A systematic review on implementation of person-centered care interventions for older people in out-of-hospital settings

Citation for the original published paper (version of record):
Ebrahimi, Z., Patel, H., Wijk, H. et al (2021). A systematic review on implementation of person-centered care interventions for older people in out-of-hospital settings. Geriatric Nursing, 42(1): 213-224.
http://dx.doi.org/10.1016/j.gerinurse.2020.08.004

Geriatric Nursing 000 (2020) 1–12

Contents lists available at ScienceDirect

Geriatric Nursing

journal homepage: www.gnjournal.com

A systematic review on implementation of person-centered care interventions for older people in out-of-hospital settings

Zahra Ebrahimi, PhD, RN[a,b,1,*], Harshida Patel, RN, PhD[a], Helle Wijk, PhD, RN[a,c], Inger Ekman, RN, PhD[a,b], Patricia Olaya-Contreras, RN, PhD[a]

[a] Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden
[b] Centre for Person-Centred Care University of Gothenburg (GPCC), Gothenburg, Sweden
[c] Chalmers University of Technology, Department of Architecture Sahlgrenska University Hospital Department of Quality Assurance and Patient Safety, Sweden

ARTICLE INFO

Article history:
Received 20 May 2020
Received in revised form 12 August 2020
Accepted 13 August 2020
Available online xxx

Keywords:
Person-centered care
person-centred care
Patient-centered care
Client-centered care
Older person
Older people
Community care
Long term care

ABSTRACT

The purpose: of this study was to explore the content and essential components of implemented person-centered care in the out-of-hospital context for older people (65+).
Method: A systematic review was conducted, searching for published research in electronic databases: PubMed, CINAHL, Scopus, PsycInfo, Web of Science and Embase between 2017 and 2019. Original studies with both qualitative and quantitative methods were included and assessed according to the quality assessment tools EPHPP and CASP. The review was limited to studies published in English, Swedish, Danish, Norwegian and Spanish.
Results: In total, 63 original articles were included from 1772 hits. The results of the final synthesis revealed the following four interrelated themes, which are crucial for implementing person-centered care: (1) Knowing and confirming the patient as a whole person; (2) Co-creating a tailored personal health plan; (3) Interprofessional teamwork and collaboration with and for the older person and his/her relatives; and (4) Building a person-centered foundation.
Conclusion: Approaching an interpersonal and inter-professional teamwork and consultation with focus on preventive and health promoting actions is a crucial prerequisite to co-create optimal health care practice with and for older people and their relatives in their unique context.

Introduction

Ageing population

As a result of the ageing population and its consequences for aged care systems, the provision of cost-effective, high-quality care of older people has been established as one of the major challenges.[1] To cope with this demographic change, elderly care continues to be a key priority for government and institutions.[2] Person-centered care (PCC) can be an approach to meeting these aims but there is no agreed-upon consensus for delivering such care.[3]

In the present paper, the concept 'PCC' is used as an umbrella term to cover all of the different terms used to convey the same meaning, such as 'person-centered practice', 'client-centered care', 'resident-focused care', etc.

Person-centered care

PCC is a concept that involves meeting the multidimensional needs and preferences of older people dependent on care, by acknowledging the carers as well as the family — taking into account each individual's needs, goals, and abilities.[4–7]

PCC focuses on the whole person and involves shared decision-making as well as better communication between health care professionals and patients.[8,9] PCC reflects principles of philosophy and ethics, based on mutuality and respect.[4] PCC is increasingly emphasized in aged care policies and national guidelines to promote health in old age across Scandinavia, Europe, the US, Australia and beyond.[1]

Although PCC has a long established tradition in nursing, the awareness of this approach has increased over the past few years, with the aim being to improve patient-related outcomes. Even though there is an overall consensus about the relevance of a person-

*Corresponding author at: Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden
E-mail address: zahra.ebrahimi@gu.se (Z. Ebrahimi).
[1] Present/permanent address. Arvid Wallgrensbacke 1, Box 457 SE 405 30 Gothenburg, Sweden.

https://doi.org/10.1016/j.gerinurse.2020.08.004
0197-4572/$ – see front matter

centered perspective, translation of the PCC framework into practice is needed.[5,10–14] This is particularly true in aged care facilities, where the coexistence of disability, cognitive decline, and chronic conditions, often framed as frailty, challenge older people's everyday life and the provision of care. There seems to be a relationship between person-centeredness, the residents' ability to perform activities of daily living, and residents' quality of life.[15]

Person-centered care – multidimensional and the area for no consensus

Across health systems and settings, PCC still lacks an agreed-upon definition. As a concept, PCC is linked to, e.g., "patient-centered care" in the USA,[16] "understanding the patient as a unique human being" in the UK,[17,18] and "partnership with the person" in Sweden.[4] Published studies use a range of terms, for example, "personally tailored activities" in care of people with dementia;[19] "people-centered care on a group level" by WHO;[20] "Patient-centered medicine",[18] which is more commonly associated with the acute and hospital setting;[21] "patient (and family)–centered care"; "relationship-centered care"; and "personalized care planning".[22] Client-centered care is more prominent in the North American residential and nursing home setting,[16,17,23] and there is inconsistent use of PCC.[7,24,25] Person-directed care is considered in long-term care policies and guidelines in a number of countries in Europe, North America, and the Pacific Rim.[1,26] There is evidence that involving patients in decision-making about their own care leads to improved quality of health care and improved health outcomes.[27–29] In addition, regarding the use of different interventions in different combinations (e.g., patient-clinician communication, shared decision-making, or self-management support), another limitation and hurdle in PCC interventions is the inability to combine the results of varied interventions, surveys and outcome measures across studies.[22,30]

Many studies and reports discuss the effectiveness of PCC; however, in the absence of consensus on crucial components of PCC, the authors only express the relative success of the different interventions and measures that have been chosen to represent PCC. Although the involvement of patients as partners in PCC has been identified as a common component, the authors in a meta-review noted difficulties in establishing clear results.[31]

Another comprehensive synthesis of evidence —from 72 review papers with 20 meta-analyses regarding service models that optimize quality of life in older people— identified two overarching classifications of service models, although each had different target outcomes: Integrated Geriatric Care, emphasizing physical function, and Integrated Palliative Care, focusing mainly on symptoms and concerns. Areas of synergy across the overarching classifications included PCC, education, and a multi-professional workforce.[32] By contrast, a synthesis of reviews found similarities between the concepts of person- and patient-centeredness.[33] The analysis revealed differences in the goals of these two concepts — namely, a meaningful life for PCC and a functional life in the case of patient-centered care.

However, in order to gain a deeper understanding of person-centeredness, we chose to refer to the work of the philosopher Paul Ricœur, who describes a person beyond the one-sidedness of "either or", and rather as a complex, intertwined and united "ipse" (who) and "idem" (what).[34] Ricœur is one of the philosophers who has —through dialogical thinking— tried to build a bridge between the two worlds of science (culture and nature) and thereby redefine science. Therefore, we have selected Ricœur's ethics namely "aiming at the 'good life' with and for others, in just institutions" as a theoretical frame of reference in the current review.[35]

Person-centered care in the hospital setting

PCC has been implemented and explored with regard to the integration of communication and shared decision-making in care for people with cancer;[36] in the context of perioperative nursing;[37] and self-management support in long-term conditions across settings;[38] as well as PCC as a concept of time,[39] reconciling conceptualizations of the body,[40] and space.[41] Researchers affiliated to Centre for Person-Centred Care University of Gothenburg (GPCC) have evaluated PCC in patients with different diagnoses and conditions.[42] For example, patients hospitalized with chronic heart failure, who were treated in line with PCC showed a shorter duration of hospital stay,[29] a better discharge process[43] and a reduction in patients' uncertainty about their disease and its treatment.[44] A reduction in health care costs and maintained functional performance was also found,[45] and after an event of acute coronary syndrome,[38,46] significantly higher self-efficacy was found in patients with an education below university level when PCC was followed, which indicates that person-centeredness does not only support equal access to care, but also actively contributes to reducing social inequality in health care.[38,47]

Person-centered care in the out-of-hospital setting

The importance of viewing health from the standpoint of functional, cognitive and social disability dimensions is critical in out-of-hospital settings.[48] PCC has been implemented in out-of-hospital settings, such as —for example— maintaining personhood in care for people with dementia,[21,49] as a means of overcoming institutionalization, dependency, and depression.[15,26,50–56] The complexity of the interventions and range of outcomes examined in the studies makes it difficult to draw accurate conclusions about the impact of the PCC interventions adopted and implemented in aged-care facilities.

A systematic review[57] evaluating the evidence of PCC interventions with aged-care residents and nursing staff found that studies incorporated a range of different outcome measures to evaluate the impact of PCC interventions on these two groups. Only two studies in a Cochrane review described their PCC interventions to be multidisciplinary and goal-directed.[58] Structural conditions and the balance between organizational policies and client autonomy has been shown to be challenging in the out-of-hospital setting,[59] but staff education has been shown to increase both residents' well-being and staff satisfaction.[60] These studies represent different PCC models to guide person-centered practice in long-term care settings, while McCormack's theory on person-centered practice is one of the most commonly used as a framework in several studies focusing on PCC in elderly care. The cornerstones of this theory are: "(1) being in relation; (2) being in a social world; (3) being in place; and 4) being with self " (11). Being in relation and in a social world emphasizes the importance of relationships and being interconnected with one's social world. Being in place recognizes the impact of the surroundings and the values one holds about one's life and how it makes sense, which has also been emphasized by Edvardsson and co-workers in their research.[61] A systematic literature review based on 132 studies on older adults with chronic conditions identified 15 descriptions of PCC — addressing 17 central principles or values. Although multiple definitions and elements of PCC abound —with many commonalities and some overlap— the field would benefit from a consensus on essential components to clarify how to operationalize PCC in health care and services for older people.[6] There is a great need for PCC approaches for older people in the out-of-hospital setting.[62] Hence, agreement on the crucial components of PCC is essential for researchers and clinicians to guide PCC development and implementation.

