have the necessary skills to negotiate care options.					
2.	When I provide care I pay attention to more than the immediate physical task.					
3.	I actively seek opportunities to extend my professional competence.					
4.	I ensure I hear and acknowledge others perspectives.					
5.	In my communication I demonstrate respect for others.					
6.	I use different communication techniques to find mutually agreed solutions.					
7.	I pay attention to how my non-verbal cues impact on my engagement with others.					
8.	I strive to deliver high quality care to people.					
9.	I seek opportunities to get to know people and their families in order to provide holistic care.					
10.	I go out of my way to spend time with people receiving care.					

11.	I strive to deliver high quality care that is informed by evidence.					
12.	I continuously look for opportunities to improve the care experiences.					
13.	I take time to explore why I react as I do in certain situations.					
14.	I use reflection to check out if my actions are consistent with my ways of being.					
15.	I pay attention to how my life experiences influence my practice.					
16.	I actively seek feedback from others about my practice.					
17.	I challenge colleagues when their practice is inconsistent with our team's shared values and beliefs.					
18.	I support colleagues to develop their practice to reflect the team's shared values and beliefs.					
19.	I recognise when there is a deficit in knowledge and skills in the team and its impact on care delivery.					
20.	I am able to make the case when skill mix falls below acceptable levels.					
21.	I value the input from all team members and their contributions to care.					
22.	I actively participate in team meetings to					

	inform my decision-making.					
23.	I participate in organisation-wide decision-making forums that impact on practice.					
24.	I am able to access opportunities to actively participate in influencing decisions in my directorate/division.					
25.	My opinion is sought in clinical decision-making forums (e.g. ward rounds, case conferences, discharge planning).					
26.	I work in a team that values my contribution to person-centred care.					
27.	I work in a team that encourages everyone's contribution to person-centred care.					
28.	My colleagues positively role model the development of effective relationships.					
29.	The contribution of colleagues is recognised and acknowledged.					
30.	I actively contribute to the development of shared goals.					
31.	The leader facilitates participation.					
32.	I am encouraged and supported to lead developments in practice.					

33.	I am supported to do things differently to improve my practice.					
34.	I am able to balance the use of evidence with taking risks.					
35.	I am committed to enhancing care by challenging practice.					
36.	I pay attention to the impact of the physical environment on people's dignity.					
37.	I challenge others to consider how different elements of the physical environment impact on person-centredness (e.g. noise, light, heat etc).					
38.	I seek out creative ways of improving the physical environment.					
39.	In my team we take time to celebrate our achievements.					
40.	My organisation recognises and rewards success.					
41.	I am recognised for the contribution that I make to people having a good experience of care.					
42.	I am supported to express concerns about an aspect of care.					
43.	I have the opportunity to discuss my practice and professional development on a regular basis.					
44.	I integrate my knowledge of the person into care delivery.					

45.	I work with the person within the context of their family and carers.					
46.	I seek feedback on how people make sense of their care experience.					
47.	I encourage the people to discuss what is important to them.					
48.	I include the family in care decisions where appropriate and/or in line with the person's wishes.					
49.	I work with the person to set health goals for their future.					
50.	I enable people receiving care to seek information about their care from other healthcare professionals.					
51.	I try to understand the person's perspective.					
52.	I seek to resolve issues when my goals for the person differ from theirs perspectives.					
53.	I engage people in care processes where appropriate.					

Appendix B

The Person-centred Climate Questionnaire – Staff

Instructions for use:

This questionnaire aims to measure the extent to which the climate of a health care setting is perceived as being person-centred. The questionnaire provides 14 statements for which you are asked to agree or disagree by ticking the most appropriate box. Please respond to all statements.

	I experience this ward as:	No, I disagree completely 0	No, I disagree 1	No, I partly disagree 2	Yes, I partly agree 3	Yes, I agree 4	Yes, I agree completely 5
1.	A place where I feel welcome.	☐	☐	☐	☐	☐	☐
2.	A place where I feel acknowledged as a person.	☐	☐	☐	☐	☐	☐
3.	A place where I feel I can be myself.	☐	☐	☐	☐	☐	☐
4.	A place where patients feel safe.	☐	☐	☐	☐	☐	☐
5.	A place where staff talk to patients so that they can understand.	☐	☐	☐	☐	☐	☐
6.	A place which feels homely.	☐	☐	☐	☐	☐	☐
7.	A place that has something nice to look at (e.g. views, artwork etc)	☐	☐	☐	☐	☐	☐
8.	A place where it is quiet and peaceful.	☐	☐	☐	☐	☐	☐

