A plea for warm nursing care in ICU
From patient-centered to person-centered

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Bachelor in de Verpleegkunde
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THOMAS MORE

Preface

It can lurk in the smallest corners that life abruptly gets turned upside down in a split second. After falling from a 3 meters height scaffolding, Michelle spent 2 years in the hospital bed as a patient. Birthdays, holidays, rehabilitating, breathing and living between 4 sterile white walls. If you were to look into her patient files, you might not believe she could ever retell her story. Being in the top 100 of the most striking Belgians has its drawbacks, you might think. However, the darkest chapters can potentially spring the most beautiful opportunities. After a successful career as an international model, Michelle had to re-evaluate her future life choices. “Start from scratch” was the card that fate had drawn for her in the summer of 2011.

It is not an everyday story, but she is very grateful to the head nurse and the nursing team at the Neurology department for their humane and soft-hearted approach. Michelle shall spare you the numerous anecdotes, but without realizing it they became the motive for that drastic professional reorientation and the reason for this thesis. These caregivers embraced the core of the nursing profession, which demonstrates that as a nurse you can unmistakably make a difference in the care experience for your patient. The experience as a patient in combination with both the Bachelor's degree in nursing and the Banaba specialization can all be seen as an exceptional interplay towards the coveted vision of patient empowerment.

Subsequently, Michelle would like to pay tribute to the five healthcare professionals who allowed to interview them during her research. Michelle felt humbled to receive only positive responses to my unusual invitation in their office. Thank you for your time, Marc (UZ Brussel), Gerwin (GZA), Eline (UZA), Eva (researcher) and another Marc (GZA). Their expertise truly opened her eyes, as they confirmed what Michelle had felt for years. In every choice we make as a healthcare provider, we must always ask the same question: **“Will my patient benefit from this?”**. It doesn't always require much and he or she may not recall your name. Yet, you can take it from Michelle, they will always remember how you made them feel in that split-second of the interaction where you made the difference.

This plea for warm nursing care is only the first ripple in the water, in the aspire to gain more expertise on this subject. Time will tell what opportunities may cross my path. In the desire that this thesis can serve as an inspiration to you, the reader, that the nursing profession is more than a perfectly executed technique and/or protocol. If you decide to retain only one element of this study, let it be that the behavior in how we treat the patient will make the biggest difference in our patient's experience of care.

“When in doubt ask the patient”

(Doctor Professor M. Noppen)

Enjoy reading.

Warm regards,
Michelle W.

Abstract

Introduction: Patient-centeredness has been gaining in importance for some time now as we strive for care that is tailored to the individual patient. From the perspective of shared decision-making, compassionate care allows the patient to be recognized as an active collaborator in his own healthcare. A method such as "What matters to you" (WMTY) is recognized as a worldwide tool to implement patient-centeredness. Asking the patient what care he desires is seen as a first step in ensuring quality in care. This patient-centeredness model emphasizes the importance of the care provider taking the characteristics of the individual into account. In the knowing that "The patient" does not exist. However, despite the benefits, it is striking that numerous barriers can be found in the scientific literature that prevent the overall implementation of this care model. For this thesis, an attempt was made to descover why patient-centeredness is so sought after and yet stumbles upon resistance in its realization in practice.

Method: Due to the growing interest in the subject, a wide range of literature can be found in the scientific databases. From the demarcation of ICU and the aspect of warm care, it was possible to find answers to the formulated research questions from several angles. For the practical part, an informative journal was made based on interviews with five healthcare professionals. Aided by their extensive professional knowledge, it became possible to test the acquired theoretical findings with the current state of affairs in practice.

Results: Thanks to the 22 scientific resources, the theoretical part explains the relevance in regards to the interests of the patient, the ICU nurse, the organization and the link with quality of care. Opposed to the various barriers such as the lack of time in the interaction. Furthermore, especially in ICU, major challenges are seen in the shift towards shared decision-making. Also, the management board of the organization will largely determine the implementation of the care model. Since clear guidelines for the implementation of the care model lack in scientific literature, the objective of this thesis is to formulate recommendations to strive towards a patient-centered culture.

Discussions: The awareness that the implementation of the care model requires a multidisciplinary approach can be a first step towards a general need to pay more attention to the actual person that is concealed behind the patient. Partly because every healthcare professional contributes to a good outcome, quality of care and therefore also the vision towards person-centeredness. Thanks to the formulated theorems and the confrontation with the obstacles in regards to the care model, it was possible to frame an evidence-based conclusion from several domains.

Conclusion: In relation to quality care, we have to shift from the term patient-centered to person-centered. Subsequently, it will also require an adjustment from the patient, whom cannot always play an active role. That is why within ICU one sees a growing added value of importance in the role of family and relatives. In both theory and practice, it became apparent that the implementation of the vision towards a person-centered culture requires a 360-degree alternation in the mentality of every healthcare professional within the entire healthcare system.

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PART 1 – THE THEORY

Introduction

Quality in care is an important barometer that is held in high esteem within hospitals. It is generally stated that thanks to the integration of protocols, guidelines, improvement measures and evidence-based practice we can now guarantee safe and effective care. In addition, multiple hospitals in Flanders are accredited, or have the ambition to work towards accreditations (Castro, 2019). One thinks of JCI, NIAZ or a Magnet-accreditation. JCI and NIAZ are quality labels that strive for patient-safe care (Raman, 2020). In contrast to Magnet, which aims at continuous improvement of patient outcomes and innovation, as well as the hospital's ability to attract and retain nursing staff (UZA, 2022). The Magnet recognition was achieved in 2017 by UZA as the first hospital in Europe (UZA, 2022).

Every hospital attempts to present an image through their management of what the organisation stands for, the mission, and formulates its goals in the vision. You might have not yet noticed that hospitals, in one way or another, mention in their vision that they put the patient at the center of their care process. One reads words such as “Providing patient-centered, personalized care that takes the needs of the patient into account” (AZ Nikolaas, 2021), a catchy slogan “The patient first” (UZ Brussel, 2021) or “Involves the patient as a full partner in the care process” (AZ Rivierenland, 2019). Isn't putting the patient at the center of care a given in a service such as healthcare?

Van Mol et. al. (2016) describes that patient-centeredness has been gaining in importance for some time now. With the shift away from traditional standards, such as a paternalistic attitude, we are now striving for care that is tailored to the individual patient (Van Mol et. al., 2016). This method is expected to have a positive impact on the perceived quality of care from the perspective of the patient (Van Mol et. al., 2016). For the nurse, the increased job satisfaction is seen as an important benefit associated with improved patient care (Jakimowicz, Perry & Lewis, 2017). Hence compassionate care is proven to be highly meaningful to the nurse while it strengthens the relationship of trust with their patient (Van De Cingel, 2020). For the patients, this contributes to a positive attitude and improves their ability to deal with setbacks (Van De Cingel, 2020).

A globally recognized method for achieving patient-centred care is the “What matters to you” (WMTY) concept. The question “What is important to you?” next to "What's the matter with you?" is according to Olsen, Debesay, Bergland, Bye and Langaas (2020) seen as a way to implement the caremodel. Thanks to the shared decision-making, WMTY is about realizing exactly what matters to the patient on a deeper level. In short, it is a tool for the patient to regain his voice (Olsen et al., 2020).

Castro (2019) also describes that care quality can be divided into 6 criteria in which our care must be patient-oriented, safe, efficient, effective, timely and equal. However, in 2018, the World Health Organization (WHO) redefined the dimension “patient-centered” to “person-centered” (Vanhaecht et al., 2019). This emphasizes the importance that caregivers must take the characteristics of the individual into account as well as his values and preferences (Vanhaecht et al., 2019).

