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Nursing Best Practice Guideline
Shaping the future of Nursing

client centred care

RNAO
Registered Nurses Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

RNAO Registered Nurses Association of Ontario L'Association des infirmières et infirmiers autorisés de l'Ontario

Greetings from Doris Grinspun
Executive Director
Registered Nurses Association of Ontario

It is with great excitement that the Registered Nurses Association of Ontario (RNAO) disseminates this nursing best practice guideline to you. Evidence-based practice supports the excellence in service that nurses are committed to deliver in our day-to-day practice.

We offer our endless thanks to the many institutions and individuals that are making RNAO's vision for Nursing Best Practice Guidelines (NBPGs) a reality. The Ontario Ministry of Health and Long-Term Care recognized RNAO's ability to lead this project and is providing multi-year funding. Tazim Virani --NBPG project director-- with her fearless determination and skills, is moving the project forward faster and stronger than ever imagined. The nursing community, with its commitment and passion for excellence in nursing care, is providing the knowledge and countless hours essential to the creation and evaluation of each guideline. Employers have responded enthusiastically to the request for proposals (RFP), and are opening their organizations to pilot test the NBPGs.

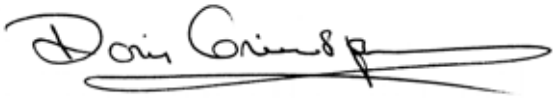
Now comes the true test in this phenomenal journey: will nurses utilize the guidelines in their day-to-day practice?

Successful uptake of these NBPGs requires a concerted effort of four groups: nurses themselves, other health-care colleagues, nurse educators in academic and practice settings, and employers. After lodging these guidelines into their minds and hearts, knowledgeable and skillful nurses and nursing students need healthy and supportive work environments to help bring these guidelines to life.

We ask that you share this NBPG, and others, with members of the interdisciplinary team. There is much to learn from one another. Together, we can ensure that Ontarians receive the best possible care every time they come in contact with us. Let's make them the real winners of this important effort!

RNAO will continue to work hard at developing and evaluating future guidelines. We wish you the best for a successful implementation!

Doris Grinspun, RN, MScN, PhD (candidate)



Executive Director
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How to Use this Document

This nursing best practice guideline is a comprehensive document providing resources necessary for the support of evidence-based nursing practice. The document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. Guidelines should not be applied in a "cookbook" fashion but used as a framework to individualize client care.

Nurses, other health care professionals and administrators who are leading and facilitating practice changes will find this document valuable for the development of policies, procedures, protocols, educational programs, assessment and documentation tools, etc. It is recommended that the nursing best practice guidelines be used as a resource tool. Nurses providing direct client care will benefit from reviewing the recommendations, the evidence in support of the recommendations and the process that was used to develop the guidelines. However, it is highly recommended that practice settings adapt these guidelines in formats that would be user-friendly for daily use.

Organizations wishing to use the guideline may decide to do so in a number of ways:

- Assess current nursing and health care practices using the recommendations in the guideline.
- Identify recommendations that will address recognized needs in practice approaches.
- Systematically develop a plan to implement the recommendations using associated tools and resources.

Implementation resources will be made available through the RNAO website to assist individuals and organizations to implement best practice guidelines. RNAO is interested in hearing how you have implemented this guideline. Please contact us to share your story. The story of the pilot implementation site is shared throughout this guideline through comments made by nursing staff, educators and administrators. These comments are quoted from the evaluation report:

Edwards, N., et al. (2002). *Evaluation of pilot sites implementation. Evaluation Summary: Client centred care*. Ottawa, Canada: University of Ottawa.

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Nursing Best Practice Guideline

Client Centred Care

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Client Centred Care

Disclaimer

These best practice guidelines are related only to nursing practice and not intended to take into account fiscal efficiencies. These guidelines are not binding for nurses and their use should be flexible to accommodate client/family wishes and local circumstances. They neither constitute a liability or discharge from liability. While every effort has been made to ensure the accuracy of the contents at the time of publication, neither the authors nor RNAO give any guarantee as to the accuracy of the information contained in them nor accept any liability, with respect to loss, damage, injury or expense arising from any such errors or omission in the contents of this work.

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summary of recommendations

Practice Recommendation

Recommendation 1

Nurses embrace as foundational to client centred care the following values and beliefs: respect; human dignity; clients are experts for their own lives; clients as leaders; clients' goals coordinate care of the heath care team; continuity and consistency of care and caregiver; timeliness; responsiveness and universal access to care. These values and beliefs must be incorporated into, and demonstrated throughout, every aspect of client care and services.

Education Recommendations

Recommendation 2

Education regarding the nursing best practice guideline for Client Centred Care should, wherever possible, be based on voluntary attendance by the nurse with organizations financially supporting this training.

Recommendation 3

The principles of client centred care should be included in the basic education of nurses in their core curriculum, be available as continuing education, be provided in orientation programs and be made available through professional development opportunities in the organization.

Organization & Policy Recommendations

Recommendation 4

To foster client centred care consistently throughout an organization, health care services must be organized and administered in ways that ensure that all caregivers, regardless of their personal attributes, enact this practice successfully. This includes opportunities to gain the necessary knowledge and skills to really engage with clients from their standpoint, as well as organizational models of care delivery that allow nurses and clients to develop continuous, uninterrupted, and meaningful relationships.

Recommendation 5

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to education.
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.
- Ongoing opportunities for discussion and education to reinforce the importance of best practices.
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the "Toolkit: Implementation of Clinical Practice Guidelines", based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline on *Client Centred Care.*

"Sometimes there are fewer problems because [we're]... getting down to the big core problems with the patient ... [We're] dealing with that and getting right down to the nitty gritty. Then all of a sudden all of the other problems disappear and ... they're just happier, they're happier with the staff and they're happier with their care just because someone spoke to them that day."

(Pilot Implementation Site)

Responsibility for Guideline Development

The Registered Nurses Association of Ontario (RNAO), with funding from the Ontario Ministry of Health and Long-Term Care, has embarked on a multi-year project of nursing best practice guideline development, pilot implementation, evaluation, and dissemination. In this second cycle of the project, one of the areas of emphasis is on client centred care. This guideline was developed by a panel of nurses convened by the RNAO and conducting its work independent of any bias or influence from the Ontario Ministry of Health and Long-Term Care.

Purpose and Scope

Best practice guidelines (BPGs) are systematically developed statements to assist practitioners' and clients' decisions about appropriate health care. The purpose of this guideline is the development and utilization of "client centred" best practice for all health sectors, which empowers the client, improves client satisfaction, and enhances quality of care and quality of work life. The central theme of the guideline focuses on the experience of the client from his/her perspective, minimizing vulnerability, and maximizing control and respect. The guideline identifies practices that facilitate achievement of client centred outcomes.

This best practice guideline focuses its recommendations on: Practice Recommendations, including values, beliefs, and core processes; Education Recommendations for supporting the skills required for nurses; and Organization & Policy Recommendations addressing the importance of a supportive practice environment as an enabling factor for providing high quality nursing care, which includes ongoing evaluation of guideline implementation.

Guideline Development Process

In May 2000, a panel of nurses with expertise from practice, research, and academic sectors in the area of client centred care was convened under the auspices of the RNAO. This panel undertook the following steps in developing the best practice guideline:

- The scope of the guideline was identified and defined;
- A systematic literature search was conducted;
- Key videos depicting client centred care principles were viewed and critiqued: "Through the Patient's Eyes"(1994, 1998), "Not My Home" (1994), "Real Stories"(1995), "Finding the Way"(1996);
- The values and beliefs that are the underpinning of client centred care were articulated by the panel. This work was supported by the literature. In addition, the panel examined these values as reflected in the Code of Ethics of both the College of Nurses of Ontario (1999) and the Canadian Nurses Association (1997);
- An extensive literature review was conducted comprised of research, theoretical papers, and articles concerning clinical practice and client experiences. Evidence to support the values and beliefs was identified and specific actions pertaining to nursing were gathered;
- Action statements for each value and belief statement were developed;
- Through a process of discussion and consensus, practice, education and organization & policy recommendations were developed;
- A draft guideline was submitted to external stakeholders for review and feedback. The feedback received was reviewed and incorporated into the draft guideline;
- The nursing best practice guideline was pilot implemented in selected practice settings in Ontario (see "Acknowledgement" for a listing of implementation sites). Pilot implementation practice settings were identified through a "request for proposal" process conducted by RNAO;
- The guideline document was further refined taking into consideration the pilot site feedback, evaluation results and current scholarship identified through a supplementary literature review.

Definition of Terms

Caring: "Caring can be considered the behaviours, actions, and attributes of nurses. Caring nurses listen to and are empathetic with clients' points of views. Generally, caring requires recognition of clients as unique individuals whose goals nurses facilitate. Clients' values and choices are of primary consideration when planning and providing care and the nurses' own personal values must never interfere with clients' right to receive care" (College of Nurses of Ontario, 1999, p. 3-4).

Client: Inclusive of individuals, families/significant others, groups, communities, and populations.

Client Centred Care: An approach in which clients are viewed as whole persons; it is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making.

Client Directed Care: An approach to care delivery where clients are considered the brokers of care, and receive what they ask for.

Clinical Practice Guidelines or Best Practice Guidelines: "Systematically developed statements (based on best available evidence) to assist practitioner and patient decisions about appropriate health care for specific clinical (practice) circumstances" (Field & Lohr, 1990, p. 8). Clinical practice guidelines or best practice guidelines are developed using the best available evidence.

Collaboration: Stanhope and Lancaster (2000) defined collaboration as "mutual sharing and working together to achieve common goals in such a way that all persons or groups are recognized and growth is enhanced" (p. G5).

Consensus: A process for making policy decisions, not a method for creating new knowledge. At its best, consensus development merely makes the best use of available information, be that scientific data or the collective wisdom of the participants (Black et al, 1999).

Education Recommendations: Statements of educational requirements and educational approaches/strategies for the introduction, implementation and sustainability of the best practice guideline.

Empowerment: Wallerstein (1992) defines empowerment as "the participation of individuals and communities in a social action process that targets both individual and community change outcomes" (p. 202). A concept that is crucial to empowererment is that community workers and professionals must "start where the people are" (Nyswander, 1956, p.69-70).This means that initial and ongoing assessment of clients' values, feelings, and actions are integral to any community work.

Evidence: "An observation, fact, or organized body of information offered to support or justify inferences or beliefs in the demonstration of some proposition or matter at issue" (Madjar & Walton, 2001, p. 28).

Humanistic Approach: A humanistic approach is based on knowing the client and the client's perspective through continuous dialogue. This allows the nurse to view the client as a whole, and recognize the interconnectedness and interrelationship between the client and the environment. This approach to care delivery focuses on restoring health, harmony and enhanced quality of life.

Key Clinical Resource Staff: These are nurses who provide day-to-day leadership (i.e. Clinical Nurse Specialists, Professional Practice Leaders, Nurse Clinicians, Clinical Consultants, and Nursing Managers, etc.).

Knowledge: Nursing practice is informed by various ways of knowing (Carper, 1978). Empirical knowledge comes from a scientific base and includes facts, models and theories. Aesthetic knowledge relates to the "art" of nursing, where knowledge comes from the empathetic relationships that the nurse creates with clients. Ethical knowledge arises from theories and principles of ethics. Through a valuing process, clarification of situations, and advocacy, the nurse interprets an ethical perspective of care. Personal knowledge is concerned with the knowing, encountering and actualizing of the concrete, individual self. One does not know about the self: one strives simply to know the self. This knowing is a standing in relation to another human being and confronting the human being as a person (Carper, 1978).

Organization & Policy Recommendations: Statements of conditions required for a practice setting that enables the successful implementation of the best practice guideline. The conditions for success are largely the responsibility of the organization, although they may have implications for policy at a broader government or societal level.

Participatory Management: The extent to which managers involve registered nurses and registered practical nurses in decisions regarding their work and aspects of the work environment. The participatory management style is characterized by the manager seeking staff input and feedback about the work environment, involving staff in decision making about their own work, providing recognition and support and taking action on the input (Ferguson-Paré, 1998).

Practice Recommendations: Statements of best practice directed at the practice of health care professionals that are ideally evidence-based.

Primary Health Care: Primary Health Care is best defined by excerpts from the Alma Ata Declaration (World Health Organization, 1978):

> "[It] is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which primary health care is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, the family, and the community with the national health system bringing health care as close as possible to where the people live and work, and it constitutes the first element of a continuing health care process" (Article VI).
>
> "Primary health care... 2. Addresses the main health problems in the community, providing promotion, preventive, curative, and rehabilitative services accordingly. 3. Includes at least education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against major infectious disease; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs" (Article VII, paragraphs 2, 3).

Primary Nursing: An organizational model of care delivery that emphasizes continuity of care and continuity of caregiver. In this model, the same nurse provides for the total care needs of a client(s) from admission and until the client is discharged from an episode of care. This includes direct caregiving, care coordination, advocacy, and education. The resultant consistency and continuity of relationship is foundational to positive outcomes and client centred care.

