Final report for Improving Fundamental Care in Hospitals: a feasibility study

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2022

Permissions and citation

Study aims and design

This study aimed to assess the feasibility and acceptability of a combined intervention to increase the delivery of patient-centred multiple fundamental care activities, specifically those related to pressure ulcer prevention (hydration, nutrition, mobility, continence and skin care). The planned combined intervention involving adapting the Tell-Us patient feedback card (Jangland et al., 2012) and PrevPlan (Beeckman et al., 2013) and combining them in a new intervention with the Creating Learning Environments for Compassionate Care (CLECC) nursing staff intervention (Bridges and Fuller, 2015).

The objectives and methods were:

Work package 1: To adapt PrevPlan and the Tell-Us Card to ensure they incorporate patient preferences with guideline recommendations for pressure ulcer prevention and deliver a care plan that can be used by patients, carers and nursing staff in the UK context.

We planned that two working groups would be established, one with patients and carers and one with staff. These groups would meet six times within six months. The meetings would involve three stages: gaining understanding, testing prototypes and polishing a final version with patients and staff.

Work package 2: To determine the feasibility and acceptability of the combined use of CLECC, and adapted versions of PrevPlan and the Tell-Us Card to patients, carers and nursing staff.

A cluster randomised trial was conducted on six inpatient wards in two NHS hospitals with four wards randomly assigned to the intervention and two wards to control. Measurements were taken at baseline (T1) prior to the intervention being implemented, and repeated at follow-up, six months after the intervention was introduced (T2). Qualitative semi-structured interviews were also carried out at T2 with staff and patients as a process evaluation to assess the awareness of, feasibility and acceptability of the intervention and experiences of receiving and delivering person-centred fundamental care.

The data collection and intervention period of this project ran from September 2017 to August 2018.

Key results

Work Package One

In an early meeting with the lead pressure ulcer prevention nurse, we discovered that the PrevPlan would not be an appropriate part of the intervention as the options available to patients were more limited than the PrevPlan algorithm would allow. It was therefore not included in the intervention. Five focus groups were completed that explored patient care and adapted the Tell Us card to reflect the UK context (two with recent patients only; two with hospital staff; one with a mixture of both groups). The wording was amended for the UK context as set out in the objective for this package, and this final wording was used in the intervention.

Work Package Two

Primary outcome measures

1. Patient perception of person-centredness of care

This was measured by the patient version of the Individualised Care Scale (ICS) (Suhonen et al., 2010) and the Person-centred Climate Questionnaire – patient version (PCCQ) (Yoon et al., 2015). The Individualised Care Scale (ICS) focuses on health professionals' ability to respond to patients' individual needs in hospital. The Person-centred Climate Questionnaire (PCCQ) explores the extent to which hospital and long- term residential care for older people is person-centred.

Items on the ICS are rated on a 5-point Likert type scale. Higher points indicate more individualized care. Each item is rated on a scale reflecting the patient's level of agreement or disagreement: 1, fully disagree and 5, fully agree with the statement. The scale has a neutral midpoint. Mean scores are calculated for each sub-scale, ranging from 1 to 5 with higher scores reflecting higher individuality in care.

Table 1. Average pre- (T1) and post- (T2) intervention patient scores on Individualized Care Scale by wards and intervention versus control wards

				Ward					
Individualized Care Scale		Intervention	Control	37	38	39	40	41	42
Mean score by trial group for T1		3.7	3.5						
Mean score by trial group for T2		3.5	3.6						
Mean score by ward for T1				3.7	3.8	3.7	3.9	3.5	3.4
Mean score by ward for T2				3.6	3.6	3.8	3.9	3.2	3.5
Overall mean score for T1	3.6								
Overall mean score for T2	3.5								
Overall mean score	3.6								

Table 2. Number of Individualized Care Scale completed by patients per ward

ICS	Wards						
	37	38	39	40	41	42	
T1	20	15	23	32	46	45	plus one missing from ward 42 (questionnaire completely blank)
T2	17	17	16	6	21	21	plus one missing from ward 39

The Person Centred Climate Questionnaire (PCCQ) includes 17 items with a six point Likert scale. Possible scores on the PCCQ for patients therefore range from 17 to 102 with higher scores reflecting a more person-centred environment.

