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Barriers and enablers to the implementation of person-centred care in an Indonesian hospital: a qualitative study

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ABSTRACT

Introduction: Person-centred care (PCC) is increasingly considered as one of the criteria standards for delivering healthcare in hospitals. Registered nurses are increasingly expected to provide PCC in daily practice. However, although the hospital commits to enhancing and improving PCC, implementing this approach into practice has faced barriers and enablers. As the implementation of PCC is still at an early stage of development, it is well-recognised that the need to identify barriers and enablers is essential. This study aims to explore these barriers and enablers to implementing PCC in Indonesian hospitals.

Methods: This study employed a qualitative exploratory study conducted from July 2023 to September 2023 at a public hospital in Pekanbaru, Riau Province. It applied semi-structured interviews to collect data on barriers and enablers to implement PCC from 2 managers and 12 nurses from the medical ward. All participants were selected using a purposive sampling technique. Data collected from interviews were transcribed and then thematically analysed.

Results: Three barriers-related themes emerged, namely time constraints and workload, lack of resources, and communication challenges. Furthermore, three enablers themes also emerged, including leadership, commitment, and sufficient monitoring and supervision.

Conclusions: The study results lead hospital managers and policymakers to overcome existing barriers using adaptive planning and strategies and to improve enablers with well-trained professionals and strong leadership to deliver a PCC approach into practice. The implications to practice are that healthcare organisations must continue their support to decrease the barriers and optimise professional care in healthcare facilities to improve healthcare services.

Keywords: barriers, enablers, Indonesia, nursing, person-centred care

Introduction

In recent years, the concept of person-centred care (PCC) has emerged as a transformative approach in the healthcare landscape, shifting the focus from merely treating medical conditions to fostering a holistic, patient-centred experience. PCC is about selecting and delivering interventions or treatments that are respectful of and responsive to the characteristics, needs, preferences and values of a person or individual (Lloyd, Elkins and Innes, 2018; Dewi and Safri, 2020). PCC has attracted the attention of leaders of visionary healthcare organisations, research institutions and public policy centres, who advocate that patients' interests and concerns should be at the centre of their healthcare experience (Dewi *et al.*, 2014). This approach is increasingly recognised for its potential to improve

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patient outcomes, enhance satisfaction, and foster a more collaborative and respectful relationship between patients and healthcare providers. This model sees clients as no longer passive clients and is where all stakeholders work together to ensure the best possible quality of care (Nkrumah and Abekah-Nkrumah, 2019).

In Indonesia, the healthcare system faces significant challenges, including a growing demand for services, diverse patient populations, and disparities in care quality across regions (Dewi *et al.*, 2014). As the country continues to develop its healthcare infrastructure and address these challenges, integrating PCC into Indonesian hospitals becomes crucial (Dewi and Safri, 2020). Therefore, the Indonesian government has presented its plan to enhance PCC within the healthcare systems at both national and state levels. This strategy includes the development of comprehensive frameworks, plans, and standards. As an illustration, Indonesian hospitals undergo evaluations based on PCC criteria outlined in the National Safety and Quality Health Service Standards as part of their accreditation requirements (Sutoto, 2022).

In addition, increasing recognition of the benefits and values of PCC is driving many health systems worldwide to implement strategies to improve PCC (McCormack, Dewing and McCance, 2011). Potential benefits of implementing PCC in hospitals include significantly transforming the patient experience and enhancing the overall effectiveness of healthcare services. For patients, PCC promises a more personalised approach that respects their needs and preferences, improving satisfaction and better health outcomes (Richter et al., 2022). For healthcare providers, embracing PCC can foster a more collaborative and supportive environment. It encourages more profound engagement with patients, leading to more accurate assessments of needs and tailored interventions. Overall, PCC has the potential to enhance care quality, promote more efficient use of resources, and contribute to a more responsive and compassionate healthcare system (McCormack, Dewing and McCance, 2011; Richter et al., 2022).