Objectives

This paper aims to explore the content and essential components of person-centered care implemented in the out-of-hospital setting for older people (65+). The following research questions guided the search:

1. What is the content/mode of PCC in care for older people implemented in the out-of-hospital setting?
2. What components are crucial in person-centered care in the out-of-hospital setting?

Material and method

This systematic review was conducted and reported according to the Preferred Reporting Items for Systematic Reviews and Meta Analyses (PRISMA) guidelines.[63]

Search strategy

A comprehensive literature search was conducted using six electronic databases related to health care: PubMed, CINAHL, Scopus, PsycInfo, Web of Science and Embase. The searches —for research articles published from 1997 to 2019— were carried out between July 2017 and December 2019. The search databases and search terms used to identify relevant articles for this review are shown in Table 1. The same search terms, strategy and limiters used with PubMed were adopted for other databases. The searches were carried out on several occasions, the first of which was in July 2017. Two additional searches were conducted in October and December 2019 to update with newly published articles, including the articles that described person-centered care as person-centered approach or practice. See the search terms for the initial search in Table 1.

Eligibility/Inclusion and Exclusion Criteria

Papers were included if they were intervention and/or implementation studies of PCC regarding older people (65+) in the out-of-hospital setting. The studies were published in English, Swedish, Danish, Norwegian and Spanish between 1997 and 2019. Only original, peer-reviewed studies were included. Study protocols, instrument evaluation studies and review articles were all excluded. See Fig. 1 for a flow chart outlining the procedure for the selection of studies.

Screening and data extraction

All database searches were conducted by the first author (ZE) assisted by an experienced university librarian. The hits were imported to Rayyan (a screening program) during the reviewing process. In Rayyan, an independent, blind screening of the abstracts was performed by the researchers (ZE, HP, POC). During the screening process, any difference of opinion was discussed by the researchers. A senior researcher (HW) screened any remaining articles considered borderline for inclusion. A total of 63 articles were included for quality assessment and analysis. The process of extracting data was conducted by 3 researchers (ZE, HP, POC) working independently. The key information in these studies was extracted and tabulated in Table A1 (see Appendix).

Quality assessment

The Effective Public Health Practice Project Quality Assessment (EPHPP)[64] was selected to assess the methodological quality of the quantitative studies. This tool includes components of study design and methods including selection and allocation bias, study design, confounding, blinding, data collection methods, and withdrawals. An overall quality rating was assigned to each article: if no weak ratings were given, the quality of the article was estimated to be "strong," one weak rating categorized the article as "moderate". The quality in qualitative studies was assessed using the Critical Appraisal Skills Programme (CASP) Qualitative checklist,[65] which consists of 10 questions assessing different aspects of quality in qualitative studies. No article was excluded in this step. All of the included articles were considered to be of good quality —from moderate to high quality, besides two articles, that were assessed as weak.

Analysis

The quantitative data was analyzed by one of the authors (POC) using a deductive thematic analysis (Clark & Brown, 2017). The qualitative data was analyzed by the first author (ZE) through an inductive thematic content analysis,[66] according to the following steps. In the first step, all articles were read several times to build an overall understanding of the content. The meaning units were then identified, condensed and coded. Codes with similar content were put together to create a category. The last step was to interpret the common patterns of the categories in order to find the crucial components of person-centered care for older people in an out-of-hospital setting; the resulting crucial components are presented in five interrelated themes. Other authors (HW, HP, IE) independently reviewed

Table 1
Databases and search terms used for the initial search.

Database	Search terms
Pubmed	("Patient-Centered Care" or "patient-centered" OR "patient-centred" OR "person-centered" OR "person-centered" OR "resident-centered" OR "resident-centred" OR "client-centred" OR "client-centered" OR "patient-focused" or "individualized" OR "individualised" AND care) [Mesh])
And	("home care" or "home care services" or "home help" or "elderly care center" or "home help services" or "home care nursing" or "home health care" or "community setting care" or "home based care" or "care home residents" or "non- hospitalized care" or "non- hospitalized care" or "residential aged care" or "home and community based service" or "household care" or "household services" or "household help" or "hospital in the home" or "home health and services" or "home care agencies" or "homemaker services" or "housebound care" or "domiciliary care" or "in-home care" or "home social services" or "community care" or "community based services" or "community health nursing" or "homebound patient" or "health services for aged" or "eldercare services" or "municipal elder care" or "continuing care setting" or "aged care facilities" or "aged care residents" or "aged care services" or "housing for the elderly" or "nursing care facilities" or "long-term care facilities" or "old age home" or "nursing home" or "residential care facilities") [Mesh])
And	("older" or "older adults" or "elderly" or "elder" or "elders" or "older person" or "older people" or "oldest old" or "elderly people" or "geriatric patient" or "older patient" or "elderly care recipient" or "community dwelling patient") AND Humans [Mesh])
Limiters	Intervention, 1997–2017, Article [Publication type], article title and abstract
Cinahl	Same search terms and limiters used on Pubmed database
Scopus	Same search terms and limiters used on Pubmed database
PsycInfo	Same search terms and limiters used on Pubmed database
Web of Science	Same search terms and limiters used on Pubmed database
Embase	Same search terms and limiters used on Pubmed database

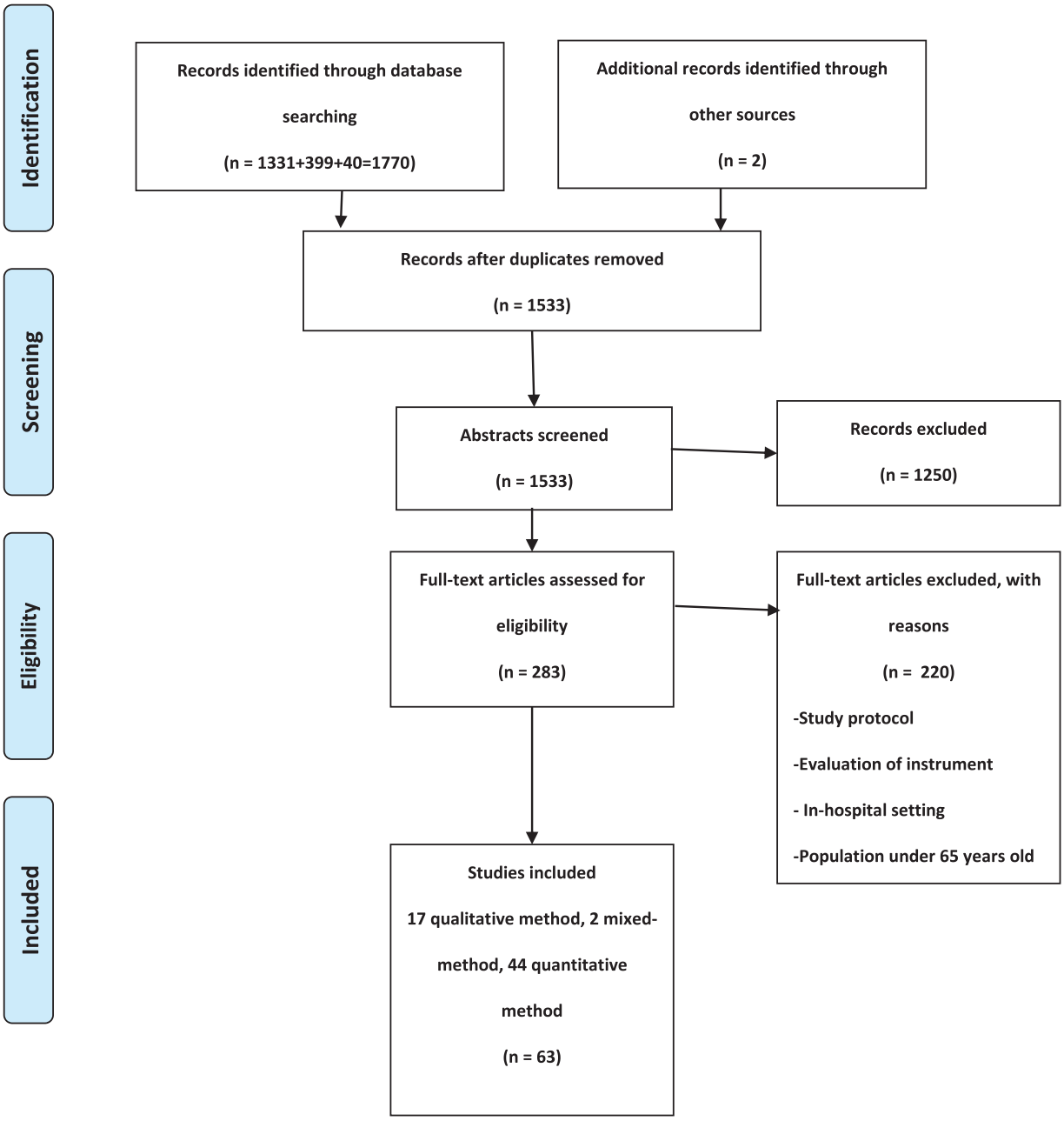

Fig. 1. Flow chart outlining the identification, screening, eligibility assessment and inclusion of studies.

the validity of the findings. The last step involved continual discussion between all authors to reach a consensus and synthesize the crucial components of PCC from the findings.