1. Difficulties - Objectives

1.1 Patient-centeredness in relation to WMTY

The Dutch researcher Van De Cingel (2020) points out that in practice there is a strong focus on the accountability of care and the associated increased registration load. With an emphasis on cost efficiency just as completing tasks within a tight timescale (Van De Cingel, 2020). In

case these aspects are given the priority, less time is left for warm nursing care (Van De Cingel, 2020). Due to the higher registration load, to some extent there is a general increase in the workload for nurses. Idewe, the external service for prevention and protection at work, indicates that absenteeism or sick leave in healthcare was no less than 36% higher in 2020 compared to other sectors. The psychosocial influence and the higher workload are, among other things, the cause of the long-term absence of healthcare personnel (Idewe, 2021). Moreover Adriaenssens, Hamelink and Van Bogaert (2017) discuss that job-related stress can lead to all kinds of health-related problems with adverse consequences for the organization, such as the loss of employees and rapid turnover. In the rat race of the job, one could question whether the patient has potentially/unintentionally become a number. Reduced to a diagnosis, a series of lab numbers or a room number, which poses major challenges to the general vision towards patient-centeredness.

With regard to quality in care, patient participation and putting the patient first are possibly concepts that are quickly used without always understanding the true purpose. The great importance of this is, as mentioned earlier, accomplished by the WMTY mentality. Zucca, Sanson-Fisher, Waller, Carey and Boadle (2017) argue that by asking the patient about the care he would like, this is a first step towards guaranteeing quality care. Delivering high-quality care means we must respond to our patient's needs (Zucca et. al., 2017).

> *"The nurse just came to make my bed, but she saw that I was not well. She spontaneously offered to give me a massage. An incredible experience, just someone touching your body without danger. You feel human again and not just the patient who is at risk of dying."* (Vanhaecht et al., 2019).

Is WMTY possibly the hidden key as an answer to beautiful slogans such as "The patient first" (UZ Brussel, 2021)? For managers and policymakers, providing safe, effective and patient-centered care is a top priority (Conelly et. al., 2019). However, it is precisely the ambition towards patient-centeredness that turns out to be the most challenging one (Conelly et. al., 2019). Where exactly lurks the problem in the realization of patient-centered care as an alternative to task-centered care?

To illustrate the relevance of the discussed issue, a few barriers that can be found in the literature will briefly be mentioned here. From the nurse's perspective, recurring arguments include lack of time, competing priorities as well as high workload (Van Mol et. al., 2016). There is also a phenomenon of compassion fatigue, which can lead to lower job satisfaction but also burnout (Van De Cingel, 2020). In addition, factors specific to the department can play a role. Jakimowicz et. al. (2017) refers, among other things, to the intensive care (ICU) patient who is not always able to receive information or make decisions, which can hinder in the shared decision-making. The ICU nurse may put more emphasis on performing the tasks directly related to health, stabilizing vital signs for example, rather than communicating about the patient's specific needs (Kwame & Petrucka, 2021). In the literature we can find various barriers that are associated with the organizational structure. One can think of overcrowded hospitals, the general shortage of nurses, the absence of guidelines for patient-centered care, lack of management support, etc. (Kiwanuka, Shayan & Tolulope, 2019).

The above indicates that there is a lot to be said about the chosen topic and that the implementation of WMTY cannot be seen as a walk in the park. However, we must remain positive in the importance of the vision towards patient-centeredness, and that it should not be written off as an unrealistic ideology.

For this study, the focus will be on the ICU nurse as a defined target group. More complex techniques are being used in these critical care departments than ever before and thus the requirements of expectations are therefore high. One would dare to doubt whether today's nurses still get enough time with and for the patient. Despite the great importance of the quality in care, is there still room and attention for warm and human care in ICU?

1.2 Objectives

In the theoretical part the objective will be to describe the relevance of the vision to patient-centered care and the values of the WMTY concept. Subsequently, the barriers will be explained in detail from different perspectives. Such as the interests with regard to the patient, the ICU nurse, the organization as well as the link with quality of care. Finally, the obstacles regarding the implementation to patient-centered care will be described, as well as possible advice that can be found in literature.

An informative video report was made for the practical part thanks to five interviews with healthcare professionals. This concerns a researcher in patient participation, the CEO of a university hospital, an expert in quality care, a head nurse as well as a nurse in ICU. From this top-down and bottom-up approach, it is the objective to analyze the acquired theoretical findings with the current state in the clinical practice. The final objective is to formulate advice on the implementation of the patient-centered care model.

2. Research questions

In order to map out the current state of affairs regarding the various challenges, one main question was formulated, followed by five sub-questions:

- **What are the benefits and barriers to implement WMTY and patient centered care by a nurse in ICU?**
  - What does WMTY stand for and what is its relevance in clinical practice?
  - Where lies the importance of patient participation in the experience of the patient and his/her family?
  - Which evidence-based barriers stand in the way of the nurse and the organization to achieve patient-centeredness?
  - How does this concept affect the ICU nurse and the quality of care?
  - What advice can be discovered regarding the implementation of patient-centered care?

3. Outcome

3.1 Patient-centered care

> Patient-centeredness is a multifaceted concept as a counter-reaction to the paternalistic caremodel in which our patient has a passive role and the healthcare professional acts as the decision expert.
>
> *(Olsen et al., 2020)*

For decades, researchers have measured 'patient satisfaction' as an important indicator of the quality of care (Cleary, 2016). In the 1970s and 1980s, patient surveys were service-oriented with the motivation to keep the patient "satisfied". However, Cleary (2016) indicates that the concept of satisfaction had its limitations when assessing the quality of care because it only indicated whether expectations were met. In addition, these early patient surveys failed to capture important aspects including clear communication, being treated with respect, and being appropriately involved in treatment decisions (Cleary, 2016). Even then, concerns arose that organizational priorities had too much influence on the way care was delivered and that surveys did not adequately take the overall patient needs into account (Cleary, 2016). Following on from that, in the late 1980s the term "patient-centered care" was defined as :

> "Care that respects and responds to the preferences, needs and values of the individual and ensures that the patient's values guide all clinical decisions" *(Cleary, 2016)*

A general belief is that thanks to a greater involvement it allows patients to have more say in their care decisions (Olsen et al., 2020). According to Kwame and Penetrucka (2021) this means that in all clinical decisions we should take the care needs, preferences and values of the individual patient into account. Thanks to consequently involving them in the complete care process. Hence patient-centered communication is fundamental in ensuring optimal

healthcare outcomes (Kwame & Petrucka, 2021). Equally, the elements of active listening, empathy and respect are at the core of nursing practice, which are recognized in the nursing code of ethics (Kwame & Petrucka, 2021). Although these concepts have been applied for many years within a holistic perspective, patient-centeredness requires more than one might initially suspect (Van Mol et. al., 2016). Therefore Van Mol et al. (2016) state that the transition from a paternalistic attitude ('I know what's best for you') to a supportive role ('What can I do for you?') requires some dedication.

Several elements can influence or contribute to this care model. Lemmers & Van der Voort (2021) identify trust as an important condition for good care within this individual approach. Distrust in the healthcare professional can lead to distrust in the organization. Which can increasingly contribute to patient dissatisfaction, an unfavorable relationship between patient and healthcare provider, poor adherence to therapy and non-compliance with medical advice (Lemmers & Van der Voort, 2021). Ergo, this trust between the patient and the healthcare provider is at stake if the current healthcare system continues to grow at a rate that does not prioritize one-on-one relationships (Lemmers & Van der Voort, 2021).

Olsen et al. (2020) state that focusing on efficiency, together with time pressure, can have a negative impact on patient engagement when practices are task oriented rather than patient oriented. Studies show that while it can be important to quickly handle medical tasks in the care process, the power of active listening is crucial in the effective communication and interaction between the patient and the nurse (Kwame & Petrucka, 2021). According to Kwame and Petrucka (2021) the nurses are obliged to show that they are accessible and that they are willing to listen to their patient. Effective therapeutic communication minimizes misunderstandings and avoids conflict when patients are denied involvement in the care process (Kwame & Petrucka, 2021). The concept of empathy is described by Stavropoulou, Rovithis, Sigala, Pantou & Koukouli (2020) as a 'soft' skill that has a positive effect on patient satisfaction, adherence, prevents anxiety and is beneficial for patient empowerment. Thus, empathic communication can help the patient understand and manage their illness effectively, which can indirectly lead to better outcomes of care (Stavropoulou et al., 2020).