Table 3. Average pre- (T1) and post- (T2) intervention patient scores on Person Centred Climate Questionnaire (PCCQ) by wards and intervention versus control wards

Person Centred Climate Questionnaire	Mean PCCQ summary scores			Wards					
		Intervention	Control	37	38	39	40	41	42
Average summary score by trial group for T1		84	79						
Average summary score by trial group for T2		80	85						
Average summary score by ward for T1				86	92	82	88	79	76
Average summary score by ward for T2				87	76	82	88	78	84
Overall Average summary score for T1	82								
Overall Average summary score for T2	82								
Overall Average summary score	82								

Table 4. Range of patient results on Person Centred Climate Questionnaire (PCCQ) by ward, pre- (T1) and post- (T2) intervention

Person Centred Climate Questionnaire (possible range = 17-102)								
Min/Max scores	Ward 37	38	39	40	41	42	Intervention	Control
T1	43-102	76-102	55-100	62-102	17-102	45-102	17-102	43-102
T2	57-102	55-102	54-102	66-101	34-102	58-102	34-102	57-102

Table 5. Person Centred Climate Questionnaire (PCCQ) patient questionnaire numbers used in analysis

Ward	37	38	39	40	41	42	
T1	20	14	23	30	45	43	plus missing (due to completely blank questionnaires): ward 42 (n=3), ward 41 (n=1), ward 38 (n=1), ward 40 (n=2)
T2	15	17	16	6	19	21	plus missing (due to completely blank questionnaires): ward 41 (n=2), ward 37 (n=2), ward 39 (n=1)

The ICS findings (Tables 1 and 2) show that in both intervention and control wards, patients rated individualised care between 3-4 ('neither agree nor disagree' – 'agree') and both remained at similar levels at T2. There were similar findings from the person-centred climate questionnaire (PCCQ: Tables 3-5), where most ratings were just under or just over '5', indicating 'Yes I agree' on a split-choice Likert scale with no neutral category (4 being 'Yes, I partly agree', 3 being 'No, I partly disagree'). Changes between baseline and intervention were very small in both cases, with little overall change before and after the intervention, particularly in intervention wards.

Qualitative findings

In interviews focused on experiences of person-centred care and implementation of the project, patients were acutely aware of the time constraints experienced by nurses and tended to avoid asking for support unless actively encouraged. Willingness to ask for support was influenced by how staff interacted with them. ‘Engaged’ interactions were open, where staff actively encouraged patients to ask for support. Patients would make fundamental care requests to staff who appeared engaged as ‘nothing was too much trouble’. However, staff were more often described as ‘distracted’ (‘they seem so busy’) or ‘disengaged’ (‘they don’t listen to you’). Patients experiencing distracted or disengaged interactions did not flag missed fundamental care even if they required physical support from staff. Patients requiring more physical support, who had communication difficulties or dementia reported or were reported to have more fundamental care omissions. While patients on one particular intervention ward described a greater number of ‘disengaged’ or ‘distracted’ interactions than other interviewees, interviewees on each ward described experiences of each kind of interaction. Full details of these findings are available in Hope et al (2022).

2. Nurses' perceptions of patient-centredness of care

These were measured using the staff versions of the Individualised Care Scale (ICS) and the Person-centred Climate Questionnaire (PCCQ). Items on the ICS are rated on a 5-point Likert type. Higher points indicate more individualized care. Each item is rated on a scale reflecting the staff member’s level of agreement or disagreement: 1, fully disagree and 5, fully agree with the statement. The scale has a neutral midpoint. Mean scores are calculated for each sub-scale, ranging from 1 to 5 and the higher scores reflect higher individuality in care.

