A patient-centred approach to assisted personal body care for patients hospitalised with chronic obstructive pulmonary disease

Annesofie L Jensen, Tina W Vedelø and Kirsten Lomborg

Aims and objectives. To explore the patients’ experiences of receiving patient-centred personal body care and to document changes compared to the patients’ experiences in previous hospital stays.

Background. Patients with severe chronic obstructive pulmonary disease suffer from breathlessness. Personal body care is therefore often a major challenge, and during exacerbation these patients may need comprehensive assistance. The quality of assisted personal body care depends largely on the patients’ and the nurses’ symptom recognition, disease management and ability to achieve therapeutic clarity in the nurse–patient interaction. We developed, implemented and evaluated a patient-centred approach to assisted personal body care in which these characteristics were sought.

Design. The study is a qualitative outcome analysis with an interpretive description methodology.

Methods. Nine female and two male hospitalised patients with severe chronic obstructive pulmonary disease were selected for patient-centred care. Specially trained nurses and nursing assistants performed the patient-centred personal body care. Data material was obtained through participant observation of body care sessions with the patients, followed by individual in-depth interviews. The transcribed interviews were analysed and an interpretive description of the patients’ experiences was established.

Results. All patients experienced the patient-centred care to be different from what they had previously experienced. The most fundamental change was the experience of being an active part of a shared project. This experience encompassed three dimensions: clear signs of acknowledgement, attentive time and security.

Conclusion. Patient-centred assistance enables patients to take an active part in their personal body care activity. The intervention may be a method for nursing staff to secure patients-centred care.

Relevance to clinical practice. Effective communication, tools for the assessment of breathlessness, clear and straightforward organisation of body care sessions, awareness of pauses and personal acknowledgment are important for the patients’ ability to take part in personal body care activities.

Key words: bathing, body care, breathlessness, chronic obstructive pulmonary disease, evaluation study, interpretive description, nurse–patient relationship, patient-centred care, qualitative research, respiratory nursing

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Introduction

Patients diagnosed with severe chronic obstructive pulmonary disease (COPD) suffer from breathlessness. Although lung function is important for the diagnosis and treatment of COPD, clinicians and patients are also very keen to learn more about the impact of the subjective experience of breathlessness on functioning and general well-being, and...
attention should therefore be given to these patient-centred outcomes (Tashkin 2006). To cope with breathlessness, the patients use strategies that span a variety of interacting physiological, cognitive, affective and psychosocial dimensions (Clark et al. 2009). In advanced stages of the disease, the patients may not be able to compensate for breathing problems and functional limitations (American Thoracic Society 1999) and will, among other daily activities, need comprehensive assistance with personal body care activities such as bathing, washing, grooming, eliminating and getting undressed and dressed (Lomborg & Kirkevold 2005).

During episodes of exacerbation, these patients are often hospitalised and their everyday routines get disrupted. While in hospital, the patients depend largely on the nursing staff’s knowledge, practical skills and approach to the patients’ breathing difficulties (Lomborg & Kirkevold 2005). In addition to their severe breathlessness and other COPD symptoms, the patients may experience unpleasant, embarrassing situations when depending on alternating professionals to receive help for personal bodily matters (Lawler 1996).

A prior study (Lomborg et al. 2005) has reported that assisted personal body care (APBC) is of great significance for the patients’ well-being during hospitalisation and that patients consider personal body care a necessary ordeal, which has to be carried out every day, regardless of the constant dilemmas: On the one hand, it contributes to preserving the patients’ integrity and includes comforting elements of touch, massage and the pure and simple pleasure of the nurse being there. On the other hand, it may also induce an unpleasant awareness of being vulnerable and dependent on help.