Reflective Practice: An ongoing process that the nurse utilizes in order to examine his/her own nursing practice, evaluate strengths, and identify ways of continually improving practice to meet client needs. Questions useful in framing the reflective process include: "What have I learned?"; "What has been most useful?"; " What else do I need?"; "What practices can I share with others?".

Senior Nurse Leader: A visible leadership position for a nurse who functions at the level of policy and decision-making to influence and advocate for nursing professional practice at the organization level. The individual has responsibility for nursing quality improvement. Nurses in these positions may be known as Chief Nursing Officer, Nursing Practice Leader, etc.

Stakeholder: A stakeholder is an individual, group or organization with a vested interest in the decisions and actions of organizations who may attempt to influence decisions and actions (Baker et al, 1999). Stakeholders include all individuals or groups who will be directly or indirectly affected by the change or solution to the problem. Stakeholders can be of various types, and can be divided into opponents, supporters and neutrals (Ontario Public Health Association, 1996).

"It was like a little breath of fresh air . . . I mean health care right now is under great stress financially. This was like 'Oh my gosh, we're not talking about finances, we're talking about how we treat patients!" (Pilot Implementation Site)

Background Context

Since its inception, a key tenet of nursing practice has been a focus on the patient/client. Nursing theorists such as Peplau (1952), Rogers (1970), Newman (1979), Watson (1985) and Parse (1998) have embedded this principle in their frameworks. Curtin (1979) stated that nurses "are human beings, our patients or clients are human beings, and it is this shared humanity that should form the basis of the relationship between us" (p. 3). Gadow (1990) described the importance of nursing's role in not just supporting clients' decisions but actively participating with clients in determining the unique meaning that the experience of health, illness, suffering or dying has for them. The clients' view of their personal health experiences is central to good nursing practice, and is one of the unique contributions nursing brings to the planning and delivery of appropriate health care services.

Nurses have expert information to share. However, creating a respectful relationship that supports the client's ability to identify his/her personal needs is essential to ensuring that information is given at the appropriate time and is relevant to the client's own decision making. The present technological era has greatly increased treatment options and client information needs. At the same time, despite the emerging consumer movement, asking individuals what they would like to do and what they might find helpful has not been well advanced. All health care practitioners should be concerned about this omission. Hearing and respecting an individual's choices improves not only his/her health but also how he/she experiences and effectively uses health care services.

The client centred care nursing best practice guideline has been developed in order to clearly articulate and support client centred nursing practice. It has been framed around a set of values that are consistent with the Ethical Framework for Registered Nurses and Registered Practical Nurses in Ontario (College of Nurses of Ontario, 1999) and the Canadian Nursing Association's (1997) Code of Ethics for Registered Nurses. In addition, the values and beliefs are comparable to the Picker/Commonwealth Program's (Gerteis, Edgman-Levitan, Daley & Delbanco, 1993) dimensions of patient-centred care. The Picker Institute has pioneered the international use of carefully designed instruments designed to elicit reports from patients about concrete aspects of their experiences, rather than ratings of satisfaction (Gerteis et al., 1993). Following extensive qualitative research to find out what patients thought about the way they were treated and what the problems were from their point of view, the Picker Institute developed questionnaires designed to focus on specific dimensions of care. The care processes associated with these

dimensions of care are congruent with the values and beliefs identified by the development panel. The panel believes that these guidelines will assist nurses to understand and enact these values and beliefs within the context of their professional code of ethics, standards of practice and all relevant legislation.

A Cochrane systematic review of randomized controlled trials focusing on patient-centred interventions (Lewin, Skea, Entwistle, Zwarensteing & Dick, 2001) related that while practicing patient-centred care may impact the satisfaction of both the patient and the provider, it may have varying acceptability and impact across different health care settings and cultures and involve different components from training to organizational restructuring. To address the importance of creating a supportive environment for individual health professionals who are practicing client centred care, comprehensive recommendations regarding education and organization & policy are included in this best practice guideline. The development panel believes that these recommendations are crucial to the successful implementation of client centred care best practices.

"I find I'm trying harder to talk to [patients]. …It's like when you're working you're rushed, rushed, rushed and it's 'get the job done'. You're so task oriented and I find now that I'm trying to say: 'Okay, the tasks are fine but I want to know this person. I want to know how they feel. What's going on with them? Are they happy? Are they sad? Are they frustrated? And do they have any ideas?', instead of… 'Oh well I have to get from Room 24 to Room 34 within the next hour'."

(Pilot Implementation Site)

Interpretation of Evidence

Evidence based practice has been defined as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of patients" (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996, p. 71). In order to ensure that current best evidence is used in the development of clinical guidelines, the methods of identification and interpretation of relevant evidence need to be critically appraised (Cluzeau, Littlejohns, Grimshaw, Feder, & Moran, 1999). Generally the gold standard is given to evidence derived from the randomized controlled trial (RCT), either in isolation or preferably in a systematic review or meta-analysis (Sweeney, 1998). In considering evidence however, Berg (1997) cautions nurses to not deny the less quantifiable aspects of nursing work.

Consequently, in developing this guideline the development panel drew their evidence from a variety of sources. Qualitative and quantitative findings, clinical expertise, and the knowledge that clients bring of their bodies in health, illness, and suffering are all important sources of evidence (Peter, 2002). The evidence was based on a systematic review, other quantitative studies, nursing theories, qualitative sources and client reports of their experiences. This range of evidence was synthesized in order to capture an understanding of client experience and nursing knowledge. Expert consensus was utilized when scientifically formalized knowledge was not available. In this way, the patterns of knowing described by Carper (1978) i.e., empirics, aesthetics, ethics and personal knowing were valued and captured in the development of this document.

"Actually, one nurse at the luncheon today said: I never realized until we began doing these readings and attending these education sessions, just what I was doing. I was going in and determining what was best for the patient instead of asking them what it is they need from me." (Pilot Implementation Site)

Practice Recommendations

Client centred care can be achieved by individual nurses in their interactions with clients, by entire units or work groups, by health care organizations, and by the health care system as a whole. More importantly, nurses through their actions and practices can influence the practice of colleagues and organizational and system policies toward this end.

Recommendation • 1

Nurses embrace as foundational to client centred care the following values and beliefs: respect; human dignity; clients are experts for their own lives; clients as leaders; clients' goals coordinate care of the heath care team; continuity and consistency of care and caregiver; timeliness; responsiveness and universal access to care. These values and beliefs must be incorporated into, and demonstrated throughout, every aspect of client care and services.

Values and Beliefs of Client Centred Care

The client is the one who decides if and who will participate in his/her care. The term client, is inclusive of individuals, families/significant others, groups, communities, and populations. The agency should choose which meaning of client is most suitable for its population.

The following are the values and beliefs that were identified as foundational to client centred care:

Respect: Respect clients' wishes, concerns, values, priorities, perspectives, and strengths.

Human Dignity: Care for clients as whole and unique human beings, not as problems or diagnoses.

Clients Are Experts for Their Own Lives: Clients know themselves the best.

Clients as Leaders: Follow the lead of clients with respect to information giving, decision making, care in general and involvement of others.

Clients' Goals Coordinate Care of the Health Care Team: Clients define the goals that coordinate the practices of the health care team. All members of the team work toward facilitating the achievement of these goals.

Continuity and Consistency of Care and Caregiver: Continuity and consistency of care and caregiver provides a foundation for client centred care.

Timeliness: The needs of clients and communities deserve a prompt response.

Responsiveness & Universal Access: Care that is offered to clients is universally accessible and responsive to their wishes, values, priorities, perspectives, and concerns.

Core Processes of Client Centred Care[1]

Living the values and beliefs of client centred care can be achieved by practicing the core processes of client centred care. These four core processes include:

- Identifying Concerns/Needs
- Making Decisions
- Caring and Service
- Evaluating Outcomes

For each of the four Core Processes, the development panel has identified nursing actions that reflect the client centred care values and beliefs. In addition, some example questions to invite client/community participation are provided.

1. Identifying Concerns/Needs

a) Initiate discussion or strategies (i.e. focus groups and surveys) in order to understand the client's perspective regarding his/her health and quality of life. Nurses may ask:

- What is this situation like for you?
- What is most important to you?
- What are your goals?
- What does quality of life mean for you?
- How involved do you want to be?
- What would you like to know about?
- What gives you strength to carry on?
- What has worked for you before?

[1] Used with permission. Mitchell, G. et al. (1996). *Sailing beyond boundaries: The nursing standards for patient care.* Toronto, Ontario: Sunnybrook Health Sciences Centre.

- Who in your family or friends would help you?
- How will you know that you will be able to manage on your own?

b) Seek to clarify the hopes, wishes, preferences, strengths, needs, and concerns of the client, from his/her perspective. Nurses may ask:

- What do you hope happens?
- What do you see down the road?
- What are your concerns?
- What do you need/expect from your health care team?

c) Seek to build the client's capacity (ability to reach independence) based on the client's goals.

d) Clarify the client's wishes and follow his/her lead in determining the involvement of others in their health care. Nurses may ask:

- Who do you want to involve in your care?
- Who else should be involved in this meeting/project?
- What is important to you?
- Who would you like to make decisions for you, if you were unable to make them for yourself?

e) Represent the client's/community's perspective of health, goals in life, as well as their concerns when making recommendations to others (i.e. the health care team, project team, community group, etc).

f) Follow the client's lead when providing information or teaching that the client wants with respect to his/her health/illness situation. Teach the client in a way that is relevant to his/her personal reality. This is based on the premise that the nurse trusts that clients will seek relevant information according to their own readiness.

g) Document the client's/community's perspective with regard to health and quality of life, goals, wishes, choices regarding information, and concerns.

2. Making Decisions

a) Make the client the key decision-maker in planning care and services.
Spend time with clients in order to understand the situation from their perspective.
Follow the client's lead regarding his/her desire for participation in decision-making.

b) Identify priorities for change or action. Nurses may ask:

- What's most important to you now?

c) Identify options from client's/community's perspective. Nurses may ask:

- What do you think your options are?
- How do you see that happening?
- Can you picture that?

d) Act as a resource for clients in deciding care strategies. Clarify and provide information or teaching that clients want and say they need, with respect to their health/illness situation or possible health strategies. Nurses may ask:

- What do you need in order to (…)?
- What would help you (….)?

e) Act as advocate for the client's/community's values and decisions.

- Invite clients to participate in all care conferences/program-planning meetings.
- Present the client's/community's perspective in care conferences/program planning meetings when the client is unable to participate or wishes not to participate.
- Document collaboration in care plan/reports.

3. Caring and Service

a) Involve clients throughout the caring and service process.

b) Acknowledge the client's expertise and encourage clients/communities to share their knowledge and skills. Follow the client's lead in using language that is appropriate to the client (including the use or non-use of technical jargon).

c) Respect and honour client choices and decisions though they may not be related to the illness/disease process or health services and regardless of the nurse's own values. The responsibility

of the nurse is to not abandon clients in times of their need/conflict, but to explore situations of ethical conflict by listening, understanding, and responding; to be aware of relevant legislation; and seek additional information and resources before next steps are taken.

d) Use trust-building strategies to develop the nurse-client relationship.

- Introduce yourself and call clients by preferred name.
- Give clients written and/or visual information identifying members of the team; explain the role of each and identify the primary contact.

e) Demonstrate respect and value for clients by listening with openness.

- Listen to accept – validate what is being said.
- Ask clients regularly about their experiences with the care and service that they are receiving.

f) Use positive language to discuss clients.

- Use the client's own words to describe situations (i.e., "Mr. Smith says he doesn't want to take his pills because …" Or, "Mrs. Jones says she doesn't want to get out of bed because …")
- Use strength-based language (i.e., instead of "demanding," or "controlling," use "good advocate," or "knows needs well").
- Do not describe clients as compliant or non-compliant.
- Do not refer to clients as diagnoses, problems, labels.

g) Involve family/significant others as per client wishes.

h) Ensure that the client's goals are central to the coordination, continuity, and consistency of care:

- Develop customized action plans with clients that reflect activities or actions aimed at achieving the clients' identified goals.
- Solicit the client's perceptions about the coordination of care or services and make this information available to the clinician in charge or discharge planners (i.e. Does the client understand the roles of service providers? Is the information provided consistent?).
- Make discharge a critical opportunity to promote independence and sustainability by identifying sources of on-going support (i.e. health care professionals, support groups, etc.).
- Act as a resource (i.e. how to reach health care professionals after discharge for consultation, who to ask to get help).