Table 6. Average pre- and post- intervention staff scores on Individualized Care Scale by wards and intervention versus control wards

		Trial group		Wards					
		Intervention	Control	37	38	39	40	41	42
Mean score by trial group for T1		4.5	4.5						
Mean score by trial group for T2		4.5	4.4						
Mean score by ward for T1				4.5	4.6	4.4	4.3	4.4	4.4
Mean score by ward for T2				4.5	4.4	4.6	4.4	4.7	4.3
Overall mean score for T1	4.5								
Overall mean score for T2	4.5								
Overall mean score	4.5								

Table 7. Completion of Individualized Care Scale by staff per ward

Wards	37	38	39	40	41	42	Total
T1	18	12	9	19	32	9	99
T2	4	15	16	16	19	3	73

Items on the PCCQ are rated on a six-step Likert scale (ranging from 1 = No, I very strongly disagree to 6 = Yes, I very strongly agree). The questionnaire is sum scored and scores can range from 14 (a climate not very person-centred) to 84 (a climate very person-centred).

Table 8. Average pre- (T1) and post- (T2) intervention staff scores on Person Centred Climate Questionnaire by wards and intervention versus control wards

Person Centred Climate Questionnaire (Staff)		Trial group		Wards					
		Intervention	Control	37	38	39	40	41	42
Average summary score by trial group for T1		69	65						
Average summary score by trial group for T2		69	63						
Average summary score by ward for T1				66	67	74	69	67	63
Average summary score by ward for T2				66	72	73	64	67	60
Overall Average summary score for T1	68								
Overall Average summary score for T2	68								
Overall Average summary score	68								

As shown in Tables 6-8, both scales showed similar results overall to the findings from patients, with the notable difference that staff rated individualised care as slightly higher than patients did in the ICS. Although overall assessment of individualised care was higher, there was little or no difference between pre- and post- intervention on the ICS and only a small difference between intervention and control groups. PCCQ findings were broadly in line with patient results when compared as a percentage, with no difference between pre- and post- intervention in the intervention group and control group.

Qualitative findings

In interviews, nursing staff described their commitment to the concepts of person-centred care and eliciting patient preference. However, they also described the difficulty of providing this due to both time constraints and the organisation of care around ward-level activities (e.g. drug rounds, mealtimes and washing). Nurses tried to mitigate this by combining questions about care preferences with other activities, such as washing or measuring vital signs. However as we have seen from the patient interviews, while staff may believe they are actively eliciting patient involvement in care decisions they could appear ‘distracted’ to patients, who would then be less likely to ask for support.

3. Quality of staff-patient interactions

Researchers using

QUIS results (see Table 9) showed that most (72%) interactions were rated in the study as positive care (938 out of 1298). We calculated the number of negative interactions by adding together the ratings of negative protective and negative restrictive. Overall, the proportion of negative QuIS ratings was 7% (96 out of 1298 interactions). As Table 11 illustrates, we found wide variation between the individual wards at baseline and follow-up in terms of the proportion of different QuIS ratings.

Table 9. Quality of staff-patient interactions (QUIS) by ward, pre- (T1) and post- (T2) intervention

Hospital	A						B						
Ward	37 (control)		38		39		40		41		42 (control)		
Time	T1	T2	T1	T2	T1	T2	T1	T2	T1	T2	T1	T2	Total
Positive social	24 16%	33 23%	17 11%	15 13%	12 24%	9 12%	22 19%	15 25%	10 8%	10 14%	5 6%	21 14%	193 15%
Positive care	91 61%	106 74%	116 75%	89 76%	38 76%	59 77%	83 71%	40 68%	86 65%	54 77%	59 75%	117 79%	938 72%
Neutral	20 13%	4 3%	11 7%	1 1%	0 0%	4 5%	5 4%	2 3%	13 10%	3 4%	4 5%	4 3%	71 5%
Negative protective	10 7%	1 1%	5 3%	8 7%	0 0%	4 5%	2 2%	1 2%	6 5%	2 3%	3 4%	2 1%	44 3%
Negative restrictive	4 3%	0 0%	6 4%	4 3%	0 0%	1 1%	5 4%	1 2%	18 14%	1 1%	8 10%	4 3%	52 4%
Total	149	144	155	117	50	77	117	59	133	70	79	148	1298
Negative protective + negative restrictive	14 9%	1 1%	11 7%	12 10%	0 0%	5 6%	7 6%	2 3%	24 18%	3 4%	11 14%	6 4%	96 7%

Table 10. Quality of staff-patient interactions (QUIS) by experimental group, pre- (T1) and post- (T2) intervention

