ACTA UNIVERSITATIS GOTHOBURGENSIS
GOTHENBURG SERIES IN PERSON-CENTRED CARE 8

# The Second Global Conference on Person-Centred Care

## Bridging Practice, Organisation and Governance

## Abstract Book

Axel Wolf & Joakim Öhlén

Editors

UNIVERSITY OF GOTHENBURG

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# Abstract


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This is the abstract book for the second Global Conference on Person-Centred Care (GCPCC) with the theme *Bridging Practice, Organisation and Governance*. The conference will take place in Gothenburg, Sweden, from 4th to 7th May, 2026 and has been organised by the University of Gothenburg Centre for Person-Centred Care (GPCC) – a strategic government-funded area in healthcare research since 2010.

The GCPCC provides a recurring international arena and platform for diverse individuals interested in furthering person-centred care in the broadest sense, i.e. care and social care from practice and organisation to governance and inter-interrelationships thereof. The theme reflects the current maturity of our field, spanning from practice at the point of care, integrated pathways and organisations to governance and macro-level perspectives.

This book presents all abstract contributions presented by the invited expert keynote speakers, pre-conference workshops, and workshops, panels/symposia, as well as oral and poster presentations selected on the basis of expert reviews of submitted abstracts. In total, the book presents over 300 abstracts.

# Contents

# Welcome to the Second Global Conference on Person-Centred Care

*Axel Wolf and Joakim Öhlén*

The University of Gothenburg Centre for Person-Centred Care (GCPCC) is delighted to welcome you to the second Global Conference on Person-Centred Care (GCPCC), an on-site event taking place in Gothenburg, Sweden, from 4th – 7th May, 2026. The GCPCC has established itself as the premier global meeting place to discuss, reflect, and learn about the future of person-centredness. The GCPCC aims to provide a recurring international arena and platform for diverse individuals interested in furthering person-centred care in the broadest sense, i.e. care and social care from practice and organisation to governance and inter-interrelationships thereof. In this way, the conference provides multiple perspectives and competences in a knowledge arena exploring how person-centred care interacts with broader transformational fields, such as integrated care, precision medicine, artificial intelligence, and systemic co-production. It is crucial to recognize that while advancements like AI or precision medicine/health offer unprecedented scientific and structural potential, they are not inherently founded on partnerships grounded in ethics; on their own, they are powerful tools that can easily become transactional or technocratic. This is precisely where person-centred care becomes the indispensable ethical glue and why fostering its practice is essential. Consequently, we hope this year's GCPCC will create opportunities for networking in a person-centred community that will flourish beyond the conference, just like the first GCPCC.

The conference is organised by the GPCC, a research centre which since 2010 has been supported as a strategic research area by the Swedish Government's prestigious strategic investment in research. The GPCC

brings together national and international researchers, healthcare professionals, leading patient and family carer partners, designers, artists, leaders and decision-makers in health care and health policy, as well as the healthcare industry and other interest groups to collaboratively contribute to evidence-based knowledge. In this way, local, regional, national and international collaborations are fostered. The centre is committed to promoting sustainable health through sustainable care, to preventing and decreasing suffering and to strengthening the efficacy of healthcare through person-centred care.

The 1st GCPCC took place in Gothenburg in May 2024 and was hosted by the GPCC, which initiated the GCPCC series. Like the first GCPCC, the 2026 conference has been organised in collaboration with Vitalis, the Nordic region's largest conference and exhibition focused on eHealth. All GCPCC conference participants have full access to the large Vitalis exhibition. Through this collaboration, there are also special collaborative sessions on Disasters and Time-Critical Events, as related to person-centred care.

This abstract book contains the contributions to the 2nd GCPCC, which includes distinguished keynote speakers and guest panellists. Thanks to the conference generating so much interest globally for submitting abstracts, we are also proud to welcome you to a number of parallel workshops, panels and poster presentations. Of the 352 submitted abstracts, 304 abstracts have been accepted, and we are honoured to have received all of these contributions – it is our conference participants who make this collaborative event and discussions possible. The 470 participants registered for the conference represent 28 countries from six parts of the world.