9.	A place where it is possible to get unpleasant thoughts out of your head.	☐	☐	☐	☐	☐	☐
10.	A place which is neat and clean.	☐	☐	☐	☐	☐	☐
	I experience this ward as:	No, I disagree completely 0	No, I disagree 1	No, I partly disagree 2	Yes, I partly agree 3	Yes, I agree 4	Yes, I agree completely 5
11.	A place where it is easy for patients to keep in contact with their loved ones.	☐	☐	☐	☐	☐	☐
12.	A place where it is easy for patients to receive visitors.	☐	☐	☐	☐	☐	☐
13.	A place where it is easy for patients to talk to staff.	☐	☐	☐	☐	☐	☐
14.	A place where patients have someone to talk to if they so wish.	☐	☐	☐	☐	☐	☐

Appendix C

Demographic and Work-Related Survey Questions

1) What is your sex?

a) Male

b) Female

c) Rather not say

2) What is your age in years? _____

3) In which setting do you practice?

a) Community

b) Inpatient

c) Emergency services

d) other

4) Which best describes the population you care for in your nursing practice?

a) adult mental health

b) geriatric mental health

c) child/youth mental health

d) adult addictions

e) youth addictions

f) forensic

g) other

5) How many years since your graduated as an RN? _____

6) How many years have you been nursing with mental health/addictions? _____

7) What is your highest level of nursing education?

a) Diploma

b) Undergraduate

c) Masters

d) PhD

8) Which health care authority do you practice in?

a) Eastern

b) Central

c) Western

d) Labrador-Grenfell

e) Private practice

9) Do you hold a current certification in psychiatric mental health nursing from the Canadian Nurses Association?

a) yes

b) no

10) Which best describes you nursing role?

a) direct care nurse

b) nurse practitioner

c) patient care facilitator

d) management

e) nurse educator

f) clinical nurse specialist

g) other

11) How satisfied are you in your current nursing position?

a) very satisfied

b) satisfied

c) Not satisfied

12) Do you intend to leave your position in the next 12 months?

a) yes

b) no

c) undecided

13) How would you describe your relationship with your immediate manager?

a) Good

b) Fair

c) Poor

Appendix D

Workplace Culture Critical Analysis Tool Revised

Workplace Culture Critical Analysis Tool Revised (WCCAT^{R})

Date: **Unit:** **Time Period: _____hrs to_____ hrs**

Normal Staffing level (RNs & LPNs): **Number of RNs/LPNs present:**

Number of Constants:

General comments on care environment as relevant to the observation *(is there anything out of the 'ordinary' that will influence or interfere with the observation?)*

What is the overall milieu of the ward environment during the observation time? Circle terms that apply.

- **<u>Emotional state:</u> calm (tranquil), uncomfortable (uneasy), anxious (on edge), very tense, frightening (terrifying)**
- **<u>Aggression:</u> cooperative, uncooperative, argumentative (conflict, shouting, making threats), violent (combative)**
- **<u>Activity:</u> goal directed, aimless, disruptive**

- **<u>Social cohesion</u>: cohesive, fragmented**

Observation Area 1: PREREQUISITIES

Observer Prompts	Observation Notes	Context
What do you observe that indicates: **Professional competence -** practitioner development/use of knowledge, skills and attitudes to negotiate and provide care. For example: • *Delivering competent care* • *The knowledge and learning that is privileged in the care setting* • *Practitioners learning and/or developing their professional competence*		

Developed interpersonal skills - communicating and engaging with service-users and significant others. For example: • *Paying attention to non–verbal communication and how this might impact on others* • *Using interpersonal skills to negotiate care* • *Demonstrating respect for self and others*		
Commitment to the job - commitment to providing person-centred, evidence informed care. For example: • *Delivering high quality care that is informed by evidence* • *Spending time with people receiving care*		

Clarity of beliefs and values – being clear about the values and beliefs that influence care. For example: • Demonstrating *actions that reflect core values and beliefs* • *Working with a shared vision* • *Consistency between desired values and beliefs and those experienced by others* **Knowing 'self'** - awareness of 'self' when engaging with others. For example: • *Drawing on own and others strengths and skills* • *Seeking out and making use of feedback* • *Providing challenge and support in the setting*		

