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Barriers and enablers of patient and family centred care in an Australian acute care hospital: Perspectives of health managers

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Cover Page Footnote

We would like to acknowledge the staff who volunteered their time and openly shared their personal experiences as participants in this study. We would like to acknowledge Dr Karen Luxford and Ms Kristina Weeks for their comments on the initial study proposal. We would also like to acknowledge the academic staff from the School of Business and Economics, University of Tasmania for their feedback on this work as part of the first author's completion of a Masters in Health Service Management.

Barriers and enablers of patient and family centred care in an Australian acute care hospital: Perspectives of health managers

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Abstract

The aim of this study was to identify and explore organisational barriers to, and enablers of, patient and family centred care within an Australian acute care hospital from the perspective of that hospital's management staff. A qualitative study, incorporating purposive sampling and semi-structured interviews was undertaken in a 215-bed metropolitan acute care public hospital in Sydney, Australia. Fifteen health managers from a broad range of professional groups, including Medicine, Nursing, Allied Health and non-clinical services were interviewed. Interview data were recorded, transcribed, and analysed for key themes using the Framework Approach. The key barriers to patient and family centred care were: i) staffing constraints and reduced levels of staff experience, ii) high staff workloads and time pressures, iii) physical resource and environment constraints and iv) unsupportive staff attitudes. The key enablers of patient and family centred care were: i) leadership focus on patient and family centred care, ii) staff satisfaction and positive staff relations, iii) formal structures and processes to support patient and family centred care, iv) staff cultural diversity and v) health professional values and role expectations. This study provides an understanding of the factors that restrict and enhance patient and family centred care specific to an Australian acute care hospital setting. Implementation of strategies targeted at these factors may help the study site, and potentially other hospitals in similar settings, to improve patient and family centred care. In turn, this may lead to improved outcomes for patients, families, staff and healthcare organisations.

Keywords

Patient centred care, patient experience, healthcare quality, health services research

Introduction

Patient and family centred care (PFCC) is a multidimensional concept¹, central to which is respect for, and partnership with, patients, their families and carers.² PFCC aims to shift focus away from the interests of healthcare providers to thinking more about what matters to patients³ and has been recognised as one of the six core domains of high quality healthcare.⁴ Supporting the value of PFCC in high quality healthcare is a growing body of evidence demonstrating that PFCC has benefits for patients, healthcare staff and organisations. In particular, research has found that interventions designed to improve delivery of PFCC can increase patient satisfaction, self-management and quality of life, and decrease staff turnover, hospital errors, and readmissions.⁵⁻⁹

Increasing recognition of the value of PFCC is driving many health systems across the world to implement strategies to improve PFCC.¹⁰⁻¹² Australia has outlined its vision to improve PFCC in national and state overarching

healthcare frameworks, plans and standards. For example, as part of ongoing accreditation requirements, Australian hospitals are assessed against PFCC criteria detailed within the National Safety and Quality Health Service Standards, notably Standard 2 'Partnering with Consumers'.¹³

A better understanding of factors that limit or facilitate PFCC could improve its delivery. Studies carried out in the USA, United Kingdom, Europe and Iran have identified a number of PFCC barriers and enablers. Common barriers include: a lack of time; insufficient staffing; inadequate training; environmental constraints; and unsupportive staff attitudes.¹⁴⁻¹⁷ Enablers include: strong, committed leadership; a clear communication of strategic vision; patient and family engagement; focus on employee satisfaction; staff capacity building; accountability and incentives; PFCC measurement and feedback; adequate resourcing for redesign; technology; physical environment; and a culture supportive of learning and change.¹⁶ However, it is not yet known whether similar barriers and enablers are relevant to PFCC in Australian hospital

settings. The present study seeks to fill this evidence gap by identifying and exploring barriers to, and enablers of, PFCC within an Australian acute care hospital setting.

Methods

Study Design

This study used a qualitative exploratory design, which enabled an in-depth exploration of PFCC barriers and enablers.¹⁸ Ethics approval was granted by the local Ethics Review Committee (Protocol No. X16-0206).

Setting

The study setting was a 215-bed metropolitan acute care public hospital in Sydney, New South Wales (NSW), Australia. The hospital caters for a population of 220,000 people over approximately 34 square kilometres. Services include emergency medicine, general surgery, general medicine, aged care, rehabilitation, paediatrics, outpatients, and obstetrics and gynaecology. Seventy per cent of the local population speak a language other than English at home, most commonly Arabic, Greek, Chinese, Italian, Vietnamese and Korean.