So, with this in mind, it is our pleasure to welcome you to the second Global Conference on Person-Centred Care. We hope the conference and its community will open up significant opportunities to share, learn, network and collaborate in expanded and new constellations that promote person-centred care in different ways.

Axel Wolf and Joakim Öhlén
Co-Chairs for the GCPCC
Director and former Director for the University of Gothenburg Centre for Person-Centred Care

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# Conference Programme

## GCPCC 2026 Programme Overview

| | | | | | | |
|---|---|---|---|---|---|---|
| **Monday May 4th** | | | | | | |
| 11.00-14.00 | Pre-conference workshop 1 (R5-6): Methodologies for equitable people-centred health measurement and analysis | Pre-conference workshop 2 (R4): Health economic evaluations of person-centered care (Part 1) | Pre-conference workshop 3 (J1): Relational Practices for Person-centred Cultures and Leadership – Elevating Lived Experience and Meaningful Engagement (Part 1), | | Pre-conference workshop 5 (R21): Sahlgrenska hemma — Person-centred Hospital@Home: from pilot to sustainable operations | |
| 15.30-17.00 | Opening keynotes (GCPCC & Vitalis)<br>Keynote speakers: Bengt Kristensson Uggla, Kevin Groot Lipman<br>Speakers: Margareta Andersson Broang, Renée Bengtsson<br>Moderators: David Edvardsson, Markus Lingman | | | | | |
| 17.00-19.00 | Reception/Mingle (GCPCC & Vitalis) | | | | | |
| 19.00-21.00 | Social event Dine-around Gothenburg (Exclusive event for GCPCC participants) | | | | | |
| **Tuesday May 5th** | | | | | | |
| 9.00-12.00 | | Pre-conference workshop 2 (G1): Health economic evaluations of person-centered care (Part 2) | Pre-conference workshop 3 (J1): Relational Practices for Person-centred Cultures and Leadership – Elevating Lived Experience and Meaningful Engagement (Part 2) | Pre-conference workshop 4 (G4): Feel, Share and Understand Experience: How to Co-design with Patients and Staff | | |
| 12.00-13.00 | Lunch | | | | | |
| 13.00-14.30 | Welcome & Keynotes (GCPCC) (G3)<br>Welcome moderators: Joakim Öhlén, Axel Wolf & Emma Forsgren<br><br>Keynote Niamh Lennox-Chhugani: Making integrated people-centred care an everyday reality<br>Keynote Juan Bornman: Listening Beyond Speech: Communication, Narrative and Person-Centred Care<br>Keynote moderator: Inger Ekman | | | | | |
| 14.45-15.45 | Art, Media & Performance (G1) Moderator: Emma Forsgren | Orals (G2)<br>Implementation & Knowledge Translation<br>Moderator: Jenny Hallgren | Panel (G3)<br>Digitalisation & eHealth<br>Moderator: Tomas Lindroth | Orals (G4)<br>Learning & Education<br>Moderator: Mari Lundberg | Workshop (J1): Core components and challenges in co-designing person-centered integrated services with older people and staff from social and primary care | 14.30-15.00 Orals (Next level stage) Healthcare in the Total Defence, Orals Disasters and Time-Critical Events<br>Moderator: Emma Spak |
| 15.45-16.30 | Poster session (Poster arena) Moderators: Tomas Lindroth, Andreas Fors | | | | | 15.30-17.00 Orals (Next level stage) Healthcare in the Total Defence<br>Moderator: Emma Spak |
| 16.30-17.30 | Orals (G1)<br>Digitalisation & eHealth<br>Moderator: Vasiliki Mylonopoulo | Orals (G2)<br>Health Equity - Women health<br>Moderator: Lina Emmesjö | Panel (G3)<br>Organisational Governance | Orals (G4)<br>Co-creation<br>Moderator: Kerry Kuluski | Workshop (J1): Two decades of delivering Care and Support Planning for people with long term conditions. Learning for person centred care and application in Sweden | |
| 18.00-21.00 | Social event at Röhsska museum of Design and Craft (Exclusive event for GCPCC participants) | | | | | |