Observation Area 2: PRACTICE ENVIRONMENT

Observer Prompts	Observation Notes	Context
What do you observe that indicates: **Appropriate skill mix -** practitioners experience and expertise to care for patients. For example: • *Skill mix in the team delivering care* • *Visibility of practitioners* • *Input from all team members being valued* • *Level/type of busyness within the environment*		

Shared decision-making systems and power sharing - evidence of practitioners discussing decisions. For example: • *Practitioners (across disciplines) and leaders actively engage with each other in decision making and taking action* • *How people are talked about and the language used* • *Practitioners appear well informed about what is going on in the team and the wider organisation* **Effective staff relationships -** Practitioners working together, evidence of collegiality. For example: • *Everyone being encouraged and supported to contribute to person-centred care* • *Practitioners offering and receiving challenge and support*		

Supportive organisational system - polices and other resources that support care delivery. For example: • *Drawing on evidence informed policies supporting the delivery of person-centred care* • *Practitioners feeling recognised, supported and involved in decision-making about care (environment) and organisational governance* **Potential for innovation and risk taking -** Support for sharing ideas to improve practice. For example: • *Preparedness to take calculated risks and/or utilise new ways of working* • *Promoting innovation in care* • *Proportionate risk assessment; where people's needs are balanced with risk reduction*		

The physical environment - The care environment is welcoming and conducive to delivering person-centred care. For example: • *People friendliness of the physical environment* • *Cleanliness, safety, tidiness, light, colour, noise* • *Use of space and spaces*		

Observation Area 3: PERSON-CENTRED PROCESSES

Observer Prompts	Observation Notes	Context
What do you observe that indicates: **Working with persons' beliefs and values**- Practitioner is aware of and works with service-user's values (what is important) and beliefs (how things are). For example: • *Diversity is respected and included in care* • *Privacy is honoured* • *Needs and choices are known and included in care processes* • *Practitioners get to know service users and use the knowledge as part of engagement and care* • *Practitioners seeking feedback on how people make sense of their experiences*		

Engaging authentically - Practitioners are genuine in the way they engage with others. For example: • *Practitioners being their natural-self* • *Understanding the person's perspective and where appropriate resolving differences* • *Being present when working with service users*		
Shared decision making - Evidence of practitioners involving patients and those important to them in decisions about care. For example: • *Choices and decisions are represented in care planning, documents, and discussions (such as hand-overs/reports and meetings)* • *Others that matter to the person receiving care are included and involved in care* • *Shared decisions are being made and acted on*		

Being sympathetically present - Practitioners listen and take time to find out what is important for the patient. For example: • *Persons narratives/care experiences is listened to and responded to* • *Practitioners pay attention to the person's needs and not only the immediate task at hand* **Working holistically -** attentive towards a person's physical, emotional, sociocultural and spiritual needs. For example: • *Persons are receiving care that reflects all the domains that matter to them* • *Choices are reviewed and care plans updated as needed*		

Feedback from staff:

Reflect on how what you have observed contributes to the existence of a healthful culture. What have you observed that indicates that service-users and practitioners experience the way things are done within the setting as being conducive to their well-being and personal growth?

Appendix E

Information Poster for Participant Observation

For Your Information!

You may note that there is a nurse researcher present on the unit from time to time. Your personal information is NOT being recorded. The researcher is studying the nursing care practices of mental health inpatient units.

The data is being collected as part of a research study title "*Exploring the person-centred care practice patterns of mental health nurses: A mixed methods study.*" If you have any questions regarding this study please contact study lead Chantille Isler, PhD Candidate at Memorial University Faculty of Nursing (Phone: 709-765-4047 Email: v43cihb@mun.ca). You may also contact the Health Research Ethics Authority at (709) 777-6974 or info@hrea.ca should you have concerns about this study.

MEMORIAL UNIVERSITY

Eastern Health

Appendix F

Interview Recruitment Poster

Were you recently admitted to a psychiatric inpatient unit in the past year?

Would you like to share your experience as part of a research study?

We are trying to gain an understanding of the nursing care experiences of those who have received adult inpatient mental health nursing treatment in the past year. The data is being collected as part of a research study title "Exploring the person-centred care practice patterns of mental health nurses: A mixed methods study."

Contact study lead Chantille Isler (phone: 709-765-4047 Email: v43cihb@mun.ca) if you are interested in participating in a 45-minute interview. You will be provided with a $100 gift card as a thank you for your time.