	T1		T2	
	Intervention	Control	Intervention	Control
Positive social	61	29	49	54
	13%	13%	15%	18%
Positive care	323	150	242	223
	71%	66%	75%	76%
Neutral	29	24	10	8
	6%	11%	3%	3%
Negative protective	13	13	15	3
	3%	6%	5%	1%
Negative restrictive	29	12	7	4
	6%	5%	2%	1%
Total	455	228	323	292
Negative protective + negative restrictive	42	25	22	7
	9%	11%	7%	2%

As Table 10 illustrates, the intervention group (wards 38,39,40, 41) and control group (wards 37,42) had similar levels of negative ratings at baseline (9% overall for the intervention wards and 11% for the control wards). At follow-up (T2), both groups had lower levels of negative ratings, but the intervention group had a higher proportion than the control group (7% versus 2%). These findings show us that the rate of negative interactions can vary between individual wards. Because this is a pilot trial, firm conclusions about whether things have changed and what caused any changes are not possible to draw.

Mean total COT^{TM} (CARES Observational Tool®) scores were calculated by summing the number of items of person-centred care that were present with a higher score representing more person-centred care than a lower score (possible range 0–16). As we did not have consent to observe care that happened when curtains were drawn, we were unable to score five items involved being able to see the patient during care provided under these circumstances (e.g. during medical examinations or personal care). Where items were missing because they could not be observed, a weighted average of non-missing responses was used to derive the total score (see Tables 11 and 12).

Table 11. CARES scores per ward, pre- (T1) and post- (T2) intervention

Hospital	A						B					
Ward	37 (control)		38		39		40		41		42 (control)	
Time	T1	T2	T1	T2	T1	T2	T1	T2	T1	T2	T1	T2
CARES	8.49	9.28	8.05	8.07	8.10	7.62	7.23	10.81	5.69	10.19	6.76	9.28

Table 12. CARES scores by intervention and control wards, pre- (T1) and post- (T2) intervention

	T1		T2	
	Intervention	Control	Intervention	Control
CARES	7.23	7.59	9.34	9.04

Again, ratings were similar in intervention and control groups, with an increase in both at the end of the intervention. This increase is most notable in Hospital B on the CARES measure, where all wards (including the control) increased ratings, possibly due to hospital-wide drive to improve care quality following care improvement recommendations from a CQC report.

Secondary outcome measures

1. Carer experiences of care

All eligible carers/visitors on each ward over a six week period were invited to complete a Carer Experiences of Care (CEC) questionnaire (Patterson et al., 2011). This included three subscales to be scored separately: giving my relative the best (A1 to A6); could do better (A7-A9); feeling significant (A10-A19; A17 is reverse scored). Results are given in Tables 13-16.

Table 13. Number of visitor questionnaires used in analysis

Wards	37	38	39	40	41	42	Total
T1	7	6	2	2	12	16	45
T2	1	0	0	0	7	7	15

Table 14. Baseline scores on Carer Experiences of Care subscales per ward

Subscale scores per Ward **T1**	37 (n=7)	38 (n=6)	39 (n=2)	40 (n=2)	41 (n=12)	42 (n=16)	Total (n=45)
Giving my relative the best Mean Min to max (6 to 30) *Higher scores=better performance*	22.6 18 to 30	25.8 18 to 29	19.5 15 to 24	21.0 21 to 21	24.1 21 to 29	19.5 8 to 26	22.1 8 to 30
Could do better Mean Min to max (3 to 15) *Lower scores=better performance*	7.1 3 to 14	4.5 3 to 6	4.5 3 to 6	5.5 5 to 6	5.7 3 to 13	6.0 0 to 10	5.8 0 to 14
Feeling significant Mean Min to max (10 to 50) *Higher scores=better performance*	33.3 25 to 43	36.0 27 to 44	34.0 32 to 36	36.5 30 to 43	32.8 21 to 43	28.1 0 to 41	31.8 0 to 44

Table 15. Post-intervention scores on Carer Experiences of Care subscales by wards