Embracing PCC could address issues such as fragmented care, inefficiencies, and gaps in patient engagement, thereby enhancing the overall quality of care (Kong, Kim and Kim, 2022). Over the past ten years, PCC has been introduced and implemented in the hospital's medical wards where this research was conducted. This ward has since become a pilot unit and a centre of excellence for implementing PCC. However, despite introducing and practising PCC for a decade, its implementation still has obstacles and challenges. Both authors are facilitators of the PCC development in the medical ward and are responsible for investigating what hinders its implementation.

Table 1 Interview Questions

Interview Questions
1. Please tell me your understanding of person-centred care.
2. What does person-centred care mean to you?
3. How does your service contribute to person-centred care?
4. What is working well or not well for you to deliver person-centred care?
5. What are the barriers to delivering person-centred care?
6. What are the enablers to deliver person-centred care?
7. How does the hospital support providing person-centred care in the clinical practice?
8. Do you have any suggestions for how the hospital could deliver better person-centred care?

A study by Terry and Kayes (2020) found that integrating PCC into the health system may face difficulties. The effectiveness of PCC implementation is more than just dependent on adopting person-centred practices. However, it is significantly shaped by the hospital system's ability to support and integrate these practices into daily operations (Johnsen *et al.*, 2022). Key factors such as leadership support, staff training and the availability of appropriate infrastructure play crucial roles in either facilitating or hindering the adoption of PCC. Many studies in developed and developing countries have identified several PCC barriers and enablers (Oppert, O'Keeffe and Duong, 2018; Nkrumah and Abekah-Nkrumah, 2019). Common barriers include a lack of time, insufficient staffing, inadequate training, environmental constraints and unsupportive staff attitudes (Johnsen *et al.*, 2022; Kong, Kim and Kim, 2022). Enablers consist of strong and dedicated leadership; effective communication of strategic goals; involvement of patients and families; emphasis on employee happiness; development of staff skills; responsibility and rewards; measurement and feedback on patient-centred care; sufficient resources for improvement; technology; workplace environment; and a culture that encourages learning and adaptation (Lloyd, Elkins and Innes, 2018; Martín-Sanz *et al.*, 2022). The absence of precise details regarding the relevance of similar barriers and enablers to PCC in Indonesian hospital settings is evident. Therefore, this study's research question is: What are the barriers and enablers to implementing PCC in an Indonesian hospital? This study aims to address this gap by pinpointing and examining the obstacles and facilitators of PCC in an Indonesian hospital environment, specifically in the context of medical-surgical care.

Materials and Methods

Study Design

This study used a qualitative exploratory approach based on an interpretive framework, which is the best method to provide a direct picture of the phenomena and to achieve the study's aim. A qualitative exploratory approach fits well with the purpose of this study, which is to use an in-depth exploration to collect data on PCC barriers and enablers (Bekele and Ago, 2022).

Setting

The study setting was a medical ward at a public hospital in Pekanbaru, Riau Province, in Sumatra, Indonesia. The authors chose this location due to its convenient accessibility, and both authors are facilitators who first introduced PCC and its practice development in this hospital, in particular in the medical ward. In addition, both authors are lecturers at the Faculty of Nursing and the Faculty of Medicine at Universitas Riau, and also act as clinical educators for students of nursing and medicine at the same hospital. The authors have not, however, have any direct personal or professional relationships with the participants involved in this study. Universitas Riau and the hospital where this research was conducted have a strong partnership involving practical development, human resource development and research activities. Also, the moderate size of the site allowed for a thorough exploration within the constraints of time and resources available.

Sampling

Purposive sampling was used to recruit various participants and to achieve data saturation. This sampling method allowed the author to recruit managers and nurses from the designated ward. The participants were recruited using the inclusion criteria of nurses who provide care at medical wards. Participants were invited to the study by providing a cover letter distributed by the authors to the ward managers for distribution to the nurses. Registered nurses who agreed to participate then signed informed consent and participated in the study. A sample total of 14 participants (two managers and 12 nurses) were involved in the study. Data saturation was achieved with 14 interviews, consistent with the recommendation of Bekele and Ago (2022) and Hennink and Kaiser (2022). Bekele and Ago (2022) conclude that the minimum number of participants (6 – 12) is required to achieve data saturation. Data saturation in this study was achieved by conducting initial data analysis during interviews to understand the participants' perspectives on the research topic. When additional data collection no longer provided new insights related to the research topic, the authors were deemed to have had gathered sufficient data to understand the phenomena being studied comprehensively.