If you have questions regarding your rights as a research participant please contact the Health Research Ethics Authority at (709) 777-6974 or info@hrea.ca

Eastern Health

MEMORIAL UNIVERSITY

Appendix G

Semi-Structured Interview Guide

1. Can you describe your experience of receiving mental health nursing care as an inpatient?
2. Describe your favorite nurse?
    a) What did they do?
    b) How did they act?
    c) Can you tell me about a time when you had a particularly good experience being cared for by a mental health nurse?
3. Could you share any experiences you have had where the mental health nursing care you received was particularly unhelpful?
4. Was there anything about the inpatient environment that you found particularly helpful to your recovery?
5. Was there anything about the inpatient environment that you found particularly unhelpful to your recovery?
6. What advise would you give to a mental health nurse on how to better care for those with mental illness in future?
7. How were your ideas incorporated into the care you received?
8. Can you tell me about a time when you felt herd and your ideas were respected?
9. Do you feel that nurses got to know you while you were there? For example, did they spend time with you? Did they talk to you?
10. Did the nurses take a caring approach with you? For example, did you feel good when you were in their company? Did they help you?
11. Did anything happen during your stay that you felt uncomfortable about?
    a) Did you ever feel unsafe?
    b) How did your nurse respond?
12. Did you feel your nurse was working for you or in your best interest?
    a) What did they do to show you that?

Appendix H

Joint-Display of the Care Process Domain using the PIP Method

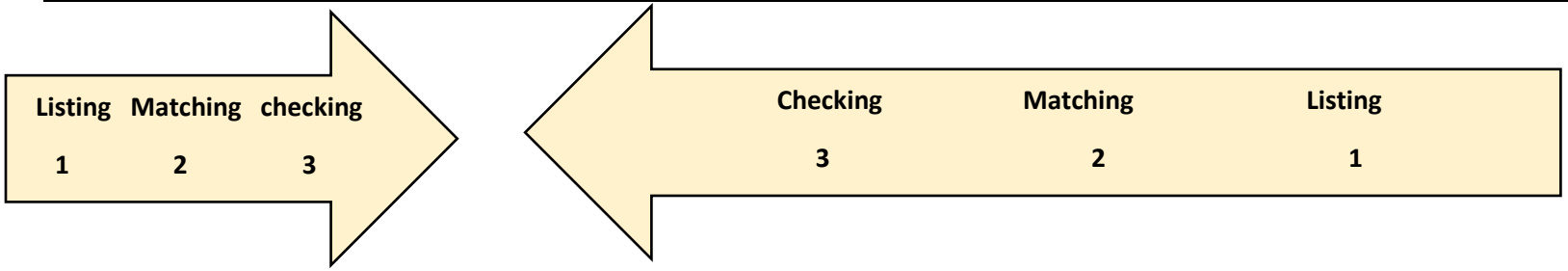
Care Process Construct	QUANT DATA Category	PILLAR	INTER-VIEW QUAL THEME	INTERVIEW QUAL DATA	OBSER-VATION QUAL THEME	OBSERVATION QUAL DATA
Holistic Care Nurses were in high agreement that they provide treatment and care that pays attention to the whole person through the integration of physiological, psychological, sociocultural, developmental and spiritual dimensions of persons" (Slater et al., 2017, p. 544).	High Agree-ment Mean score = 4.4 (SD = 0.7)	**Integrative Theme:** When mental health professionals took an individualized approach with their patients, it was experienced by the individual as helpful and affirming. It also provided new knowledge to support the individual's recovery.	**Theme:** Rare moments of PCC	**Exert 1:** I think the fact that they allowed me like quiet space [was helpful to my recovery] because the unit was so busy and I was having anxiety issues while I was in there, what if I came up to the nursing station and just asked, can I just go into this quiet room and read or do whatever? They were very helpful in doing that (2_53-57) . **Exert 2.** Oh yeah. I have a stuffed animal that goes everywhere with me. It's a cat, a stuffed cat. Well I've had him for years and years and he's an exact duplicate of a real cat I had at one time. And my daughter had given me this stuffed animal and of course I slept with it and hugged it and it was a kind of a security blanket I guess. And of course, by the time I left everybody knew its name which is Ginger. Then when I left that day, they all said, goodbye Ginger. [laugh]Like they got to know me. They got to know my personality. Yea, it did. It made me feel like they were paying attention to me. You know they knew I was there (8_187-200).	**Theme:** PCC practices, inspiring but fleeting	**Exert 1:** Staff celebrating a patient's weight loss as it is his goal for discharge to lose weight and better his mobility. The RN and LPN provided positive reinforcement for person to keep up the good work (2E_13h_19S). **Exert 2:** The social worker used paper and a pen to communicate with a person who has a speech impediment. This was very successful and she understood what he was looking for in terms of housing for discharge. She told the nurses that this was the best form of communication with this particular person. The RN assigned to the person indicated she would add it to his handover report for other nurses to see (13E_13h_19S).