A recent study (Lomborg et al. 2011) documented the feasibility of a training programme to improve the competences of respiratory front-line nursing staff to act in a patient-centred manner and surpass the patients’ physical strains of COPD and the potentially unpleasant situations and delicate matters of being assisted with personal body care. The study, however, exclusively addresses the nursing perspective, and further warrant of the efficiency of patient-centred APBC from the patient perspective is therefore needed. Consequently, we conducted a randomised clinical trial (RCT) in which a total of 82 hospitalised patients with severe COPD were included to receive either ‘patient-centred personal body care’ or ‘personal body care-as-usual’ during hospitalisation. The primary outcome measure was the amplitude of the patients’ breathlessness and the secondary, their perceived quality of care. We will attempt to publish the results of the RCT in a forthcoming article. Complementary to the RCT we conducted a qualitative outcome analysis (QOA) (Morse et al. 2000) of patient experiences of the patient-centred APBC intervention. In this article, we present findings from the QOA.

**Background**

The incidence of COPD is increasing worldwide (World Health Organisation 2011). Episodes of exacerbations are part of the typical COPD illness course (GOLD 2010), and in spite of supportive primary health care services and long-term oxygen therapy, the severely breathless patients are frequently admitted to hospital (Kinnunen et al. 2007, Mannino 2007).

Breathing difficulty is the most prevailing and disabling problem experienced by a large population of people suffering from COPD (Meek 2004, Barnett 2005, Fraser et al. 2006). Breathlessness is a subjective experience defined as ‘the subjective feeling of laboured breathing with or without dyspnoea and/or abnormal pulmonary function’ (West & Popkess-Vawter 1994). Breathlessness consists of qualitatively different sensations with fluctuating intensity occurring as a result of an interaction between physiological, psychological and sociocultural factors (GOLD 2010). COPD-induced breathlessness is arduous and difficult to treat (Nici et al. 2006). Physiologically, breathlessness is associated with an increase in muscle force requirement, a reduction in respiratory muscle strength and endurance, and an increase in the recruitment of the rib cage and accessory muscles. Unsupported arm exercise further compromises respiratory muscle capacity for ventilation because it requires the muscles’ concomitant recruitment in the maintenance of chest wall stabilisation (Breslin 1992).

In advanced stages of COPD, the impairments of unsupported arm function endurance debilitate even rather simple activities of daily living such as self-grooming and showering thereby limiting the patients’ independent functioning (American Thoracic Society 1999). Consequently, the patients develop a range of both constructive and less constructive coping strategies over time. Reducing their level of activity is one of the most commonly used strategies in dealing with breathlessness (Pitta et al. 2005). For instance, people with COPD may often delimit a daily activity like personal body care because the accomplishment of this activity is gruelling and wearsome (Leidy & Haase 1999, Lomborg & Kirkevold 2005, Lomborg et al. 2005).

In general, the nursing staff’s ability to facilitate patients in managing personal body care is considered a central area of the nursing practice (Castledine 2003). More specifically,
the challenges of APBC in patients with COPD have been reported in a number of studies (Barnett 2005, Kanervisto et al. 2007, Gullick & Stainton 2008, Clancy et al. 2009). These studies offer general advice, e.g. that nurses and other health care professionals should listen to how the symptoms affect the patients, and subsequently provide innovative patient care. However, none of these studies report any detail of nurse–patient interaction during APBC and offer only few pieces of practical clinical advice, such as the breaking up of routines into smaller parts (Fraser et al. 2006) and developing strategies for supporting the individual patient to manage episodes of breathlessness and avoiding panic attacks (Barnett 2005). To our knowledge, only one study has addressed nurse–patient interactions during APBC in patients diagnosed with COPD (Lomborg & Kirkevold 2008). The study demonstrates the importance of achieving therapeutic clarity in the nurse–patient interaction characterised by the following: (1) reaching a common understanding of the patient’s current condition (breathlessness in particular), and stage of illness trajectory, (2) negotiating a common scope and structuring body care sessions and (3) clarifying roles.