The site was selected based on its size and accessibility by the researchers. Its small-medium size enabled a richness of understanding within the available time and resources. The performance of the hospital on PFCC measures based on 2015 survey data was slightly poorer than the average performance of similar NSW hospitals.¹⁹ For example, 53% of adult admitted inpatients reported that they were definitely involved, as much as they wanted to be, in decisions about their care and treatment (compared with NSW peer hospital group average of 60%) and 83% reported that they were always treated with respect and dignity while in hospital (compared with NSW peer hospital group average of 87%).

Sampling and Recruitment

Purposive sampling was used to recruit a maximum variation sample of 'key informant' hospital managers.²⁰ This approach enabled recruitment of managers from clinical and non-clinical areas in positions and/or with experience that was likely to provide rich insights into the research topic. Managers needed to have been employed at least six months at the hospital, to facilitate understanding of local contextual factors impacting PFCC. An email was sent from the first author to invite selected managers to participate. Written informed consent was obtained from participants prior to interview participation.

Sample Size

A sample of 15 participants was intended for this study, based on the available time and resources and the minimum number of participants estimated would be required to achieve data saturation.²¹ Saturation was

defined as no new barriers or enablers identified in two consecutive interviews.

Data Collection

Semi-structured interviews were conducted by the first author in person at the hospital site (n=13) or via phone (n=2) between 7 July 2016 and 4 August 2016. Demographic information (age, gender, position title, length of time employed at the study site and type of work performed) were collected via a paper survey from participants at the beginning of each interview.

Interviews were audio-recorded and transcribed. The interview guide (see Appendix) was developed following review of the PFCC literature in consultation with the study co-investigators. Initial questions sought to elicit participant interpretation of PFCC and awareness of local PFCC data. This helped to orient participants to the topic and guided subsequent questions focussed on barriers to, and enablers of, PFCC. The interview schedule was piloted with one health manager and subsequently amended so that questions about 'barriers' were asked before 'enablers' prior to commencing data collection. This change was made to facilitate interview discussions based on the assumption that participants may be better able to focus on enablers once barriers were explored.

To aid trustworthiness of data collection, the first author checked transcript accuracy against interview audio-recordings,²² participants were asked to review the transcript for their interview, and the authors critically reflected on their assumptions, beliefs and values and the impact of these on the research process.²³ The position of the first author as an employee at another site within the same health organisation was reflected upon because he conducted the interviews. The first author was employed at an education service that provided services to the study site but he had not worked with any of the study participants. This may have facilitated open and straightforward discussions during interviews because he was not directly associated with the study setting but was aware of certain contextual factors.

Data Analysis

Thematic analysis of interview data was undertaken following the Framework Method²⁴ and commenced after the first interview. Thematic analysis was chosen because of its ability to facilitate a rich and detailed exploration of data²², in keeping with the study aim. The Framework Method was used for its advantage in managing and mapping interview data.²⁵ Analysis included: reading and familiarising with interview data including audio-recordings, interviewer notes and transcripts; open coding of transcripts; development and application of a thematic framework; and data charting and interpretation.²⁵ Throughout this iterative process, data were constantly compared and contrasted between participants, with

themes and deviant cases sought out and examined.²⁶ Initially, a more inductive approach to analysis was taken by drawing out themes grounded in participant data. As themes emerged, a more deductive approach was used to interpret and add meaning to these in light of existing literature.²⁵

Coding was performed manually by the first author. Peer checking was employed to aid credibility and confirmability of data analysis,²⁷ whereby two transcripts were open-coded by a second author (ME or LJ). Differences in coding or interpretation of the thematic framework were resolved by discussion between the authors.

Results

Fifteen participants were interviewed (mean interview time=35min, range=16min to 59min), with no new PFCC barrier or enabler themes identified by the final participant. Table 1 shows that characteristics varied among the cohort of management staff, reflecting the sampling objective of maximum variation.

Analysis of interview data revealed four key PFCC barriers and five key PFCC enablers. These barriers were: i) staffing constraints and reduced levels of staff experience, ii) high staff workloads and time pressures, iii) physical resource and environment constraints and iv) unsupportive staff attitudes. Enablers included: i) leadership focus on PFCC, ii) staff satisfaction and positive staff relations, iii) formal structures and processes to support PFCC, iv) staff cultural diversity and v) health professional values and role expectations. Each barrier and enabler is detailed below. Additional data are provided in Tables 2 and 3 to further illustrate each barrier and enabler, respectively.