Results

A total of 63 original articles were included in the final analysis — 17 articles with qualitative methods, 2 articles with mixed-methods and the remaining 44 articles were studies using a quantitative method (sample size: 14–1042). The articles included varied widely in terms of the countries and settings. A total of 35 studies were from diverse countries around Europe, 20 studies were from USA and Canada, 4 studies were from New Zealand and Australia, and there were 4 studies from China, Japan, Taiwan and Korea. In total, 32 studies were conducted in nursing homes, and 31 studies took place in the ordinary home with either primary care or home care. For further details on the articles included, see Table A1 in the Appendix. An overview of the content, identified components and crucial components of implemented PCC is described in Table 2.

Key findings from quantitative data

The components of applied PCC for older people in the out-of-hospital context from a quantitative perspective is interpreted and presented in two themes and three sub-themes. Key findings from these studies showed that PCC was implemented through knowing, engaging and empowering the older people, their family, and staff. Furthermore partnership operationalized through mutual communication, trusting relationships and shared responsibility.

Table 2
An overview of the content and components of person-centered care (PCC) implementation.

Study design	Content/Mode of PCC implementation	Sub-themes/Identified components of implemented PCC	Themes/Crucial components of PCC
Quantitative	Advance Care Planning including the patient's storytelling approach, and approaches targeting residents with dementia including personal care Giving voice to the resident through storytelling and personal goal setting Engaging residents by Client/Community-centered approach. Interactive step-wise action research intervention	Knowing the person's needs, resources and preferences Goal setting through storytelling, shared power and responsibility	Advance care plan and goal setting through narratives, shared responsibility and decision-making
	Home-based programs addressing specific or multiple needs of residents with chronic health conditions A theory driven person-centered training intervention	Communication based on relationship, trust and respect	Mutual communication and trusting relationship between staff, the older person and his/her relatives
Qualitative	Tailor-made health/care plan Relation-based practice, role-play scenarios, drama-based education, attentive engagement and trusting relationship	Conducting a tailored personal health plan through relation-based approaches Knowing the older person as a whole	Conducting a tailored personal health plan through knowing and confirming the patient as a whole person
	Interdisciplinary team meeting and co-creating with the older people and their relatives Inter-professional teamwork and collaboration	Confirming the older person as part of the team Inter-professional consultation and co-creation	Inter-professional teamwork and consultation with and for the older person and his/her relatives
	Supporting self-care, assessing decision-making capacity, welcoming, safe, homely and a neat and clean environment, Supporting the older people and their relatives' engagement in care An ongoing critical reflective process Flexible leadership, professional friendship Being attentive to verbal and non-verbal cues, active listening, recognition, person-centered care plan documentation	Enhance the older person's capabilities, supporting preventive care and facilitating self-care Managing of competing values in the team by engagement, professional friendship and keeping distance, a flexible organization and situational leadership Appropriate person-centered communication skill and documentation	Building a flexible proactive foundation to strengthen the older person's capabilities and relatives' engagement in the person-centered co-creation process

Advance care plan and goal setting through narratives, shared responsibility and decision-making

Knowing the person's needs, resources and preferences

Knowing the older person and his/her needs, resources and preferences was emphasized as an essential component of PCC. For instance, the incorporation of pre-specified and discretionary in-person home visits was essential, as this afforded the opportunity to visually identify a wide range of home and personal safety needs (e.g., fall risk, clarifying prescribed medications, risk of wandering), as well as the physical condition of participants and study partners.[67–69] The personal care moment, interactive and step-wise increased the staff self-reported person centeredness and reduced their 'stress of conscience' by enabling them to provide the care and activities they wanted to provide.[70–73] Furthermore older people rated a person-centered environment as being in a hospitable, welcoming, safe, homely, neat and clean environment.[74] The multicomponent supportive care programs to care for people with dementia at home improved the ability to age in place; the dementia care coordination model with the Maximizing Independence (MIND) at Home reported significant reductions in unmet care needs related to safety.[67] These approaches represent an alternative to better prepare and interact with older people with dementia, addressing emotional and relational skills with PCC.[72,73,75] The approaches emphasized strategies such as reminiscence, closeness, and connectedness with older people for matching "at the moment capabilities" that helped the older people to respond positively to contact offered and improve wellness.[67,76–80]

Goal setting through storytelling, shared power and responsibility

Health care providers and organizations need to promote PCC by engaging people in partnership, i.e., shared decision-making and participation.[81,82] This was verified in a Swedish study with non-Swedish older people that focused on determining how they perceived leadership in the nursing home, while also focusing on the particular skills that staff chose as those required to lead PCC effectively and how this approach had or had not contributed to the level of the teamwork in the household.[83]

Shared power and responsibility were also observed when monitoring the quality of care involving both the older people and their families.[81] Engaging older people in an activity-oriented/goal program showed that the residents met their personal goals related to, for example, self-care.[84–87] It was confirmed that the process of personal goal setting was a strategy in and of itself for increasing motivation toward achievement of the goals.[84,88,89] The PCC further aimed to create encounters where participants support one another to make decisions in daily life to improve their overall health.[83] Engaging older people with these client-centered interventions that were tailored to meet the specific needs of the person aimed to increase basic activities of daily living, improve health-related quality of life, nutrition and mobility; decrease bodily pain; alleviate constipation; and prevent functional decline, depressed mood, and admissions to hospital for acute care.[69,84,87,90–92] A face-to-face motivational approach, along with the provision of information and advice by geriatrician and nurses to older people with chronic diseases who were being treated by polypharmacy, clarified prescribed medications and seemed to improve the level of medication taking.[93] The interventions meeting goals for preference fulfillment improved the quality of care and quality of life.[94] In addition, the preference for everyday living intervention showed "having regular contact with family" as an important priority. Having privacy, choice about what to eat, when to bathe, and activity options were also important preferences for most of residents.[94] However, other interventions such as the "Multimethod program", did not show the effectiveness of each single

intervention.[92] This is a good example of "one-size does not fit all".[95–97] Advance Care Planning —including the patient 'storytelling' approach that brings the focus back onto the person— encouraged the older people to communicate their preferences and mitigated their existential distress, in both older people with chronic conditions and, particularly, in those at the end of life.[82,94,98,99] The "On the Move" program focused on the timing and coordination of movements critical for preventing functional decline and disability without any increased risk to the older people. In this program, older people and stakeholders were involved in the design and execution of the study, and it was found that it is critical to build lasting relationships and that it was therefore important "to take the time to listen to and socialize with the resident."[82,89]

Mutual communication and trusting relationship between staff, the older person and his/her relatives

Communication based on relationship, trust and respect

Mutual communication characterized by trust and respect was found to be a cornerstone in all the interventions, and they were also dependent on the older person's cognitive function and the staff's skills in communicating with those who were cognitively impaired.[77,99] Some of the interventions focusing on reaching specific goals or needs of the older people did not appear to engage the staff in iterative communication where the patient could tell the story or improve his/her self-determination. These interventions did not give older people a voice to prioritize their goals.[96,100] Home-based programs addressed specific or multiple and varied needs of older people with chronic health conditions and have customized the specific services to the older people, leading to a positive effect on diverse outcomes such as an improvement in daily activities of life, nutritional status, incontinence, physical condition, or mood.[82,86,87,92,95–97,101–107] The exercise-based programs, i.e., task-specific exercises —focusing on, e.g., muscular strength, coordination and cognitive function— had a greater impact on older people with mild cognitive impairment than on those with moderate to severe cognitive impairment.[86,88] Exercise improved function in frail older people,[97] resulting in reduced depressive symptoms in older people with depression compared with usual care.[108] Trials of activity programs in the community have also yielded increases in activity levels but without improvement or changes in quality of life, self-management outcomes, or depression.[86,92,109,110] Person-centered training promoted interdependence, trust and reciprocity as a basis for older people with low cognitive function —and their families— to engage in a partnership with staff.[77,89,104,111] The individualized interaction between the older person and the staff helped older people with dementia to cope with their fears, agitation, aggressive behavior and isolation.[68,71,72,76,78,79,112] Additionally, individualized interactions involving the family and care assistant significantly improved positive interactive behavior of care-dependent older people with dementia.[73,76,78,81]

Key findings from qualitative data

The components of applied PCC for older people in the out-of-hospital context from a qualitative perspective is interpreted and presented in three interrelated themes and seven sub-themes. The key findings from these studies showed the importance of conducting a tailored personal health plan, knowing, confirming and empowering the older person in the team — in order to enhance the older person's capabilities, support preventive care and facilitate self-care through an inter-professional teamwork based on friendship and distance with and for older people.