On the basis of these previous findings, we developed, implemented and evaluated a patient-centred APBC intervention in which therapeutic clarity was sought. The overall ideal of patient-centred health care is to empower patients and their families (Reynolds 2009). There is no widely accepted definition of patient-centred care (Mead & Bower 2000, Sidani 2008). In this study, we regarded patient-centred care to include a bio-psychosocial perspective, a recognition of the patient as a person, a shared power and responsibility, a therapeutic alliance and a view on the health care professional as a person (Mead & Bower 2000). In practice, it reflect recognition of patient’s needs and preferences and includes cultivating good communication skills, providing the patients with clear and useful information and including the patient in the decision-making process as it concerns the individual health needs (Mead & Bower 2000, Reynolds 2009). The intervention aimed at involving patients in APBC in a patient-centred manner, respecting the patients’ individual illness conditions (breathlessness in particular), needs and preferences and safeguarding the patients’ integrity. As recommended by Schumacher et al. (2005), we chose a qualitative research method to add a dimension to the RCT that could not be obtained through measurement of isolated variables alone. The aim was to explore the patients’ experiences of receiving patient-centred APBC and to document changes compared to the APBC procedures as usual as experienced by the same patients during previous hospital stays.

Methods

The study was designed as a QOA (Morse et al. 2000, Polit & Beck 2004). QOA builds on an already completed qualitative study in which a clinical problem has been examined. It is an inductive research strategy, which permits researchers to examine the dynamics of clinical interventions without prescriptive hypotheses. Unlike more traditional forms of evaluation research, QOA addresses issues of both process and outcome to enhance intervention applicability to complex clinical experiences. In accordance with Morse et al.’s advice, the study was conducted in five steps:

1. An intervention protocol was outlined based on three inter-related grounded theory studies (Lomborg & Kirkevold 2005, 2008, Lomborg et al. 2005).
2. Relevant types of data collection were identified.
3. A protocol for data collection was described.
4. Data analysis was conducted covering both process and outcome findings.
5. The study findings were reported.

The data collection and analysis were guided by the principles for interpretive description as described by Thorne (2008). With its inductive approach and its focus on applied science within the health science discipline, this strategy fits well with QOA. Applying the principles for interpretive description to our study meant that the study was located within the above outlined existing body of knowledge to construct new findings and relate these to the research literature in the field. We strove to obtain maximal variation sampling on the themes that emerge from the initial inductive analysis and we consciously sought the commonalities within the data material leaving eccentricities behind our scope. The analytic process was based on synthesising, theorising and re-contextualising rather than simply sorting and coding. To produce sound and usable knowledge, we engaged in both the ethereal abstractions of theorising and the concrete realities of the practice context.

The intervention protocol

The patient-centred APBC sessions were performed by seven nurses and six nursing assistants who had completed a patient-centred APBC training programme as described by Lomborg et al. (2011). This programme was based on three overarching principles: (1) The individual patient should be in focus, and special attention should be given to the patients’ experience of breathlessness; (2) The nursing
staff should establish a patient relationship; and (3) The APBC session should be structured. These principles were substantiated during four consecutive phases:

1. Initiation of the session offering all the necessary assistance and an invitation for the patient to participate as much as possible and preferably, taking the patients’ breathlessness and other critical conditions and concerns into account.

2. Information exchange to (1) reach a common understanding of the patient’s current conditions and stage of illness trajectory, (2) negotiate a common scope and structure the body care session, including preplanned pauses to prevent escalating breathlessness and (3) clarify roles.

3. Accomplishment of the body care session in flexible accordance with the negotiated scope, structure and role taking.

4. Evaluation to (1) share experiences (2) identify future assistance needs and preferences.

As the first part of the information exchange, patients were encouraged to score their level of breathlessness on The Modified Borg Scale (Kendrick et al. 2000). The activity plan was adjusted according to the patients’ score, and pauses were included subsequently during the APBC sessions to prevent escalating breathlessness. The nursing staff used Lomborg et al. (2011) ‘agreement sheet’ as a tool to support structuring the information exchange regarding all details of the APBC sessions, clarifying mutual expectations and maintaining common agreements. The idea of using this tool is to ease the patients’ decision-making and to prevent communication-induced escalation of the patients’ breathlessness during the body care procedure. The tool is a one-sided easy to sign A4 paper sheet with the objectives (1) assessment of breathlessness and other patient specific conditions that should be taken into account as the point of departure for planning and performance of APBC; (2) provisions (e.g. preferred time for procedure, use of medical devices and preplanned pauses); (3) procedure (bed bath, shower, soft towel etc.), body care products (deodorant, body lotion etc.), clothing and aids (glasses, dentures, nappies etc.); (4) special needs and desires concerning all parts of the body (face wash, hands wash, intimate hygiene, nail care, teeth and mouth care etc.); (5) support needs (full assistance, partial assistance or self-assisted); and (6) evaluation including assessment of peak of breathlessness during the APBC session and provisional agreements about APBC the following day.