Barriers to Patient and Family Centred Care

Staffing constraints and reduced levels of staff experience

Both clinical and non-clinical service managers consistently reported that staffing constraints limited PFCC. Managers often spoke about being below their full-time-equivalent target due to recruitment delays and staff leave.

'I think the number of staff that we have – our target number's okay, but we're hardly ever at that target, so you tend to limit what you do for people to match the general number of staff that you've got.' (Clinical service manager 3 (C3))

In addition, a lack of administrative staff to assist clinicians was described as restricting time for PFCC.

'...if I didn't have to do my own admin, there would be basically a lot more ability and time to do patient-centred work and get the [health professionals] thinking about more patient-centred work.' (C9)

Managers reported that staff leave was often not back-filled and that because of this that they were not able to deliver the same level of PFCC as with full staffing. One manager noted that reduced staffing negatively impacted on PFCC by demotivating managers and staff in the workplace (Table 2). When leave was back-filled by casual staff, this still limited PFCC because often these staff did not have the same level of context-specific experiential knowledge as permanent staff.

'We do get staff, but what happens is that they're pool staff members, sometimes without [speciality] experience. So sometimes we could get two pool staff members with two of our own and obviously the service delivery is not good.' (C5)

High staff workloads and time pressures

Managers frequently described high workloads and time pressures as barriers to PFCC. This included both clinical and administrative workloads. Some managers outlined that these workloads were increasing because of increasing patient presentations.

'...time pressure in a busy department is a problem ... there are many times when patient satisfaction would probably be improved by the doctor going in, or the nurse ... and giving a nice timely considered explanation to the patient and family about what's going on, and in busy times that's sometimes just not possible.' (C2)

Some managers also commented that performance targets contributed to time pressures.

'All of the pressures and KPIs that [department name] has don't traditionally work well with giving patients time to digest information and make choices about their care.' (C8)

High administrative workload for clinical staff was also reported as limiting PFCC.

'...with the amount of phone calls and whatnot that the nurses are taking their time to come and answer phones and doing administrative work when they could be in doing patient care.' (C5)

Physical resource and environment constraints

Physical resource and environment constraints included a lack of space available for private conversations with patients and families and a lack of equipment such as beds, computers and comfortable chairs.

'...on the ward you might like to have a reasonably personal conversation with someone but there's four people in a room which is quite small and there is nowhere else to go.' (C3)

Table 1. Participant Characteristics (n=15)

Characteristic	n	(%)
Department¹		
Nursing & Midwifery	3	(20%)
Allied Health	3	(20%)
Medical	3	(20%)
Non-Clinical Service ²	6	(40%)
Professional Background¹		
Nursing & Midwifery	6	(40%)
Allied Health	3	(20%)
Medical	3	(20%)
Non-clinical	3	(20%)
Direct provision of patient care		
Yes ≥ 50% work role	4	(27%)
Yes < 50% work role	3	(20%)
No	8	(53%)
Reporting levels to facility General Manager		
0-1	6	(40%)
2	7	(47%)
3	2	(13%)
Years employed at facility		
½ to < 3	3	(20%)
3-5	4	(27%)
6-10	3	(20%)
11-20	3	(20%)
> 20	2	(13%)
Years employed in the health system		
6-10	2	(13%)
11-20	4	(27%)
> 20	9	(60%)
Age (years)		
25-34	1	(7%)
35-44	3	(20%)
45-54	4	(27%)
≥ 55	7	(47%)
Gender		
Female	10	(67%)
Male	5	(33%)

¹Some staff with clinical professional backgrounds were employed in non-clinical departments, explaining the variation between these two characteristics; ²Non-clinical service areas with ≤ 2 participants were not identified to protect participant confidentiality.

Budgetary constraints and insufficient capital investment to match increased service demand were described as contributing factors to the physical resource/environment limitations.