The patient-centered care and communication continuum (PC4 model) was developed in Canada by Kwame and Petrucka (2021) as a leading model in achieving patient-centered communication in patient-centered care:

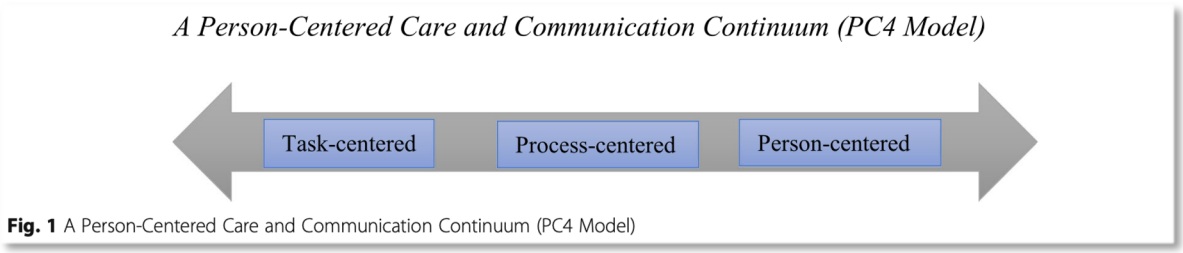


Fig. 1 A Person-Centered Care and Communication Continuum (PC4 Model)

Note: Conveyed from Kwame A. & Petrucka P. M. (2021). *A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward.* Canada: BMC Nursing.

The proposed PC4 model illustrates how communication can proceed from three aspects between caregiver and care recipient (Kwame & Petrucka, 2021). Within the task-oriented care model, the nurse will complete the medical tasks as quickly as possible, which requires little communication with the patient. He or she can be seen as a body with the focus on identifying, registering, treating or curing the disease symptoms. Task-oriented communication often uses medical terminology, as here it is not the aim to involve the patient in the care process (Kwame & Petrucka, 2021). Non-verbal signals are overlooked and there is no room for the patient to ask questions. Process-oriented communication is an intermediate stage, in which care providers recognize the patient as a person, but without being expected to express their opinion or influence the care process itself (Kwame & Petrucka, 2021). Finally,

there is patient-oriented communication, the highest point of the PC4 model. In this phase patients are treated as unique individuals with specific care needs and seen as an active participant. The content of the communication at this stage is both 'personal' and 'explicative'. It gives room to create a meaningful relationship and it encourages the patient to share feelings about the care situation. Reaching this level requires empathic communication in patient care from a warm approach (Kwame & Petrucka, 2021).

3.2 What Matters To You

Following on from the previous, we bridge the gap with the WMTY way of thinking to find out where the relevance lies for a patient-centered approach. The question "What is important to you?" has become a globally recognized way to realize patient-centered care within the holistic approach (Olsen et al., 2020). It is a way of implementing shared decision-making and improving the quality of healthcare through vivid slogans such as:

A Belgian translation of WMTY was introduced by KU Leuven (2018) as a mango moment model. Which generally improves the patient and family experience, facilitates compliance and has a positive effect on patient resilience.

(Vanhaecht et al., 2020)

"No decision about me without me." (Olsen et al., 2020)

Olsen et al. (2020) describe WMTY as a tool for personal and clinical goal setting and suggest that ideally every patient should be given the opportunity to do so. Concretely, WMTY concerns the following description:

> "WMTY is about compassion, seeing the person behind the patient and realizing what matters to the patient in a deeper way. It is a tool for setting personal and clinical goals with the ideal that every patient has the opportunity to do so.
> The patient's goals should guide all our clinical decision-making" (Olsen et al., 2020)

The WMTY movement is seen as a simple method to understand what matters to the patient in the approach to patient-centered care (Conelly et. al., 2019). Although good medicines and the many hands in care are essential in the treatment of diseases, one should not forget the little things (Kwame & Petrucka, 2021). In this view, nurses act as a core component as they spend a lot of time with the patient, so a positive relationship between both parties can have a abundant impact on care outcomes (Kwame & Petrucka, 2021). The WMTY question can act as a tool for the nurse to give a personal voice to the patient by involving them in the care process (Olsen et al., 2020). When the nurse lets go of his/her own agenda, this gives room for the understanding of the concept that what is important from a medical perspective may not be important for the patient:

> *"Perhaps it is important for the healthcare provider that we treat the heart failure by giving diuretics. But it is inconvenient for the patient if he has to get up every night."* (Olsen et al., 2020)

There is a perception that healthcare professionals take it for granted to always know what is best for the patient, where the WMTY question can reignite them to collaborate with them (Olsen et al., 2020). And so WMTY can help in discovering new, sometimes surprising elements about our patient (Olsen et al., 2020).

Furthermore, nurses indicate that they view the aspect 'compassion' as a core value of good nursing care as well as their motivation for the profession (Van Der Cingel, 2020). Nonetheless, the way in which compassion is expressed can be influenced by their personality and personal values. Van Der Cingel (2020) says that for some, compassionate behavior means standing up for the patient's wishes, e.g. towards the doctors. Others use presence, listening and calmness or attach importance to the fact that there is a 'click' with the patient. Because they may be able to identify with them e.g. when they have the same age or hobbies (Van Der Cingel, 2020).

Note: Conveyed from Van Der Cingel M. (2020). *Strategiën voor compassievolle zorg. Onderzoek & Praktijk, 20(01).* Consulted on November 4 2021 through https://link-springer-com.am.thomasmore.e-bronnen.be/content/pdf/10.1007/s41184-020-0149-3.pdf

The mango moment model, a Belgian translation of WMTY, is defined as:

> "Small unexpected actions or gestures that are of great value in the care experience of patients, families and healthcare professionals. They take place during normal care activities and require almost no additional resources, time or energy." *(Vanhaecht et al., 2020)*

While this model is based on the culture of patient-centered care and the similarities between the models are striking, the concepts should not be confused. Vanhaecht et al. (2020) identify one clear distinction in which patient-oriented care starts from the perspective of the healthcare provider who must take into account the preferences, values and norms of the individual patient. While a Mango moment arises from all kinds of perspectives (care professional, patient and management) in different types of relationships. The argument of Vanhaecht et al. (2020) is that the impact of positive experiences such as a smile or even a micro-moment of positive resonance should be an essential daily need.

The vision of warm healthcare has a positive impact on the healthcare professional in the form of more fun at work, a positive team atmosphere, more satisfaction and growth in personal competence and it can prevent burnout (Vanhaecht et al., 2020). Which can lead to a better relationship of trust between the patient and the nurse, bring about higher feelings of tolerance for negative experiences and open communication within a safe climate. Among other things, nurses say the following:

"This touches the core of why people chose a career in healthcare"
(Vanhaecht et al., 2020)

Mango moments lead to a positive experience for the patient and can stimulate the zest for life in the healing process. Thanks to the small gestures, patients themselves indicate that they are more adherent to therapy (Vanhaecht et al., 2020). A positive resonance with the application of mangomoments is that this open communication, e.g. in case of doubts, promotes the general safety climate (Vanhaecht et al., 2020).

WMTY may seem like a simple question, but using it in everyday practice is a complex process that requires expertise (Olsen et al., 2020). A concept such as mango moments, or patient-centeredness, can be seen as a cornerstone of improvement in leadership (Vanhaecht et al., 2020). If we want to improve quality and safety in healthcare, compassion and respect for the patient, as well as the happy employee, as a whole are not the icing on the cake but the foundation (Vanhaecht et al., 2020). According to Vanhaecht et al. (2020), this is the only way forward for policymakers.