**Setting and sample**

A convenient, consecutive sample from the RCT intervention group was invited to participate. Patients were hospitalised in two different departments of a Danish university hospital. The one was a department of respiratory diseases with an annual intake of approximately 241 acute patients with COPD. The other was a department of endocrinology and internal medicine with an annual intake of approximately 206 acute patients with COPD. The included patients were hospitalised due to acute exacerbations of their COPD. The patients were in COPD stage II–IV (GOLD 2010). They were dependent on assistance with personal body care (judged by the nursing staff), were able to communicate and had intellectual capacity to understand what was going on. Furthermore, the patients had at least three days of experience with patient-centred APBC and should, for comparison, previously have been hospitalised and received APBC according to their COPD. Following these inclusion criteria, nine female and two male patients diagnosed with moderate-to-severe COPD were invited and subsequently accepted to participate. All the patients received medical treatment and continuous oxygen therapy. The age of the patients ranged from 54–85 with a mean age of 71. Their distribution to the separate departments was as follows: four patients from a unit in the department of respiratory diseases and from the department of endocrinology and internal medicine came two and five patients from two different units. The patients’ profiles and body care procedures are described in Table 1.

<table>
<thead>
<tr>
<th>Participant no.</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Procedure of APBC</th>
<th>Degree of COPD</th>
<th>Time of APBC (minutes)</th>
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<tr>
<td>01</td>
<td>Female</td>
<td>69</td>
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<td>Male</td>
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<td>B</td>
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<td>Male</td>
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<td>A</td>
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<td><strong>Mean</strong></td>
<td></td>
<td>71</td>
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A = Shower.  
B = Partial washing of the body, sitting with Bag Bath at the edge of the bed.  
C = Partial washing of the body, sitting in front of a sink.  
APBC, assisted personal body care; COPD, chronic obstructive pulmonary disease.
Data collection

During a period of 12 months (2007–2008), the first and second author collected data from 7–4 patients respectively. Data material was obtained through participant observation of APBC sessions, followed by individual in-depth interviews with the participants using a semistructured guide. Sessions were defined from when the nursing staff introduced themselves to the patient and asked how he or she would like to be bathed or washed. The end point was defined as when the nursing staff left the room after assisting with personal body care and the patient was dressed again. During participant observation, the researchers observed the nurse–patient interaction with a modest degree of participation in conversations with the nurse or patient, and only when directly addressed which sometimes occurred, for example when a patient made a joke. Field notes were taken during and immediately after participation using a semistructured guide. The guide included questions like, ‘when and how did action take place?’ as well as more specific questions like ‘who took the initiative for a pause (the patient or the carer)?’ or ‘who resumed body care after the pause?’ Studying the patients-centred APBC by participant observation provided a basis to adjust and qualify the interview guide and made it possible to ask situational questions during the interview.

The in-depth interviews were completed one to three hours after the patient-centred APBC session and took place in the patient room or a quiet area in the unit. The break between the patient-centred APBC and the interview made it possible for the patient to regain strength, as well as to reflect on the experiences (Sandelowski 1999). Furthermore, the researchers had more time to read through the notes taken during participant observation and to prepare specific questions related to the observed interaction between the patients and nursing staff. The interviews lasted from 25–65 minutes and were audio taped and transcribed.