'We haven't had the capital investment in providing the space to do it in a patient-centred way. Comfort, physical surrounds, all these elements you know, emotional support, all go out the window.' (C6)

Unsupportive staff attitudes

In some areas, managers described staff attitudes that at times were unsupportive of, and acted as a barrier toward, PFCC. These descriptions included cynical views toward PFCC, inflexible decision-making, little motivation for change and a lack of engagement with quality improvement. For example, one clinical service manager commented:

Table 2. Barriers to patient and family centred care

Barrier	Illustrative quote
Staffing constraints and reduced levels of staff experience	<i>'...the last three years we have been stretched. We've always been short staffed because there was somebody away.... We do the basics. We'll get in there and do what we have to do. But we probably could do so much more.'</i> (C9) <i>'If the person was there doing the job on Friday, there still needs to be the same person there to do the job on Monday unless our patient numbers drop. Where is the sense to wait six months to 12 months to sign off a position? So, you get demotivated staff, demotivated managers which all affect patient care.'</i> (NC5)
High staff workloads and time pressures	<i>'The nurses have to take on a fair bit of that work, discharging patients, those clerical issues, non-nursing duties do get in the way.'</i> (C5) <i>'You might have 10 people show up at once ... it's impossible. So, you call backup, but that backup has to come from another area where they're overwhelmed with their own patient load. They've got to leave them to go help. When you're in a situation like that, it's difficult to give all the information the patient needs.'</i> (C8)
Physical resource and environment constraints	<i>'...even simple things like comfortable reclining chairs that I think should be part and parcel of what we do, we don't do. You know, our quiet room was lost, because we needed more beds.'</i> (C6) <i>'...our hospital ... wasn't [designed] to cope with these increases. So, the challenge is when the patients increase what should we do? We haven't got enough beds ... and these numbers just keep increasing.'</i> (C1)
Unsupportive staff attitudes	<i>'Nurses tend to get quite judgemental about who they give their compassion to. Like, who deserves it and who doesn't.'</i> (C8) <i>'...the VMOs are not engaged with PFCC at all and that's our major problem.'</i> (C7) <i>'There is often a perception with nursing staff that, well, no, you can't; visiting hours are over and you have to leave.'</i> (NC2)

C: clinical service manager; NC: non-clinical service manager; PFCC: patient and family centred care; VMO: visiting medical officer

'I do think cynicism reigns, not just in medical but in all departments about [PFCC] ... But people will say exactly the same as I've said ... they'll say, "Well, I always do that."' (C7)

One manager commented that the reason staff attitudes do not always support change to improve PFCC may be because some patients don't have a choice of where to receive their healthcare.

'I think a key element of why we don't give [PFCC] the attention it deserves is that we rely on the fact [that] ... ultimately people don't have ... a choice. I've got a fracture, I need it reviewed, I'll put up with [waiting] five hours ... I've got a pregnancy, I've got to come here, because the baby's delivered here, I don't have a choice.' (C6)

Enablers of Patient and Family Centred Care

Leadership focus on PFCC

A key enabler of PFCC was the focus of frontline and executive managers on leading PFCC among their teams.

'...to get that strong engagement, you need people buying into [PFCC], and you get them buying into it by engaging them and getting them on board, getting them talking about it, getting them to drive it.' (Non-clinical service manager 3 (NC3))

Managers working in clinical and non-clinical departments described leadership facilitating employee engagement and buy-in into PFCC, supporting positive staff relations and communicating clear expectations for PFCC. In some interviews, managers also commented on the importance of leadership for developing a 'PFCC culture'.

'It's about leadership that lives, breathes, talks the talk and walks the walk that patient-centred care matters to me and my service and therefore ... I'm going to ensure you, as part of my service, are part of that cultural road.' (C6)

Staff satisfaction and positive staff relations

Managers also noted that staff satisfaction and good working relations between and within teams were important for enabling PFCC.

‘...we have to look at what affects our patient and family centred care, and one of those things is the staff themselves ... if we have a good, healthy and a happy workforce ... to provide all this care, that goes down to that. You can’t just have happy families without happy staff.’ (NC5)

Several examples of positive staff relations were described (Table 3). Some managers also made specific reference to staff well-being programs as enabling PFCC through facilitating staff resilience and promoting job satisfaction.

‘...a lot of the work we do with [name of nursing staff well-being program] is to try and ... [give nurses] strategies to cope with their stress better, so they feel more able to give compassion.’ (C8)

Formal structures and processes to support PFCC

A range of processes and formal structures were reported as enabling PFCC. These included ‘patient rounding’ and the ‘Five Ps’ (Table 3), as well as ‘structured interdisciplinary bedside rounds’. These processes and structures were described as supporting communication between hospital staff and patients and/or patient families.