4. Evaluating Outcomes

a) Engage the client in evaluating care delivery and health related outcomes. Nurses may ask:

- How is the care you are receiving?
- How do you feel about your progress?
- What is important to you in achieving your goals?

b) Support the client if or when goals cannot be met. Nurses may ask:

- Is there another way to achieve the same outcome?
- What would help you?
- What else can I do to help?

c) Utilize specific processes/evaluations that provide continuous feedback from the client's perspective about the quality of nursing care. Nurses may ask:

- How was your care/service today?

d) Demonstrate an attitude of openness and a willingness to change in order to improve the quality of care from the client's perspective.

- What could we have done better?

e) Change care plans and practice approaches in order to improve quality from the client's perspective.

"Before we used to … chart they were confused, agitated or what not. Now we chart why this person was that way. Because if they're agitated you have to find the reason why they are agitated. You just don't write they're agitated …" (Pilot Implementation Site)

Education Recommendations

Recommendation • 2

Education regarding the nursing best practice guideline for Client Centred Care should, wherever possible, be based on voluntary attendance by the nurse with organizations financially supporting this training.

Recommendation • 3

The principles of client centred care should be included in the basic education of nurses in their core curriculum, be available as continuing education, be provided in orientation programs and be made available through professional development opportunities in the organization.

The guideline development panel further recommends that all staff that undergo education regarding client centred care be provided education based on the program that is outlined below, which may be tailored to meet the needs of the individual organization. Please refer to Appendix A for a detailed course outline regarding the recommended program.

Introduction and Overview

The program will begin with introductions, a brief synopsis of the background (i.e. of the RNAO Nursing Best Practices Guidelines project), and an overview of the educational program.

Values Clarification Process.

The educational program approaches teaching-learning about client centred care as a process of values clarification and individual and group discovery through ongoing dialogue. To this end, learners participate in a series of classes that are highly interactive and experiential and that foster self-reflection. Through dialogue and reflection, learners are supported to discover meaningful insights into the linkages among values, beliefs, language, and actions. In order for dialogue and learning to flourish, an open, non-judgmental learning space is essential. It is the facilitator's role to foster such a learning space by modeling and supporting the dialogical process with course participants.

Other Teaching-Learning Strategies

Suggested strategies include watching videos that portray client experiences in various practice settings, having a simulated experience as a health care client, and reading clients' narratives in books and articles.

Informal 'Practicum' Assignments

In order to practice client centred approaches, learners are asked to seek opportunities to engage clients in dialogue. Participants record these interactions, reflect upon and critique them based on the principles of client centred care, and bring them to class for feedback. The course facilitator can review the dialogue transcripts and give written feedback. These practice experiences provide important material for classroom discussions and learning from peers.

Please refer to Appendix A1 for a sample dialogue, Appendix A2 for sample case studies, Appendix B for a list of Educational Resources, and Appendix C for additional Recommended Readings.

"My nursing practice hasn't changed…because I lived and breathed it anyway. Other than maybe the way that you can change your wording in the way that you chart something. Trying to [do the BPG] actually really makes you very cognizant of the way that you're saying things, the way that you're presenting the patient. You know that when you label a patient you're really colouring the water for the next person who walks in…" (Pilot Implementation Site)

Organization & Policy Recommendations:

Preamble

Client centred care gets expressed through individual practitioner's behaviours and actions. These behaviours and actions happen within, and are conditioned by, the particular organizational context in which the nurse-client interaction takes place. The culture, administrative style, and model of care delivery therefore have a profound effect on the nature of interaction that professionals and clients achieve. Without diminishing the importance of individual care providers, or taking away their accountability, we recognize that the organizational context in which client centred care is being implemented is crucial to ensuring successful achievement of this practice.

Recommendation • 4

To foster client centred care consistently throughout an organization, health care services must be organized and administered in ways that ensure that all caregivers, regardless of their personal attributes, enact this practice successfully. This includes opportunities to gain the necessary knowledge and skills to really engage with clients from their standpoint, as well as organizational models of care delivery that allow nurses and clients to develop continuous, uninterrupted, and meaningful relationships.

Successful implementation of client centred care requires the following strategies:

1. Organizational and managerial support. This entails explicit endorsement from the Board and senior administration to a client centred care delivery of health care services (i.e., vision, mission, and value statements). It also requires the allocation of adequate resources for facilitating the cultural change, obtaining the required knowledge and skills necessary to adopt client centred care and enact congruent practices.

2. Organizational champions. New initiatives require leaders who will transform an idea into a lived reality. Nurses are pivotal players in the enactment of client centred care. The senior nurse leader and key clinical nursing staff must lead, in collaboration with other team members, the implementation of client centred care. Such a commitment from nursing leaders will ensure that client centred care becomes a priority. They can also serve as a vital linkage to senior management, sharing information, influencing others and fostering synergy with broader organizational goals.

3. Education and training for nurses. Proper orientation and continuing staff education and training are fundamental to the enactment of client centred care practices. Clarification of personal values, as well as the values and beliefs that underlie client centred care, is central to facilitate changes in perspective and behaviours. Peer review of nurses and attending to clients' experiences will assist in developing caring skills from a client's standpoint. Please refer to the section on Education Recommendations and Appendix A for a more detailed description of the program. Nurses will be provided with the opportunity to acquire the knowledge and skills to contribute to participatory management by speaking out on all issues that impact on client care.

4. Education and training for non-nurses. Client centred care should guide the practices of all those involved in health care provision, either directly or indirectly, and across the continuum of care. To achieve this, staff education must extend beyond nurses to other provider groups.

5. Model of care delivery that ensures continuity of care and continuity of caregiver. Of crucial importance is how the specific provision of nursing care is organized. To enact client centred care, nurses need to have opportunities to get to know their clients and develop trusting and meaningful relationships. Continuity of caregiver is paramount for this to occur. The nurse provides care to the client at a frequency that achieves consistency and continuity of care and continuity of the caregiver, and allows for the nurse-client relationship to flourish. The development panel strongly recommends primary nursing as the preferred model of care delivery for the implementation of client centred care.

6. Organizational and unit policies congruent with client centred care. It is essential that organizational policies be planned to encourage the enactment of client centred care practices. For example, visiting hours should be open to accommodate the needs of clients and their loved ones.

7. Positive work-life environment. The enactment of client centred care practices requires motivated and professionally fulfilled nurses. This is best achieved through a quality work-life environment that promotes respect, recognition, opportunities to share knowledge and skills, opportunities for professional development and continuing education, and a participatory and responsive management. Key ingredients are adequate staffing and appropriate levels of full-time nurses, which are paramount to achieving continuity of caregiver.

8. Organizational structures that promote interdisciplinary partnership. Such a partnership is important for clients and for caregivers. For the client, it means a seamless experience with reduced service duplication, consistent communication, and higher responsiveness to his/her needs. For caregivers, it means better understanding of one another's role, resulting in enhanced care for the client and higher respect and trust amongst various health care disciplines. It also means shared understandings of client centred care and congruent practices.

9. Outcomes evaluation. The implementation of client centred care in an organization or group practice is a systematic process that requires baseline and interval evaluations of the changes experienced by clients and caregivers. Key elements to evaluate are: Do clients feel they are respected? Do they feel caregivers value their personal expertise? Do clients say they are listened to? Is there evidence of the client's/community's view in the plan of care/program plan? For caregivers, the evaluation includes how the care they provide, and the satisfaction they experience from their work, changes as a result of client centred care. Staff nurses, nurse researchers, and the health care organization should join in the responsibility to continuously update practices based on their evolving knowledge of client centred care.

10. Humanizing the physical environment, routines, and the language of care giving. The physical environment and the routines of institutional care have a significant impact on clients and their loved ones. Hospital beds and gowns, nametags, and treatment schedules, are examples of routines that objectify clients and detach them from their personal world. Creating a more humane and home-like environment with personal items and pictures can assist clients to maintain a sense of identity, and signals that caregivers honour the client's world. Demystifying routines and language (i.e., reports, laboratory tests, medical jargon), explaining and offering independence from others (i.e., self-medication), and providing freedom to choose (i.e., bathing time)—are some of the measures that allow clients to maintain a sense of control over care provision.

Practice in the community setting acknowledges that the caregiver is a guest in the client's home and all efforts are made to honour the client's world.

11. Monitoring client centred care implementation and fostering continuous improvement. Like any new initiative, client centred care requires continuous monitoring that reflects the client's/community's perception of nursing (and other disciplines') care/practice. Ongoing patient and family feedback to the caregivers is crucial. Client centred care should also be reflected in the client's/community's records. For example, documentation should include the client's own view of his/her progress and goals to attain. Refer to Appendix D for further details regarding documentation. Constructive feedback and suggestions for improvement from clients, colleagues and others is an excellent strategy to enhance one's practice. Performance appraisals need to reflect the nurse's achievement of client centred care and areas for personal growth in enacting this practice.

12. Reflective practice: Nurses must be given opportunities to engage in reflective practice, including nursing practice concerns, systems issues and ethical questions.

"So, the units being involved with one another has been good in that the communication has really improved. And everybody seems to know what everybody else is doing while in the beginning nobody knew what anybody else was doing or why they were doing it. Now there seems to be more camaraderie and collaboration. I mean before we make decisions, we talk with other people, not that we didn't do that before, but the communication wasn't the same."

(Pilot Implementation Site)

Recommendation • 5

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as the appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- An assessment of organizational readiness and barriers to education.
- Involvement of all members (whether in a direct or indirect supportive function) who will contribute to the implementation process.
- Ongoing opportunities for discussion and education to reinforce the importance of best practices.
- Opportunities for reflection on personal and organizational experience in implementing guidelines.

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the "Toolkit: Implementation of Clinical Practice Guidelines", based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline on *Client Centred Care*.

Client centred care can be achieved by individual nurses in their interactions with clients, by entire units or work groups, by health care organizations and by the health care system as a whole. Please refer to Appendix E for a description of the "Toolkit: Implementation of Clinical Practice Guidelines".

Evaluation & Monitoring

Organizations implementing the recommendations in this nursing best practice guideline are advised to consider how the implementation and its impact will be monitored and evaluated. The following table, based on framework outlined in the RNAO *Toolkit: Implementation of clinical practice guidelines (2002)*, illustrates some indicators for monitoring and evaluation:

	Structure	Process	Outcome
Objectives	• To evaluate the supports available in the organization that allow for nurses to provide client centred care.	• To evaluate changes in practice that lead towards improved client centred care.	• To evaluate the impact of implementing the recommendations.
Organization/ Unit	• Review of best practice recommendations by organizational committee(s) responsible for policies/ procedures. • Nurse leaders have been identified to champion the implementation process. • Model of care delivery ensures continuity of care and continuity of caregiver (primary nursing).	• Modification to policies and/or procedures consistent with the values and beliefs of client centred care.	

Provider	• Percent of nurses attending education sessions (orientation, organization professional development opportunities) on client centred care.
	• Percent of non-nursing staff attending education sessions (orientation, organization professional development opportunities) on client centred care.
		• Nurses' self-assessed knowledge of:
		  • Recognizing the importance of listening to the client;
		  • Using open ended questions to elicit a client's perspective; and
		  • Documenting the client's understanding of a situation, rather than the nurse's judgement of the client.
		• Percent of nurses self-reporting:
		  • Adequate assessment of a client's perceived needs for care
		  • Adequate assessment of a client's goals for care.
		  • Adequate documentation of a client's personal goals for care.
		  • Sharing client's concerns/choices with other members of the health care team.
		  • Discharge teaching guided by the client's goals for managing their care at home.
			There is evidence of the client's/community's view in the plan of care/program plan
			
			Nurses seek feedback from clients about the quality of nursing care.
			
			Nurses modify/change practice based on feedback from clients.

	Structure	Process	Outcome

Client			• Clients report:
			  • feeling cared about.
			  • feeling that their values and beliefs were respected.
			  • being listened to.
			• Clients feel caregivers value their personal expertise.

Financial costs	• Provision of adequate financial resources for the level of staffing necessary to provide continuity of care and continuity of caregiver (primary nursing).	• Costs for education and other interventions and supports.	• Overall resource utilization.

"…with one lady we were able to implement that right away and she's very pleased and so was her family. Her family has seen a big difference in her from the unit that she came from and they are very, very pleased and … the son was reluctant to have her come over here but since the change he's very, very pleased."

(Pilot Implementation Site)

Process for Update/Review of Guideline

The Registered Nurses Association of Ontario proposes to update the nursing best practice guidelines as follows:

1. Following dissemination, each nursing best practice guideline will be reviewed by a team of specialists (Review Team) in the topic area every three years following the last set of revisions.

2. During the three-year period between development and revision, RNAO Nursing Best Practice Guideline project staff will regularly monitor for new research, scholarship and implementation experiences.

3. Based on the results of the monitor, project staff may recommend an earlier revision period. Appropriate consultation with a team of members comprising original panel members and other specialists in the field will help inform the decision to review and revise the guideline earlier than the three-year milestone.