The interviewers followed a semistructured guide covering four themes: (1) living with COPD, (2) being a patient, (3) receiving help for personal body care and (4) comparing past experiences of personal body care with present. Each theme comprised four to six open-ended questions such as ‘please describe your everyday life and how your illness has affected it?’, ‘what is it like to be a patient with COPD?’, ‘please describe what was going on during your personal body care?’ and ‘how would you compare the way you received assistance with body care with the care received during previous hospitalisations?’ The participants were encouraged to speak freely about their experiences and reminded that there were no right or wrong answers and that the nursing staff would not be informed about their reflections.

Analysis

The QOA was so-called goal-free evaluation (Patton 2002) meaning that the approach was inductively searching for the actual efficacy of patient-centred APBC. The analysis addressed process content and outcome and consisted of an interpretive description (Thorne 2008) of the patients experience of patient-centred APBC. In accordance with the interpretive description strategy, data construction and analysis were conducted concurrently, asking questions like ‘what is the data telling us?’ and ‘which conceptual units do these experiences relate to?’ The second author performed the initial open coding and analysis based on the first four interviews. These initial analyses led to data sets sorted into initial units, tested for relationships, which resulted in basic conceptual units and an initial interpretation. For example, initial units labelled: ‘pause as an instrument’, ‘showing you have time’ and ‘equalising time’ later formed the pattern of ‘attentive time’. The first author continued the analysis by integrating the remaining interviews in a process of going back and forth between the data, the codes, the basic conceptual units and initial interpretation. Questions such as ‘what do I see and why?’ were continually asked. Being this familiar with the data material made it possible to consider similarities and differences with respect to the wide range of dimensions among the individual cases. Finally, the systematic comparative analysis enabled us to establish a coherent, defensible and data-grounded interpretive description that articulated the participants’ overall experiences. The data collection and analysis were supported using the software programme Nvivo.

Ethical considerations

The Danish Data Protection Agency approved the project (J. No. 2006-41-6843) and the study was approved by the Chief Executives of the participating clinics. According to the Scientific Committee for the Regional County, the Biomedical Research Ethics Committee System Act does not apply to this study. With reference to The Helsinki Declaration (World Medical Association 2011) all participants received written and oral information about the study and informed content was obtained. Confidentiality and anonymity was ensured as names and recognisable places were removed. By the end of the interview, the participants were asked how they experienced the researchers being
present during APBC. None of the participants mentioned any discomfort.

Finding

All participants experienced patient-centred APBC to be different compared with previous experiences of APBC during hospital stays. The most obvious change was the experience of being an active part of a shared project. Based on the participants’ wishes and needs, and despite of their limited physical resources, the participants found themselves actually being able to take an active part in their personal body care. The expression ‘being an active part of a shared project’ related to the participants’ experiences of personal body care being the main activity not only for themselves but also for the nursing staff and this, in turn, appeared to legitimise their needs of getting help and being properly assisted with personal body care activities. This overarching experience was important for the participants’ well-being and helped them to maintain their integrity. The underlying patterns of establishing a shared project included the establishment of clear signs of acknowledgement, attentive time and security. These patterns remained significant across the four consecutive phases of the APBC session.

Clear signs of acknowledgement

All participants described how the nursing staff’s communication had an impact on their experience of patient-centred APBC. It appeared that working together with the nursing staff developed into a comforting interpersonal relationship:

They are nice and friendly and they don’t talk down to you. That’s important. (…) It is important to show mutual respect, which means a lot to me. (Participant 01)

The participant also described this by referring to the nursing staff as ‘friendly’, ‘nice’, ‘listening’ and ‘loyal’, and they experienced how the nursing staff kept an open mind when they asked about the participants’ perception, experiences of breathlessness and needs for APBC. As one patient described:

Others don’t care how you feel when you are finishing getting washed, if you are content? They don’t care; they just want the job done. But here… I think it’s nice here. You are treated… well, like a human being… (Participant 06)

The nursing staff’s patient-centred approach seemed to result in receptiveness towards the participants’ thoughts and feelings, implying an experience of recognition and acceptance of the participants’ situation.