Conducting a tailored personal health plan through knowing and confirming the patient as a whole person

Conducting a tailored personal health plan through relation-based approaches

Creating a tailored personal health plan was an essential component in implementing PCC.[111] Trusting relational practice and engagement to know the person as a whole[113] through respectful dialogue with the person and his/her relatives were among the other prerequisites for conducting the tailored care plan.[114] The dialogue with the older people was practiced by carefully listening to the older people's description and experiences of the illness and life situation, in order to get a better understanding of their needs, problems and wishes.[111] A nuanced care plan enabled the older people to have more control over their own life situation,[114] supported them in their daily routines and reinforced their capacities to self-manage.[111] Among the crucial prerequisites were the older people's narrative of their own experience,[115] attention to their bodily and existential needs,[116] involvement of the older person and their relatives in the planning of care,[117] and the sharing of information and decision-making via interdisciplinary team meetings.[111,114]

Knowing the older person as a whole

Creating a well-functioning relationship between the older people, their relatives and the staff was among the crucial components in developing PCC.[118] The professionals appreciated the relation-based practice, which raised their awareness of diversity in its broadest sense.[119] For example, role-play scenarios in drama-based education increased the practitioners' awareness, insight, patience and optimism with regard to supporting the older people with dementia in their strive towards an independent life.[114] The professionals realized that the older people are not a homogenous group and therefore "one size does not fit all".[119] Appreciating this made it possible to know every single person's reality, which was described as a more nuanced effort beyond culture, gender, race, and religion. Research indicates that embedding awareness of diversity in practice can be achieved through active listening and respectful communication.[119] Applying relation-based practice increased the professional's confidence and stimulated a behavioral change toward being less prejudicial of older people based on their associated stereotypes.[119] There was another point related to knowing the patient as a whole — that is, the intention to avoid reducing the patient to his/her disease/diagnosis. Furthermore, emphasis was placed on the significance of understanding the illness from the patient's perspective, giving spaces for the patient's voice and comprehending how the disease affects the patient's entire life situation.[99] The professionals underlined the importance of "all little things" that they expressed or did to confirm the older patient as a person.[119] For example, integrating the older person's life history into the conversations was among the efforts made to recognize the patient as an unique person.[120] However, knowing the older people with dementia as a person was challenging and depended on the professional's authentic engagement in establishing professional relational practice and discovering the person's life history, priorities and wishes.[121] The importance of shifting from a task-oriented approach to person-centered relational practice with the older person was underscored by professionals.[113]

Inter-professional teamwork and consultation with and for the older person and his/her relatives

Confirming the older person as part of the team

Partnership as a co-creation process was crucial in implementing person-centered teamwork, which was perceived as both a limiting and improving factor for change in individual behavior and organizational procedures and policies.[119] User-involvement was an intention that

was appreciated by the staff, and is one that requires a flexible approach, including spending sufficient time and having patience during the initial stage of an intervention.[122] This long-term process required a modification in the professional's attitudes and practice — a transition from "doing for" to "doing with"[122] and from "providing" to "co-creation".[119] A well-functioning interdisciplinary relationship and cooperation between the older people, their relatives and the staff[118] were among the crucial prerequisites to create a tailored care plan and to follow up on planned goals.[111,119] This minimized overlapping tasks but was perceived as time-consuming.[111] Continually adapting co-creation processes could increase users' awareness of their own potential for improved activities of daily life function through professional user meetings and the inclusion of dialogue with open-ended questions, active listening, and appreciation of users' views.[122]

Inter-professional consultation and co-creation

Older people's involvement in decision-making regarding their own care was another essential component in PCC, which required attentive engagement and a trusting relationship.[121] Frail older people appreciated their independence, and preferred taking their own decisions and finding solutions by themselves.[111] Mechanisms that support older people's involvement in decision-making include actions aimed at (i) increasing the older people's autonomy, control and privacy[123]; (ii) ensuring that they are taken seriously by health care professionals[111]; and (iii) providing appropriate information and patient education.[114,116] Establishing the basis for decision-making was challenging for health care professionals caring for people with dementia.[121] Having an inter-professional teamwork and consultation with the older people, their support networks and key relationship was essential to accurately interpret the person's needs and wishes and thereby involve the person in a meaningful decision-making process.[121] Furthermore, relation-based care of people with dementia was practiced through forging a friendship, sharing experience, developing trust and feeling appreciated, as well as taking time and making time.[124] Relational care through the shared experience of living with dementia connected and developed bonds with others and helped people to feel a sense of safety and equality, which led to development of trust and appreciation among community health care staff, people living with dementia, and family care partners.[124] In addition, factors such as having greater flexibility, staff education and developing skills to engage older people in decision-making were highlighted.[125] Studies emphasized the impact of the involvement of older people and their relatives in the creation of an education package to meet needs and take diversity into account,[126] building tailored care plans and sharing both information and decision-making by an interdisciplinary team.[111,116]

Building a flexible proactive foundation to strengthen the older persons' capabilities and relatives' engagement in the person-centered co-creation process

Enhancing the older person's capabilities, supporting preventive care and facilitating self-care

Another essential component of PCC was to support the older people in their self-care and enable them to remain independent.[111] Frail older people desired to remain independent; they preferred to take their own decisions and to find solutions by themselves in order to have more control over their daily lives.[111,127] Accessibility was another important aspect in self-care, which was described in the following terms: older people's access to transparent information about available services; the impact of such services on their health; how to navigate within the health care system; cultural and social factors that affect older people's acceptability; as well as autonomy and capacity to choose appropriate health care services. Furthermore, whether health care services are available and can be reached physically in a timely manner —together with the economic capacity of frail older people to spend their time and resources using health and social care services— were described as factors affecting accessibility.[127]

From the patient's point of view, a person-centered approach was characterized by: being taken seriously as a 'worthy' person by the health care professional with resources and capacities,[111,122] being part of the team,[119] being involved in decision-making,[121] being supported in self-care and maintaining independent lives.[111] PCC was described as a shifting focus from reactive care to proactive and preventive care,[113] supporting older people's connection to everyday life, which increased their feeling of well-being and enhanced their capabilities to be 'in charge of' their self-care.[111,116]

Managing of competing values in the team by engagement, professional friendship and keeping distance, a flexible organization and situational leadership

Competing priorities in clinical and organizational practice were perceived as a hindrance to the goal of achieving PCC; for instance, the conflict between safety and autonomy[117] — or, for example, being effective and working quickly according to old traditional practices competing with the time required to facilitate user's involvement.[122] Rules were discussed as an area of focus to avoid rigidity and improve flexibility in care plans. In addition, limited resources —particularly staffing— were commonly mentioned as a reason for lack of follow-through on the older person's goals.[117] Perceived conflicts between PCC and medical care were the most frequently reported source of arguments among physicians and nurse practitioners.[125] Supporting the resident's and their family's involvement in care planning through regularly scheduled care conferences, and informal engagement between residents or family members and staff in the form of an open door policy were emphasized. Furthermore, the importance of broad commitment across staff roles to the overarching principle of PCC was highlighted.[117] In post-acute care situations, the importance of health/medical goals over the older people's preferences needs to be explicitly documented in care planning in order to reduce doubt and perceived conflicts.[125]

Having a person-centered leadership, a flexible organization and an ongoing critical reflective process to facilitate person-centeredness among staff were among the most important prerequisites for implementing PCC.[128] Changing the focus from "doing" to "being" person-centered was stressed, as was building a functioning and integrated team through collaboration, open communication, appreciation and trust.[128] A person-centered foundation was characterized by a combination of developing culture and transformational leadership. In addition, the supportive organizational systems put in place to achieve these changes and the practitioners were open to learn from each other and there was a high level of interaction between older people and organizational management to enable practitioners to identify and resolve issues by themselves.[115]

Appropriate person-centered communication skill and documentation

The importance of appropriate person-centered communication was underscored.[120] Person-centered communication was characterized by four indicators: first, to recognize older people as each being a unique person by incorporating their life histories into conversation; second, to negotiate about older people's preferences, desires and needs by consulting them and their relatives; third, to facilitate older people's involvement in the conversation or action; and fourth, validation — which involves expressing and understanding the feelings of the older people with dementia.[120] The importance of communication and collaborative skills in motivating and stimulating older people to improve their self-management abilities and independence —such as listening and asking the right questions, understanding implicit messages, and providing feedback— was also

emphasized.[113] Additionally, allowing sufficient time, speaking clearly and directly, explaining the different options available, pausing to allow the person to process information and repeating information were among the professionals' communication skills and strategies designed to enable a person with dementia to be meaningfully involved in decision-making.[121] Furthermore, "listening to the other person with the heart" by being alert and giving the other person full attention[128] and also "being attentive to non-verbal cues" were among other important points regarding person-centered communication.[121] Providing PCC was experienced as a learning process that delivered opportunities for personal and professional growth; for instance, attentive listening was undervalued by the staff at the start of the intervention and was described as actually doing nothing, but staff members later realized that attentive listening was indeed "doing something".[113]

Building a trusting relationship by taking sufficient time, being attentive, and by keeping their promises[113] and confirming the individual as a person by calling him/her by name reinforced the sense of self.[120] Furthermore, creating a sociable atmosphere enhanced the sense of connectedness and partnership.[113] There were contexts in which missed opportunities for person-centered communication occurred; for instance: when the older person said something but the staff member ignored it and/or moved onto the next topic; when staff began and ended their interactions; when staff members told older people what to do without providing options or without inviting their help in completing the task; when staff did not ask for permission prior to performing an action; when staff members failed to acknowledge the older person's feelings, uncertainty, distress, discomfort, lack of confidence or self-deprecating emotions.[120]

Many nursing records were incomplete and information regarding psychosocial aspects of care was often lacking, despite the fact that value was placed on documentation of the person's involvement in the health care processes, shared decision-making and care plan.[129] The nursing documentation was not completed in partnership with the older people. Nevertheless, documentation focusing on the older person's beliefs and values was perceived as a factor promoting more meaningful relationships between nurses and older people.[129] Formulating and documenting a tailored personal care plan through interdisciplinary cooperation minimized the overlapping of tasks. Digitalization may avoid such task overlap, facilitate the exchange of data with other professionals, reduce time-consuming tasks, and increase interdisciplinary cooperation.[111]

Synthesis

A PCC perspective requires ethics as a basis for analysis and interpretation. Such an ethical view can briefly be formulated as follows: "Aiming at the good life with and for others, in just institutions".[34] In health care, a significant part of the complex biology of human beings can be readily explained. However, in the case of old, ill and dependent people, tracing biological weakness in order to cure the disease —or at least alleviate inconvenience— through relevant treatment and care is not enough. There is also a clear need for knowledge about health and human existential dimensions as well as good and ethical care. Ricœur is one of the philosophers who —through dialogical thinking— has tried to build a bridge between the two worlds of science (culture and nature) and helped to redefine science. Since PCC is based on an epistemology that includes these dimensions of the human being, we have used Ricœur's ethics as a theoretical frame of reference in this paper in an attempt to describe important components published in scientific journals on PCC in the care of older people.[35]

Accordingly, the components of PCC from both quantitative and qualitative findings have been interpreted and synthesized according to Ricœur's ethics.