4. Three months prior to the three-year review milestone, the project staff will commence the planning of the review process as follows:
   a. Invite specialists in the field to participate in the Review Team. The Review Team will be comprised of members from the original panel as well as other recommended specialists.
   b. Compile feedback received, questions encountered during the dissemination phase as well as other comments and experiences of implementation sites.
   c. Compile new research, scholarship and implementation experiences.
   d. Develop detailed work plan with target dates and deliverables.

The revised guideline will undergo dissemination based on established structures and processes.

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Appendix A: Educational Program Outline[2]

Introduction and Overview

The educational program outlined below consists of 16 classroom hours. The suggested format is eight 2-hour classes held at weekly intervals. This schedule gives participants the opportunity to complete reading assignments, reflect, and apply what they've learned into practice with clients, which in turn provides experiences for further exploration in class discussions.

Teaching-Learning Strategies

Values clarification through dialogue. The educational program approaches teaching-learning about client centred care as a process of values clarification and individual and group discovery through ongoing dialogue. To this end, learners participate in a series of classes that are highly interactive and experiential and that foster self-reflection. Through dialogue and reflection, learners are supported to discover meaningful insights into the linkages among values, beliefs, language, and actions. In order for dialogue and learning to flourish, an open, non-judgmental learning space is essential. It is the facilitator's role to foster such a learning space by modeling and supporting the dialogical process with course participants.

Other teaching-learning strategies. Suggested strategies include watching videos that portray client experiences in various practice settings, having a simulated experience as a health care client, and reading clients' narratives in books and articles.

Informal 'practicum' assignments. In order to practice client centred approaches, learners are asked to seek opportunities to engage clients in dialogue. Participants record these interactions, reflect upon and critique them based on the principles of client centred care, and bring them to class for feedback. The course facilitator can review the dialogue transcripts and give written feedback. These practice experiences provide important material for classroom discussions and learning from peers.

[2] Based on the educational program "Finding the Way", developed at Sunnybrook and Women's College Health Sciences Centre. (see Appendix B)

Learning Outcomes

By the end of the course, participants will be able to:

- Identify eight foundational values and beliefs of client centred care;
- Describe how these values and beliefs are lived out through the four core processes of client centred care;
- Compare and contrast the values, beliefs, language, and culture of the client centred approach to health care with those of traditional health care;
- Demonstrate the values, beliefs, and core processes of client centred care in interactions with clients.

Weekly Outline

Week 1

- Foundational Values and Beliefs of Client Centred Care
- Health And Quality Of Life From The Person's Perspective

Week 2

- Dialogue and Listening
- Client Centred Care Core Processes

Week 3

- Trusting Clients as Experts for their own Lives

Week 4

- Respect and Dignity
- Documentation and Accountability

Week 5

- Clients as Leaders

Week 6

- Clients as Leaders
- Organizational Culture and Client Centred Care

Week 7

- The Process of Change from Provider Focused to Client Centred Care
- The Nurse's Role on The Multidisciplinary Team

Week 8

- Moral Courage and Moving Beyond

Syllabus

The detailed outline that follows suggests weekly topics, relevant readings, teaching-learning activities, and time lines. These can be altered to meet participants' specific learning needs and interests. Note that classes build cumulatively. Topics are highlighted in the weeks they are introduced, but continue to be woven throughout remaining sessions.

Formative Evaluation

At the end of the first session and periodically throughout the course, obtaining feedback from course participants can be helpful in maximizing effectiveness of future sessions. Suggested evaluation questions are:

1. What do you understand better as a result of today's discussion?
2. What aspect of the session was most helpful?
3. What suggestions do you have for future sessions?

Week 1

In this session, the foundational values and beliefs of client centred care are introduced. Reflection on the meaning of health and quality of life heighten awareness of the significance of personal meanings and values.

Topics

- Foundational values and beliefs of client centred care
- Health and quality of life from the person's perspective

Teaching-Learning Activities

1. Introductions: (10 minutes)
   - Ask participants to say who they are, what brings them to the class, and what they hope to gain from it.

2. Background of the RNAO Nursing Best Practice Guideline on Client Centred Care (5-10 minutes)

3. Overview of the Educational Program (10 minutes)
   - Teaching-learning approaches and learning outcomes.

4. Exercise: *Exploring Values and Beliefs about Health and Quality of Life* (15-20 minutes)
   - Ask participants to think for a minute about the question, "What does health mean for you?" and then, jot down their thoughts.
     Similarly, ask participants to think and write about, "What does quality of life mean for you?" (5 minutes) When it appears that most have completed this activity, ask them to share their answers. Write points on flip chart paper. When finished, examine the list. What are the commonalities? What things are unique?
   - What does this exercise tell us about the meaning of *health*? Of *quality of life*? Can personal meanings be "right" or "wrong"?

5. Introduce Client Centred Care values and beliefs (see pg. 19) (10-15 minutes)

6. View video: *Not My Home* (45 minutes)
   - Reflections on video: (10 minutes)
   - What struck you while watching the video? Refer to the Client Centred Care values and beliefs. Which values and beliefs were evident or not evident in the video?

7. Assign Readings for Week 2:
   - Baier, S. (1996). The view from bed number ten. *Healthcare Forum Journal*, March/April, 60-67.
   - Messner, R. L. (1993). What patients really want from their nurses. *American Journal of Nursing* ,*93*(8), 38-41.

Week 2

The aim this week is to explore the centrality of dialogue and listening to client centred care. Also, the core process of client centred care are introduced.

Topics

- Dialogue and Listening
- Client Centred Care Core Processes

Teaching Learning Activities

1. Introduce Dialogue Assignment (see below): (20 minutes)
   - Share a sample nurse-person dialogue (see Appendix A1). Notice how open-ended questions are used to seek depth and clarity (see pages 20-24).
   - *Dialogue Assignment:* Each week, look for opportunities to have meaningful interactions with clients (individuals, families, or groups) from your practice setting. Record and submit five (5) dialogues, with critical reflection on each. The focus of each interaction will depend on the context. It could include, for example, clients' descriptions of their health situations, identification of health needs or concerns, and/or their hopes and plans for moving on with their situations. Begin each interaction with an open-ended question and then "go with the flow" (stay where the person is) by asking questions that seek depth and clarity (see pages 20-24). As soon as possible afterward, record the interaction as accurately as possible. Later, reflect upon and critique your participation in the dialogue, in relation to the values, beliefs, and core processes of client centred care.

2. Discussion of Assigned Readings (Baier, Messner) (20 - 30 minutes)
   Suggested questions for discussion:
   - How do the articles correspond with your experiences with health care organizations?
   - What are people saying they want from health care professionals? How can we learn what's most important to them?

3. Introduction of the Client Centred Care Core Processes (see pg. 20) (20 minutes)
   - If staff in the Baier article had practised the client centred care core processes, how might the patient's experience have been different? How do the core processes correspond with the ideas in Messner's article?

4. View Video: *Through the Patient's Eyes* (20 minutes)
   Reflection on video: Suggested questions: (15 minutes)
   - How do people's illness and experiences in health care organizations effect their quality of life?
   - What did the people in the video say they wanted/expected from health care professionals?
   - How do the dimensions of patient-centred care in the video compare with the values and beliefs stated in the Client Centred Care Nursing Best Practice Guideline?

5. Assign Readings for Week 3:
   - Hayhoe, B. (1997). I have lived. *Journal of Emergency Nursing, 23*(2), 98.
   - Macurdy, A. H. (1997). Mastery of life. In J. Young-Mason, *The patient's voice: Experiences of illness* (pp. 9-15). Philadelphia: F.A. Davis.
   - Nichols, M. P. (1995). "Did you hear what I said?" Why listening is so important. In *The lost art of listening* (pp. 9-22). New York: The Guildford Press.
   - Spee, R., Chua, L., & Nose, L. (2001). Patient focused care. A dialogue with your patient. *Canadian Nurse, 97*(5), 19-22.

Week 3

Through exploring participants' values and beliefs concerning agency in their own lives, this session broaches the fundamental assumption that clients are experts for their own lives.

Topic

- Trusting Clients as Experts for their Own Lives

Teaching-Learning Activities

1. Sharing of Dialogues with Clients (20 - 30 minutes)
   - Invite participants to reflect on their participation in the dialogue. Suggested questions: What was helpful and what was not helpful in seeking depth and clarity about the client's perspective? Refer to client centred care Core Processes. How did the interaction correspond with the core processes? What did you learn from the dialogue? What are areas of discomfort? Areas for improvement?
2. Discuss Assigned Readings (Hayhoe, Macurdy, Nichols, Spee) (30 minutes)
   Suggested questions for discussion:
   - Have you ever made a decision that others disagreed with? How did you feel when others disagreed? What did you do? Who was responsible for your decision? For the outcomes?
   - If clients are considered the experts for their own health and quality of life, how would practice change?
   - What makes listening so important? What is it like to not be listened to?
   - Who are nurses accountable to?

3. Read "Case Studies" ("The Man Who Wanted A Beer," "The Man Who Couldn't Live Without His Aspirin") (See Appendix A2) (30 minutes)

4. View Video: *Real Stories* (first 2 vignettes) (approximately 15 minutes)
   Critique the vignettes in light of client centred care Core Processes (see pg. 20).
   (15 - 20 minutes)
   - To what extent were the vignettes consistent with client centred care? What would you do differently, in light of the client centred care Core Processes?

5. Assign Readings for Week 4:
   - Deegan, P. (1993). Recovering our sense of value after being labeled. *Journal of Psychosocial Nursing, 31*(4), 4-11.
   - Ahmann, E., & Lawrence, J. (1999). Exploring language about families. *Pediatric Nursing, 25*(2), 221-224.
   - Hewison, A. (1995). Power and language in a ward for the care of older people. *Nursing Times, 91*(21), 32-33.

Week 4

Respect and dignity, two fundamental values of client centred care, are explored through an examination of practices that diminish clients' dignity. These values are tied to the notion of professional accountability. Implications for documentation are also discussed.

Topics

- Respect and Dignity
- Documentation and Accountability

1. Sharing of Dialogues with Clients. (30 minutes)
   Invite participants to reflect on their participation in the dialogue. Suggested questions:
   - What was helpful and what was not helpful in seeking depth and clarity about the client's perspective? Can you identify any "blocks" to communication? How did the interaction correspond with the client centred care Core Processes? What did you learn from the dialogue? Were there areas of discomfort? Areas for further development?
   - What would you document, and where? (If possible, participants could bring copies of their documentation, with identifying data removed, for discussion in class.)

2. Discussion of Assigned Readings (Hewison, Deegan, Ahmann & Lawrence) (30 minutes). Suggested questions:
   - What are the ethical implications of unequal power between health professionals and clients? How does language reflect power relations?
   - What is it like to be labeled? How does labeling affect relationships between clients and health professionals? How does it fit with professional accountability?
   - What are the implications for documentation? (see Appendix D)

3. View Video: *Real Stories* (next 3-4 vignettes) (approximately 20 minutes)
   - Critique the vignettes in light of client centred care values and beliefs and Core Processes. (20 minutes)
   - If you were the nurse (health care professional) in these scenarios, how would you respond?

4. Assign Readings for Week 5:
   - Mitchell, G.J. (1994). The dignity of risk and the right to failure: One profile of patient-focused care. *Perspectives, 18*(3),10.
   - Gray, J.A. (1978). The old have a right to be at risk. *Sunday Times*, London.
   - Davies, C. (1991). A dilemma called Ellen. *Canadian Nurse, 87*(7), 23-24.
   - Mattice, M. & Mitchell, G. J. (1990) Caring for confused elders. *Canadian Nurse, 86*(11), 16-18.

Week 5

In this class, the implications of viewing clients as leaders of their care are explored, beginning with participants' assumptions about personal choice (autonomy), responsibility for choices, and taking risks.

Topic

- Clients as Leaders

Teaching-Learning Activities

1. Sharing of Dialogues with Clients (30 minutes)
   - Invite participants to reflect on their participation in the dialogue. Suggested questions:

- What was helpful and what was not helpful in seeking depth and clarity about the client's perspective? Can you identify any "blocks" to communication? How did the interaction correspond with the client centred care Core Processes? What did you learn from the dialogue? Were there areas of discomfort? Areas for further development?
- What would you document, and where?

2. Discussion of Assigned Readings (Mitchell, Gary, Davies, Mattice) (30 minutes).
   Suggested questions for discussion:
   - Have you ever taken a risk? What made it worth it?
   - What happens when people make choices that we don't agree with? Who is responsible for the outcomes of their choices?
   - What happens to our attitudes toward risk-taking when it comes to the elderly?
   - How is it possible for elderly persons living with dementia to be leaders of their care?
   - What situations in your practice are challenging, with respect to viewing clients as experts for their lives and the leaders of their care? How would the client centred care Core Processes guide you in such situations?

3. View Video: *Real Stories* (remaining vignettes not yet viewed) (approximately 15 minutes)
   - Critique the vignettes in light of client centred care values and beliefs and Core Processes. (15 minutes)
   - If you were the nurse (health care professional) in these scenarios, how would you respond?