The use of ‘the agreement sheet’ and the patient-centred approach instigated a mutual understanding of the patients desired needs for APBC, which lead to the experience of APBC being carried out according to the patients’ wishes. Of the 11 participants, 10 considered it to have been their decision about how they wanted assistance with a shower, a bed bath or partial wash when sitting at the edge of the bed or in front of a sink. The last participant experienced codetermination. One of the 10 patients expressed:

It felt like I was in charge. I didn’t feel pressurised. Not at all. We could talk about it and there were no problems at all. Then she said: Do it like this and not like this – and we just talked about it. She allowed me to do what I wanted to do, but she took over if I couldn’t manage. (Participant 09)

The patients’ experience of the nursing staff as open minded and appreciative became the foundation for further support and guidance during the performance and evaluation of APBC. For example, the participants described how the nursing staff supported them on how and when to take a pause or the pros and cons of being transported to the bathroom in a wheelchair. Being given the opportunity to describe, discuss, decide and evaluate the amount of assistance needed seemed important for the patient’s ability to participate in the body care activity:

It was on equal terms – that is what I feel. I haven’t just been washed. We were equal and I made my own decisions. She didn’t just sit me down on a stool and say ‘let’s get you washed’ and then disappear. We were equal, and we talked about it and that is important. (Participant 07)

Patient-centred APBC established the basis for generating an acknowledging atmosphere, allowing free exchange of the necessary information and instruction and establishing a mutual understanding of the patients’ need of APBC. It ‘transformed’ the participants into active partners in the body care activity.

Attentive time

The participants described how time was an important issue in relation to APBC, as sensing a feeling of time pressure and high physical activity would increase the risk of escalating breathlessness. During patient-centred APBC, the participants described how the nursing staff was genuinely in attention. According to the participants, APBC was carried out on their conditions taking careful concern to their breathlessness. Making attentive time implied that the nursing staff adopted an attentive, participating and wait-and-
see attitude, where the normal time pressure was absent. One of the participants described that a nurse said:

I have enough time, how do you want me to help. (Participant 04)

Attentive time did not mean infinite amounts of time or spending more time than usual on APBC. Instead, the participants’ experienced how the carefully planned APBC and the presence of the nursing staff during the whole APBC session created both efficiency and no time pressure. The participants elaborated that the possibility of taking it easy and taking a pause during the APBC procedures were essential for minimising the risk of escalating breathlessness. One participant described the help during a shower like this:

Participant: Yes, I choose the pauses and when we were to continue. She just stood there and waited patiently

Interviewer: did you feel pressurised in relation to ‘I have to finish’?

Participant: Not at all, not at all, because I knew she had set aside the necessary time. Whether it’s a quarter of an hour, half hour or one hour. I didn’t feel pressurised, because I knew she was there, just for me. (Participant 03)

The fact, that participants experienced recognition of their need for a pause and found that the nursing staff encouraged them to take pauses during the APBC, enabled the participants to contribute on their own terms and made them feel more self-sufficient:

I felt calm and confident because I had the feeling that she took it so patiently and I got some pauses in between. It didn’t feel bad getting washed, it felt nice. (Participant 08)

Overall, attentive time contributed to the participants’ experience of getting help to control their breathing and reducing their experience of discomfort during personal body care sessions.

Security

The participants experienced a sense of security to minimise their breathlessness and increase their level of activity. Patient-centred APBC helped them to feel secure by knowing what was going to happen during APBC, and increasing their awareness of both their own capability to complete APBC and of the nursing staff’s competences. The exchange of information and use of ‘the agreement sheet’ focused on planning what was going to happen during the APBC:

We have a plan, which I know and she knows. (Participant 09)

This made it possible to gain knowledge about how certain activities influenced the participants’ breathing and made them ready to adjust action plans to current conditions. For example, participants would be transported to the shower and then used their energy to undress or dress by themselves. The participants experienced how talking to the nursing staff about the performance of personal body care gave insight into the nursing staff’s knowledge and skills, and made them feel secure knowing that the nursing staff were sufficiently competent to help them during personal body care session. Another important issue was the constant presence of the nursing staff:

Knowing she is there and will take over if I can’t manage. That is a very good thing. (Participant 09)

Several had the feeling that the nursing staff kept an eye on them and that they could get immediate help if they needed it. According to the participants, the security enabled them to test their capabilities and challenge their breathlessness. This experience provided a feeling of control and clarification of how to cope after discharge and complied with their wishes of being as self-sufficient as possible.