Sympathetic presence: "An engagement that recognizes the uniqueness and value of the individual, by appropriately responding to cues that maximize coping resources through the recognition of important agendas in their life" (Slater et al., 2017, p. 544).	High Agreement Mean score = 4.4 (SD = 0.6)	**Integrative Theme:** When mental health nurses spent time getting to know their patients, patients felt cared for and accepted.	**Theme:** Rare moments of PCC	**Exert 1:** …I had tried to commit suicide and that's why I was in there. And every day she [a nurse] came in and she would ask my mood. She wouldn't say, do you feel like killing yourself today? Like the other nurses would come in and say, do you feel like you want to take your own life today but I mean she didn't phrase it that way. It was more of a sympathetic thing. She was just so nice (8_37-45). **Exert 2:** [One nurse] took an interest in getting to know me as well. Like he noticed my tattoo and he talked to me about a show that I liked and he watched and that sort of thing. A personal sort of connection but not like unprofessional, just knew that it would calm me down and so he started talking about something while he had to do what he was doing (2_84-86, 88-90).	**Theme:** PCC practices, inspiring but infrequent	**Exert 1:** RN used positive reinforcement and encouraging language when discussing with a patient her plan to go on a day pass. RN and patient discussed the importance of this next step in her treatment plan. This interaction occurred in the doorway of the patient's room (31W_09h_8A). **Exert 2:** A patient … came to the nursing desk. The person was tangential and started talking about his family. An RN … was actively listening to the person. When they paused, the RN asked him a follow up question … This got the [person] to answer her question and he went into more detail about his childhood. The nurse continued to actively listen, leaning toward the person, maintaining eye contact and nodding her head. She continued to ask the [person] questions about his life where she could. At the end of the conversation the

						person was becoming increasingly tangential and the story was no longer making sense therefore she dismissed the conversation by indicating to the person that she had to prepare her report (17W_19h_A16).
Engaging authentically: **"**The connectedness of the practitioner with a patient and others significant to them, determined by knowledge of the person, clarity of beliefs and values, knowledge of self and professional expertise" (Slater et al., 2017, p. 544).	High Agreement Mean score = 4.4 (SD = 0.6)	**Integrative Theme:** Authentic engagement b/t the nurse and patient went beyond social interaction and came to rest at a place meaningful to the individual. It was an opportunity for growth.	**Theme:** Rare moments of PCC	**Exert 1:** There was another nurse in PAU. She would get really personal with you, not really personal with you but kind of the same thing like she'd have a conversation with you and take care of you in a way that's not just oh, yeah, this is what's wrong with you, you need this. She'd actually say, I saw you here yesterday and you weren't acting like that, what happened? Like really, and I think we need that especially (1_143- 149). **Exert 2:** Like she [a nurse] could talk to me on my level and I really liked that. (1_142-143).	Theme: PCC practices, inspiring but infrequent	**Exert 1:** RNs seem to have rapport with patients allowing them to adjust their tones and their communication style with different patients. For example, the RN joked with a patient after he had come out of the tub as he stated, "That tub is huge!" and the RN replied, "We'll have to get you rubber ducky for the next time!" Patient laughed with nursing staff (18W_13h_8A). **Exert 2:** A patient approached nursing desk asking for pain medication. The RN checked the MAR and noticed that he could not have any at this time due to already receiving the medication within a recent timeframe. The patient then became upset and started raising his voice at the RN. The RN used a calm tone of voice and suggested other methods [non-medicinal] to alleviate his pain. RN was able to deescalate patient within 5