4. Assign Readings for Week 6:
   - Holm, S. (1993). What is wrong with compliance? *Journal of Medical Ethics, 19*(2), 108-110.
   - Hansen, M. & Fisher, J.C. (1998). Patient-centred teaching from theory to practice. *American Journal of Nursing, 98*(1), 56-60.
   - Gage, M. (1994). The patient-driven interdisciplinary care plan. *Journal of Nursing Administration, 24*(4), 26-35.

Week 6

The implications of viewing clients as leaders is further explored in relation to the notions of compliance, patient teaching, and client participation in care planning. In addition, the significance of organizational culture to client centred care is discussed.

Topic

- Clients as Leaders
- Organizational Culture and Client Centred Care

Teaching-Learning Activities

1. Discussion of Assigned Readings (Holm, Hansen & Fisher, Gage) (30 - 40 minutes).
   Suggested questions:
   - What does "non-compliant" mean if persons are considered as experts for their lives and the leaders of their care?
   - How can nurses/health professionals help clients to be the key decision-makers in planning care and services? (see pg 22)
   - Reflect on the Hansen & Fisher article in light of the client centred care Core Processes. How congruent is it?
   - How is the view of clients as leaders reflected in documentation?
   - To what extent are structures like practice guidelines, policies, and chart forms consistent with client centred care?

2. Sharing of Dialogues with Clients (30 minutes)
   Invite participants to reflect on their participation in the dialogue. Suggested questions:
   - What was helpful and what was not helpful in seeking depth and clarity about the client's perspective? Can you identify any "blocks" to communication? How did the interaction correspond with the client centred care Core Processes? What did you learn from the dialogue? Were there areas of discomfort? Areas for further development?
   - What would you document, and where?

3. Optional: View a segment of a popular movie such as those listed in Appendix B.

4. Assign Readings for Week 7:
   - Mitchell, G.J. (1990). Struggling in change: From the traditional approach to Parse's theory-based practice. *Nursing Science Quarterly, 4*, 170-176.

- Mitchell, G.J. (1992). Parse's theory and the multidisciplinary team: Clarifying scientific values. *Nursing Science Quarterly, 5*(3) 104-106.

Week 7

Participants have the opportunity to reflect on their experiences with changing to a more client centred practice, and how that has influenced their relationships with the multi-disciplinary team.

Topics

- The Process of Change from Provider Focused to Client Centred Care
- The Nurse's Role on The Multidisciplinary Team

Teaching-Learning Activities

1. Sharing of Dialogues with Clients (30 minutes)
   - Invite participants to reflect on their participation in the dialogue. Suggested questions: What was helpful and what was not helpful in seeking depth and clarity about the client's perspective? How did the interaction correspond with the client centred care Core Processes? What would you document, and where?
   - Looking at your progress over your set of dialogues, what changes do you see? What have you learned from the dialogue? What are areas for development?

2. Discussion of Assigned Readings (Mitchell, 1990; Mitchell, 1992) (40 minutes)
   Suggested questions:
   - What happens in practice settings when nurses begin to practice client centred care?
   - When nurses practice client centred care, what unique contribution can they make to the multidisciplinary team?
   - How does client centred care change relationships among multidisciplinary team members? (see also article by Gage, Week 6)

3. Assign Reading for Week 8:
   - Kelly, B. (1996). Speaking up: A moral obligation. *Nursing Forum, 31*(2), 31-34.
   - Chalef, I. (1995). Introduction. In I. Chalef, *The Courageous Follower: Standing up to and for our leaders* (pp. 1-8). San Fransisco: Berrett-Koehler Publishers.

Week 8

This session is intended to highlight the rewards of changing to a more client centred practice, while also recognizing the risks and challenges. The importance of being true to one's beliefs is highlighted, along with ways to continue learning and growing.

Topic

- Moral Courage and Moving Beyond

Teaching-Learning Activities

1. Discussion of Assigned Readings (Kelly, Chalef) (30 minutes)

   Suggested questions:

   - What are some of the risks and challenges of making the change to client centred care? What are the possibilities and rewards?
   - What strategies would help other nurses to change their practice?
   - What strategies would help participants to continue to develop knowledge and skill in client centred care?

2. Optional: View clip from a popular video that celebrates courage. This is an effective way to heighten awareness of the moral imperative of living one's beliefs. For example, in the movie, Babe, there is a scene near the end, where the farmer (who has risked acting on what he believes by entering the pig, Babe, in a sheep-herding competition), watches Babe perform. The crowd's ridicule turns to amazement as Babe proves that the farmer's beliefs were well founded. (Link with previous discussion.)

OR

   View video, *Finding the Way.* (See Appendix B) Staff nurses who completed the Patient Focused Care Course at Sunnybrook Health Sciences Centre discuss their experiences and how their practice has changed.

3. Evaluation. Give participants a page with space to answer open-ended questions, such as:

   - Briefly describe how learning about client centred care has changed your practice.
   - What aspects of the sessions were most helpful?
   - What aspects of the course would you like to have changed?
   - What suggestions do you have for future courses?

Appendix A1
Sample Dialogue

The following interaction takes place in an ambulatory care dialysis unit. The nurse's critical reflections, indicated with footnote numbers, are included after the transcript of the dialogue. The facilitator's suggestions appear as italicized text in square brackets, and further feedback is included at the end.

Nurse: *Hi John! How are you doing?*

John: Great, I guess.

Nurse: *Getting ready for Florida?* [1]

John: We're getting there. Dorothy's getting things organized. You know Dorothy.

Nurse: *Dr. S. said he'd see you here today. While we're waiting we might as well do your blood work here.*

John: Sure! Any coffee around here?

Nurse: *John, of course. Let me get it for you. Just a little milk, right?*

John: Have you got a steady hand? (as I'm taking his blood)

Nurse: *Sure do, George! Any problems with your dialysis at home?* [2]

John: No problems.

Nurse: *You're feeling okay? Any hypotension?*

John: I'm feeling alright. Not bad.

Nurse: *What do you mean, John?*

John: Oh, just the normal aches and pains for us twenty-year-olds! (J. is 75 years old)

Nurse: *Are you sure? [Alternative: Tell me about them.]*

John: Ya! Ya! (went across the hall with Dr. S. for clinic appointment.)

When John returned to our office, Dr. S ordered a "stat" stress ECG test.
John's facial expression was sad.

Nurse: *John, what is the problem?*

John: I've been having some chest tightness and discomfort for several weeks now. Not sure what it is but thought I ought to mention it before I go to Florida.

Nurse: *I guess so, John!*[3] *How are you feeling about this?*

John: What will be will be.

Nurse: *John, have you talked to Dorothy about your chest discomfort?*[4]

John: No, I haven't. I wasn't sure it was anything and I didn't want to worry her.

Nurse: *How can I help you now, John?*[5] *[Alternative: What do you mean? Or, What happens when she worries?]*

John: Well, I guess you could phone Dorothy and tell her I won't be home for lunch and why. Then we need to get some lunch here.

John spent the next couple of hours in our office having lunch and waiting for his test.

When he returns…

Nurse: *Hi John! How are you doing?*

John: Not good. I didn't last long and they say the test was positive. Whatever that means.

Nurse: *John, come and sit down. How can I help you? [Alternative: What do think it might mean? Or, What is going to happen?]*

John: Well, this means I have some heart muscle problems. I need a cardiologist. Dr. S. is getting me that referral.

Nurse: *John, how are you feeling about this?*

John: Well, I'm not sure. Years ago, I would have stewed and stewed, but I have learned to take things as they come.

Nurse: *I can see you are worried, how can I help?*[6] *[Alternative: What do you mean? Or, Tell me more about that.]*

John: Well, let's see what the cardiologist says.

Nurse: *John, if I can help, please feel free to call. I'll go to Dr. M's office and see when his earliest appointment is. Remember to call or go to Emergency if you have any chest discomfort or pain.*

John: Ya! Ya! Go get the appointment.

(Nurse goes and returns.)

Nurse: *John, here's your appointment with Dr. M in two days, on Thursday at 1:30. Here's the card with the room number and phone number.*

John: Thanks a lot, B (gives a hug). See you on Thursday.

Critical Reflections

I find reviewing and critically evaluating interactions challenging. When you look back on a conversation you felt went well, it may not have, considering the values and beliefs of client centred care. In critiquing this interaction, it was apparent where I blocked conversation and didn't use open-ended questions. In (1), I should have asked what he meant by "I guess," to get his perspective on how he was doing. In (2), the question should have been phrased, "How are things going at home?" By asking about problems, I'm leading the conversation by making the assumption that there are problems. (3) Could possibly have blocked the conversation momentarily, as I was making a judgment. In this case, I could have asked him, "What is this like for you?" I was able to see where I changed the direction he may have been going, as in (4). I should have sought more clarity about his phrase, "What will be will be." I could see clearly where the use of open-ended questions helped John to identify what his concerns are and what is important to him. In (5), he was able to identify what was important from his perspective, simply by my asking him. Lastly, in (6), I was making a judgment that he was worried. Reflecting back, I could have asked him what he needs the most. I can see in this conversation where even subtle changes in my questions would have got at John's meaning and helped him to see his own possibilities. Hopefully, this conversation style will come more 'second nature' with practice.

Facilitator's Feedback

Betty, an excellent critique! You did very well picking up the blocks to communication.

Two suggestions:

(a) Try to seek more understanding instead of moving straight to what will help.

(b) Try asking what might be helpful, instead of "How can I help."

Nice work!

Appendix A2: Sample Case Studies

The Man Who Wanted A Beer*

Jo Deck, RN & Jan Linscott, RN, MScN

Tom is an 82-year-old gentleman, who was recently admitted to a long-term care facility. One day Tom waved and asked to speak with me. Tom began to tell me how angry he was at the doctor for not letting him have a beer. He said everyone blames his poor health on beer and cigarettes. He said he hates it when "the almighty think they know what is best for everyone!". He showed me how much his hands were trembling and said, "I need to have a beer, it is the only thing that will help me. I know this is what I need." He asked if I would speak with the doctor to see what could be done.

Discussion Questions

- *What is most important, from Tom's perspective? (Identifying Needs/Concerns)*
- *If you were Tom's nurse, how would you proceed?*

At interdisciplinary rounds, members expressed concern that the beer might affect Tom's behaviour. Questions were raised, such as: Would Tom remember if he only had one beer? Would he demand more than one? Would the beer be a problem for Tom's fluid restriction diet? Would the beer interact with the psychotropic medications he was on? And how would Tom's family feel about this? What would they think?

- *As Tom's nurse, how would you proceed?*

*Used with permission. Jo Deck and Jan Linscott wrote this case study while working at Sunnybrook and Women's College Health Sciences Centre. Toronto, Ontario.

The next day Jo, the Primary Nurse, followed up with the pharmacist and psychiatrist and both agreed that it was okay for Tom to have a beer. The Primary Nurse brought Tom's request to the interdisciplinary team and presented it as a quality of life issue for Tom. She said that given a choice, he said he would like to have a beer at noon and at 4 p.m. Three days later, on Tom's birthday, his wish to have a beer was fulfilled. Several weeks later, a second beer was added. Tom smiled and jovially said, "This makes my day!". Thereafter, the nurses found Tom to be much more content and noted how Tom looked forward to getting up out of bed for his 12 o'clock beer. Tom's quality of life was enhanced, as were his interpersonal relationships with the nurses because they did not have to remind, reinforce, or tell Tom all the reasons why he could not have a beer. For Tom, one thing most important to his quality of life was now a part of his life.

- *According to the client centred care Core Processes, how do nurses evaluate outcomes?*

The Man Who Couldn't Live Without His Aspirin

Ria Spee, RN, MSc

Alfred, a 92-year-old war veteran who was very hard of hearing and liked to play the mouth organ, had an old head injury from the war for which he had medicated himself with aspirin prior to admission. He had one episode of aspirin toxicity prior to being transferred to hospital, and one after being admitted to our unit. The health care team was in a quandary about what to do to keep Alfred alive and free from risk of another overdose. Although he was receiving Tylenol on a q4h basis, Alfred still felt the need to go out and obtain his own supply of Aspirin, which he found more effective for his headaches. His self-medication put his nurses in the uncomfortable position of having to search his belongings for Aspirin bottles from time to time and then be obligated to confiscate his supply, because it was hospital policy that no medications could be kept at the bedside.

For a period of time, the physician ordered a placebo and placed it in an Aspirin bottle at the bedside. Alfred soon found these to be ineffective and resumed his desperate and cumbersome journeys outside to again obtain a reliable supply of Aspirin. And the nurses continued to search his bedside and remove any Aspirin that they found when Alfred wasn't looking.

Discussion Questions

- *You are Alfred's nurse. What are your considerations in this situation?*
- *How would you proceed?*

Alfred's daughter had several unhappy visits with him, in which he threatened her if she wouldn't bring him his Aspirin. Finally, she made a desperate plea to the team to ask if it would be possible to prescribe his own supply of Aspirin in a measured amount, which the nurses could leave at his bedside for his own use. After much discussion, the physician wrote an order that Alfred could have his own supply of six Aspirin a day, to be delivered to his bedside each morning.