Knowing and confirming the patient as a whole person and co-creating a tailored personal health plan

PCC is not a 'one-size-fits-all' model, but it is about achieving 'practical wisdom' based on an apparent action ethic. Furthermore, PCC is a relation-based approach, which is about being attentive to diversity, knowing and confirming the patient as a whole person, and it thus aims to achieve a nuanced, tailored personal health plan that reinforces the older person's internal and external capabilities in practice.

Inter-professional teamwork and collaboration with and for the older person and significant others

A person-centered inter-professional teamwork is characterized by efforts and processes that aim to include the patient as an equal person in the team and establish the basis for collaboration. Conducting a person-centered health plan involves "aiming at the good life with and for others" through a co-creation process between the professionals, the older person and often his/her relatives/significant others. These collaborative processes involve a professional friendship, mutual communication and ongoing shifting between closeness and distance. Neither the naturalistic objective- nor the humanistic subjective perspective alone can achieve person-centered practice. Hence, ongoing inter-professional team collaboration and co-creation between the inside and outside knowledge "with and for" the older person is essential for implementing PCC.

Building a person-centered foundation

Creating a person-centered foundation in all health care levels and processes is another crucial component, which —in practice— is a challenging ambition. Implementing PCC requires an appropriate "just institutions" foundation, where the opportunities of everyone (all staff, older people and their relatives) to take responsibility are reinforced, with the team members working in mutual respectful partnership, perceiving each other as experts and encouraging and improving each other's abilities. Confirming the older people as members of the team, knowing and supporting them with self-care, and endorsing their resources and capabilities are among the factors that create a proper foundation to implement PCC for older people. Other such factors include reinforcing their access to the health care system in an appropriate manner, time and place, and having a flexible organization based on trusting relationships and authentic engagement.

Discussion

Essential components for implementing PCC, which were confirmed in both the quantitative and the qualitative studies, included knowing the older patient as a person, building a relationship of trust, confirming and utilizing the person's resources, working in an inter-professional team with and for the older person, empowering the person and co-creating a tailored personal health plan with a focus on health promotion and preventive efforts and supporting the older person's opportunities for self-care.

Enhancing the person's capabilities and co-creation of an appropriate health plan with and for the older person were cornerstones for implementing PCC. However, some of the interventions focused on reaching specific goals or needs of the older people and did not involve mutual communication between the older people and the staff.[96,100] Furthermore, the majority of these interventions focused on varied needs and impairments of the older people with chronic health conditions and the customization of specific services to older people.[82,87,92,95,96,101] PCC should not only focus on the person's

needs and impairment, but also on his/her resources and abilities and, furthermore, the health plan should be created in collaboration with the older person — as well as with his/her relatives.[98]

Even though the target group in the present study were older people in general (65+), most of the included studies concerned people above 80 years. In 15 of the included studies, the participants were diagnosed with dementia in various stages from mild to moderate and severe, and in 32 studies the participants were living in nursing homes. It is well known that high age is a predictor for disability, frailty[130,131] and dementia[132,133] among the oldest old. However, it is likely that implementing the crucial components of PCC revealed from this review (see Table A1), will be valuable for all persons above 65 years including those with disability and cognitive impairment. For example using the life story approach enabled care staff to see and know the person behind the diagnosis and thereby to enhance PCC to the older persons and their families. It has also been shown to be more effective in preventing and managing behavioral and psychological symptoms of dementia.[134,135] Furthermore, implementing PCC in dementia care improved staff awareness and reduced stress. The interventions described increased positive affective (e.g., pleasure and alertness) and positive verbal and nonverbal behavior when involving residents in activities that they were likely to enjoy.[67,70,71,76–80,98]

Abilities and capabilities are defined and redefined in different contexts, based on one's physical and non-physical resources, as well as problems and obstacles in relation to the environment.[136] Frail older people face a constant challenge in creating harmony and balance in their everyday lives[137] despite comorbidity, disability and dependence. In this redefining process, person-centered team collaboration enables consultation between different professionals, supporting the frail older person to redefine themselves and their abilities in relation to the environment's resources and obstacles. A person-centered health plan should be created with and for the older person in the team. PCC based on an established and sustainable philosophy of ethics, originally conceived by Paul Ricœur, is an appropriate solution. Aiming at a good life with and for older people requires collaboration and partnership, where everyone's expertise and knowledge is appreciated and recognized. In the same way, the older person's experience of illness and well-being must be recognized and valued in all health and care processes.

Raising awareness of the value of the engagement and the conflicts that will be present in the creation of a person-centered team is essential for creating a person-centered foundation for care. The person-centered health plan is the 'practical wisdom' that is co-created through team collaboration and partnership in a just foundation, where interpretation conflicts between inside and outside perspectives will encourage each other and drive the health care system from fragmented, reactive and task-oriented efforts towards a person-centered, proactive and coherent continuum of health care processes with and for older people.

Strengths and Limitations

The complexity of PCC and a lack of consensus regarding the definition of 'person-centered' leading to a wide variation in the implementation of PCC were among the factors that were challenging in choosing relevant search terms for this review. For instance, for person-centered care within some disciplines —for example, occupational therapy— the word 'care' is not used; the terms 'person-centered practice' or 'person-centered approach' are employed. However, the search for relevant studies for this review was performed on three occasions. In the first search, the terms used were as per Table 1; in the second, we used the same search terms but replaced 'care' with 'practice' and 'approach'; and the third and final search was conducted to update the latest published studies. This approach may reduce the reproducibility of the searching process. However, the approach was unique in that it included a large range of definitions of person/patient/client-centered care/approaches and practice regarding older people in different communities, cultures and countries, which can also be considered a strength of this review.

Another strength of this review is that it includes studies that describe PCC from the point of view of older people, in addition to that of staff and stakeholders. Furthermore, the included studies have explored PCC from different perspectives — inter-personal and professional relationships, environmental considerations, the health care process and health care organization.

Another strength of this review is the application of a congruent ethic for approaching the review throughout all of the steps including choosing different search terms of PCC from diverse disciplines, including studies with qualitative and quantitative methods, and rigorous analysis of the data. Ricœur's ethic was also chosen to synthesize the results in order to confirm and stress the importance of dialectical movement between different views about science that describe PCC from both natural/objective and cultural/subjective perspectives.[35] This review emphasizes that, in order to understand and implement PCC, an intertwined web of sciences and knowledge is clearly required

Conclusion

Approaching interpersonal and inter-professional teamwork and consultation with a focus on preventive and health promoting actions is a crucial prerequisite to co-create optimal health care practice with and for older people and their relatives in their unique context. Awareness of the ethical basis of PCC facilitates the provision of genuine and collaborative care that is flexible and can be adapted by all health care professionals together with the older person and significant others.

Acknowledgement

Funding: This work was supported by The Swedish Research Council (grant number 2017-01230) and the Centre for Person-Centred Care at the University of Gothenburg, Sweden (GPCC) (date for approval 2019-11-01).

Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.gerinurse.2020.08.004.

References

1. Edvardsson D, Backman A, Bergland Å, Björk S, Bölenius K, Kirkevold M, et al. The Umeå ageing and health research programme (U-Age): Exploring person-centred care and health-promoting living conditions for an ageing population. *Nordic J Nurs Res*. 2016;36(3):168–174.
2. Brodsky J, Habib J, Hirschfeld M, Siegel B. Care of the frail elderly in developed and developing countries: the experience and the challenges. *Aging Clin Exp Res*. 2002;14(4):279–286.
3. The American Geriatrics Society Expert Panel on Person-Centered Care. Person-centered care: a definition and essential elements. *J Am Geriatr Soc*. 2016;64(1):15–18.
4. Ekman I, Swedberg K, Taft C, Lindseth A, Norberg A, Brink E, Carlsson J, Dahlin-Ivanoff S, Johansson IL, Kjellgren K, Lidén E, Öhlén J, Olsson L-E, Rosén H, Rydmark M, Stibrant Sunnerhagen K. Person-centered care — Ready for prime time. *Eur J Cardiovas Nurs*. 2011;10(2011):248–251.
5. McCormack B, McCance T. *Person-centred nursing: Theory and practice*. Wiley; 2010.
6. Kogan AC, Wilber K, Mosqueda L. Person-centered care for older adults with chronic conditions and functional impairment: a systematic literature review. *J Am Geriatr Soc*. 2016;64(1):e1–e7.
7. Lines LM, Lepore M, Wiener JM. Patient-centered, person-centered, and person-directed care: they are not the same. *Medical Care*. 2015;53(7):561–563.