Data Collection

The authors conducted semi-structured in-person interviews at the hospital site (n=14). Both authors have more than 15 years of leadership experience with expertise in qualitative research. Interviews were conducted in *Bahasa Indonesia* and transcribed and translated into English for publication. The first author translated Indonesian into English as the author had previous experience. After completing the translation, the author cross-checked with a colleague who possesses both active and passive English skills and has engaged in similar activities so as to prevent any loss of words or changes in meaning. The authors guaranteed the participants' privacy during the interviews. Interviews were conducted in secure and comfortable locations chosen by the participants and lasted, on average, one hour. The authors developed eight primary questions (Table 1) following a review of the PCC literature and the purposes of the study. These questions were piloted internally through interviews with registered nurses at the hospital. A paper survey was used at the beginning of each interview to collect demographic information. Interviews were audio-recorded using a digital recorder and then transcribed.

Rigour

The authors conducted trustworthiness of data collection by checking accuracy against interview audio recordings, and participants were asked to review the transcript of their interviews. The initial author's role as a clinical educator at the identical institution facilitated candid and transparent conversations during interviews, as she had no prior interaction with the individuals involved in the study. This situation enabled her to connect closely to the study environment while being mindful of specific contextual factors.

Data analysis

The authors conducted data analysis independently. All authors read every transcript several times to familiarise themselves with the data and then conducted data analysis. The authors employed qualitative thematic analysis to examine the data and enable them to comprehensively incorporate all aspects of the observed phenomena, deriving themes directly

Table 2 Individual participant characteristics

Participants' code (Manager = M)	Gender	Highest education level	Years of employment
M-01	F	Master Degree	18
M-02	F	Master Degree	14
Participants' code (Nurses = N)	**Gender**	**Highest education level**	**Years of employment**
N-01	F	Bachelor Degree	7
N-02	F	Bachelor Degree	11
N-03	F	Diploma	8
N-04	F	Bachelor Degree	12
N-05	F	Diploma	8
N-06	F	Bachelor Degree	9
N-07	F	Diploma	6
N-08	F	Diploma	6
N-09	F	Bachelor Degree	10
N-10	F	Bachelor Degree	10
N-11	F	Bachelor Degree	14
N-12	F	Bachelor Degree	14

Table 3 Profile of Managers (M) and Nurses (N)

Characteristics of Managers (M)	(n=2)	(%)
Gender		
• Female	2	(100%)
Age		
• 45-54	2	(100%)
Educational background		
• Master of Nursing	1	(100%)
Years employed in the hospital	2	(100%)
• > 10 years		
Characteristics of Nurses (N)	**(n=12)**	**(%)**
Gender		
• Female	12	(100%)
Age		
• 25-34	5	(41.7%)
• 35-44	5	(41.7%)
• 45-54	2	(16.6%)
Education background		
• Bachelor of Nursing	8	(66.7%)
• Diploma of Nursing	4	(33.3%)
Years employed in the hospital		
• 6-10	8	(66.7%)
• >10 years	4	(33.3%)

from the unprocessed data. Moreover, thematic analysis is considered a fundamental approach to qualitative analysis due to its adaptability (Clarke, Braun and Hayfield, 2015; Peel, 2020). Each sentence within the interviews served as the unit of analysis for this study. The thematic analysis utilised in this research was guided by Clarke et al.'s (2015) framework for analysing qualitative data, which involves six distinct steps. All these steps encompass becoming familiar with the data to generate initial codes, identifying themes, reviewing the identified themes, defining and labelling the themes, and ultimately producing a comprehensive report.