After this arrangement was made, Alfred's daughter remarked that her father was more content and her visits with him were much more pleasant. Whereas before, she dreaded having to come in to hear about his Aspirin "going missing," she now looked forward to her visits and felt good when she left, knowing he was not always worrying about what he is going to do about his headaches without the Aspirin.

When we listen to the resident and family and see them as leaders in their care, trusting that they know the way, both the resident's quality of life and the nurses' quality of work life are enhanced.

- *Can you identify how the client centred care Core Processes were followed in this situation?*

*Used with permission. Ria Spee is a Professional Practice Leader at Sunnybrook and Women's College Health Sciences Centre. Toronto, Ontario.

Appendix B: List of Educational Resources

Courses

The following are examples of courses offered on client centred care. Contact your local community college/university for courses in your area.

Ryerson University

Continuing Education

http://ce-online.ryerson.ca/ce/

Quality of Life:
The Client's Perspective (CVNU324)

Prerequisite: College of Nurses of Ontario Certificate of Competence.

Formerly: Patient Focused Care: Creating Organizational Culture.

This course focuses on exploring the knowledge and skills required to form genuine partnerships with individuals, families, and groups. Patient stories and qualitative research findings about quality of life, as a lived experience, will provide opportunities for students to critically reflect on the values that guide practice and the nurse-person relationship. Thinking consistent with human science will instruct students as they synthesize the literature on quality of life and explore their participation in partnership with clients.

York University

http://www.atkinson.yorku.ca/frschnurs.htm

Client-Centred Care (AK/NURS 3790B)

This course is an elective 3000-level course in the BScN program. It examines the emerging paradigm of client-centred care in light of the prevailing bio-medical paradigm of health care. Students explore how health care "cultures" are reflected in practice with clients (whether individuals, families, groups, or communities). The premise is that the norms, values, and world view of the dominant paradigm, and the power relations that sustain it, largely shape the delivery of care and services in health care organizations. The bio-medical "culture" is deeply embedded, but it is increasingly being challenged by an emerging, client-centred paradigm, in which clients are recognized and respected as the leaders of their care.

(This course is modeled after one developed by G. Mitchell, RN, PhD, Chief Nursing Officer, Sunnybrook and Women's College Health Sciences Centre)

Health and Healing III: Living Client-Centred Care (AK/NURS 4130)

This 4000-level course will be added to York's collaborative BScN program in the winter semester of 2003. The above course will continue to be offered as an elective in the post-RN program. The course examines and enacts the emerging paradigm of client-centred care, in which clients are respected as the leaders of their care. It integrates the human science perspective that is basic to the mission and philosophy of the School of Nursing in nursing praxis in complex care situations. Nursing theory informs the construction and interpretation of client centred approaches to care. Students experience and critique how healthcare cultures are reflected in practice with individuals and families. The course is visionary in that it reflects societal trends and the recommendations of official agencies and emphasizes the unique role of nursing in complex care.

Sunnybrook and Women's College Health Sciences Centre

Sunnybrook Campus, Toronto

Client Centred Care – "Finding the Way"

This program includes a video and handbook designed to facilitate the teaching and learning process of client centred care.

Contact: Donna Empacher
416-480-6100 ext. 5995

Health Care Design Action Kit

http://www.healthdesign.org/actionkit.html

A set of tools that helps designers and healthcare leaders:

- Understand what patients want from the built environment
- Enhance the design process through consumer involvement
- Build patient-centred environments
- Improve design quality and consumer satisfaction

Initiated by The Center for Health Design and developed by The Picker Institute, this research-based kit includes several assessment tools and a recommended strategy to help designers and healthcare leaders incorporate patients' and families' perspectives into the hospital building and design process.

The kit was created as a result of extensive research with patients and family members that helped identify what is important in the built environment and why such things are important to them. The patient-centred tools include:

- 18-minute video, *Enhancing the Quality of Health Care with the Built Environment: Through the Patient's Eyes — Acute Care*
- Patient-centred Environmental Checklist
- Patient Survey
- Focus Group manual and Moderator's Guide

Videos

"Through the Patient's Eyes"

The Picker Institute
1295 Boylston Street, Suite 100
Boston, Massachusetts
02215

"Through the Patient's Eyes" is a highly acclaimed video and companion to the best-selling book by the same title. The video focuses on the how patients view their care and treatment during hospital stays. "Through the Patient's Eyes" has aided institutions and clinicians in reinventing how they do business and deliver care. The video series covers eight dimensions of patients' experience: access to care, respect for patients' preferences, coordination of care, information and education, physical comfort, emotional support, involvement of family and friends, continuity and transition. This video was the Winner of a 1996 Telly Award for Medical video.

"Not My Home"

Deveaux-Babin Productions
1 Langley Avenue
Toronto, Ontario
M4K 1B4

This award-winning Canadian video production is a compelling look at life inside a nursing home. In candid interviews, nurses and aides discuss the demands of caring for residents in the face of tight schedules and minimal staffing. Residents discuss how the depersonalization of institutional living makes dealing with the basic problems of aging more trying, and their family members reveal the guilt they feel at not being able to provide the care their relative needs.

"Real Stories"

Deveaux-Babin Productions
1 Langley Avenue
Toronto, Ontario
M4K 1B4

Real Stories examines how older people are treated in the health care system. Among the five vignettes that make up the video you meet a widower from Sri Lanka who describes the last days of his wife's life in a hospital; an older woman with a speech difficulty tells us what it's like to be on the receiving end of a very busy home care visit, and an older male patient struggles to be allowed to have a say in the management of his own health. As each story unfolds one becomes aware how older men and women are often ignored by dedicated caregivers who work to heal the illness while often forgetting the person.

"Curtain Call"

Terra Nova Films
9848 South Winchester Avenue
Chicago, Illinois
60643

This video unfolds the real-life story of the clash of emotions between a mother who has had a stroke and her daughter as they struggle to find a balance between the daughter's concern for her safety and the mother's desire to make her own choices and live her own life. Curtain Call effectively and emotionally engages the viewer with questions of risk and protection, autonomy and independence, family dynamics, and the roles of caregivers as well as the broader questions of aging and meaning and the struggle for independence in later life.

"The Grief of Miscarriage"

Medical Education Consultants
P.O. Box 315, Station A
Richmond Hill, Ontario
L4C 4Y2

This video provides insight into the very personal experience of miscarriage on the individual and family. This look at grief and crisis experienced within the family is a powerful way of examining issues related to client centred care.

Movies

Popular movies are a unique tool that you might want to consider for bringing forward the values and beliefs of client centred care. The development panel has used segments of the following movies to illustrate these values and beliefs:

"Girl Interrupted"

drama

Set in the changing world of the late 1960s, "Girl Interrupted" is the searing true story of a young woman who finds herself at a renowned mental institution for troubled young women, where she must choose between the world of people who belong on the inside or the often difficult world of reality on the outside.

"Babe"

drama; family

Babe is a comic fable about not fitting in and the lengths to which an ordinary pig will go to find acceptance. This fanciful film follows the tale of Babe, a pig who defies destiny by daring to be different, by daring to be, of all things, a sheepdog.

"A Beautiful Mind"
historical psychodrama

A mathematical genius, John Forbes Nash, Jr. made an astonishing discovery early in life and stood on the brink of international acclaim. But his prodigious career was sidetracked by problems that would have broken many men. Nash, however, fought back. He had always been driven by his quest for one truly original idea and never lost sight of that dream. After many years of struggle, he triumphed over tragedy and literally changed the world. The film is inspired by events in the life of John Forbes Nash, Jr., and in part based on the biography A Beautiful Mind, by Sylvia Nasar.

"Nuts"
drama

A strong-willed, high-class prostitute has committed murder and her family and attorney want her to plead guilty by reason of insanity. She insists on holding on to her sanity and her lawyer must battle his own prejudice and her inexplicable belligerence to discover the truth.

Other Resources

Documentary

"On Our Own Terms: Moyers on Dying"
PBS

Bill Moyers goes from the bedsides of the dying to the front lines of a movement to improve end-of-life care in "On Our Own Terms: Moyers on Dying". Two years in production, this four-part, six-hour series crosses the country from hospitals to hospices to homes to capture some of the most intimate stories ever filmed and the most candid conversations ever shared with a television audience.

Play

"Handle with Care"

This docudrama is a series of vignettes in which the actors, breast cancer patients whose cancer has spread, confront the realities of daily life. That life now includes a diagnosis of cancer, unpleasant treatment, and uncertain outcome but also sadness, fear and awkwardness from friends and families who don't know what to say or do.

Appendix C: Recommended Readings

Ahmann, E. & Lawrence, J. (1999). Exploring language about families. *Pediatric Nursing, 25*(2), 221-224.

Baier, S. (1996). The view from bed number ten. *Healthcare Forum Journal, 39*(2), 60 – 71.

Buresh, B. & Gordon, S. (2000). *What nurses know and must communicate to the public*. Ottawa: Ontario. Canadian Nurses Association.

Davies, C. (1991). A dilemma called Ellen. *Canadian Nurse, 87*(7), 23-24.

Gage, M. (1994). The patient-driven interdisciplinary care plan. *Journal of Nursing Administration, 24*(4), 26-35.

Gary, J. A. (1978). The old have the right to be at risk. *Sunday Times,* London.

Gerteis, M., Edgman-Levitan, S., Walker, J., Stoke, D., Cleary, P., & Delbanco, T. (1993). What patients really want. *Health Management Quarterly, 15*(3), 2–6.

Gordon, S. (1994). Inside the patient-driven system. *Critical Care Nurse, 14*(3 Supp), 3-28.

Hayhoe, B. (1997). I have lived. *Journal of Emergency Nursing, 23*(2), 98.

Hewison, A. (1995). Power and language in a ward for the care of older people. *Nursing Times, 91*(21), 32-33.

Kelly, B. (1996). Speaking up: A moral obligation. *Nursing Forum, 31*(2), 31-34.

Kerfoot, K.M. & LeClair, C. (1991). Building a patient focused unit: The nurse manager's challenge. *Nursing Economics, 9*(6), 441-443.

Liaschenko, J. (1994). Making a bridge: The moral work with patients we do not like. *Journal of Palliative Care, 10*(3), 83-89.

Messner, R. L. (1993). What patients really want from their nurses. *American Journal of Nursing, 93*(8), 38-41.

Mitchell, G. (1992). Parse's theory and the multidisciplinary team: Clarifying scientific values. *Nursing Science Quarterly, 5*(3), 103-106.

Mitchell, G. (1994). The dignity of risk and the right to failure: One profile of patient focused care. *Perspectives, 18*(3), 10.

Mitchell, G. (1994). Looking beyond the disease to see the person. *Alzheimer's Alert, 10*(13), 1-2.

Mitchell, G. (2000). *A personal view of waiting: Opening doors to understanding. A profile for staff and volunteers*. Toronto, Ontario. Sunnybrook & Women's College Health Sciences Centre.

Mitchell, G., Closson, T., Coulis, N., Flint, F., & Gray, B. (2000). Patient-focused care and human becoming thought: Connecting the right stuff. *Nursing Science Quarterly, 13*(3), 216-224.

Nichols, M. (1995). *The lost art of listening: How learning to listen can improve relationships*. New York: The Guilford Press.

Young-Mason, J. (1997). *The patient's voice: Experiences of illness*. Philadelphia: F. A. Davis Company.

Appendix D: Documentation

Gage (1994) has identified the following principles of client centred documentation:

- Client focused versus discipline focused
- Interdisciplinary versus multidisciplinary
- Goal oriented versus problem oriented.

Keeping these principles in mind, client centred documentation should be structured in order to include:

Client's Concerns – The assessment of the client during the initial contact with the nurse, and on an ongoing basis, should include the identification of the client's concerns and issues.

Client's Desired Outcomes – Nurses need to explore and document the client's concerns, with a focus on what the client would consider to be the most appropriate outcome. These outcomes should not be measurable and time limited statements, but rather a reflection of the client's own words. Measurable outcome statements flow from the key step of ensuring the client's outcomes drive the care plan. Clients need to be encouraged to prioritize outcomes to ensure that their goals coordinate the care of the health care team.

Evaluation – Outcomes need to be identified in such a way as to ensure that the source of the outcome is clear. For example, an outcome may be set by the client, may be negotiated with the nurse, may be set by the nurse, or the family may take on the function of setting desired outcomes when the client is unable to participate. Effectiveness is measured from the individual client's perspective, not the perspective of the health care provider.

Documentation tools will need to be adapted to reflect the client population and the care setting. The following sample documentation form provides an example of how one organization has incorporated a client centred focus into their documentation system. This tool is one component of a client centred documentation system developed by the City of Hamilton Social and Public Health Services Department.