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| **Wednesday May 6th** | | | | | | |
| 8.30-9.30 | Keynotes (G3)<br>Keynote Chris Graham: Measuring and improving person centred care: patient experiences past, present, and future<br>Keynote Erna Haraldsdottir: "Making the jump" from a possibility in principle to possibility in practice: Transforming and developing person-centred practice within health and social care organisations Moderator: Philip Moons | | | | | |
| 9.45-10.45 | Networking SICoP (G1) | Orals (G2)<br>Learning & Education<br>Moderator: Carina Sparud Lundin | Panel (G3)<br>Tools & Assessments | Orals (G4)<br>People of Old Age<br>Moderator: David Edvardsson | Workshop (J1): Reaching Consensus on the Purpose of Person-Centered Care: A Real-Time Delphi Workshop | 10.00-10.30 Open mic (Next level stage) |
| 11.15-12.15 | Orals (G1)<br>Health Equity<br>Moderator: Filipa Ventura | Orals (G2)<br>Organisational Governance<br>Moderator: Lina Emmesjö | Panel (G3)<br>Implementation & Knowledge Translation | Orals (G4)<br>Patient & Public Involvement<br>Moderator: Jana Bergholtz | Workshop (J1): From participants to partners: Strengthening the role of older adults as research partners | |
| 12.15-14.15 | Lunch / Poster session 12.45-13.30 (Poster Arena) Moderators: Anneli Ozanne, Stefan Nilsson / Art walk 13.30-14.00 / Networking meetings (See digital program for futher information) | | | | | 12.30-13.00 Open mic (Next level stage) |
| 14.15-15.15 | Art, Media & Performance (G1) Moderator: Sepideh Olausson | Orals (G2)<br>Tools & Assessments<br>Moderator: Jae-Yung Kwon | Panel (G3) Rural person-centred care | Orals (G4)<br>Illness Communication<br>Moderator: Stefan Nilsson | Workshop (J1): Digital Storytelling as a Qualitative Research Method for Patient and Public Involvement in Health Research | 15.00-15.30 Open mic (Next level stage) |
| 15.15-16.00 | Poster session (Poster Arena) Moderators: Matilda Cederberg, Catarina Wallengren | | | | | |
| 16.00-17.00 | Art, Media & Performace (G1) Moderator: Emma Forsgren | Orals (G2)<br>Learning & Education<br>Moderator: Emmelie Barenfeldt | Panel (G3)<br>Patient & Public Involvement | Orals (G4)<br>Informal Care & Support<br>Moderator: Eva Angelini | Workshop (J1): Designing digital health that works for everyone: a practical workshop on the Picker Principles of Digital Health | 15.30-17.00 Orals (Next level stage) Healthcare in the Total Defence, Orals Disasters and Time-Critical Events<br>Moderator: Emma Spak |
| 19.30-23.59 | Social event Conference dinner/party (For GCPCC and Vitalis participants) | | | | | |
| **Thursday May 7th** | | | | | | |
| 8.30-9.30 | Panel (G1)<br>Evaluation of Interventions | Orals (G2)<br>Organisational Governance<br>Moderator: Ewa-Lena Bratt | Panel (G3)<br>Implementation & Knowledge Translation | Orals (G4)<br>Digitalisation & eHealth<br>Moderator: Joanne Fuller | Workshop (J1): Sexual Expression in Persons Living with Dementia | |
| 9.45-10.45 | Art, Media & Performance (G1) | Orals (G2)<br>Health Equity<br>Moderators: Ava Mehdipour & Jae-Yung Kwon | Panel (G3)<br>Comprehensive & Integrated Care | Orals (G4)<br>Comprehensive & Integrated Care<br>Moderator: Philip Moons | Workshop (J1): Embodied Experience of Health History Narration, Mindfulness as a New Approach to Care | |
| 11.15-12.45 | Keynotes (G3)<br>Keynote Swarup Sarkar: Kaleidoscopic views of person-centred care: a global perspective of included and excluded populations<br>Keynote Nasim Bergman Farrokhnia: Applied AI for Person-Centred Care – Global Insights from Practice, Management, and Innovation<br>Keynote moderator: Hanna Gyllensten<br><br>Awards & Closing<br>Moderator: Joakim Öhlén | | | | | |