						minutes and the patient walked away from desk (3W_13h_8A).
Working with persons' Beliefs and Values: "Having a clear picture of what the patient values about his/her life and how he/she makes sense of what is happening from their individual perspective, psychosocial context and social role" (Slater et al., 2017, p. 544).	Moderat Agree Mean score = 4.1 (SD = 0.6)	**Integrative Theme:** When nurses understand patients' concerns and wishes, they provide helpful responses that are positively received.	**Theme:** Rare moments of PCC	**Exert 1:** If there was a medication I found I didn't like, I would say to them, I don't think this is working for me and they would talk to the doctor or sometimes they would even research it for me and print out the information for me and kind of go over it with me and show me why it's good for what I need (1_461-465). **Exert 2**: Like I did find my ideas were listened to. I didn't feel like I was pushed aside (1_465-466).	**Sub-theme:** Limited Participation by individuals in care decisions	**Exert 1:** RN using deescalating techniques with a patient who was experiencing paranoia. The patient asked for juice however he indicated that he could only drink out of Styrofoam cups because he believed he was allergic to paper. The nurse reminded him that he had drank from a paper cup the day prior however if he was more comfortable with Styrofoam cups she would have some ordered for him. This interaction took place in the kitchen. The nurse then came back behind the nursing desk and promptly asked the MSA to bring Styrofoam cups to the unit. Styrofoam cups were brought to the unit 30 minutes later (15W_13h_8A). **Exert 2:** The night shift RN went around and introduced herself to her assigned patients. One person was in their room and the other was in the TV room. She had a patient who identified as a trans female and she asked the person their preferred name and pronouns. The person thanked the RN for asking and told her their name and desired pronouns (8W2_19h_15S).

Shared Decision Making: The facilitation of involvement in decision-making by patients and others significant to them by considering values, experiences, concerns and future aspirations (Slater et al., 2017, p. 544).	Lower Agreement Mean score = 3.7 (SD = 0.8)	**Integrative Theme:** Mental health nurses made few attempts at shared decision making with patients. They did pass patient requests on to the physician and speak with family members about the patient's plan of care.	**Theme:** Rare moments of PCC	**Exert 1:** If I wanted to take my medication a little bit earlier one night, I could say to the nurse, you know, what do you think if I tried this, and they'd say, well, it would be better if you did it this way or it would be better if you tried it this way. Maybe we can switch it to the morning. Let me talk to the doctor. They were really open to anything I had to say (1_455-459).	**Sub-theme:** Limited Participation by individuals in care decisions	**Exert 1:** A RN noted to be speaking to a family member about a patient's care plan before letting them off the unit. RN using sympathetic language. Family member thanked RN for the care being provided to the patient (7W2_09h_12S). **Exert 2:** Another RN was in the rounds room with her patient from 0956 to 1021 (28W_09h_8A).



Appendix I

Recruitment Email Sent by Provincial Nursing Regulatory Body

Dear Registered Mental Health Nurse

We welcome you to participate in a research study that is exploring the person-centred care practice patterns of mental health nurses. You are invited to complete this survey package because you identified as a mental health nurse on your 2021/22 registration and you indicated a willingness to be contacted for research purposes. Your input is valuable in collecting information that represents the voice of mental health nurses in the province. To read more about the survey and to participate, please click the link below.

https://mun.az1.qualtrics.com/jfe/form/SV_8J2orMAGMsPA4D4

Appendix J

Participant Recruitment Poster - Survey

Registered Nurses working In Mental Health & Addictions! Let your voice be heard!

You are invited to complete a survey regarding the care you provide in your work environment!

Survey Link: https://mun.az1.qualtrics.com/jfe/form/SV_8J2orMAGMsPA4D4

The data is being collected as part of a research study title "Exploring the person-centred care practice patterns of mental health nurses: A mixed methods study." If you have any questions regarding this study please contact study lead Chantille Isler, PhD candidate at Memorial University Faculty of Nursing (phone: 709-765-4047 Email: v43cihb@mun.ca). If you have questions regarding your rights as a research participant please contact the Health Research Ethics Authority at (709) 777-6974 or info@hrea.ca

MEMORIAL UNIVERSITY

Appendix K

Information Letter - Survey

Information Letter

Study Title: Exploring the person-centred care practice patterns of mental health nurses: A mixed methods study proposal

Principle Investigator: Chantille Isler, MN RN PhD(c)
Faculty of Nursing, Memorial University
Email: v43cihb@mun.ca

Co-PI: Joy Maddigan PhD RN
Faculty of Nursing, MUN
email: jmaddigan@mun.ca

Co-Investigator: Alice Gaudine, PhD RN
Faculty of Nursing, Memorial University

Co-Investigator: Robin Burry PhD RN
Faculty of Nursing, MUN

Dear Registered Mental Health Nurse

You are being asked to participate in a research study that is exploring the person-centred care practice patterns of mental health nurses in your province. You are invited to complete this survey package because you identified as a mental health nurse on your 2021/22 CRNNL registration and you indicated a willingness to be contacted for research purposes. This study is part of my PhD dissertation. I hope to establish the types of person centered care practices that are demonstrated by mental health nurses while caring for individuals on an inpatient unit. The survey package includes three short questionnaires. The first is a 13 item demographic questionnaire. The second questionnaire is the Person Centered Care Inventory that consists of 59 items that uses a Likert scale. This tool measures different aspects of person-centered care demonstrated by nurses. The third questionnaire, the Person Centered Climate Scale, contains 14 items and focuses on measuring aspects of a person-centred unit climate. The three questionnaires will take less than 15 minutes to complete.