Client Worksheet

Client: _____ **Page #:** _____

Date/Time Signature	Contact	Listen	Dialogue	Action	Outcome

Used with permission. The City of Hamilton Social and Public Health Services Department. Healthy Lifestyles and Youth Branch. School Team.

Appendix E: Description of the Toolkit

Toolkit: Implementation of Clinical Practice Guidelines

Best practice guidelines can only be successfully implemented if there are: adequate planning, resources, organizational and administrative support as well as appropriate facilitation. In this light, RNAO, through a panel of nurses, researchers and administrators has developed a "Toolkit: Implementation of Clinical Practice Guidelines" based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of any clinical practice guideline in a health care organization.

The "Toolkit" provides step-by-step directions to individuals and groups involved in planning, coordinating and facilitating the guideline implementation. Specifically, the "Toolkit" addresses the following key steps:

1. Identifying a well-developed, evidence-based clinical practice guideline.
2. Identification, assessment and engagement of stakeholders.
3. Assessment of environmental readiness for guideline implementation.
4. Identifying and planning evidence-based implementation strategies.
5. Planning and implementing evaluation.
6. Identifying and securing required resources for implementation.

Implementing guidelines in practice that result in successful practice changes and positive clinical impact is a complex undertaking. The "Toolkit" is one key resource for managing this process.

The "Toolkit" is available through the Registered Nurses Association of Ontario. The document is available in a bound format for a nominal fee, and is also available free of charge off the RNAO website. For more information, an order form or to download the "Toolkit", please visit the RNAO website at www.rnao.org.

Appendix F: Summary of Values, Beliefs and Core Processes

Definition of Client Centred Care:

Client centred care is an approach in which clients are viewed as whole persons; it is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting clients' autonomy, voice, self-determination, and participation in decision-making.

Values and Beliefs of Client Centred Care include:

- Respect
- Human dignity
- Clients are experts for their own lives
- Clients as leaders
- Clients' goals coordinate care of the health care team
- Continuity and consistency of care and caregiver
- Timeliness
- Responsiveness and universal access

Core Processes of Client Centred Care include:

1. Identifying Concerns/Needs

The nurse can identify concerns/needs by asking questions such as:

- What is most important to you?
- What are your concerns?
- What are your goals?

2. Making Decisions

The client is the key decision-maker in planning care and services.
The nurse may ask:

- What is most important to you now?
- What do you think your options are?
- What would help you (……..)?

3. Caring and Service

When providing care and service involve the clients by:

- Acknowledging their expertise
- Building trust
- Respecting and valuing clients and their choices

4. Evaluating Outcomes

The nurse can evaluate outcomes by asking questions such as:

- How is the care you are receiving?
- What would help you?
- How was your care/service today?

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Nursing Best Practice Guideline

Shaping the future of Nursing

client centred care

supplement

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Supplement Integration

This supplement to the nursing best practice guideline *Client Centred Care* is the result of a three year scheduled revision of the guideline. Additional material has been provided in an attempt to provide the reader with current evidence to support practice. Similar to the original guideline publication, this document needs to be reviewed and applied, based on the specific needs of the organization or practice setting/environment, as well as the needs and wishes of the client. This supplement should be used in conjunction with the guideline as a tool to assist in decision making for individualized client care, as well as ensuring that appropriate structures and supports are in place to provide the best possible care.

The Client Centred Care guideline strongly reflects the principles of primary healthcare as stated by the World Health Organization at Alma-Ata 1978, (WHO, 2005) as listed below:

Accessibility – reasonable access to essential health services with no financial or geographic barriers.

Appropriate Technology – technology and modes of care should be based on health needs, and appropriately adapted to the community's social, economic and cultural development.

Community Participation – communities encouraged to participate in planning and decision making about their health.

Prevention and Health Promotion – health systems focus on helping people stay well rather than treating the ill.

Intersectoral Collaboration – professionals from various sectors work with community members to promote the health of the community.

In addition, The Coalition for Primary Healthcare has twelve principles as the foundation of reform which are reflected in the *Client Centred Care* guideline. These principles are as follows: ensure access to a wide range of comprehensive services; provide primary healthcare 24 hours a day, seven days a week; establish interdisciplinary group practices; service based on community need; primary healthcare must be not-for-profit; community boards; enrollment; funding; information management; coordination of care; rights, responsibilities, and accountability; and education (RNAO, 2005).

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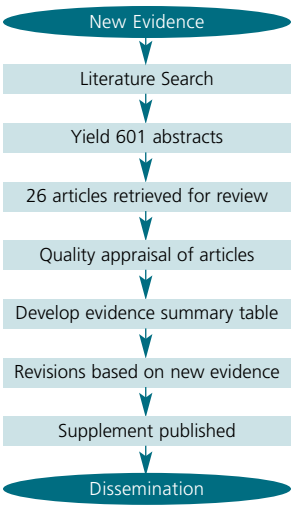
Revision Process

The Registered Nurses' Association of Ontario (RNAO) has made a commitment to ensure that this practice guideline is based on the best available evidence. In order to meet this commitment, a monitoring and revision process has been established for each guideline every three years. The revision panel members (experts from a variety of practice settings) are given a mandate to review the guideline focusing on the recommendations and the original scope of the guideline.



Definitions:

The following definitions are new or revised and are to be added to those in the "Definition of Terms" section starting on page 12 of the guideline.

Client Centred Care

An approach in which clients are viewed as whole; it is not merely about delivering services where the client is located. Client centred care involves advocacy, empowerment, and respecting the client's autonomy, voice, self-determination, and participation in decision-making.

Client Directed Care

In contrast to Client Centred Care, Client Directed Care is an approach to care delivery where clients are considered the brokers of care, and receive what they ask for.

Clinical and Interpersonal Competence (knowledge and skill)

This is the approach to care that combines the skill, knowledge and abilities of all team members (client and family included) through direct observation/interaction, allowing each to share and influence one another in the caring process of client centred care.

Clinical Knowledge

It is knowledge about the health/illness condition of a patient/client/community, and about ways to maintain or improve health and well-being. This type of systematic knowledge is based on evidence and is acquired and developed through professional education, experience and research (Grinspun, 2004).

Decision Coaching

Decision coaching is provided to clients by a trained facilitator who is supportive but neutral in the decision. Coaching can be provided face to face (individual, group) or using communication technologies (telephone, Internet). Decision coaching is used alone or in combination with patient decision aids. The strategies may include:

- monitoring decisional conflict (uncertainty about the course of action and related modifiable deficits in knowledge, values clarity and support);
- tailoring decision support to needs (e.g. facilitating access to evidence-based information, verifying understanding, clarifying values, building skills in deliberation, communication, and accessing support; and
- monitoring progress in decision making and decision quality.

The goal is to help clients improve the decision making process and decision quality (Greenfield, Kaplan & Ware, 1985; Kennedy et al., 2002; O'Connor, Jacobsen & Stacey., 2002; Stacey, Murray, Dunn & O'Connor, in press).

Decision Quality

The extent to which the chosen option best matches informed clients' values for benefits, harms, and scientific uncertainties (O'Connor et al., 2005; Sepucha, Fowler & Mulley, 2004).

Family Centred Care

Generally indicates an approach to care in which the family is viewed as the unit of care, rather than just the identified patient. This approach is consistent with a client centred approach when each individual's meaning of "family" is respected and families are viewed as an integral whole.

Interactional Knowledge

It is knowledge about ways of relating with an individual, group, or community. It includes interactions that are verbal and non-verbal (i.e, gaze, posture, tone of voice and demeanour); that are purposeful and constructive; where there is a sincere desire to connect or engage with the others; and whose intent is to enable others to be leaders of their journey (Grinspun, 2004).

Patient Decision Aid

Patient decision aids are evidence-based tools designed to prepare clients to participate in making specific and deliberative choices among healthcare options in ways they prefer. Patient decision aids supplement (not replace) clinician's counseling about options. These tools aid decision making by:

a) providing evidence-based information about a health condition, the options, associated benefits, harms, probabilities, and scientific uncertainties;
b) helping clients recognize the values-sensitive nature of the decision and clarify the value they place on the benefits, harms, and scientific uncertainties. Strategies include: describing the options in enough detail that clients can imagine what it is like to experience the physical, emotional, and social effects; and guiding clients to consider which benefits and harms are most important to them; and
c) providing structured guidance in the steps of decision making and communication of their informed values with others involved in the decision (e.g. clinician, family, friends).

The ultimate goal of patient decision aids is to improve the process of decision making and the decision quality (O'Connor et al., 2005; O'Connor, Llewelyn-Thomas & Flood, 2004).

Quality of Decision Making Process

The quality of the decision making process can be judged using certain criteria. There is evidence that the patient is helped to: a) recognize that a decision needs to be made; b) know about the available options and associated procedures, benefits, harms, probabilities, and scientific uncertainties; c) understand that values affect the decision; d) be clear about which features of the options matter most to them (e.g. benefits, harms, and scientific uncertainties); e) discuss values with their clinician(s); and f) become involved in decision making in ways they prefer (O'Connor et al., 2005 ; O'Connor et al., 2002).

Summary of Evidence

The following content reflects the changes made to the original publication (2002) based on the consensus of the review panel.

changed
✓ unchanged
\+ additional information

Recommendation 1

Nurses embrace the following values and beliefs: respect; human dignity; clients are experts for their own lives; clients as leaders; clients' goals coordinate care of the healthcare team; continuity and consistency of care and caregiver; timeliness; responsiveness and universal access to care. These values and beliefs must be incorporated into, and demonstrated throughout, every aspect of client care and services.

The wording of this recommendation has been revised for further clarification. The following paragraphs will be added on page 22 under 2e):

f) Provide Decision Support

Nurses have a unique role to play in partnering with clients facing health decisions. A client centred partnership means that nurses respect and advocate for clients – as experts in their own lives – to lead the healthcare team; while nurses – as professional experts – have a central role in providing/sharing clinical expertise to facilitate clients' decision making on areas where they need or want more information. This partnership aims at strengthening clients' ability to reach decisions that are well-informed and best for them (Grinspun, 2004).

The following content has been included from the work of Stacey, Murray, Dunn & O'Connor (In press).

- Involve clients in decision making in ways they prefer. The majority of Canadians want to be involved in health decisions (Magee, 2003; Martin, 2002; O'Connor et al., 2003). Participation to preferred level, rather than participation itself, results in improved outcomes (Gaston & Mitchell, 2005).
- Provide structured decision support to clients using patient decision aids and decision coaching. The following process is based on the Ottawa Decision Support Framework and has been evaluated in multiple studies (Murray, Miller, Fiset, O'Connor & Jacobsen, 2004; O'Connor et al., 1999; O'Connor et al., 2002; Stacey, O'Connor, Graham & Pomey, in press).
  - Assess decision and decisional conflict:
    i. Decision: Tell me about the decision you are facing.
    ii. Stage: How far along are you with making a choice?
    iii. Certainty: Do you feel sure about the best choice for you?
    iv. Knowledge: Do you know which options are available to you? Do you know both the benefits and risks of each option?
    v. Values: Are you clear about which benefits and risks matter most to you?
    vi. Support: What role do you prefer in making your choice? Do you have enough support and advice to make a choice? Are you choosing without pressure from others? Who else is involved?
  - Tailor decision support to needs:
    i. Uninformed: reinforce accurate knowledge; clarify misconceptions; provide facts; re-align expectations.
    ii. Unclear values: clarify what matters most to the client and facilitate the client sharing their values with others involved in the decision making.
    iii. Unsupported: Build skills/confidence in: decision making, management, communicating needs, accessing support/resources, handling pressure, implementing change.
  - Evaluate:
    i. decision quality (informed, realistic expectation, choice matches values/priorities) (O'Connor & Stacey, 2005; Ratliff et al., 1999; Sepucha et al., 2004).
    ii. actions (progresses in stage of decision making/change)

Additional Literature Supports

Anthony & Hudson-Barr, 2004; Cott, 2004; Ford, Schofield & Hope, 2003; Gaston & Mitchell, 2005; Grinspun, 2004; Joff, Manocchia, Weeks & Cleary, 2003; Lewin, Skea, Entwistle, Zwarenstein & Dick, 2005; Magee, 2003; Martin, 2002; Murray, Miller, Fiset, O'Connor & Jacobsen, 2004; O'Connor et al., 1999; O'Connor et al., 2002; O'Connor et al., 2003; O'Connor & Stacey, 2005; Ponte et al., 2003; Ratliff et al., 1999; Stacey, Murray, Dunn & O'Connor, 2006; Stacey, O'Connor, Graham & Pomey, in press ; Sepucha et al., 2004; Sumsiun, 2005

Recommendation 2

*Recommendation has been deleted and incorporated as a bullet under recommendation 5

Recommendation 3

The principles of client centred care should be included in the basic education of nurses in their core curriculum, be available as continuing education, be provided in orientation programs and be sustained through professional development opportunities in the organization. Organizations should engage all members of the healthcare team in this ongoing education process.