8. Scholl I, Zill JM, Harter M, Dirmaier J. An integrative model of patient-centeredness - a systematic review and concept analysis. *PloS One*. 2014;9:(9) e107828.
9. NHS. *National Voices. A Narrative for Person-Centred Coordinated Care. Think Local Act Personal*. London, UK: NHS England; 2013.
10. Glasdam S, Henriksen N, Kjaer L, Praestegaard J. Client involvement in home care practice: a relational sociological perspective. *Nurs Inq*. 2013;20(4):329–340.
11. McCormack B. Person-centredness in gerontological nursing: an overview of the literature. *J Clin Nurs*. 2004;13(3a):31–38.
12. McCormack B, Dewing J, McCance T. Developing person-centred care: addressing contextual challenges through practice development. *Online J Issues Nurs*. 2011;16(2):3.
13. McCormack B, McCance TV. Development of a framework for person-centred nursing. *J Adv Nurs*. 2006;56(5):472–479.
14. Rahman AN, Applebaum RA, Schnelle JF, Simmons SF. Translating research into practice in nursing homes: can we close the gap? *The Gerontologist*. 2012;52 (5):597–606.
15. Sjogren K, Lindkvist M, Sandman PO, Zingmark K, Edvardsson D. Person-centredness and its association with resident well-being in dementia care units. *J Adv Nurs*. 2013;69(10):2196–2205.
16. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med*. 2000;51(7):1087–1110.
17. Institute of Medicine Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington DC: National Academy Press; 2001.
18. Balint E. The possibilities of patient-centered medicine. *J R College Gen Practi*. 1969;17(82):269–276.
19. Mohler R, Renom A, Renom H, Meyer G. Personally tailored activities for improving psychosocial outcomes for people with dementia in long-term care. *Cochr Database Syst Rev*. 2018;2: Cd009812.
20. Pacific WHOROftW. People-centred health care: a policy framework: Manila: WHO Regional Office for the Western Pacific; 2013. 20 p.
21. Edvardsson D, Innes A. Measuring person-centered care: a critical comparative review of published tools. *The Gerontologist*. 2010;50(6):834–846.
22. Coulter A, Entwistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. *Cochr Database Syst Rev*. 2015(3).
23. Brookman Cea. Client-Centred Care in the Canadian Home and Community Sector: A Review of Key Concepts: Saint Elizabeth; 2011.
24. Ballard C, Corbett A, Orrell M, Williams G, Moniz-Cook E, Romeo R, et al. Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *PLoS Med*. 2018;15:(2) e1002500.
25. Chen J, Mullins CD, Novak P, Thomas SB. Personalized strategies to activate and empower patients in health care and reduce health disparities. *Health Educ Behav*. 2016;43(1):25–34. the official publication of the Society for Public Health Education.
26. Scales K, Lepore M, Anderson RA, McConnell ES, Song Y, Kang B, et al. Person-directed care planning in nursing homes: resident, family, and staff perspectives. *J Appl Gerontol*. 2019;38(2):183–206. the official journal of the Southern Gerontological Society.
27. Simces Z.ARCHIVED-Exploring the Link between Public Involvement/Citizen Engagement and Quality Health Care: A Review and Analysis of the Current Literature Health Canada; 2003.
28. Pirhonen L OE, Fors A, Ekman I, Bolin K. Effects of person-centered care on health outcomes-A randomized controlled trial in patients with acute coronary syndrome. *Health Policy*. 2017;121(2):169–179.
29. Ekman I, Wolf A, Olsson LE, Taft C, Dudas K, Schaufelberger M, et al. Effects of person-centred care in patients with chronic heart failure: the PCC-HF study. *Eur Heart J*. 2012;33(9):1112–1119.
30. Rathert C, Wyrwich MD, Boren SA. Patient-centered care and outcomes: a systematic review of the literature. *Med Care Res Rev : MCRR*. 2013;70(4):351–379.
31. Olsson LE, Jakobsson Ung E, Swedberg K, Ekman I. Efficacy of person-centred care as an intervention in controlled trials - a systematic review. *J Clin Nurs*. 2013;22 (3-4):456–465.
32. Evans CJ, Ison L, Ellis-Smith C, Nicholson C, Costa A, Oluyase AO, et al. Service delivery models to maximize quality of life for older people at the end of life: a rapid review. *Milbank Q*. 2019;97(1):113–175.
33. Håkansson Eklund J, Holmström IK, Kumlin T, Kaminsky E, Skoglund K, Höglander J, et al. "Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient Educ Counsel*. 2019;102(1):3–11.
34. Ricoeur P. *Oneself as Another*. Adlibris: University of Chicago Press; 1994.
35. Kristensson Uggla B. *Homo Capax. Texter av Paul Ricoeur om etik och filosofisk antropologi i urval av Bengt Kristensson Uggla Göteborg*. Diadalos AB; 2011.
36. Street Jr. RL, Mazor KM, Arora NK. Assessing patient-centered communication in cancer care: measures for surveillance of communication outcomes. *J Oncol Pract*. 2016;12(12):1198–1202.
37. Arakelian E, Swenne CL, Lindberg S, Rudolfsson G, von Vogelsang AC. The meaning of person-centred care in the perioperative nursing context from the patient's perspective - an integrative review. *J Clin Nurs*. 2017;26(17-18):2527–2544.
38. Fors A, Ekman I, Taft C, Björkelund C, Frid K, Larsson MEH, et al. Person-centred care after acute coronary syndrome, from hospital to primary care — A randomised controlled trial. *Int J Cardiol*. 2015;187:693–699.
39. Rushton C, Nilsson A, Edvardsson D. Reconciling concepts of time and person-centred care of the older person with cognitive impairment in the acute care setting. *Nurs Philos Int J Healthcare Profess*. 2016;17(4):282–289.
40. Rushton C, Edvardsson D. Reconciling conceptualisations of the body and person-centred care of the older person with cognitive impairment in the acute care setting. *Nurs Philos Int J Healthcare Profess*. 2017;18(4).
41. Rushton C, Edvardsson D. Reconciling concepts of space and person-centred care of the older person with cognitive impairment in the acute care setting. *Nurs Philos Int J Healthcare Profess*. 2017;18(3).
42. Ekman I. The GPCC. *Eur Heart J*. 2018;39(7):495–496.
43. Ulin K, Olsson LE, Wolf A, Ekman I. Person-centred care - An approach that improves the discharge process. *Eur J Cardiovasc Nurs*. 2016;15(3):e19–e26.
44. Dudas K, Olsson LE, Wolf A, Swedberg K, Taft C, Schaufelberger M, et al. Uncertainty in illness among patients with chronic heart failure is less in person-centred care than in usual care. *Eur J Cardiovas Nurs : J Working Group Cardiovasc Nurs Eur Soc Cardiol*. 2013;12(6):521–528.
45. Brannstrom M, Boman K. Effects of person-centred and integrated chronic heart failure and palliative home care. PREFER: A randomized controlled study. *Eur J Heart Fail*. 2014;16(10):1142–1151.
46. Fors A, Swedberg K, Ulin K, Wolf A, Ekman I. Effects of person-centred care after an event of acute coronary syndrome: Two-year follow-up of a randomised controlled trial. *Int J Cardiol*. 2017;249:42–47.
47. Fors A, Taft C, Ulin K, Ekman I. Person-centred care improves self-efficacy to control symptoms after acute coronary syndrome: a randomized controlled trial. *Eur J Cardiovasc Nurs*. 2016;15(2):186–194.
48. Svalastog AL, Donev D, Jahren Kristoffersen N, Gajovic S. Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society. *Croatian Med J*. 2017;58(6):431–435.
49. National Institute for Health and Care Excellence. Dementia: assessment, management and support for people living with dementia and their carers: NICE guideline [NG97]June 2018.
50. Corazzini KN, Meyer J, McGilton KS, Scales K, McConnell ES, Anderson RA, et al. Person-centered nursing home care in the United States, United Kingdom, and Sweden: Why building cross-comparative capacity may help us radically rethink nursing home care and the role of the RN. *Nordic J Nurs Res*. 2016;36(2):59–61.
51. Schoberer D, Leino-Kilpi H, Breimaier HE, Halfens RJ, Lohrmann C. Educational interventions to empower nursing home residents: a systematic literature review. *Clin Intervent Aging*. 2016;11:1351–1363.
52. Sjogren K, Lindkvist M, Sandman PO, Zingmark K, Edvardsson D. Organisational and environmental characteristics of residential aged care units providing highly person-centred care: a cross sectional study. *BMC Nurs*. 2017;16:44.
53. Vikström S, Sandman P-O, Stenwall E, Boström A-M, Saarnio L, Kindblom K, et al. A model for implementing guidelines for person-centered care in a nursing home setting. *Int Psychogeriatr*. 2015;27(1):49–59.
54. Lepore M, Scales K, Anderson RA, Porter K, Thach T, McConnell E, et al. Person-directed care planning in nursing homes: a scoping review. *Int J Older People Nurs*. 2018;13(4):e12212.
55. Hill NL, Kolanowski AM, Milone-Nuzzo P, Yevchak A. Culture change models and resident health outcomes in long-term care. *J Nurs Scholarship*. 2011;43(1):30–40. an official publication of Sigma Theta Tau International Honor Society of Nursing.
56. Beech Roger, Ong Bie Nio, Jones Sue, Edwards V. Delivering person-centred holistic care for older people. *Qual Ageing Older Adults*. 2017;18(2):157–167.
57. Brownie S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities: a systematic review. *Clin Intervent Aging*. 2013;8:1–10.
58. Abraha I, Rimland JM, Lozano-Montoya I, Dell'Aquila G, Velez-Diaz-Pallares M, Trotta FM, et al. Simulated presence therapy for dementia. *Cochr Database Syst Rev*. 2017;4: Cd011882.
59. Olsen CF, Bergland A, Debesay J, Bye A, Langaas AG. Striking a balance: Health care providers' experiences with home-based, patient-centered care for older people—A meta-synthesis of qualitative studies. *Patient Educ Counsel*. 2019.
60. Edvardsson D, Sandman PO, Nay R, Karlsson S. Predictors of job strain in residential dementia care nursing staff. *J Nurs Manag*. 2009;17(1):59–65.
61. Ruggiano N, Shtompel N, Edvardsson D. Engaging in coordination of health and disability services as described by older adults: processes and influential factors. *The Gerontologist*. 2015;55(6):1015–1025.
62. Kogan AC, Wilber K, Mosqueda L. Person-centered care for older adults with chronic conditions and functional impairment: a systematic literature review. *J Am Geriatr Soc*. 2016;64(1):e1–e7.
63. Moher D, Liberati A, Tetzlaff J, Altman DG. The PRISMA group. preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *PLoS Med*. 2009;6(7).
64. Armijo-Olivo S, Stiles CR, Hagen NA, Biondo PD, Cummings GG. Assessment of study quality for systematic reviews: a comparison of the cochrane collaboration risk of bias tool and the effective public health practice project quality assessment tool: methodological research. *J Eval Clin Pract*. 2010. https://doi.org/10.1111/j.1365-2753.2010.01516.x. ISSN 1365-2753.
65. NCCMT NCCfMaT. *Critical Appraisal Tools to Make Sense of Evidence. Hamilton*. ON: Mc Master University; 2011. uppdated September 18, 2017; http://www.nccmt.ca/registry/view/eng/87.
66. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24(2):105–112.
67. Samus QM, Johnston D, Black BS, Hess E, Lyman C, Vavilikolanu A, et al. A multidimensional home-based care coordination intervention for elders with memory disorders: the maximizing independence at home (MIND) pilot randomized trial. *The Am J Geriatr Psychiatry*. 2014;22(4):398–414. official journal of the American Association for Geriatric Psychiatry.