# Introduction to the Conference Theme

*Axel Wolf, Eva Angelini, Jana Bergholtz, Ida Björkman, Lina Emmesjö, Emma Forsgren, Hanna Gyllensten, Annika Lindström & Joakim Öhlén*

The theme for this year's conference, *Bridging Practice, Organisation, and Governance* as related to person-centred care, aims to build on the current maturity of the field. We have largely moved past the point of needing to prove that person-centred care works. Substantial user and system perspective evidence from clinical interventions clearly demonstrates its efficacy, which has been systematised in several literature reviews over the last few years. A core challenge today is moving towards a system-learning approach to understand implementation and large-scale transformation into person-centred organisations and health and welfare systems.

How do we align the bottom-up evidence generated at the point of care with the top-down frameworks of macro-level governance? Creating a truly adaptive infrastructure requires a multi-directional approach. While there is a need to elevate the grassroots level and translate successful, isolated examples and patient perspectives, there is also a need to drive structural change at the macro level through policy and governance, thus influencing change at the meso and macro levels. Making this leap to sustainable, system-wide implementation is where rigorous methodology and broad organisational commitment must meet.

This need for robust, interconnected practice-organisational-governance systems is further underscored by the turbulent times we live in. Amidst global crises, natural disasters and conflicts, person-centred care cannot be viewed as a peacetime luxury. Rather, person-centredness is a fundamental pillar of resilient health and welfare systems. An infrastructure built on co-

created routines, transparency and adaptability fosters trustful partnership – and adaptability is exactly what anchors care when it is tested the most.

To build systems capable of this kind of resilience and scale, we need to critically examine and highlight evidence gaps and outdated structures where current practices and systems fall short, particularly in regard to structural injustice and disadvantaged populations. We must move past tokenism in patient-, family carer- and public involvement to ensure genuine and participatory engagement. Further, there is a need to unpack how person-centred care relates to and integrates with other operational frameworks.

Crucially, this transformation must extend beyond traditional healthcare system walls. A truly person-centred system seamlessly integrates health care, social welfare, community care, and informal self-care. To succeed, we must recognise and structurally support civil society in the indispensable role it plays in the web of formal and informal care. The ownership is not singular but relational, emerging across constellations of actors and networks in which all share responsibility for the whole.

The conference theme is the result of an ongoing dialog with the GPCC Steering Committee, Person Council and international expert advisers. Their suggestions have been incorporated into the conference programme, including the 'Open Mic' sessions, and a dedicated networking space for and with patient and carer representatives. Many of these colleagues are also actively participating in the conference; please feel free to get in touch, and the GPCC exhibition booth is always available as a meeting place.

The depth of this challenge is reflected in our comprehensive programme. With over 300 abstracts accepted alongside our diverse keynotes, workshops, seminars and lectures, we hope that the GCPCC provides a forum to synthesise and further develop different types of knowledge. For those wishing to explore structural and analytical tools of importance for person-centred care, our pre-conference workshops cover topics such as:

- methodologies for equitable, people-centred health measurement and analysis
- economic evaluations of person-centred care, moving from evidence to study design

- the transition from pilot programs to sustainable operations, as seen in the Sahlgrenska Person-centred Hospital@Home model
- relational practices for person-centred cultures and leadership, and
- actionable strategies to truly co-design with patients and staff by understanding lived experiences

We are honoured indeed to have the contributions of seven distinguished keynote speakers. Together, they reflect interrelationships between practice, organisation and governance of person-centred care, as related to, for example, integrated care, communication challenges, inclusive participation and measuring and making use of patients' experiences. An international invited panel will explore structures supporting patient and public involvement with impact on person-centred care and related research.

The main programme also includes workshops and panels, as well as oral and poster presentations covering a range of person-centred care topics, such as rural care, digitalisation and eHealth, implementation and knowledge translation. Other topics highlighted in the oral and poster sessions include person-centred care in old age, health equity, informal care and support, illness communication, and learning and education. Additionally, the poster presentations feature children and youth-related topics.