First, data were managed and appropriately organised into secure files. Second, data were familiarised by reading and re-reading while manually highlighting patterns in the data to find the most relevant statements. Third, the coding process involves breaking down accurate data into smaller, more manageable pieces that can then be categorised and analysed for patterns and themes. Coding enables authors to identify specific data elements relevant to the research question, which can then be used to develop a more comprehensive understanding of the underlying concepts and ideas. Fourth, in developing themes, the authors engaged in deeper interpretation, moving beyond the concrete categories derived from the initial coding process to uncover abstract patterns or trends that shed light on the research questions. Fifth, pattern codes were generated through second-cycle coding to identify emerging themes. Sub-themes described participant experiences by providing quotes, emotions and context to ensure that the participants' voices, feelings and meanings were described in sufficient detail. Finally, these were contextualised and represent the findings. This step signifies the culmination of the analysis; it encapsulates all the findings and insights derived from the data.

The authors formulated a conceptual model grounded in the research findings to address the research questions comprehensively and adopted an inductive analysis method by identifying themes based on the data collected from the participants. Once these themes were identified, a deductive approach was employed to interpret and provide further insights concerning existing literature (Li and Zhang, 2022). The authors carried out the coding process manually and independently. Peer checking was utilised to ensure the credibility and reliability of the data analysis, where the authors independently coded two transcripts. Any discrepancies or differences in coding or interpretation of the thematic framework were resolved through discussions between the authors.

Ethical Consideration

Before conducting the study, ethics approval was obtained from the Ethic Committee of Nursing and Health Research Universitas Riau (No.385/UN.19.5.1.8/2023). Participants were required to give written informed consent, receive a written study information sheet, and listen to a verbal explanation of the study before the interview. Subsequently, written informed consent for audio-recording interviews, anonymous reporting, and publication of research data were also acquired from all participants.

Results

A total of fourteen individuals were interviewed, with their ages ranging from 35 to 50 minutes. The participant's characteristics can be found in Table 2. It is worth noting that all participants were female, and the majority (67%) had 5-10 years of experience in both work and care within the medical ward. Upon analysing the interview data, three primary barriers PCC were identified, along with two key enablers. The barriers included time constraints, workload, lack of resources and communication challenges, while the enablers consisted of leadership, commitment to PCC and sufficient monitoring and supervision. For a more comprehensive understanding of each barrier and enabler, please refer to the detailed information in Table 3.

Barriers to Person-centred Care

Time constraints and workload

Most nurses constantly reported that time constraints and workload limited the implementation of PCC. The issues of 'time' and 'task allocation' were an ongoing concern for nurses. Much of the attention was given to the idea that better care was associated with time-effective and clear-cut task allocation. Nurses spoke about the need to spend more time with clients and families, but time was limited by the demands of other important tasks and the limited availability of staff numbers.

"The tasks (patient care and paperwork) are important and need our full attention … but we do not have much time. It is so hard to prioritise." (N-01-68)

Managers reported that inappropriate time utilisation and management restricted the nurses' ability to engage therapeutically with the patients, discuss their care and attend to complaints. Factors contributing to poor time utilisation include general work demands and the necessity of completing other auxiliary tasks.

"Sometimes, nurses were still not providing direct care and promptly getting to know their patients… instead, they busied themselves with other jobs that were not their primary tasks, such as collecting samples for the laboratory. The time is gone … it is useless… the patient should be their priority." (M–01-7)

Lack of resources

A lack of resources in the ward was also considered an obstacle to implementing person-centred care, resulting in clients perceiving that care delivery needed to be more appropriate. More basic equipment was needed for adequate care, and the lack of supporting resources in the ward had become an issue within the hospital. The poor availability of appropriate resources, such as bedframes, mattresses, wound care kits, oxygen cylinders and suctions and even clean water, were also reported during the interviews. One manager reported:

"Shockingly … the wound care kit has been shared between two patients. This is a hazardous practice … the nurse attended to the minor wound before the larger wound of the next patient. She must have believed this is the most innovative way to avoid cross-infection … but it is unsafe." (M-02- 9)