68. Gerdner LA. Effects of individualized versus classical "relaxation" music on the frequency of agitation in elderly persons with Alzheimer's disease and related disorders. *Int Psychogeriatrics*. 2000;12(1):49–65.
69. Spoorenberg SL, Reijneveld SA, Uittenbroek RJ, Kremer HP, Wynia K. Health-related problems and changes after 1 year as assessed with the geriatric ICF core set (GeriatrICS) in community-living older adults who are frail receiving person-centered and integrated care from embrace. *Arch Phys Med Rehabil*. 2019.
70. Edvardsson DS, Man PO, Borell L. Implementing national guidelines for person-centered care of people with dementia in residential aged care: effects on perceived person-centeredness, staff strain, and stress of conscience. *Int Psychogeriatr*. 2014;26(7):1171–1179.
71. Yasuda M, Sakakibara H. Care staff training based on person-centered care and dementia care mapping, and its effects on the quality of life of nursing home residents with dementia. *Aging Mental Health*. 2017;21(9):991–996.
72. Ballard C, Corbett A, Orrell M, Williams G, Moniz-Cook E, Romeo R, et al. Impact of person-centred care training and person-centred activities on quality of life, agitation, and antipsychotic use in people with dementia living in nursing homes: A cluster-randomised controlled trial. *Plos Med*. 2018;15(2).
73. Barbosa A, Nolan M, Sousa L, Figueiredo D. Person-centredness in direct care workers caring for residents with dementia: Effects of a psycho-educational intervention. *Dementia*. 2017;16(2):192–203.
74. Kelly F, Reidy M, Denieffe S, Madden C. Older adults' views on their person-centred care needs in a long-term care setting in Ireland. *Br J Nurs*. 2019;28(9):552–557.
75. Hilgeman MM, Allen RS, Snow AL, Durkin DW, Decoster J, Burgio L. Preserving Identity and Planning for Advance Care (PIPAC): Preliminary outcomes from a patient-centered intervention for individuals with mild dementia. *Aging Mental Health*. 2014;18(4):411–424.
76. de Vocht HM, Hoogeboom AM, van Niekerk B, den Ouden ME. The impact of individualized interaction on the quality of life of elderly dependent on care as a result of dementia: a study with a pre-post design. *Dement Geriatr Cogn Disord*. 2015;39(5):272–280.
77. Coleman CK, Medvene LJ. A person-centered care intervention for geriatric certified nursing assistants. *Gerontologist*. 2013;53(4):687–698.
78. Van Haitsma KS, Curyto K, Abbott KM, Towsley GL, Spector A, Kleban M. A randomized controlled trial for an individualized positive psychosocial intervention for the affective and behavioral symptoms of dementia in nursing home residents. *J Gerontol - Ser B Psychol Sci Soc Sci*. 2015;70(1):35–45.
79. Van Bogaert P, Tolson D, Eerlingen R, Carvers D, Wouters K, Paque K, et al. SolCos model-based individual reminiscence for older adults with mild to moderate dementia in nursing homes: a randomized controlled intervention study. *J Psychiatr Ment Health Nurs*. 2016;23(9-10):568–575.
80. Parsons JG, Parsons MJ. The effect of a designated tool on person-centred goal identification and service planning among older people receiving homecare in New Zealand. *Health Soc Care Commun*. 2012;20(6):653–662.
81. Boorsma M, Frijters DH, Knol DL, Ribbe ME, Nijpels G, van Hout HP, et al. Effects of multidisciplinary integrated care on quality of care in residential care facilities for elderly people: a cluster randomized trial. *CMAJ: Canad Med Assoc J*. 2011;183(11):E724–E732.
82. Brach JS, Perera S, Gilmore S, VanSwearingen JM, Brodine D, Wert D, et al. Stakeholder involvement in the design of a patient-centered comparative effectiveness trial of the "On the Move" group exercise program in community-dwelling older adults. *Contempor Clin Trials*. 2016;50:135–142.
83. Arola LA, Barenfeld E, Dahlin-Ivanoff S, Häggblom-Kronlöf G. Distribution and evaluation of sense of coherence among older immigrants before and after a health promotion intervention – results from the RCT study promoting aging migrants' capability. *Clin Interv Aging*. 2018;13:2317–2328.
84. Toto PE, Skidmore ER, Terhorst L, Rosen J, Weiner DK. Goal attainment scaling (GAS) in geriatric primary care: a feasibility study. *Arch Gerontol Geriatr*. 2015;60(1):16–21.
85. Andrew N, Meeks S. Fulfilled preferences, perceived control, life satisfaction, and loneliness in elderly long-term care residents. *Aging Mental Health*. 2018;22(2):183–189.
86. Sackley CM, Walker MF, Burton CR, Watkins CL, Mant J, Roalfe AK, et al. An occupational therapy intervention for residents with stroke related disabilities in UK care homes (OTCH): Cluster randomised controlled trial. *BMJ: Br Med J*. 2015;350:11.
87. Jung JY, Park SY, Kim JK. The effects of a client-centered leisure activity program on satisfaction, self-esteem, and depression in elderly residents of a long-term care facility. *J Phys Ther Sci*. 2018;30(1):73–76.
88. Díaz-Veiga P, Sancho M, García T, Rivas E, Abad E, Suárez N, et al. Effects from the Person Centered-Care Model on quality of life of cognitive impaired persons from gerontological centers. *Revista Espanola de Geriatria y Gerontologia*. 2014;49(6):266–271.
89. McWilliam CL, Vingilis E, Ward-Griffin C, Higuchi K, Stewart M, Mantler T, et al. An evaluation of the effectiveness of engaging Canadian clients as partners in in-home care. *Health Soc Care Community*. 2014;22(2):210–224.
90. De Vriendt P, Peersman W, Florus A, Verbeke M, Van De Velde D. Improving health related quality of life and independence in community dwelling frail older adults through a client-centred and activity-oriented program. A pragmatic randomized controlled trial. *J Nutr Health Aging*. 2016;20(1):35–40.
91. Berglund H, Wilhelmson K, Blomberg S, Dunér A, Kjellgren K, Hasson H. Older people's views of quality of care: a randomised controlled study of continuum of care. *J Clin Nurs*. 2013;22(19-20):2934–2944.
92. Palese A, Granzotto D, Broll MG, Carlesso N. From health organization-centred standardization work process to a personhood-centred care process in an Italian nursing home: Effectiveness on bowel elimination model. *Int J Older People Nurs*. 2010;5(2):179–187.
93. Moral RR, Torres LA, Ortega LP, Larumbe MC, Villalobos AR, Garcia JA, et al. Effectiveness of motivational interviewing to improve therapeutic adherence in patients over 65 years old with chronic diseases: a cluster randomized clinical trial in primary care. *Patient Educ Couns*. 2015;98(8):977–983.
94. Abbott KM, Klumpp R, Leser KA, Straker JK, Gannod GC, Van Haitsma K. Delivering person-centered care: important preferences for recipients of long-term services and supports. *J Am Med Direct Assoc*. 2018;19(2):169–173.
95. Alkema GE, Reyes JY, Wilber KH. Characteristics associated with home- and community-based service utilization for medicare managed care consumers. *Gerontologist*. 2006;46(2):173–182.
96. Delbaere K, Bourgois J, Van Den Noortgate N, Vanderstraeten G, Willems T, Cambier D. A home-based multidimensional exercise program reduced physical impairment and fear of falling. *Acta Clin Belg*. 2006;61(6):340–350.
97. Graff MJL, Vernooij-Dassen MJF, Hoefnagels WHL, Dekker J, de Witte LP. Occupational therapy at home for older individuals with mild to moderate cognitive impairments and their primary caregivers: a pilot study. *OTJR: Occup Particip Health*. 2003;23(4):155–164.
98. Chan HYL, Pang SMC. Let me talk - an advance care planning programme for frail nursing home residents. *J Clin Nurs*. 2010;19(21-22):3073–3084.
99. Shippee T, Shippee N, Fernstrom K, Mobley P, Frazer M, Jou J, et al. Quality of life for late life patients: mixed-methods evaluation of a whole-person approach for patients with chronic illnesses. *J Appl Gerontol*. 2019;38(7):910–930.
100. Sahlen KG, Boman K, Brännström M. A cost-effectiveness study of person-centered integrated heart failure and palliative home care: based on a randomized controlled trial. *Palliative Med*. 2016;30(3):296–302.
101. Stark SL, Sbaum A, Palmer JL, Somerville EK, Morris JC, et al. Client-centred home modifications improve daily activity performance of older adults. *Can J Occup Ther*. 2009;76:235–245.
102. Beck AM, Kjær S, Hansen BS, Storm RL, Thal-Jantzen K, Bitz C. Follow-up home visits with registered dietitians have a positive effect on the functional and nutritional status of geriatric medical patients after discharge: a randomized controlled trial. *Clin Rehab*. 2012;27(6):483–493.
103. Wikby K, Ek A, Christensson L. Implementation of a nutritional programme in elderly people admitted to resident homes. *Scand J Caring Sci*. 2009;23(3):421–430.
104. Wijk H, Corazzini K, Kjellberg IL, Kinnander A, Alexiou E, Swedberg K. Person-centered incontinence care in residential care facilities for older adults with cognitive decline feasibility and preliminary effects on quality of life and quality of care. *J Gerontol Nurs*. 2018;44(11):10–19.
105. Huang TT, Yang SD, Tsai YH, Chin YF, Wang BH, Tsay PK. Effectiveness of individualised intervention on older residents with constipation in nursing home: A randomised controlled trial. *J Clin Nurs*. 2015;24(23-24):3449–3458.
106. Klay M, Marfyak K. Use of a continence nurse specialist in an extended care facility. *Urol Nurs*. 2005;25(2):101–102. official journal of the American Urological Association Allied7-8.
107. Nielsen TL, Andersen NT, Petersen KS, Polatajko H, Nielsen CV. Intensive client-centred occupational therapy in the home improves older adults' occupational performance. Results from a Danish randomized controlled trial. *Scand J Occup Ther*. 2019;26(5):325–342.
108. Kerse N, Hayman KJ, Moyes SA, Peri K, Robinson E, Dowell A, et al. Home-based activity program for older people with depressive symptoms: DeLLITE—a randomized controlled trial. *Ann Fam Med*. 2010;8(3):214–223.
109. Spoorenberg S, Wynia K, Uittenbroek RJ, Kremer HPH, Reijneveld SA. Effects of a population-based, person-centred and integrated care service on health, wellbeing and self-management of community-living older adults: A randomised controlled trial on Embrace. *PLOS*. 2018. January 19.
110. Mozley CG, Schneider J, Cordingley L, Molineux M, Duggan S, Hart C, et al. The care home activity project: does introducing an occupational therapy programme reduce depression in care homes? *Aging Mental Health*. 2007;11(1):99–107.
111. Metzelthin SF, Daniëls R, Van Rossum E, Cox K, Habets H, De Witte LP, Kempen GIJM. A nurse-led interdisciplinary primary care approach to prevent disability among community-dwelling frail older people: A large-scale process evaluation. *Int J Nurs Stud*. 2013;50(9):1184–1196.
112. Gillis K, Lahaye H, Dom S, Lips D, Arnouts H, Van Bogaert P. A person-centred team approach targeting agitated and aggressive behaviour amongst nursing home residents with dementia using the Senses Framework. *Int J Older People Nurs*. 2019.
113. Uittenbroek RJ, Kremer HPH, Spoorenberg SLW, Reijneveld SA, Wynia K. Integrated care for older adults improves perceived quality of care: results of a randomized controlled trial of embrace. *J General Internal Med*. 2017;32(5):516–523.
114. Kontos PC, Mitchell GJ, Mistry B, Ballon B. Using drama to improve person-centred dementia care. *Int J Older People Nurs*. 2010;5(2):159–168.
115. Buckley C, McCormack B, Ryan A. Valuing narrative in the care of older people: a framework of narrative practice for older adult residential care settings. *J Clin Nurs*. 2014;23(17-18):2565–2577.
116. Kristensen DV, Sundler AJ, Eide H, Hafskjold L, Ruud I, Holmström IK. Characteristics of communication with older people in home care: a qualitative analysis of audio recordings of home care visits. *J Clin Nurs*. 2017.
117. Scales K, Lepore M, Anderson RA, McConnell ES, Song Y, Kang B, et al. Person-directed care planning in nursing homes: resident, family, and staff perspectives. *J Appl Gerontol*. 2019;38(2):183–206.

