A Guest Editorial

Last Word: Patient- and Family-Centered Care

The recent movement in nursing and other health care professions to provide patient/family-centered care (PFCC) is rooted in the Institute of Medicine report *Crossing the Quality Chasm*, which called for systems to include both the patient and the family in health care planning on an individual and institutional level. Patient/family-centered care is a laudable and well-directed effort that just makes sense. What hospitalized patient would not prefer to be cared for in a setting that individualized care and welcomed their family at the bedside? In recent issues of *Dimensions of Critical Care Nursing*, there have been articles discussing the implementation of PFCC and literature reviews. All of these articles provide help to the nurse trying to implement PFCC changes. This is important because many patient care services are welcoming PFCC initiatives in their journey to become a designated Magnet hospital.

Resources for those who want to reshape their workplace to provide PFCC are increasing under the leadership of the Institute for PFCC. But in this day of evidence-based practice, we need to demonstrate the outcomes of PFCC. The Agency for Health Research and Quality has funded such studies to demonstrate the benefits of care that is based on a patient and family model. Having empirical evidence provides a stronger base of support for the PFCC initiative.

However, it is important to note that PFCC is not a new idea. Modeling and role modeling (MRM) is a nursing theory proposed by Erickson et al in 1983 that has long advocated this approach. The patient and the family are the primary sources of assessment data, and determining the patient’s perceptions of the situation is essential for individualizing the approach to care. The assessment builds a model of the patient’s world, and interventions are aimed at remodeling that world to promote health outcomes. Five aims of intervention guide the nursing plan of care (Table). This theory has been updated in 2 more recent books edited by Helen Erickson. New ideas for holistic healing across the life span and in varied settings are introduced, but the 5 main interventions persist.

One reason often cited for why PFCC is not adopted or not successfully implemented is that the model of care is vague and difficult to apply in practice. Magnet requires that a model of care be clearly articulated. I suggest that any hospital without a model of care explore delineating a practice model built on the concepts within MRM. Start by really building a model of the patient’s/family’s world. Simply ask the patient what is going on. Then work with the patient and family to remodel that world using the 5 aims of intervention. The Goal of the Day is a perfect example of how you can implement this PFCC approach.

Decades of research support these 5 simple interventions across the life span and in a variety of settings. So let’s get started and apply this research to practice. Patient/family-centered care should not be a trendy new approach to care. It is time for PFCC to be clearly articulated in all patient care settings. The MRM theory can help make that happen.

References


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