Additional Literature Supports

Bauman, Fardy & Harris, 2003; Cott, 2004; Lewin et al., 2005; Parley, 2001

Recommendation 4

To foster client centred care consistently throughout an organization, healthcare services must be organized and administered in ways that ensure that all caregivers, regardless of their personal attributes, enact this practice successfully. This includes opportunities to gain the necessary knowledge and skills to really engage with clients from their standpoint, as well as organizational models of care delivery that allow nurses and clients to develop continuous, uninterrupted, and meaningful relationships.

Additional Literature Supports

Bauman, Fardy & Harris, 2003; Cott, 2004; Jonas & Chez, 2004; Lewin et al., 2005; Parley, 2001

Recommendation 5

Nursing best practice guidelines can be successfully implemented only where there are adequate planning, resources, organizational and administrative support, as well as appropriate facilitation. Organizations may wish to develop a plan for implementation that includes:

- Board and senior management understanding and support.
- An assessment of organizational readiness and barriers to education.
- Community involvement (whether in a direct or indirect supportive function) who will contribute to the implementation process.
- Ongoing opportunities for discussion and education to reinforce the importance of best practices.
- Opportunities for reflection on personal and organizational experience in implementing guidelines.
- Initial and sustained financial support.
- Members of the public.

In this regard, RNAO (through a panel of nurses, researchers and administrators) has developed the *"Toolkit: Implementation of Clinical Practice Guidelines"*, based on available evidence, theoretical perspectives and consensus. The Toolkit is recommended for guiding the implementation of the RNAO nursing best practice guideline on Client Centred Care.

* Deleted recommendation 2 has been incorporated as a bullet above.

The wording of this recommendation has been revised to incorporate the deleted recommendation 2 as a bullet and to further expand on key resource and planning areas.

Additional Literature Supports

Cott, 2004; Chin, 2004; Kuokkanen & Katajisto, 2003; McCormack, 2003; Nelligan, Grinspun, Jonas-Simpson, McConnell, Peter, Pilkington et al., 2002; Ponte et al., 2003

Implementation Strategies

The evidence continues to support the recommendations identified with the addition of some new understanding of the successes and challenges faced during implementation. The initial pilot of the guideline in 5 organizations reaffirmed the importance of adopting all recommendations. Successful client centred care not only requires nurses to embrace the values and beliefs of client centered care but they need to do so in conjunction with the other professional team members and with the organizational support of appropriate policies and procedures.

Client centred care requires:

- a shift in organizational focus to remove 'power' barriers;
- inclusion of practice structures that allow for the sharing of power;
- advocacy within the power structures that exist; and
- placement of patient and family needs at the center of the entire health team and healthcare delivery system.

Adequate and continual training and resources to support the adoption of client centered practices are paramount (refer to figure A). Rigid hospital system schedules, lack of supportive documentation tools, inadequate time to educate and care for self can create barriers to successful implementation (refer to figure B). Procedures put in place previously may need to be challenged and assessed against the best practice recommendations for client centred care. Client centred care is a joint responsibility of the individual nurse and other healthcare providers and the organization in which practitioners work.

Additional Literature Supports

Chin, 2004; ; Kuokkanen & Katajisto, 2003; Spence Laschinger, Finegan, Shamian & Piotr, 2001; Worthley, 1997

Research Gaps & Implications

In reviewing the evidence for the revision of this guideline, several gaps in the research have been identified. These gaps include:

- A need to evaluate the impact that a client centred care approach has in decreasing complications and readmissions, and assisting in readiness for discharge.
- A need to evaluate the impact that a supportive client centred organizational environment can have on client outcomes.
- A need to evaluate the contribution of clients in the provision of care and its effects on quality of care.

In addition to the tips mentioned above, RNAO has published implementation resources that are available on the website. A *Toolkit* for implementing guidelines can be helpful, if used appropriately. It is available for free download at www.rnao.org/bestpractices.

Figure A

Success Factors for Client Centred Care

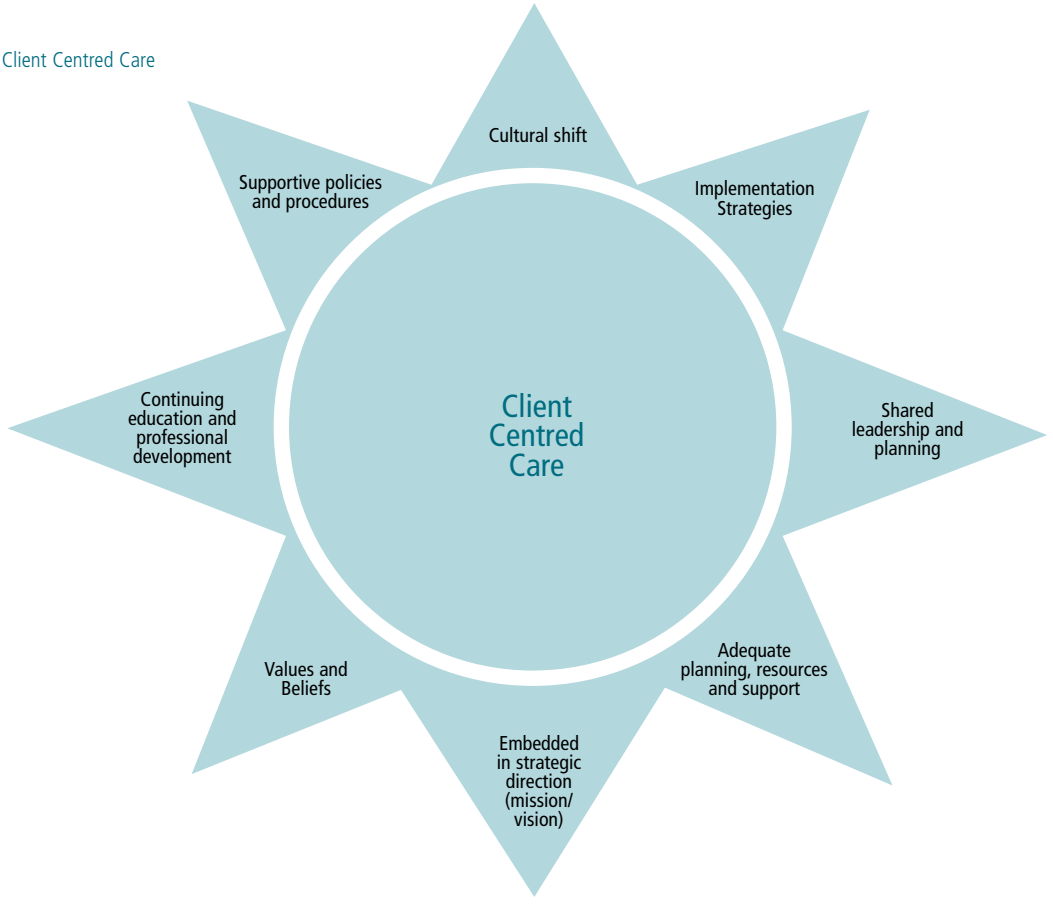
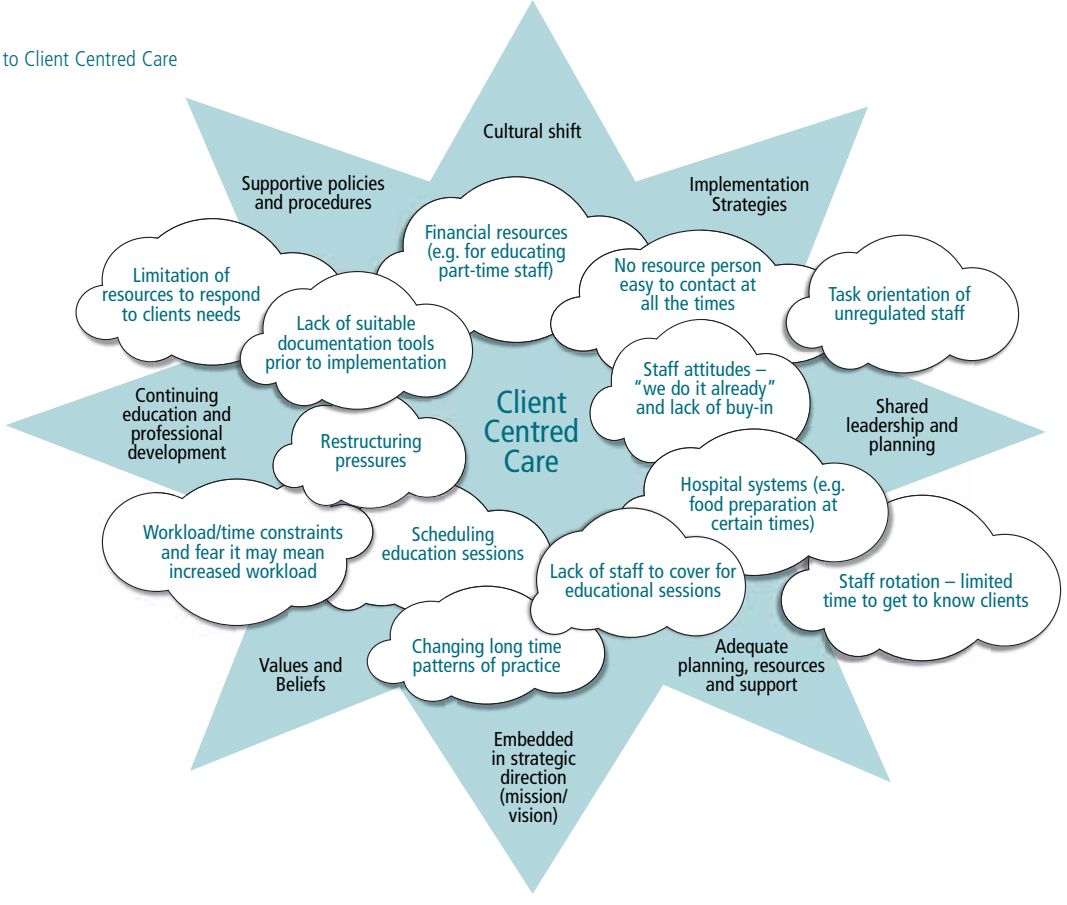


Figure B

Challenges/Barriers to Client Centred Care



The following case studies are included as additional content in appendix A2 on page 60.

Case Study – Scenario 1 (York University, Toronto, Ontario: NURS 4130 6.0- Living Client Centred Care in Complex Care)

Tony is a teenager who has recently been diagnosed with schizophrenia. He has been told by his physician that he will need to take neuroleptic medications for the rest of his life. He has been hospitalized twice in the past six months. Tony would like to eventually reduce the amount of medication that he is taking as he finds the side effects interfere with his life. He tells the nurse that they make him feel like he is losing himself. His parents insist that he will stay on the medication and they are also adamant about his need for ongoing psychotherapy. One day in the hall, Tony's father tells the nurse that he hopes that one day Tony will be cured. Later that same day, Tony tells the nurse that he feels like his hopes and dreams have been shattered. During this admission, Tony has begun to isolate himself from others and has also begun to refuse attendance at any of his group activities. Many of his friends from school who had visited Tony many times during his first admission have now stopped seeing him.

You have been assigned to be Tony's primary nurse. Describe your nursing care. In particular, how would you enact the relevant values, beliefs, and core processes of client centred care with Tony and his family? Provide rationales for your approach and actions.

Additional Related Readings:

Ahmann, E., & Lawrence, J. (1999). Exploring language about families. Pediatric Nursing, 25(2), 221-224.

Deegan, P. E. (1993). Recovering our sense of value after being labeled. Journal of Psychosocial Nursing and Mental Health Services, 31(4), 7-11.

Case Study – Scenario 2 (York University, Toronto, Ontario: NURS 4130 6.0- Living Client Centred Care in Complex Care)

You have been caring for Mr. C. (age 60) in the Intensive Care Unit since his admission two weeks ago, after he sustained a head injury and multiple fractures in a fall from the second story of his house. Meantime, you have gotten to know Mrs. C very well. She has shared that she feels guilty because she had asked her husband to clean the leaves off the roof and that's when he fell. The physicians have just spoken to Mr. C's family about discontinuing life support, because of his poor prognosis. You are in Mr. C's room, along with Mrs. C, their son, Robert, and his long-time, same-sex partner, Sam. Suddenly, Mrs. C starts yelling at her husband to get up. Robert angrily tells her that it's all her fault this has happened. Sam tells him to leave her alone. He adds that that he doesn't believe the doctors have tried hard enough for Mr. C and that they should not agree to the withdrawal of life support.

Discuss how the readings about families and the RNAO best practice guideline on *Client Centred Care* would guide you to think about this situation. Also, describe how you would respond, with rationales.

Additional Related Readings:

Ahmann, E., & Lawrence., J. (1999) Exploring language about families. Pediatric Nursing, 25(2), 221-224.

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