3.3 The effect on quality of care

> A general lack of time in the interaction between the nurse and the patient is seen, by both parties, as detrimental to the quality of care.
> *(Kwame & Petrucka, 2021)*

An undeniable argument regarding patient-centeredness and WMTY is the effect on the quality of care. Asking the patient about the care they would like and their specific needs is seen by Zucca, Sanson-Fisher, Waller, Carey and Boadle (2017) as the first step in ensuring high quality care. Among other things, the previously discussed concept of empathic care is seen as closely linked to care outcomes (Stavropoulou et al., 2020). In particular, ICU care teams can face a demanding work environment (Stavropoulou et al., 2020). The ICU nurses are exposed to chronic stressors, carry a high level of responsibility, work with advanced technologies and are involved in morally challenging situations (Stavropoulou et al., 2020). Stavropoulou et al. (2020) state that such circumstances can cause compassion fatigue and burnout. As a result, empathy can decrease, resulting in a negative effect on the quality of care (Stavropoulou et al., 2020). Patient-centered nursing is widely seen as a supportive care model thanks to humanizing qualities such as compassion, relationship building, and empathy. Aspects that would benefit the patient and their experience in regards to quality of care (Jakimowicz, Perry & Lewis, 2017). Jakimowicz et al. (2017) state that developing a therapeutic relationship as well as a constructive dialogue with the patient, and their family, in ICU is an important part of patient-centeredness. Van Mol et al. (2016) identify both communication and respect as an important factor within this care model, as it can influence the perceived quality of care in ICU, from the perspective of both the patients and their family members. Research shows that this extra support for family members can increase the perceived quality of care, with regard to their informational needs (Van Mol et al., 2016). As a result, the pursuit of excellent quality of care is essential for improving patient outcomes and tailoring care to what the patient indicates they need (Van Mol et al., 2016). The Institute of Medicine recognizes six patient-centered aspects that describe high quality health care:

> "1) Respect the values, preferences and expressed needs of patients 2) The care is coordinated and integrated 3) It provides information, communication and education 4) It provides physical comfort 5) It provides emotional support 6) Family involvement"
> *(Van Mol et al., 2016)*

For the organization, the global shortage of nurses is an important obstacle within this topic (Kwame & Petrucka, 2021). However, Kwame & Petrucka (2021) state that, it is above all, the quality of the interaction that will be decisive and not the amount of time spent with the patient. Spending long periods of time with patients does not always result in positive care relationships (Kwame & Petrucka, 2021). Kwame & Petrucka (2021) argue that patient-centeredness does not take up extra time and that the nurse's perception to generally be too busy cannot be an excuse for poor therapeutic interaction.

When nurses are more involved with their patients, they are less likely to make mistakes (Santana et. al., 2017). Santana et. al. (2017) mention that involvement and shared decision-making contribute to better health outcomes, quality of care and patient safety. Overall, patient participation is conducive to achieving the previous triple objective, with the reduction of healthcare costs as an additional bonus (Kiwanuka et. al., 2019). Policymakers argue that healthcare is more effective if the patient plays the leading role (Castro, 2019).

3.4 The relevance at ICU

> Trust between the patient and the healthcare provider plays an important role in the shift to shared decision-making. This can be especially challenging at ICU as research has shown that ICU nurses score lower on emotional empathy.
>
> *(Lemmers & Van Der Voort, 2021)*

Research from the UK indicates that patients themselves have a need to humanise the ICU (Conelly et. al., 2019). There is increasing evidence that both the patient as the caregiver are confronted with traumatic experiences at the critical ward, thus person-centredness is gaining importance at ICU in particular (Conelly et. al., 2019). In this department it can be seen as a challenge as the patients are often physiologically unstable and subject to invasive treatments (Conelly et. al., 2019). This is due to their high vulnerability where life-threatening risks often, if not always, take place (Lemmers & Van Der Voort, 2021). Lemmers and Van Der Voort (2021) believe that these patients may experience feelings of fear, pain, uncertainty and total dependence and that the aspect of trust between the patient, family and caregiver are essential to their well-being.

Furthermore, the delivery of patient-centered care can be compromised by both the nature of the critically ill patient population and the demanding role of the ICU nurse (Jakimowicz et. al., 2017). The application of this vision to ICU may differ from general wards for many reasons. Jakimowicz et. al. (2017) discuss that the ICU patient is often unable to receive information or make decisions, which questions shared decision-making. The ICU environment requires expert nursing skills, experience, technological knowledge as well as compassion (Jakimowicz et. al., 2017). As such, these nurses have a multidimensional role in providing professional and compassionate care that benefits not only the patient, but also the nurses in terms of job satisfaction (Jakimowicz et. al., 2017).

This patient population has a need to understand what will happen to them in relation to its critical concerns (Conelly et. al., 2019). Admission to ICU often gives patients time to reflect on lifestyle choices, from which they may ask for support to improve their health, for example to quit smoking (Conelly et. al., 2019). Conelly et. al. (2019) identify the presence of their loved ones as an important theme, as this can contribute to their sense of security. Furthermore, Kiwanuka et. al. (2019) state that scientific progression at ICU has created a care environment where patients and families often remain in the gray area when it comes to medical decisions. Hence, WMTY can again bring us closer to the care recipient and contribute to discovering that what is valuable to the patient can be different from what is important to the nurse (Olsen et al., 2020).

Asking the WMTY question humanises care in this critical department, in regards to improved care outcomes (Conelly et. al., 2019). Numerous efforts have been made in the last 10 years and most of the strategies have had the same focus: Understanding the critically ill patient as an individual from a pharmacological as well as a psychological viewpoint (Conelly et. al., 2019). Conelly et. al. (2019) cite WMTY as a method of achieving patient-centeredness in ICU. In this shift to shared decision-making, trust between the patient and the healthcare provider plays an important role (Lemmers & Van Der Voort, 2021). According to Lemmers & Van Der Voort (2021), the ICU nurse keeps an emotional distance as a protective measure towards their own emotional health. A nurse says:

> *"I feel the ICU nurses have become too technical and tend to distance themselves"*
> (Jakimowicz et. al., 2017)

ICU belongs to the acute care chain, where care providers have less or little time to build up the intended relationship of trust. This time sensitivity together with the high dependence on the ICU patient explain why developing trust in this setting is crucial (Lemmers & Van Der Voort, 2021). Nurses indicate that despite the sometimes serious situations, the connection in the relationship with patients and families contributes to their job satisfaction (Jakimowicz et. al., 2017). However, the strictly standardized protocols specific to the ICU do not always take

the individual needs of the patient into account (Jakimowicz et. al., 2017). Also, the historically complex relationship between nurses and physicians influences decision-making processes in the recognition of the nurse's voice (Jakimowicz et. al., 2017). The overall nursing involvement in care planning is an important part, since when they get excluded from this process it will limit them to inform the patient. Improved cooperation between healthcare professionals is indispensable in maintaining the autonomy and identity of the individual patient (Jakimowicz et. al., 2017). In any case, the growing role of the nurse is nothing new (Jakimowicz et. al., 2017). Jakimowicz et. al. (2017) associate this respect, their empowerment and the increased autonomy of the ICU nurse with improved patient care and job satisfaction. Lemmers & Van der Voort (2021) discuss that it should not be forgotten that it is the nurses who spend the most time with the patient. Nursing communication skills have an important effect on patient confidence (Lemmers & Van der Voort, 2021). Good communication skills in ICU, e.g. presenting information in an understandable way, are recognized as a factor for quality of care (Van Mol et. al., 2016).

The importance of empathy, which was discussed earlier, is even more true for the patients in ICU. Considering they face emotionally challenging situations, and so too can person-centered care greatly contribute to the patient's biopsychosocial needs (Stavropoulou et al., 2020). With the aim of seeing the patient as a whole, ICU nurses themselves emphasized that communication and empathy care are fundamental. Nurses describe it as recognizing the patient's needs, whether they are expressed or not, to make them feel safe (Stavropoulou et al., 2020).

In times of nursing understaffing, increased workload and high levels of job-related stress in ICU, empathic care cannot always be applied effortlessly (Stavropoulou et al., 2020). In addition, Stavropoulou et al. (2020) point out the undeniable influence of the organization on a good working environment and the importance of facilities to realize warm care in practice.