During the interview, participants reported that more capital investment was needed to increase service demand. One of the nurses stated that;

"The hospital's lack of facilities and equipment has made the services hard to deliver safely." (N-04-47)

Communication challenges

Effective communication between the nursing staff and patients was essential in implementing person-centred care. Some participants identified that inadequate communication among nurses and between nurses and patients might inhibit the practice of PCC. A nurse manager reported:

"What can I say? … Honestly, the nurse rarely visited the patient … the only time they come to the patient is to accompany a doctor's visit and during the shift handover. It is worse at night … no one asked nor visited. How can the staff member know the patient's condition? They (the nurses) should communicate and attempt to find out if there are any concerns or questions about our medication." (M-02-19)

Moreover, limited information and education were provided to patients or their families during their stay and before discharge (discharge information is an integral part of the care). Patients and their families were uncertain about any follow-up information without appropriate discharge planning.

"Sometimes, patients and families are only advised about the outpatient check-up schedule and limited information about prevention after discharge from the hospital. Patients receive no further explanation, for example, on what food to avoid and how to administer the medication … as a result, patients were hospitalised again." (M–01-21)

Enablers of Person-centred Care

Leadership and commitment to PCC

One critical enabler of practising PCC was the focus of frontline and executive managers on leading PCC

among their teams. In this study, the commitment of the nurses and managers in the ward was evident, and there were considerable changes in nursing practice. All participants recognised that person-centred care requires commitment and that it could not be achieved instantly, so they encouraged themselves to move towards the achievement of the desired outcomes.

"Providing........... high-quality healthcare that is person-centred… on highly motivated and trained staff is compulsory to deliver PCC." (N-02-32)

An executive (manager) recognised as favouring PCC highlighted the importance of establishing committees tasked with pinpointing quality deficiencies and creating strategies to enhance healthcare quality. The quality assurance committee was noted to be responsible for executing both targeted and broad quality enhancement measures within the hospital, with designated champions in different units overseeing the implementation and coordination of improvement efforts.

"We have Quality Assurance and Quality Improvement committees charged with ensuring that the healthcare provided to patients is of good quality." (M-01-23)

"Patients' complaints and feedback are discussed at management meetings. We involve ward heads in such meetings to provide solutions to patients' concerns. Where necessary, we hold emergency staff meetings to disseminate decisions to improve patient care among staff management." (M-02-25)

Managers articulated leadership as a means to enhance employee engagement within PCC, foster harmonious staff relationships, and convey unambiguous expectations for PCC. During specific interviews, managers also emphasised leadership's significance in cultivating a PCC practice.

"It is about leadership … that person-centred care matters to me and our service, and therefore … I am going to ensure you, as part of my service, are part of that cultural path.' These are our responsibilities in the nursing division." (M-01-26)

Sufficient monitoring and supervision

The participants reported that mid-level management nurses regularly monitored and provided direct supervision. Participants reported that they were well-supported and that the head of the ward understood and valued their efforts to deliver PCC in daily practice.

"The supervision provided is sufficient and ideal. The head of the ward and the supervisors carried out direct supervision and communicated with the nurse and the patients." (N-03-47)

They also reported that supervision from this level of managers had influenced the change process because it encouraged them to discuss and share their experiences and problems in practice. This was also evident from the participant's statement:

"The supervisors reminded us in a friendly manner that this is what we want … support and supervision … not just pointing out and being told what to do." (N-05-62)