Table 3. Enablers of patient and family centred care

Enabler	Illustrative quote
Leadership focus on PFCC	<p><i>‘...our Director of Nursing ... it’s something that she has ... really emphasised to put yourself in the position, that this person is one of your family members and how would you want to be treated? ... she puts it kind of into a real context for us and I think that filters down to everybody.’ (C5)</i></p> <p><i>‘...you’re educating them on what you expect from them in that delivery of care, and if I’m saying I expect you to involve your patients, I expect you to talk to them and tell them what their plan is. I expect you to obtain consent before you do anything. Then they know that’s the expectation of care they’re meant to give.’ (C8)</i></p>
Staff satisfaction and positive staff relations	<p><i>‘I think it’s just the friendliness of the team; a lot of us have been together for a long time.’ (NC1)</i></p> <p><i>‘People feel they’re valued in the team here, and I don’t think you’d find any of our nursing staff who wouldn’t be brave enough to stand up and say to me, “Hang on, you’re forgetting something here,” or, “...wait a minute, do you really want to do that?” ... Everybody is in the team and everybody adds to the decision.’ (C2)</i></p>
Formal structures and processes to support PFCC	<p><i>‘...Five Ps where every hour, you asked ... did [the patient] have everything close to them, was everything plugged in, did they need to go to the toilet, what pain relief did they need and did they need to change position. So that care was centred totally at the patient.’ (NC5)</i></p> <p><i>‘...under the [hospital-specific program] the NUMs round on staff to ask them what the problem is ... and they’ll also have a certain amount of patients they have to speak to everyday and ask questions about how everything’s working.’ (NC2)</i></p>
Staff cultural diversity	<p><i>‘...there’s people from many different backgrounds and I think the patients feel comfortable to see that there’s a range of people.’ (C3)</i></p> <p><i>‘We’ve got a high ethnic population ... [and] they do make people welcome and speaking their same language ... and they kind of know a patient with a surname or their looks and they might say bello in their native tongue.’ (NC1)</i></p>
Health professional values and role expectations	<p><i>‘I think we’re actually in a fortunate position in our profession because ... [PFCC] is all what it’s about.’ (C3)</i></p> <p><i>‘...the [health professional] has to take care of the patient because the patient is under our care.’ (C1)</i></p> <p><i>‘...to be professional means that you have patients as the centre of your care.’ (C7)</i></p>

C: clinical service manager; NC: non-clinical service manager; NUM: Nurse Unit Manager; PFCC: patient and family centred care

'SIBR, which is a structured, interdisciplinary bedside round ... it's done deliberately by the bedside and it's a conversation held with the nurse, doctor and the patient ... and their family, who are invited to be there ... that's a deliberate attempt to enshroud the principles of patient-centred care.' (C6)

Other structures, such as clinician orientation programs, were also described as enabling PFCC.

'They have ... a five-day orientation so they get those [PFCC] skills, plus if they're graduates, they're actually under a graduate program for a year.' (NC5)

Staff cultural diversity

Some managers commented that their workforce was made up of staff from a range of different cultural backgrounds and that this diversity enabled PFCC through promoting respect for patient and family cultural considerations.

'...the demographics of our staff match the patients and so there's a respect for the cultural considerations, there is a respect for the individual, there's a general understanding that we need to involve families in the care of patients.' (C2)

However, one non-clinical manager expressed an alternate view. They noted that this diversity could also act as a barrier to PFCC by making communication difficult.

'When you have people whose English is not their first language and you're handling and caring for patients who English is not their first language, it's very hard because the accents can make it harder ... you're both trying to speak in English and neither of you have English as your first language.' (NC5)

Health professional values and role expectations

Another key enabler of PFCC, highlighted specifically by clinical managers, was the professional values and expectations of health professionals. These managers described PFCC as 'core business' and something that they 'must do'.

'...[PFCC is] something very, very important to [profession] because that's our core value and core business.' (C9)

'...the clinicians must, always, their life must be patient and family centred. You can't be a good clinician unless you do that.' (C7)

Discussion

Interviews with a diverse range of clinical and non-clinical service managers identified four key barriers to, and five key enablers of, PFCC. The factors managers most often spoke about as restricting PFCC were staffing constraints and reduced levels of staff experience, and high staff workloads and time pressures. The two factors managers most frequently spoke about as enabling PFCC were

leadership focus on PFCC, and staff satisfaction and positive staff relations. This suggests that these four factors in particular were having an important impact on restricting or enabling PFCC delivery at the study site.