Subscale scores per Ward **T2**	37 (n=1)	38 (n=0)	39 (n=0)	40 (n=0)	41 (n=7)	42 (n=7)	Total (n=15)
Giving my relative the best Mean Min to max (6 to 30) *Higher scores=better performance*	24.0	No data	No data	No data	23.3 18 to 29	22.4 16 to 30	22.9 16 to 30
Could do better Mean Min to max (3 to 15) *Lower scores=better performance*	5.0 5 to 5	No data	No data	No data	5.6 3 to 7	5.3 3 to 8	5.4 3 to 8
Feeling significant Mean Min to max (10 to 50) *Higher scores=better performance*	34.0 34 to 34	No data	No data	No data	32.3 23 to 37	31.7 17 to 49	32.1 17 to 49

Table 16. Pre-intervention scores on Carer Experiences of Care subscales by intervention and control wards

Subscale scores per Trial Group **T1**	Intervention (n=22)	Control (n=23)
Giving my relative the best		
Mean (SD)	23.9 (3.6)	20.4 (5.1)
Min to max (6 to 30)	15 to 29	8 to 30
Higher scores=better performance		
Could do better		
Mean (SD)	5.2 (2.4)	6.3 (3.2)
Min to max (3 to 15)	3 to 13	0 to 14
Lower scores=better performance		
Feeling significant		
Mean (SD)	34.1 (6.5)	29.7 (11.9)
Min to max (10 to 50)	21 to 44	0 to 43
Higher scores=better performance		

Table 17. Post-intervention scores on Carer Experiences of Care subscales by intervention and control wards

Subscale scores per Trial Group **T2**	Intervention (n=7)	Control (n=8)
Giving my relative the best		
Mean	23.3	22.6
Min to max (6 to 30)	18 to 29	16 to 30
Higher scores=better performance		
Could do better		
Mean	5.6	5.3
Min to max (3 to 15)	3 to 7	3 to 8
Lower scores=better performance		
Feeling significant		
Mean	32.3	32.0
Min to max (10 to 50)	23 to 37	17 to 49
Higher scores=better performance		

Table 13 shows that there was low recruitment at both pre- and post-intervention, with no data available on half of the wards at follow-up (Table 15). When comparing intervention and control over pre- and post- intervention, there was little improvement or change in the intervention condition, with some minor improvements observed in the control wards, but these numbers were based on very small samples so are unlikely to be representative.

2. Feasibility of study design to inform a future definitive trial, capturing levels of recruitment, recruitment difficulties and feasibility of intervention

Recruitment

Recruitment targets during the preintervention phase were 120 hours of observations for QUIS and CARES observations, with a minimum of 60 patients (one 'index patient' per two hour observation session), 84 staff surveys, 96 patient surveys and 36 visitor surveys (6 per ward). These recruitment targets were met (120 hours of observations were carried out with 98 patients) or exceeded (181 patient, 99 staff and 45 visitor surveys).

In the post-intervention phase recruitment targets were 120 hours of observations for QUIS and CARES observations, with a minimum of 60 patients (one 'index patient' per two hour observation session), 84 staff surveys, 96 patient surveys, 36 visitor surveys (6 per ward), 30 qualitative interviews with staff and 24 qualitative interviews with patients. These were partly exceeded (98 patient surveys), met (120 hours of observations were carried out with 92 patients, but with some lower recruitment for staff surveys (73) and visitor surveys (15). Qualitative interview targets were both slightly exceeded (with 31 members of staff interviewed) and partly met (20 patients interviewed).

These were ambitious recruitment targets in a complex and demanding intervention. While we met or exceeded initial targets, follow-up rates were lower for staff and particularly for visitors. These added to the workload of both ward managers and of research nurses, and future similar work could consider providing additional researcher support when recruitment is lower than expected.

Intervention feasibility

We assessed the feasibility of the intervention through interviews with members of staff on the intervention wards, ward leaders and the Practice Development Nurses (PDNs) who led the intervention. In addition, we asked patients about their experiences of person-centred care (findings described above) and whether they had ever used or seen the Tell Us card. Our key findings were that:

- This combined intervention was complex and required a high level of time and task commitment from wards.
- Use of the PrevPlan was not feasible as the pressure ulcer prevention options available to patients in the hospitals were more limited than the choices included in the PrevPlan algorithm
- There were varying levels of commitment to the intervention, particularly on one ward where a significant ward-level reorganisation coincided with the intervention part of the study.
- Staff appreciated the CLECC elements of the study, although they sometimes struggled to implement the meetings required in this intervention and ward leads varied in their commitment to releasing staff to attend training sessions.
- The Tell Us card was used intermittently and was viewed with skepticism by staff, as was the training around providing person-centred care.
    - Staff members tended to believe they were already providing person-centred care and found the Tell Us care overly formal, or it was perceived as an unwieldy additional part of routinised care.