3.5 The interest from the organization

Nurses state that thanks to WMTY they experience job satisfaction, it prevents burnout and they remain more loyal to their organization.
(Vanhaecht et al., 2020)

Support from management is essential for the realization of patient-centeredness and the WMTY way of thinking (Vanhaecht et al., 2020). In addition, obtaining an in-depth patient-centered care culture is essential because otherwise there is little chance of developing a well-founded patient-centered system (Santana et. al., 2017). If the organization wants to give priority to this model, opportunity must be created for the 'voice' of both the nurse and the patient (Jakimowicz et. al., 2017). ICU nurses report that the support of managers and colleagues is motivating in their challenging work environment (Jakimowicz et. al., 2017). A nurse says:

> *"This situation felt safe because as a nurse I am supported by my managers and my colleagues. When we feel supported in the team, we can handle anything"* (Jakimowicz et. al., 2017)

Similarly, Jakimowicz et. al. (2017) state that the increasing shortage of experienced nurses today, but also in the future, is a universal problem. This not only because of the aging of the workforce, but also because of the lack of a stimulating working atmosphere, few training opportunities, burnout and compassion fatigue (Jakimowicz et. al., 2017). Policy makers need to understand that providing high quality nursing care is positively related to job satisfaction and subsequently the preservation of its employees (Jakimowicz et. al., 2017). An aspect that UZA is strongly committed to change thanks to their Magnet recognition (UZA, 2022). UZA in Edegem (Belgium) invests in the role of nurses and the development of their autonomy, personal growth and teamwork (UZA, 2022). Being truly patient-oriented requires the organization to create a favorable environment for staff, but also for patients (Kiwanuka et. al., 2019). Kiwanuka et. al. (2019) point out the need for role models. A nurse says:

> *"Due to a lack of role model colleagues in the ICU, and when our managers fail to provide a supportive environment, topics like patient-centeredness are only talked about"* (Kiwanuka et. al., 2019)

WMTY can potentially contribute to making our care somewhat warmer. In general, this view brings increased loyalty to the organization because patients typically return for e.g. a particular care team (Vanhaecht et al., 2020). Thanks to WMTY, nurses have more feelings of job satisfaction, so they remain more loyal to their organization (Vanhaecht et al., 2020). Vanhaecht et al. (2020) argue that satisfied healthcare professionals as well as patients can potentially become and remain ambassadors for the organization. Subsequently, nurses desire more support through training (Jakimowicz et. al., 2017). Which according to Jakimowicz et. al. (2017) creates a tension in a financially constrained environment, where patient-centeredness is expected to flourish due to an increasing "privatization of care". The switch to this care model may initially have a price tag, but supporting the patient in making his own care decisions provides a better price-quality ratio in the long term (Santana et. al., 2017). This is because the costs associated with the implementation go entirely to what patients really value (Santana et. al., 2017).

While delivering safe, effective, and patient-centered care is a top priority for policymakers, Conelly et. al. (2019) mention that in particular the patient-centered vision can be the most challenging. As previously explained, thanks to WMTY care can be personalized with improved long-term care outcomes (Conelly et. al., 2019).

3.6 Barriers

> When the organization emphasis on task-oriented care, more attention will go to completing care procedures, which prevent meeting the needs of the patient.
>
> *(Kiwanuka et. al., 2019)*

Despite the fact that the good relationship between the nurse and the patient has a positive impact on both parties, there are several factors that prevent this view (Kwame & Petrucka, 2021). Regardless of previous explanation of the positive outcomes towards patient-centeredness and WMTY, they are rarely applied in ICU (Kiwanuka et. al., 2019). Achieving the patient-centered communication between the patient and nurse is complex because it involves environmental, communication, behavioral and personal barriers (Kwame & Petrucka, 2021). Researchers also point out that many barriers arise from the healthcare system itself. Can one say that the realization of this care model stands or falls with the organization, or is that farfetched? This section provides an overview of the evidence-based barriers.

a) Healthcare system related barriers

Shortages of nurses, the high workload, limited time and burnout are complicated obstacles (Kwame & Petrucka, 2021). Moreover, the elements should not be seen as separate aspects, but can have a cumulative effect. Staff shortages hinder the nurse from making time for the patient (Kwame & Petrucka, 2021). This shortage in combination with the high workload can result in less patient interaction with a risk of limited therapeutic communication (Kwame & Petrucka, 2021). At the system level, conflicting organizational goals and a lack of resources play a role (Olsen et al., 2020). This lack of resources is an obstacle to fully incorporate the relational approach (Olsen et al., 2020). Likewise, the nurse's primary concern is the lack of time to sit down and listen (Olsen et al., 2020). A nurse says:

> *"Organizationally, WMTY is difficult because of limited time, and asks maybe a forty-five-minute conversation until one gets to the core of what's important to the patient"* (Olsen et al., 2020)

Other organizational obstacles include unfavorable environmental factors, lack of guidelines or resources, lack of support, overcrowded hospitals as well as the scarcity of role models (Kiwanuka et. al., 2019). In general, it is stated that the applied management styles can

facilitate or hinder patient-centeredness (Kiwanuka et. al., 2019). As a result, the operational management will, in great measure, determine the implementation.

b) Nursing barriers

There is general uncertainty about the skills and responsibilities required in the patient-centered approach (Olsen et al., 2020). Researchers utter this is due to the tension between the professional goals that are more disease-oriented and the patient's personal goals related to the small and big things in life. In relation to professional competence, there is a risk that WMTY is applied too superficially and that nurses wrongly believe that they have to fulfill all patient preferences, instead of listening. Similarly, there are doubts about the vague boundaries of the nurse's new responsibility for patient-centered care, as well as the increased responsibility given to the patient. Nurses believe they cannot meet patient preferences due to unrealistic goals (Olsen et al., 2020).

Kiwanuka et. al. (2019) indicate that the attitude of the nurse has a major influence on the interaction and consequently on patient-centered care. Due to the high workload, lack of time and staff shortages, nurses can develop emotional detachment. There is also a challenge in nursing communication skills. Poor communication can increase patient and family anxiety with a negative impact on developing a compassionate relationship (Jakimowicz et. al., 2017). Unstable communication can result in medical procedures that are inconsistent with the individual patient's wishes (Jakimowicz et. al., 2017). In addition, miscommunication can lead to misunderstandings, but also when the nurse does not listen, or forces the patient to obey instructions, this can cause disastrous care outcomes (Kiwanuka et. al., 2019).

Furthermore, individual elements such as cultural backgrounds, language differences, other belief systems, but also disrespectful behavior can prevent warm care (Kiwanuka et. al., 2019). Lemmers & Van der Voort (2021) debate that differences in values and norms can form an obstacle, from which trust issues arise. Nurses testify that ethical dilemmas prevent them from always providing the best care according to their own values (Jakimowicz et. al., 2017). Jakimowicz et. al. (2017) refers, among other things, to conflicts with doctors as the cause. Examples such as false hopes due to lengthy treatments, which create ethical dilemmas for the nurse in performing painful procedures where the patient is believed to have a poor prognosis (Jakimowicz et. al., 2017). Starting nurses can feel a tension between their own values and what their environment expects of them and will usually emphasize task-oriented care in the first few years (Van Der Cingel, 2020). In addition, Santana et. al. (2017) indicate that empathy generally decreases over time and that nurses gradually desensitize.

c) Barriers specific to the ICU environment

For many reasons the implementation of patient-centered nursing in ICU can differ from other departments. Jakimowicz et. al. (2017) discuss that the ICU patient is often unable to receive information or make decisions, which hinders shared decision-making. In ICU, expressing feelings can be seen as least important and interpersonal relationships receive less attention than critical care (Van Mol et. al., 2016). The ICU nurse is much more task-oriented, focused on the care tasks directly related to the patient's health, rather than communicating about their specific needs (Kiwanuka et. al., 2019). This complicates holistic care, even when the nurse is less busy (Kiwanuka et. al., 2019). Possibly the nurses deliberately avoid emotional interference due to the high job demands and they may even feel threatened by it (Van Mol et. al., 2016). Nonetheless, in order to increase trust with the patient, one should no longer keep an emotional distance (Lemmers & Van der Voort, 2021). Nurses say that because of the high workload, compassion fatigue can develop as a result of emotional self-protection (Stavropoulou et al., 2020):

> *"I advise young nurses not to commit to the patient, because losing them will be difficult"* (Stavropoulou et al., 2020)