Taking part in this study is voluntary. You may take as much time as needed to complete the survey. It is possible that you will become upset or distressed while answering the survey questions. At the end of the survey, we have provided a list of mental health resources that you can contact. We also encourage you to seek assistance from your medical provider if required.

There is no direct benefit to you in participating in the study. The survey is anonymous meaning that there is no way for the researcher to determine who submitted the survey. This also means that once you have submitted your responses there is no way for your questionnaires to be removed. Only three

people will have access to your completed questionnaires: Chantille Isler (study PI), Dr. Joy Maddigan (Chantille's PhD Supervisor & Co-PI), and members of the Health Research Ethics Board who oversee the conduct of ethical research in our province. If you have any questions about taking part in this study, you can contact the investigator who is in charge of the study. That person is: Chantille Isler PhD (c) RN (Tel: 709 765 4047/ E-mail: v43cihb@mun.ca). Alternatively, you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through the Ethics Office (Tel: 709-777-6974/ Email: info@hrea.ca). This study has received ethics approval.

You can access the survey package by clicking on the following link:

Once you click on the link, you are giving your consent to participate in the study.

Thank you

The Research Team

Appendix L

Interview Consent Form

MEMORIAL UNIVERSITY

Consent to Take Part in Research

QUALITATIVE COMPONENT

TITLE: Exploring the person-centred care practice patterns of mental health nurses: A mixed methods study

RESEARCHER(S): Chantille Isler RN PhD(c) Phone Number: 709-765-4047

SUPERVISOR(S): Dr. Joy Madigan

SPONSOR/FUNDER: **N/A**

You have been invited to take part in a research study. Taking part in this study is voluntary. You may choose to take part or you may choose not to take part in this study. You also may change your mind at any time.

This consent form has important information to help you make your choice. It may use words that you do not understand. Please ask Chantille Isler, the researcher who will talk with you, to explain anything that you do not understand. It is important that you have as much information as you need and that all your questions are answered. Please take as much time as you need to think about your decision to participate or not, and ask questions about anything that is not clear. You may find it helpful to discuss it with your friends and family. Chantille Isler will tell you about the study timelines for making your decision.

1. Why am I being asked to join this study?

You are asked to join this study because you have received inpatient hospital care from mental health nurses sometime during the last year. This study will gather information about mental health nursing practice. Your time as a patient will provide helpful information about what mental health nurses do, and how they do it. We will measure the kind of care that you received from nurses to better understand ways to improve it.

2. How many people will take part in this study?

Eight individuals will be interviewed about the care they received from mental health nurses while they received treatment on a mental health inpatient unit.

3. How long will I be in the study?

As a participant of this study, you will be asked to take part in one interview only. The interview will take no more than one hour (60 minutes) and you can decide when you want to stop.

4. What will happen if I take part in this study?

If you agree to be interviewed for the study, a meeting with the researcher will be made for a time that is good for you. You can choose to meet in person or by video. The researcher, who is also a nurse, will first talk to you about the study and the kinds of questions you will be asked. The researcher will go through the consent form with you and when you are sure you understand the study, you will sign the consent form. A copy of the consent will be given to you. When you are ready, the researcher will start the interview. The interview will be about one hour but you can stop the interview at any time. You will be asked to talk about the care you received from nurses during your most recent inpatient admission Waterford admission (that occurred within the last 6 months). You can choose not to answer questions if you wish. You can stop the interview if you become upset or distressed and continue at another time. Those individuals who choose video conferencing as a means to be interviewed do not have to turn on their camera, unless they choose to do so.

Your interview with the researcher will be audio recorded. The researcher will not ask for your name or any other identify information during the interview, but if you provide identifying information, she will ensure this is not entered into the transcript. If you like, I can call you by a different name to keep the information in the interview even more private. The recorded information will be written out (transcribed) by a professional and confidential service that will also double check that the written interview does not contain any information that could identify you. The information from the interview will be analysed by the researcher and the researcher's PhD supervisor. The audio recording will be destroyed after it has been transcribed and checked for accuracy.