In addition to all of this, the programme also offers art, media, and performance presentations. These include vocal testimonies from the Voices for Women Foundation, documentary music theatre catalysing person-centred care for people with dementia, enabling inclusion through a patient engagement podcast, and performative explorations of storytelling, relatedness and the patient perspectives.

Continuing our successful partnership from the first GCPCC, we are once again proud to collaborate with Vitalis. Together, we are bringing over 6,000 participants to Gothenburg in the intersect between person-centred care, digital health, health tech, and life science. This joint effort is a powerful example of sharing knowledge across disciplines and contexts and a unique collaboration creating an unprecedented opportunity to exchange ideas and shape the future of healthcare, social welfare, and technological innovation. This is vital as we look to the future, with digitalisation, health tech, precision medicine, and AI increasingly having a profound influence and becoming crucial drivers enabling person-centred care and systems at scale. Such

influences may nevertheless also have unintended consequences, sometimes with an excluding and negative impact, and implementation must be carefully balanced.

All that remains now is to express a sincere thank you to everyone from around the globe who has contributed to this abstract book. It is our hope that you will continue to contribute during the conference and beyond, furthering your work within existing and new networks and groupings. We will be excited to share critical, reflective and fruitful discussions and have enriching encounters, together bridging the realities of person-centred care practices, organisation, and governance.

Welcome to Gothenburg!

# GPCC Patient Partners' Reflections on the Conference Theme

*Rolf Åström & Ann-Christine Baar*

As patient representatives, we are delighted to welcome all readers of this abstract book, which captures a variety of pioneering scientific presentations, as well as art and performances featured in the second Global Conference on Person-Centred Care in Gothenburg, Sweden, 5–7 May 2026. For almost 15 years, The GPCC has contributed both in Sweden and internationally to disseminating knowledge about person-centred care and its benefits for healthcare, society and individual patients, as well as family carers when they are seen as partners. Since fostering collaborations and gathering a variety of perspectives is important in order to move the field forward, it was a natural next step for the GPCC to host this global conference. We are pleased that the GPCC's person council was consulted, and that two patient representatives actively participated in the conference organising committee.

While human society is facing serious challenges worldwide, such as increasing demographic imbalances, widening inequalities and a diversification of threats, there is also much hope rising amongst us patients as we follow the latest research on person-centred care. In fact, we are delighted to see keynote speakers addressing matters such as whole-system approaches, equity for disadvantaged populations, and how to partner with patients and carers to improve healthcare systems worldwide.

Healthcare is constantly changing as research creates new opportunities to cure and treat patients. The development of digital tools has enabled better conditions for communication between patients and healthcare, meaning great opportunities today for good patient participation and partnerships, which creates person-centred care.

Attitudes to various issues in society have changed over time. Younger generations are being brought up to have a more questioning and critical

attitude than older generations. Such changes therefore place new demands on the healthcare system because patients can sometimes have a head start on and more information about their illnesses than the healthcare professional.

Everyone's knowledge and experiences are different, which combined is very valuable in healthcare and research. Unfortunately, these resources are rarely exploited. Researchers are happy to initiate projects within their own areas of interest and that can develop their academic careers. The involvement of patient representatives in research still needs to be improved. In order for the research to be conducted effectively, projects must be based on the demands of patients and users, and the latter must also be included as partners in these projects.

Different workshops and panels/symposia are being offered at the conference to foster dialogue and interaction on important topics, such as communication, transitions, mental health and also ethics, collaboration and representativeness. We deeply appreciate the high number of abstracts submitted for the oral and poster sessions on children and youths, the elderly, co-creation, implementation of person-centred care and tools to measure and assess experiences and outcomes.

Healthcare is currently in a difficult financial situation, which also means limited opportunities for developing person-centred care and patient involvement. The big challenge for the future is to make the concept and meaning of person-centred care known to the general public, healthcare professionals and decision-makers. Increased person-centredness results in satisfied patients and safer care. We would like to thank everyone who has contributed and submitted abstracts to GCPCC. We hope that this abstract book serves as a catalyst for further dialogue, collaboration and innovation in the field of person-centred care, both now and in the future.