Jakimowicz et. al. (2017) refers to Moral distress caused by ethical dilemmas as a negative effect on the job satisfaction of the ICU nurse. Because they spend more time with the patient and their families, the nurse may have a greater appreciation for the psychosocial aspects of the patient. However, the protocols in ICU do not always take this into account (Jakimowicz et. al., 2017).

d) Obstacles in the implementation

WMTY cannot be approached as "just a question" but requires certain competences (Olsen et al., 2020). The ability to understand exactly where, when and how to use WMTY is a major barrier (Olsen et al., 2020). Nurses emphasize that understaffing and the increased registration burden stand in the way of the realization of compassionate care (Stavropoulou et al., 2020). If the organization continues to emphasize technical knowledge and procedural skills, it will be difficult for the nurse to develop soft-natured qualities (Stavropoulou et al., 2020). The organizational support is seen as a key factor to realize patient-centeredness in practice (Stavropoulou et al., 2020). In addition, a lack of understanding of what exactly is needed to achieve this vision can be linked to a lack of teamwork (Kiwanuka et. al., 2019). Kiwanuka et. al. (2019) points out that if one wants to see patient-centeredness, with its positive care outcomes, embedded in the broad healthcare system then it must be supported by a broad foundation. Despite the fact that the term mango moments are warmly welcomed by many organizations, the translation in the practice remains uncertain (Vanhaecht et al., 2020). In addition, literature frequently indicates that more research is needed to understand the optimal methods for implementing WMTY and patient-centeredness in practice (Conelly et. al., 2019).

3.7 Implementation Advices

> The transition to patient-centeredness will require a shift in the mindset of every healthcare professional.
>
> *(Van Model et. al., 2016)*

Despite worldwide efforts to apply patient-centered care, its practical realization is a challenge for every organization (Santana et. al., 2017). Recognizing the barriers can function as a first step to conduct the needed interventions to support this vision (Kiwanuka et. al., 2019). Increased awareness among the healthcare professional about the relevance of patient-centered care can lead to an understanding of its benefits (Kiwanuka et. al., 2019). In doing so, creating a feedback-friendly culture, in which both bottom-up and top-down feedback are common can ensure that the professional will do everything they can to be the best version of themselves (Lemmers & Van der Voort, 2021).

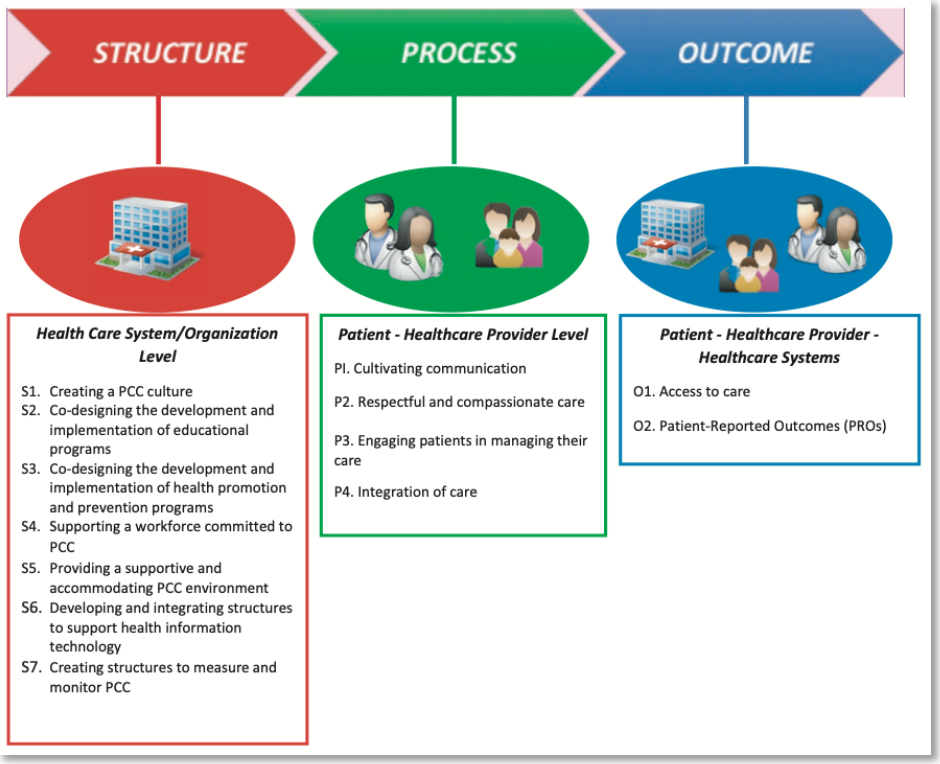
Olsen et al. (2020) recommend a standardized WMTY questionnaire that can serve as a tool to measure WMTY in practice. Integrating this aspect into the electronic health record can allow the patient's goals to be transferred between the different disciplines. Within the multidisciplinary collaboration, a WMTY column can be added to the patient board, in addition to other columns such as the fall risk assessments. However, without the right approach to implementation, one should be aware that WMTY should not be used as a new task-oriented objective (Olsen et al., 2020).

In terms of mango moments, the personality and authenticity of the practitioner is of influence (Vanhaecht et al., 2020). This regarding the effect of the general attitude of the caregiver, his friendliness and honesty (Vanhaecht et al., 2020). Consequently, according to Kwame and Petrucka (2021), the practitioner should be able to identify and improve the potential barriers in their communication. Achieving patient-centered care will require building a solid nurse-patient relationship through effective therapeutic communication (Kwame & Petrucka, 2021). Kwame and Petrucka (2021) advise that the nurse should remember the conversations with the patient in order to rebuild on that during later interactions. To promote continuity the recommendation is to assign the same nurse to the same patient for the duration of the stay (Kwame & Petrucka, 2021). The question remains whether this is feasible in every setting.

In addition to the importance of patient involvement, attention should also be paid to improving the relationships between ICU professionals (Kiwanuka et. al., 2019). Teamwork will contribute to care coordination and building on a purposeful relationship with the patient (Kiwanuka et. al., 2019). Kiwanuka et. al. (2019) advises changing the "me" to "us" mentality. Likewise, Jakimowicz et. al. (2017) sees the solid collegial relationships among the nurses as a strong component in the implementation. Many nurses desire more autonomy and empowerment in their role, where respect is seen as intrinsically linked to job satisfaction (Jakimowicz et. al., 2017).

Guidelines and procedures are necessary to structurally involve patients in their care process (Castro, 2019). Castro (2019) points out that this may seem contradictory, but states that a formal structure is needed to make room for informal conversations.

Although the previous is useful advice, in practice it is not yet possible to implement it at a structural level. According to Santana et. al. (2017) there is a lack of conceptual frameworks that are aimed at the effective realization of this vision. The researchers therefore developed a step by step roadmap on how to achieve extensive implementation in practice (Santana et. al., 2017).



Note: Conveyed from Santana et. al. (2017). *How to practice person-centered care: A conceptual framework.* Canada: John Wiley & Sons Ltd

The structure, created by Santana et. al. (2017), demonstrates the critical importance in creating a patient-centered culture and that the organization should pay attention to support in resources as well as policies. In addition, it is seen that the lack of training regarding the vision of this care model forms a gap for its strategic implementation in practice. Furthermore, patient-centeredness aims at respect and human dignity for the patient, the care provider as well as the management. In relation to the quality of care, the intention is that the care providers do things actively with people, instead of 'to' or 'for' them (Santana et. al., 2017).

Similarly, policymakers should measure the process and the results in order to learn from it (Santana et. al., 2017). The process is the next step on the roadmap and encompasses the importance of patient-care provider interaction. This part includes, on the one hand, cultivating strong communication by incorporating the patient's values and needs into the care process, with a view to shared decision-making. Subsequently, Santana et. al. (2017) state the importance of compassionate care and recognizing the patient as an expert in their own

health. The involvement of patients and caregivers will improve healthcare because both parties feel empowered with a positive effect on overall continuity. Finally, there is the last step in the outcomes, which provides a link between the improved care delivery and the care results (Santana et. al., 2017).