5. Are there risks to taking part in this study?

During the the interview, you may become uncomfortable or experience some anxiety, emotional and/or psychological distress due to the nature of the questions. Remember, you can skip questions, take a break or stop answering at any time. The researcher can also provide you with a list of mental health resources to contact if you need support after the interview.

It is important for you to understand if during the interview your responses indicate that there is a serious risk of harm to yourself or others, confidentiality will be broken in order to protect you or another person from harm. If we feel that you need urgent care as result of participating in this research study we will intervene according to routine clinical care practices.

Even though your name will not be part of the audio recording or the written interview, your voice may still be identifiable as your voice. Three people, the researcher, the researcher's supervisor and the professional who writes out the interview will be the only ones to hear the audio recording.

There is an inconvenience of time. Each study interview will take about approximately 90 minutes as the consent process will be done prior to the interview.

Despite protections being in place, there is a risk of unintentional release of information. Researchers will make every attempt to protect your privacy.

6. What are the possible benefits of participating in this study?

There may not be direct benefit to you from taking part in this study. We hope that the information learned from this study can be used in the future to benefit other people with mental health nursing care.

7. If I decide to take part in this study, can I stop later?

It is your choice to take part in this study, participation is voluntary. You can change your mind at any time during the interview, or after the interview is completed. The study team may ask why you are withdrawing for reporting purposes, but you do not need to give a reason to withdraw from the study if you do not want to. Withdrawal from the study will not have any effect on the care you will receive. If you decide to leave the study, you can contact your researcher. If you withdraw after the interview is completed you have the right to request the destruction of your information collected during the study, or you may choose to leave the study and allow the investigators to keep the information already collected about you until that point. If your interview data has been analyzed it cannot be removed from the study findings.

8. What are my rights when participating in a research study?

You have the right to receive all information that could help you make a decision about participating in this study, in a timely manner. You also have the right to ask questions about this study at any time and to have them answered to your satisfaction.

Your rights to privacy are legally protected by federal and provincial laws that require safeguards to ensure that your privacy is respected.

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form you do not give up any of your legal rights against the study doctor, sponsor or involved institutions for compensation, nor does this form relieve the study doctor, sponsor or their agents of their legal and professional responsibilities.

You have the right to be informed of the results of this study once the entire study is complete.

You will be given a copy of this signed and dated consent form prior to participating in this study.

9. What about my privacy and confidentiality?

Study information collected during the study will kept at Memorial University and stored in a secure, locked place that only the researcher and the researcher's supervisor will be able to access. Study information is kept for 5 years before it is destroyed.

All information that identifies you will be kept confidential, and to the extent permitted by applicable laws, will not be disclosed or made publicly available, except as described in this consent document. Every effort to protect your privacy will be made. Even though the risk of identifying you from the study data is very small, it can never be completely eliminated. The study data will be stored securely at Memorial University of Newfoundland, in the Faculty of Nursing, Room 5004 Education Building for 5 years and then destroyed. If there is a breach of your privacy resulting from your participation in this study within that time you will be notified.

10. Your access to records

You have the right to see the information that has been collected about you for this study. If you wish to do so, please contact the researcher.

.

11. Declaration of financial interest, if applicable

Not applicable

12. What about questions or problems?

If you have any questions about taking part in this study, you can meet with the principal investigator who is in charge of the study. That person is:

[Chantille Isler, 709-765-4047]

Or you can speak with her supervisor:

[[Dr. Joy Maddigan at 709-864-3606]

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office at 709-777-6974

Email at info@hrea.ca

Signature Page

My signature on this consent form means:

- I have had enough time to think about the information provided and ask for advice if needed.
- All of my questions have been answered and I understand the information within this consent form.
- I understand that my participation in this study is voluntary.
- I understand that I am completely free at any time to refuse to participate or to withdraw from this study at any time, without having to give a reason, and that this will not change the quality of care that I receive.
- I understand that it is my choice to be in the study and there is no guarantee that this study will provide any benefits to me.
- I am aware of the risks of participating in this study.
- I do not give up any of my legal rights by signing this consent form.
- I understand that the interview will be audio recorded for the purpose of data analysis
- I understand that all of the information collected will be kept confidential and that the results will only be used for the purposes described in this consent form.
- I agree to take part in this study.

Signature of participant	Printed name	Day Month Year
Signature of person conducting the consent discussion	Name printed	Day Month Year

To be signed by the investigator:

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant/substitute decision maker fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

Signature of Researcher Name Printed Day Month

Year