Discussions

Interviews with participants revealed three critical barriers to, and two key enablers of, PCC. The factors that participants reported as restricting PCC were time constraints and workload, lack of resources and communication challenges. The factors reported enabling PCC were leadership, commitment to PCC, and sufficient monitoring and supervision. This study depicts that all these factors have an essential impact on constraining and enabling PCC delivery at the study site. Compared to studies carried out in diverse countries, they reported similar issues related to barriers and enablers of PCC. Factors barriers to PCC identified in this study are consistent with the literature found in various studies where time constraints and workload, lack of resources and communication challenges limit PCC delivery (Lloyd, Elkins and Innes, 2018; Oppert, O'Keeffe and Duong, 2018; Nkrumah and Abekah-Nkrumah, 2019; Kong, Kim and Kim, 2022; Lee, Yang and Lee, 2023). Moreover, the barriers relating to workload were also broadly consistent with those reported in the international literature and included a lack of staff and interruptions to the delivery of nursing care (Huang *et al.*, 2020; Marulappa *et al.*, 2022). Time constraints and demands for completing unrelated tasks have also been reported as barriers (Lloyd, Elkins and Innes, 2018).

Consequently, providing effective person-centred care was reported to be difficult and illustrated how limited resources can act as a barrier to implementing PCC. The nurses highlighted several impediments that interrupted the delivery of direct personal care. Many of these resulted from high client-nurse ratios and extensive paperwork requirements.

A significant barrier identified during this study was a lack of equipment or resources. This barrier differed from the situations reported in Western literature about

shortages of the correct sizes of equipment or resources (Huang et al., 2020; Johnsen et al., 2022). The nurses reported that a lack of essential equipment in the ward impeded the effective and safe delivery of the person-centred model of care. The most basic requirements for health, such as water for washing, were in short supply. Individual needles and dressing trays were observed being used for multiple clients. These issues were related to funding the overall infrastructure and the hospital's financial management system, which the nurses need to control.

More resources are needed to deliver a new system, particularly in human services organisations, which many public hospitals in developing contexts will likely experience. For person-centred care to promote a philosophical change in practice, it must be linked to how resources are allocated and used. Scholars have discussed the factors, such as the financial costs of change and resource constraints, that impede the transformation process (Huang *et al.*, 2020; Johnsen *et al.*, 2022; Marulappa *et al.*, 2022), and it has been suggested that organisations that value flexibility are reasonable environments in which to implement new healthcare models (Johnsen *et al.*, 2022). However, the fact that the concept of person-centred care could be introduced provides evidence that this hospital was a reasonable environment in which to implement the model.

Effective communication between the nursing staff and patient was found to be essential in implementing person-centred care. However, the challenge of communication was found to be a significant barrier in this study. Some nurses preferred to use facial expressions or physical gestures instead of verbal language. Instead of responding verbally, the nurses bowed their heads to indicate they understood. Little communication occurred amongst themselves to confirm that care had indeed occurred, and, as a consequence, some clients complained that the care delivered needed to be based on their needs due to a lack of communication.

Effective communication's significance regarding patient satisfaction, compliance and recovery cannot be overstated. It is widely acknowledged as the cornerstone of all patient care, as emphasised by Maeda and Socha-Dietrich (2021). Effective communication and strong communication skills are crucial in nursing, as they significantly impact the quality of care provided. Research indicates that individuals often express concerns regarding communication issues and a lack of information about their medical condition (Maeda and Socha-Dietrich, 2021). Recent findings suggest that poor communication poses a significant obstacle to delivering quality healthcare, with notable disparities in the effectiveness and frequency of nurse-patient interactions (Tiainen, Suominen and Koivula, 2021). Various elements could have played a role in causing this issue, such as insufficient support from colleagues and ineffective policies. The type of support provided plays a significant role in influencing nurses' ability to communicate effectively, impacting their job satisfaction and overall outcomes in healthcare settings.

It is worth noting that this study has successfully identified two crucial elements that played a pivotal role in enabling the adoption of person-centred care: leadership and commitment to PCC and sufficient monitoring and supervision. In this study, the nurses' commitment as a team in the ward was evident during the interviews. The participants recognised that person-centred care requires commitment and that it could not be achieved instantly, so they encouraged themselves to move towards achieving the desired outcomes. Engaging a new approach in practice requires attention, energy and commitment from a whole team (McCormack, Dewing and McCance, 2011; Ferreira *et al.*, 2022; Richter *et al.*, 2022), suggesting that the transformation to a new culture or practice is a challenging process requiring a sustained effort and commitment from all levels of the organisation.