This broad roadmap links many of the pain points discussed earlier, making it clear that the effective realization of patient-centeredness is only possible through a broad approach (Santana et. al., 2017). Santana et. al. (2017) mention that this vision creates many challenges, especially with regard to how patients and care providers interact. Nevertheless, the numerous benefits are clear and this care model can be seen as a promising overall vision with the perspective of improving health care from multiple domains (Santana et. al., 2017). Therefore, as Castro (2019) points out, support from the hospital board is indispensable. Not only from the management, the core within the hospital, but also the quality department as well as the social service function as a facilitator in the realization of patient centeredness (Castro, 2019).

PART 2 – THE PRACTICE

1. Method

Although patient-centeredness has been gaining importance for some time now and we strive for care that is tailored to the individual person, its effective implementation is not evident. Starting from the insights gained from recent literature, it became clear that, partly due to the barriers with regard to the subject, one can speak of a gap between theory and practice. Moreover, the scientific literature lacks clear guidelines for the implementation of this patient centered care model.

For the practical part of this study, an informative report is made thanks to interviews with 5 healthcare professionals from the field. This concerns a patient participation researcher, Eva, who is also part of the mango moment team. Marc, the CEO of a university hospital. Eline, a quality department employee. Marc, a head nurse in ICU as well as Gerwin a ICU nurse. From the top-down and bottom-up approach and the variety of expertise, it will be possible to test the acquired theoretical findings with the current state of affairs in clinical practice. The ultimate goal is to formulate evidence-based recommendations for the implementation of the patient-centered care model in ICU, based on the insights obtained from both components.

2. Practical elaboration

In the interviews statements will be presented, which originate from the theoretical findings. The confrontation about the pain points in the realization of the subject will make it possible to partake a dialogue from the professional experience in practice. The variety of expertise makes it possible to approach the subject from multiple angles in relation to the aspect of warm healthcare. To obtain continuity, each participant receives the same introduction regarding the importance of the topic. Depending on the expertise, 4 additional statements will be offered and each participant will receive the same final question. There are no right or wrong answers. The aim is to enter into a dialogue about the theoretical propositions and how these translate into practice based on everyone's expertise.

An informative video report was made, of which the highlights can be found in the following component. The entire informative report and the video compilation of the 5 interviews can be found online via the following link:

https://vimeo.com/708158399/5345b525f0 *(Dutch spoken)*

3. The statements

1) INTRODUCTION: Quality of care can be subdivided into 6 dimensions. In 2018, the WHO redefined the dimension "patient-centered" to "person-centered".

The transition from the patient-centered to person-centered dimension shows that one has to look at the person behind the patient. Despite the same medical diagnosis, the individual patient may have different care needs because The patient does not exist. As patient empowerment covers many fields, one can never generalize. Furthermore, with the term patient-empowerment we run the risk of overlooking other aspects that are contained in a person. The tendency towards person-centeredness shows that one has to look beyond the medical. In the therapeutic choices, one must take into account the background, the personal story and the nearby network. In addition, everyone can have different needs to obtain a quality life and only our patient can determine his clinical goals. However, not every patient wants to take on that active role, and thus in practice, we often see they prefer to leave the difficult choices to the care provider based on his expertise. Person-centeredness will contribute to a stronger relationship of trust between the patient and the caregiver and patients are seen to entrust confidential aspects more quickly. When they are a full participant in their own care process, this stimulates safer care and therefore better quality of care. Being person-centered means that our communication may require a different approach. Although in decisions in regards to therapy is often discussed with the patient, not all circumstances allow the shared decision-making. Such as in ICU when the patient cannot express his preferences explicitly.

2) In practice, there is a strong focus on the justification of care with an increased registration burden. If these aspects are given priority, there is less room for warm nursing care and person-centeredness.

Registration remains an important part of the care process. Although this aspect can be a frustration for the nurse in practice, they may not be sufficiently aware of the added value of certain tasks or why we should register our actions. Task oriented care or registration will contribute to our care being more efficient, effective and safe. This aspect should not stand in the way of a person-centered approach because both elements form a whole. Moreover, if one has the objective to implement a person-centered model, a procedure will be needed for this. Because frameworks are necessary to make room for the autonomy of the care provider. Both the head nurse as well as the nurse in ICU indicate that the registration obligations could be more user-friendly, so that more energy can go to fully connecting with the patient.

3) 'Compassion' and 'empathy' are core values of good nursing care. Research shows that empathy generally declines as ICU nurses gradually desentasize.

All participants recognize themselves in the statement that over time many care providers lose their original motivation to choose a job in healthcare. In regard to compassion fatigue, it is confirmed that this can depend on the personality of the caregiver. Possibly, reflection can contribute to taking a distance from the day-to-day workload. Person-centeredness and thus also the WMTY concept not only have a positive effect on the patient's care experience, but also result in more job satisfaction for the healthcare professional. Unfortunately, managers do not always pay attention to these soft skills. The advantage in the ICU department is that the nurse is assigned fewer patients and takes on total care. Which contributes to autonomy and can provide more job satisfaction. Happy employees are necessary to acquire happy patients.

4) A person-centered culture requires effective therapeutic and patient-centered communication.

A communication style that is tailored to the individual patient is a clear condition that emerges in these conversations to enable shared decision-making. A warm culture is a general objective because it will contribute to the internal motivation of the healthcare professional to

always put his best foot forward in the interest of the patient. However, in practice one encounters limits in the sometimes-strict care planning. Finding a balance in this does not always appear to be feasible, which means that in reality the preferences of the individual patient cannot always be taken into account. In the past, decisions were often made by the healthcare provider and the patient was not sufficiently involved. Now that we strive to move away from this, person-oriented communication will be essential so that the patient can fully participate in his care. If the care recipient is not sufficiently informed, this can lead to uncertainty for both the patient and those close to him. Furthermore, the importance of our communication can be found in all layers of healthcare. Even when the technician or cleaning assistant enters the patient room, this can be done in several ways. Swiftly entering and leaving the room or addressing the patient briefly brings about a completely different dynamic in the care experience.

5) Family and loved ones are playing an increasing role in the realization of this vision.

In addition to the transition to person-centeredness, the most recent models of quality care incorporate the growing importance of relatives. This also includes caretakers or even a close friend. Each participant confirms the importance of the role that the family can play, but also that this entails organizational challenges. For example, in the case of a dying patient, contact with the family is an important part of the care system. Which is even more important in ICU because of the challenges in shared decision making. In this critical department, the family often cannot communicate with their loved one and they may feel that they cannot contribute. Nevertheless, there are possibilities to involve loved ones in the care process, such as the example of foot massage and aromatherapy. However, there is concern that sometimes too little time is taken for the more delicate conversations. Another example is that also leaving a pet behind due to hospitalization can be challenging in the hospital experience.

6) WMTY states that patient goals should guide our clinical decision making.

Like the Mango moments, WMTY asks for an interplay between the experiences of the patient, or those close to them, and the knowledge of the professional. Without integrating both perspectives, it will be difficult to determine the right therapy for every individual. The difference between WMTY and a Mango moment is that the latter is about the small gestures that don't require extra effort. While WMTY is one of the preconditions in achieving mango moments. Both aspects have a positive effect on the patient, his relatives and the care provider. In ICU, it is believed that therapy-limiting conversations should receive more attention in terms of quality of life, while taking the preferences of the patient into account. In this both doctors and nurses play an equal role. However, the care provider must capture these needs in order to sense where the necessities may lie. Because only then one can achieve mango moments as part of warm care. The creators refer to “A micro moment of positive resonance” as a way to connect with the patient in a very short time. The care teams must consider the personal goals of the patient at every step of the care process. In the interviews it is repeatedly confirmed that our interaction with the patient and therefore the way of treatment makes the biggest difference in the care experience.

7) In the realization of the one-on-one relationship with the patient, the nurses operate as a core component in this vision.