    - Half the patients we interviewed had never seen the card, or if they had completed one, had not seen or were unsure there had been any changes based on their requests.
    - Nursing teams were unclear about what to do with the card and could interpret it as ward-level feedback like the Friends and Family card, posting it in the research box without acting on individual patient requests.
    - However, staff interviewees could identify instances of it highlighting patient needs that had not been picked up through existing practices

There were no adverse events associated with this feasibility trial.

In summary, two key issues made using CLECC and a patient feedback card not feasible as a final combined intervention in this context:

1. The burden of additional work required to implement these two interventions together. Previous work in the CLECC project shows us this programme is acceptable to staff as a standalone element (Bridges et al., 2018), and in qualitative interviews staff were more likely to discuss this part of the intervention as beneficial and show commitment to it.

2. A lack of commitment to the Tell Us card, and a working assumption that person-centred care was being provided through communication with patients while carrying out other activities. However, interviews with patients highlighted that staff were often unaware of care omissions because patients would not discuss these with staff they perceived as distracted – too busy carrying out other tasks, or as disengaged. This highlights an important gap between how staff believe they are delivering person-centred care and how patients actually experience this care.

3. Pressure ulcer prevalence (as a proxy for fundamental care activities being carried out satisfactorily) measured using audit data

This was not a feasible measure as there was no data available that could accurately indicate a change in care over the period of this study at a ward level.

Conclusion

The quantitative findings indicate that the combined intervention made little difference to staff, patient, and observer judgements of the person-centredness and quality of care. This lack of change can be attributed to the difficulties staff teams had in implementing this complex combined intervention and to a lack of commitment to an intervention targeted at improving person-centred care, which teams felt they already provided. However, our interviews highlight an important difference in how patients and staff perceive person-centred interactions, and that there could be great variation within staff teams. Current research within our group is building on these findings to develop interventions to improve care, particularly for groups most likely to experience care omissions.

Outputs

Publications from the study

Hope, J., Schoonhoven, L., Griffiths, P., Gould, L., & Bridges, J. (2022) ‘I’ll put up with things for a long time before I need to call anybody’: Face work, the Total Institution and the perpetuation of care inequalities. *Sociology of Health & Illness.* https://doi.org/10.1111/1467-9566.13435

Bridges, J Gould, L Hope, J Schoonhoven, L & Griffiths, P (2019) The Quality of Interactions Schedule (QuIS) and person-centred care: concurrent validity in acute hospital settings. *International Journal of Nursing Studies Advances 1, 100001.* https://doi.org/10.1016/j.ijnsa.2019.100001

Conference presentations

Hope, Jo, Bridges, J., Schoonhoven, L., Gould L., Griffiths, P (2018). 'We Give Them Choices within Parameters that Make Them Safe': Fragmented Nursing Practices and Limits to the Personalisation Project. Paper presented at British Sociological Association Medical Sociology Annual Conference 2018, 12-14 September, Glasgow, UK

Further dissemination

We have incorporated the key findings on style of interaction into a module on person-centred nursing care for pre-registration nurses, which runs at undergraduate and postgraduate levels at the University of Southampton and will be sharing with colleagues at Bangor University. We are creating a series of outputs for nursing staff and members of the public. Please contact Dr Jo Hope (j.l.hope@soton.ac.uk) with requests for any further outputs.

Funding

This study was funded by the National Institute for Health Research Collaboration for Leadership in Applied Health Research and Care (NIHR CLAHRC) Wessex. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

Acknowledgements

With grateful thanks to the patients and staff who participated in the study. We'd also like to thank Jess Atkinson, our Patient and Public Involvement representative, for her advice during the project and feedback on early drafts and findings, and the members of Different Strokes Southampton, who gave us encouraging feedback on our initial findings

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