Management voiced a desire to become a centre of excellence for person-centred care in Indonesia. This situation highlights the commitment of the nurses and the managers to this new model of care. However, it is apparent in the literature that changes to practice will only occur by relying on something other than individual or team motivation. Instead, the implementation of person-centred care requires support and motivation from leaders at all levels of an organisation (Ferreira *et al.*, 2022), as supervision and monitoring have been identified as essential facilitators during the process of transforming care practice (Marulappa *et al.*, 2022).

Monitoring and supervision are also considered key elements to deliver PCC. The participants reported that mid-level management nurses regularly monitored and provided direct supervision. The managers were deeply connected to the organisation's goal of providing patient-centred care due to their strong sense of professional identity as healthcare professionals. This connection to the mission of delivering high-quality care was a driving force behind their dedication and commitment to their work within the organisation. This finding is consistent with previous studies that suggest

that facilitating organisational change and developing practices require managerial support and supervision (Huang *et al.*, 2020; de Jong *et al.*, 2021; Petersson *et al.*, 2023). The literature suggests that investment in staff that can supervise has become a framework that could contribute to quality service provision. As noted in this study, support can also provide opportunities to share and enhance staff knowledge (Marulappa *et al.*, 2022). Here, it was revealed that the middle-level managers directly communicated with the patients and the nurses in a friendly way to remind them of their responsibilities and that they were there to support and discuss issues with them if needed. This direct communication helped the nurses deliver care appropriately.

Implementing person-centred care in practice is complex (McCormack, Dewing and McCance, 2011; Ferreira *et al.*, 2022; Richter *et al.*, 2022). Facilitating factors, such as supervision and a strong team commitment, emerged in this study as aspects that positively influence the development of new practices in the ward; however, implementing a new model of care required a sustained commitment and support from all levels of the organisation. Increasing awareness at all levels helped ensure that person-centred care was made more explicit and operationalised in everyday care services. Potthoff et al. (2023) have pointed out that the reliance on interview data in this study is seen as a limitation, as there is a possibility that the actual events differed from what the participants described. This limitation may be attributed to various biases that could have influenced the information shared by the participants, such as the protection of their professional identity and values or a lack of trust in participant anonymity. This limitation could have significantly impacted the findings since clinical nurses and managers identified the barriers and enablers directly. Nonetheless, due to the limited timeframe, additional barriers and enablers may have yet to be reported, thus potentially affecting the results and analysis. Furthermore, there is a possibility of author or interviewer bias influencing the outcomes, but the authors took measures to address this concern by engaging in reflexive discussions throughout the research process.

The limitation of this study was that, due to hospital regulations, the participants involved were limited to the nurse managers and nurses in the inpatient medical ward. The participants should represent several wards to provide a general overview of the barriers and enablers to implementing person-centred care. However, this is still appropriate for a qualitative study.

Conclusion

Implementing PCC can lead to significant health benefits for individuals, yet there is room for improvement in its application. This research study highlights various barriers to implementing PCC, explicitly focusing on the study site. As noted by local health professionals, factors influencing PCC in different countries were found to be equally important in this particular setting. Further investigation is required to fully comprehend the relationships between these factors and their impact on PCC. The study underscores the importance of healthcare organisations paying close attention to these identified factors when developing targeted strategies to enhance PCC. For instance, organisations could consider implementing interventions aimed at bolstering staff leadership skills to support PCC better, improving available resources, enhancing staff relationships and communication abilities, and establishing formal structures and methodologies to facilitate the delivery of PCC. The practical implications are that healthcare organisations must maintain support to identify and implement effective strategies for applying person-centred care in clinical settings. This ongoing support is essential to overcoming barriers and enhancing professional care within healthcare facilities, ultimately leading to improved healthcare services.

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Conflict of Interest

The researcher holds a specific role within the institution where this study was conducted. This role may introduce potential biases in the research process. However, the two authors have taken into account professional relationships, as there are no direct

personal relationships with the participants involved in this study

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