It is seen that patients are more likely to share confidential information with the nurse than with the doctor because they spend less time with them. That is why it is important that all information is mutually shared because information is everywhere. Medicine should be approached as a team sport in which everyone plays an equal role. Although the nurse plays an important role in patient contact, this care model requires contribution from the entire care system. Every healthcare professional contributes to a good outcome. All the more so in ICU where the strong collaboration between the care teams will ensure that everyone is on the same page. Thanks to a multidisciplinary approach, responsibility can never depend on one party in the healthcare system. However, the care provider must be able to capture the needs

of the patient, because only then can one come to mango moments as part of warm care. In relation to this statement, we can question whether all talents can be contained in one person. Some nurses are technically stronger, while a colleague naturally pays more attention to the individual person. Are our expectations too high and are we looking for super humans? A good mix in the team of each profile remains the most achievable.

8) A overall lack of time is seen, by both the nurse and the patient, as detrimental to the quality of care.

This topic is a frequently recurring argument in the scientific literature. Also the "lack of time" is mentioned several times in the interviews. Yet it cannot be so that in practice we will first complete all tasks and only afterwards say "and now we will briefly work in a person-centered way". Fundamentally, this should flow into each other. It is known that receiving warm care, such as a mango moment, does not require any extra time. Our patients will undoubtedly feel the difference between a nurse who quickly walks in and out of the room to change an IV or someone who does share a few words to connect. Although this does not take any extra time, it will greatly contribute to the nursing-patient relationship and the quality of care. More than the time aspect, mostly the personality of the healthcare professional will determine whether person-centredness is intertwined in the entire healthcare process. A better sense of individual needs could be learned through reflection. Likewise, there is a need for role models who have a greater eye for warm care, on which the manager's vision can be of influence. Out of literature it became clear that spending more time with the patient does not always result in better care, which all participants confirm. It concerns both the language and the actions and requires an active input from the healthcare provider. The lack of time is considered a general problem throughout the healthcare system and is not nursing specific. However, one can still be patient-centered in one's own way as a result of a different interpretation of the term.

9) The management styles can facilitate or hinder the achievement of this vision as the business operations will determine the implementation.

The management's vision towards person-centered approach will have a significant impact on the sought-after achievements, as they should be setting the example. However, a management that unilaterally decides to implement patient-centeredness will not be sufficient. In order to achieve change, the objective must be intertwined everywhere. Whereby one must always question whether a certain choice is better for our patient, yes or no. Moreover, a concept such as person-centeredness has multiple facets and can be interpreted differently by everyone. Hence the importance of the organization to provide training and concrete tools. If this vision is a clear pillar, an internal strategy must be deployed that will lead to more success. Simply mentioning the term in the vision will not suffice. A clear policy is needed so that care teams can reflect on the importance of it.

4. Implementation recommendations

10) CLOSING QUESTION: The implementation of the person-centered culture requires a shift in the mindset of every professional in the healthcare system.

It is now known that involving the patient in his care process will lead to improved outcomes. The general mindset about this has already changed. In addition, it is known that every healthcare professional will contribute to the realization of this healthcare model. However, it is the organization that must create the conditions to enable the realization of this care model in practice. Because only then can the care teams contribute in this vision. Working with patient councils is a proposal that is regularly cited. Their advice can be asked for major decisions, with feedback being fed back to the management. The developers of the mango moment model have been running their implementation projects for several years now. Within the healthcare network they offer reflection workshops thanks to online video material and assignments. Experiences are shared during InterVision moments and the options for

integrating the reflection projects into their training are currently being examined. The general mindset is that we already work in a person-centered way, and yet it is often difficult to put into words exactly how this is done. The term mango moment can assist in obtaining those small moments of positive resonance. When everyone understands the theoretical framework, it is possible to integrate a person-centered culture into the entire healthcare system. One can conclude that the warm culture must be everywhere. It starts from the nurse, the doctor, but also from the management to the volunteers who must radiate the same values and standards. This also applies to the quality department, which can start an improvement project in consultation with the management. To even the kitchen that provides nourishing meals. The interviews confirm that during implementation the culture must be interwoven in the entire care process. To arrive at the person-centered dimension, this will require a 360-degree movement for every healthcare provider. Subsequently, this vision will also require an adjustment in the mentality of the patient, who might not always be able, or willing, to take an active role in his own care process.

5. Discussion

5.1. Critical review of the literature

Due to the growing interest in the subject, a wide range of scientific literature can be found in the databases. Which is challeng because the care model contains several facets. On the whole, for this paper, 22 resources were processed from several angles and it was possible to constitute explicable findings. The initial aim of this paper was to inspire the nurse towards warm care, starting from the assumption that they can make the biggest difference in the patient's care experience. However, the literature revealed that although the nurse has historically played an important role in the contact with the patient, the realization of the care model will require a broader strategy. Consequently, thanks to the clear mark out of ICU and the aspect of warm care, it was possible to find answers to the formulated research questions. In the results, the importance and benefits of the care model are discussed broadly in regards to the nurse, the organization, the patient and to a limited extent that of the family as well. The multitude of barriers as well as the lack of implementation guidelines form a clear gap between the theoretical and the practical. Raising awareness that the implementation requires a multidisciplinary approach can be a first step towards a general need to pay more attention to the person within the patient. As such this study comes to the important findings that every healthcare professional contributes to a good outcome, quality of care and therefore in the vision of person-centeredness.

5.2. Critical review of the practical segment

Offering the theoretical propositions to 5 healthcare professionals made it possible to bridge the gap from multiple domains, between the theory and the current state of affairs in the field. The interviews went fluently, partly due to the broad interest in the subject. The bottom-up and top-down approach in confronting the obstacles to the care model contributes to the evidence-based approach. In addition, the diversity of expertise provides many new insights. Certain theoretical propositions where unmistakably recognized by the participants. Among other things, there must be a clear management policy if hospital-wide commitment is to be made towards patient centeredness. The statement that empathy with ICU nurses indeed decreases over time is a remarkable finding in this part of the practice. Furthermore, some doubts arose about other statements because theory does not always correspond to the field. For example, that the care model does not ask for more time. Incidentally, in this section it was questioned whether we are aiming for superhumans and that not all qualities can be contained in one nurse. These elements confirm that the transition towards person-centeredness involves many aspects. In the future, every starting nurse will have to be mindful for their warm qualities in the interaction. With regard to ICU, the growing importance of family and relatives in the domain of quality care was mentioned. Although

this was explained in the theory, on closer inspection it could have been discussed in more detail, since this aspect is widely reflected in the literature. In order to achieve implementation in the field, the reflection workshops of the mango moment model offer a clear framework in the creation of warm care. Although evident frameworks regarding implementation are lacking in literature, the importance and benefits of the care model were widely demonstrated.

6. Resolution

WMTY is seen as a tool to implement patient-centeredness. Asking the patient about the care he or she wants is a first step in guaranteeing quality care. This research emphasizes that the way we treat will make the biggest difference in the care experience of our patient. The mango moment model enhances the patient and family experience. In addition, it will have a positive effect on patient compliance and resilience. In this matter it concerns the small unexpected actions that require almost no extra resources or time. Subsequently, WMTY can provide more job satisfaction for the nurse with less absenteeism as a powerful gain. In knowing that The patient does not exist, we can conclude that one should switch from the term patient-centered to person-centered. In relation to the ICU department, one sees a growing interest of family and relatives in the domain of shared decision-making. Moreover, the development of compassion fatigue in the ICU nurse appears to be an unmistakable obstacle. Thanks to a tool similar to WMTY and the mango moment model, the care provider may be able to achieve more job satisfaction and thus a stronger collaboration from the patient. For the happy caregiver will contribute to the happy care recipient. The countless barriers to the person-centered approach are discussed in the results from several angles. Aided by the aspects of theory and practice, one can formulate substantiated advice that the implementation towards person-centeredness will require a 360-degree maneuver for every healthcare professional in the whole healthcare system. In the realization of this vision, the reflection projects of the mango moment model can function as a theoretical framework to achieve a hospital-wide person-centered culture. Subsequently, this vision will also require an adjustment from the patient, who is not always able or willing to take an active role in his own care process.

Needless to say, this paper only discusses the tip of the iceberg. Since the subject contains many aspects and it can be interpreted very differently by each and everyone. The interviews and the expertise of the five healthcare professionals confirm the importance of the vision, but are only a first step towards bridging the gap between theory and practice.

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