Discussion

In this outcome analysis, we found that compared to the participants’ usual experiences of APBC during prior hospitalisations, the patient-centred care had a significant impact on participants’ experience of being an active part of the body care activities. According to the participants’ the patient-centred APBC enabled them to take part in decision-making and contribute on their own terms in activities of personal body care. This new experience safeguarded the maintenance of the participants’ integrity and strengthened their experiences of being acknowledged as individuals with certain disease-specific challenges to overcome. In particular, the clear structure of patient-centred APBC seemed to support active participation. First, the exchange of information created predictability and awareness of the nursing staff’s competences, which made the participants feel more secure during the APBC sessions. Second, the experiences of acknowledgement made it possible to establishing a mutual understanding of how body care was to be carried out. This mutual understanding increased the participants’ involvement and promoted their personal view of being included in the sessions to follow. Nursing guidelines on personal hygiene prescribe that the procedure is carried out in a logical order with the implicit or explicit purpose of
protecting the patients from contamination (Taylor 2011). Our findings suggest, however, that when complying with procedures that intrude on personal matters such as body care, the nursing staff risks ignoring the patients’ own experiences and decreasing the patients’ ability to participate. On the contrary, the simultaneous involvement of the patient and the structured session of APBC as recommended in patient-centred care seemed to improve the patients’ overall experiences and strengthen their self-care. We advance the viewpoint that patient involvement can be achieved without compromising principles of good hygiene and patient safety. Participants noticeably considered patient-centred APBC as an interactive procedure between nursing staff and patient. The initiation of the session and information exchanged is described by the participants as a dialogue focusing on their concerns and needs. Our findings indicate that patients may learn and improve their awareness of their own concerns and needs, when the nursing staffs incorporate disease-specific knowledge into the conversation and the accomplishment of body care activities. Participants also described how the nurse–patient interaction continued during APBC, as the nursing staff helped them to use pauses as a tool to enable the accomplishment of body care, and, subsequently, feel less dependent. Our findings confirm that the participants’ basic problems with APBC are not exclusively related to physical symptoms, but also to vulnerability, dependency and lack of acknowledgement as also suggested by Lomborg et al. (2005) and Lomborg and Kirkevold (2005). Thus, patient-centred APBC seems to sufficiently respect and comply with the participants’ preferences, needs and values, and thereby reaches the goal in patient-centred care (Reynolds 2009). In patient-centred care, the therapeutic alliance is a key element for an evolving health care atmosphere, which allows patients to play a more active role. It not only minimises complaints, repetition and potential litigation but also influences the patient’s ability to gain and maintain health (Mead & Bower 2000). The participants in our study described how the nursing staff’s ability to communicate in a friendly, supportive, neutral and non-judgemental way led to an experience of acknowledgement. The participants experienced recognition and acceptance of their situation because the nursing staff valued and included their views and feelings during patient-centred APBC. In a study on what constitutes effective and ineffective health care communication across four different chronic diseases, Thorne et al. (2004) found that attitude is the gold standard of effective health care communication. According to Thorne and colleagues, people with a chronic condition believe that the relationships with the professionals were critical for their ability to access necessary information and assistance (Thorne et al. 2004). For example, the health care professionals’ ability to listen, to be polite and to remember the patients’ names was described as leading to effective health care communication and inclusion of patient expertise and shared decision-marking. Our participants’ experiences of patient-centred APBC seems to include these elements and the approach may, therefore, lead to effective health communication and provide patients with the necessary information and support to preserve integrity and improve self-care in bodily matters, and thereby avert potential embarrassment (Lawler 1996).