118. Ashburner C, Meyer J, Johnson B, Smith C. Using action research to address loss of personhood in a continuing care setting. *Illness, Crisis & Loss*. 2004;12(1):23–37.
119. Meyer C, Appannah A, McMillan S, Browning C, Ogrin R. 'One size does not fit all': Perspectives on diversity in community aged care. *Aust J Ageing*. 2018;37(4):268–274.
120. Savundranayagam MY. Missed opportunities for person-centered communication: Implications for staff-resident interactions in long-term care. *Int Psychogeriatr*. 2014;26(4):645–654.
121. Sinclair C, Bajic-Smith J, Gresham M, Blake M, Bucks RS, Field S, et al. Professionals' views and experiences in supporting decision-making involvement for people living with dementia. *Dementia*. 2019.
122. Jokstad K, Skovdahl K, Landmark BT, Haukelien H. Ideal and reality; Community healthcare professionals' experiences of user-involvement in reablement. *Health Soc Care Commun*. 2019;27(4):907–916.
123. Klaassens MML. Experiences of home and institution in a secured nursing home ward in the Netherlands: a participatory intervention study. *J Aging Stud*. 2015;34:92–102.
124. de Witt L, Fortune D. Relationship-centered dementia care: insights from a community-based culture change coalition. *Dementia*. 2019;18(3):1146–1165.
125. Parker V, Engle RL, Afable MK, Tyler DA, Gormley K, Stolzmann K, et al. Staff-perceived conflict between resident-centered care and quality in the skilled nursing facility: are both possible? *Clin Gerontol*. 2019;42(3):267–276.
126. Tsui K, Fleig L, Langford DP, Guy P, MacDonald V, Ashe MC. Exploring older adults' perceptions of a patient-centered education manual for hip fracture recovery: "Everything in one place. *Patient Pref Adher*. 2015;9:1637–1645.
127. Kurpas D, Gwyther H, Szwamel K, Shaw RL, D'Avanzo B, Holland CA, et al. Patient-centred access to health care: A framework analysis of the care interface for frail older adults. *BMC Geriatrics*. 2018;18(1).
128. Lynch BM, McCance T, McCormack B, Brown D. The development of the person-centred situational leadership framework: revealing the being of person-centredness in nursing homes. *J Clin Nurs*. 2018;27(1-2):427–440.
129. Broderick MC, Coffey A. Person-centred care in nursing documentation. *Int J Older People Nurs*. 2013;8(4):309–318.
130. Fried L, Ferrucci L, Darer J, Williamson JD, Anderson G. Untangling the concepts of disability, frailty, and comorbidity: implications for improved targeting and care. *J Gerontol Ser A Biol Sci Med Sci*. 2004;59(3):255–263.
131. Ferrucci L, Guralnik JM, Cavazzini C, Bandinelli S, Lauretani F, Bartali B, Repetto L, Longo DL. The frailty syndrome: a critical issue in geriatric oncology. *Crit Rev Oncol/Hematol*. 2003;46(2):127–137.
132. Jonker C, Geerlings MI, Schmand B. Are memory complaints predictive for dementia? A review of clinical and population-based studies. *Int J Geriatr Psychiatry*. 2000;15:983–991.
133. Reid LM, Maclullich AMJ. Subjective memory complaints and cognitive impairment in older people. *Dement Geriatr Cogn Disord*. 2006;22:471–485.
134. Sun Kyung K, Myonghwa Park. Effectiveness of person-centered care on people with dementia: a systematic review and meta-analysis. *Clin Intervent Aging*. 2017;12:381–397.
135. Mckeown J, Clarke A, Ingleton C, Ryan T, Repper J. The use of life story work with people with dementia to enhance person-centred care. *Int J Older People Nurs*. 2010;10:148–158.
136. Nussbaum MC. *Creating Capabilities: The Human Development Approach*. Cambridge, Massachusetts and London: The Belknap Press of Harvard University Press; 2011.
137. Ebrahimi Z, Wilhelmson K, Dea Moore C, Jakobsson A. Frail elders' experiences with and perceptions of health. *Qual Health Res*. 2012;22(11):1513–1523.