In comparison with those studies in other countries that identified PFCC barriers previously, both staffing constraints and high workload/time pressures were reported,^{14,15,17} as well as unsupportive staff attitudes^{16,17} and physical resource/environment constraints.¹⁷ The main environment constraints described by participants in this study were a lack of private space, beds and comfortable chairs. Previous studies also identified leadership, staff satisfaction and positive staff relations, and formal structures and processes as enablers of PFCC.^{15,16} This suggests that many of the PFCC barriers and enablers identified in other settings were also important factors impacting PFCC in this Australian acute care hospital. Therefore, this study supports that interventions designed to target these factors may assist healthcare organisations to improve PFCC.

Importantly, this study identified two new factors that enabled PFCC: staff cultural diversity, and the values and role expectations of health professionals. A contributing factor to why staff cultural diversity was reported by the participants in this study may have been the high proportion of patients and staff from culturally and linguistically diverse backgrounds at the study site. Despite not being identified in earlier studies reporting PFCC barriers/enablers, some authors have highlighted that a culturally diverse workforce may have a better understanding of the needs and preferences of a culturally diverse patient population and be better able to meet these needs.²⁸ Therefore, there is some support for healthcare organisations to consider exploring workforce cultural diversity as a strategy to enable PFCC (e.g. through targeted recruitment, where appropriate, or by establishment of culturally diverse work teams), however further research to explore this area is needed.

The role of health professional values and role expectations in enabling PFCC was specifically raised by the clinical service managers interviewed in this study. This suggests that these managers felt strong affinity for the organisation's mission of delivering PFCC through their professional identity as health professionals. However, whether these values actually transferred into enabling PFCC is not known. As Sellman²⁹ pointed out, there are often 'corrupting pressures' in healthcare organisations that can influence health professionals to make decisions based on managerial targets rather than on clinician values of patient centrality, respect and compassion. Additionally, despite clinical managers' declared PFCC values, and articulation of these in professional codes and standards, there is evidence that suggests applying these in practice does not always meet the needs of patients and

families.^{30,31} Further research exploring the effects of clinician values on PFCC would help to determine whether strategies designed to cultivate these values are indicated for improving PFCC.

A limitation of this study, as in other studies reliant on interview data, is the possibility that actual events were different from what participants described.³² This could be due to certain biases influencing what information participants disclosed, such as protection of professional identity and values, or a lack of trust in participant anonymity. However, because the barriers and enablers were identified from a broad range of managers it is considered unlikely that this occurred. Also, due to the limited timeframe preventing confirmation of data saturation as defined in this study, there is risk that additional barriers/enablers were not reported. Because little new data relevant to answering the research question was collected after the 10th interview and no new PFCC barriers or enablers were identified in the 15th interview, we believe that this risk is small and that the number of interviews completed effectively supports our findings.³³ The results and analysis may have been affected by author/interviewer bias in relation to their roles within the study setting,³⁴ but the authors took actions to mitigate this risk, including reflexive discussions throughout the research process.²⁵

Conclusions

This was the first known study to explore PFCC barriers and enablers in an Australian acute care hospital. Many factors identified as influencing PFCC in other countries were also found to be important in this setting based on the perspective of local health managers. Unique to this study, staff cultural diversity and the values and role expectations of health professionals were identified as PFCC enablers. Further research would help to better understand the relationships and impact of these factors on PFCC. Importantly, this study identified factors that warrant close attention by healthcare organisations in designing targeted strategies to improve PFCC. For example, to improve PFCC, health organisations could consider interventions aimed at strengthening staff leadership capabilities to support PFCC, enhancing staff satisfaction and positive staff relations and embedding formal structures and processes to enable PFCC.

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Appendix - Interview Guide

1. What does patient and family centred care (PFCC) mean to you?
2. In your opinion, how do you think your service contributes to the delivery of PFCC?
3. How does your service measure or receive feedback on the delivery of PFCC?
4. Are there any factors that limit you and your service from contributing to better delivery of PFCC?
5. If you could choose to overcome any of these barriers, which do you think would make the most difference to improving PFCC?
6. What factors do you think have helped enable your service to contribute to better delivery of PFCC?
7. Do you have any suggestions for how your service could improve its contribution to the delivery of better PFCC?
8. And more broadly, do you have any suggestions for how you think the hospital could deliver better PFCC?