The evaluating component of patients-centred APBC focused on whether the participants’ experience of APBC correlated with their conditions, ability and strategies to participate. Evaluation seemed important as it enabled self-reflection and the future planning of APBC. The participants and nursing staff talked about how APBC could be accomplished with a minimum of undue breathlessness, how the pauses were experienced or how the participant imagined managing body care after discharge. This method of evaluating differ from description of evaluating personal hygiene, which generally focus on level of patient’s participation, changes related to specific psychological or psychological problems and the patients knowledge on personal hygiene (Iggulden et al. 2009, Taylor 2011). The assessment of APBC as described in patient-centred APBC seemed a valuable contribution to the participants’ ability to be active and less dependent, as it focused on the development of skills that could minimise the risk of breathlessness.

Study limitations and strengths

Our study offers a deeper understanding of hospitalised respiratory patients’ experiences of patient-centred APBC. It does, however, have some limitations. The age of the participants in our study correspond to the mean age for hospitalised patients with COPD in Denmark, but there was an over representation of women in our study (two male and nine female patients). Research on gender differences in patients with COPD is limited, but some studies report that women for example perceive respiratory symptoms differently from men. Women also have a higher risk of being hospitalised, contrary to studies about patients’ satisfaction of the quality of health care, which indicate no statistical significance between genders. In our study, we experienced no gender differences in the participants’ experiences of patient-centred APBC. Including more male patients might, however, contribute more knowledge about gender differences.
Assisted personal body care was viewed from the perspective of patient with COPD stage II–IV. Breathlessness leading to hospital admission most often occurs at stages III–IV (Garcia-Aymerich et al. 2011). It would be interesting to know more about the perspectives of patients with COPD stage I–II and better understand the special challenges involved in personal body care, and the APBC needs of these patients’ during the acute phase of COPD exacerbation.

Using participant observation to gain insight into patient-centred APBC made it possible to grasp meaningful and important events that could be explored further during the interviews. It also added to the validation of findings because asking more detailed questions about situations helped the participant to describe and explore the experience of patient-centred APBC. The patients were well aware of the presence of the researchers. This may have had an effect on the APBC session. Asked directly, the patients expressed no discomfort about being observed. On the contrary, they sometimes forgot about the researchers. Participant observation seems to be a valid and conducive method of gaining insight into patient-centred APBC and the semi-structured interview.

Inclusion of patients from a department with different medical specialities (respiratory medicine, endocrinology and general internal medicine) contributed to strengthening the findings with a broader interpretation and alleviating the transition to other clinical settings. However, we cannot omit the possibility that local conditions may have influenced our data material and we cannot contend that our interpretation is the one and only way to interpret data.

The study was designed to conduct an interpretive description of the patients’ experiences of the APBC intervention. We did not focus on gender, degree of COPD, choice of procedure of APBC and staff time spent on APBC. Future research should include larger samples and a comparison of time consumption in patient-centred APBC vs. care-as-usual to document the effectiveness.

Conclusion

This study provided a detailed evaluation of patient-centred APBC from the viewpoint of hospitalised COPD patients. We found that patient-centred APBC enables the patients to take an active part in the body care activity. This, in turn, improves the patients’ feelings of being acknowledged and secured.

Relevance to clinical practice

Coping with breathlessness especially during psychical activity such as personal body care is a daily challenging and frightening ordeal for patients with COPD. Interventions on how to structure, perform and evaluate APBC have received little attention so far. Our study demonstrates that effective communication, tools to assess breathlessness and to organise APBC sessions, awareness of pauses, predictability, security and acknowledgment are important for COPD patients’ ability to take part in body care activities. Along with the findings on how to achieve competences in patient-centred APBC (Lomborg et al. 2011), it is relevant to emphasise the importance of continuing training and improvement of practical skills in patient-centred care for the nursing staff. In patient-centred APBC, the nursing staff must accept that personal hygiene is the main focus of the nurse–patient interaction. Furthermore, constant vigilance and patience is vital. Our findings emphasise the importance of the nursing staff’s role in improving the patients’ well-being and self-care. We consider patient-centred care to be a relevant and effective approach to patients diagnosed with COPD.

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Contributions

Study design: KL, TWV, ALJ; data collection and analysis; ALJ, TWV, KL and manuscript preparation; ALJ, TWV and KL.

Conflict of interest statement

There is no conflict of interest.

References


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