Rolf Åström, Board member, National Association for Carers, Sweden

Ann-Christine Baar, SPF Seniorerna – The Swedish Association for Senior Citizens, and both members of the Person Council at the GPCC

# Reflections on the Conference Theme from an International Research Perspective

*Philip Moons & Hilde Verbeek*

The theme of bridging practice, organisation and governance in person-centred care reflects a central challenge in contemporary health systems worldwide. While the principles of person-centred care are widely endorsed, their translation into coherent and sustainable practice across system levels remains uneven. From an international research perspective, the need to connect what happens in clinical encounters with organisational structures and policy frameworks is increasingly recognised as essential for achieving meaningful and equitable care, thereby contributing to peoples' everyday life.

At its core, person-centred care is grounded in a relational and ethical understanding of health and social care, where individuals are recognised as active partners rather than passive recipients. However, this orientation is often impeded by organisational routines, professional hierarchies, and governance mechanisms that prioritise efficiency, standardisation, and measurable outputs. The challenge, therefore, is not only to implement person-centred practices at the bedside, but also to align the broader system in ways that enable and sustain such practices in everyday life. This requires a shift from viewing person-centred care as an isolated intervention to understanding it as a system-wide approach.

Internationally, there is considerable variation in how health systems attempt to bridge these levels. In high-income countries, efforts have often focused on integrating services, improving care coordination, and incorporating patient-reported outcomes into quality frameworks. While these initiatives have contributed to greater visibility of patient perspectives, they have not always resulted in substantive changes in care experiences. One explanation lies in the limited integration between measurement systems and

everyday clinical decision-making. When patient-reported data are collected but not meaningfully used, the potential of person-centred care remains under-realised. Moreover, the everyday life of an individual is often not taken into account, with living environments that are disabling. Person-centred support, care and treatment need to empower people in the normal routines of their daily life.

In low- and middle-income contexts, the challenges are often more structural. Resource constraints, workforce shortages, and fragmented professional infrastructures can limit the feasibility of implementing person-centred approaches. At the same time, these contexts frequently offer important insights into community-based, relational, and culturally grounded models of care that challenge dominant paradigms. From an international perspective, this underscores the importance of avoiding a 'one-size fits all' model and instead recognising the diversity of pathways and contexts through which person-centred care can be realised. The living environment is crucial in establishing person-centred care practices.

A key issue in bridging practice, organisation and governance is the role of organisational culture. Research consistently demonstrates that person-centred care is more likely to be sustained in environments characterised by trust, shared values, and relational leadership. However, transforming organisational culture is inherently complex and cannot be achieved through policy directives alone. It requires long-term investment in professional development, reflective practice, and the active involvement of patients and communities in shaping services. Without such cultural alignment, policy ambitions risk remaining symbolic rather than transformative.

Governance structures play a critical role in shaping these dynamics – policies that promote person-centred care must be accompanied by appropriate incentives, accountability mechanisms and regulatory frameworks. Nevertheless, there is often a disconnect between policy rhetoric and implementation realities. For example, while many health systems formally endorse patient participation and shared decision-making, these principles may not be adequately supported by time, resources, or training in clinical practice. Bridging this gap requires a more nuanced understanding of how governance can *enable* rather than *constrain* relational forms of care.

Equity is another fundamental dimension of the theme. International evidence indicates that person-centred care is not experienced equally across populations. Marginalised groups, including those defined by socioeconomic status, gender, ethnicity or migration background, often encounter barriers to participation and autonomy in healthcare. Bridging practice, organisation and governance therefore also entails addressing structural determinants of health and ensuring that person-centred approaches are inclusive and responsive to diverse needs. This highlights the intersection between person-centred care and broader agendas related to health equity and social justice.

Technological innovation introduces both opportunities and challenges in this context. Digital tools, including artificial intelligence and remote monitoring systems, have the potential to enhance access, support personalised care planning, and facilitate communication. However, their integration into healthcare systems raises questions about data governance, transparency and the preservation of human relationships in care. There are various ethical and societal risks, including exacerbating bias, lack of transparency in decision-making, and undermining of persons' privacy and self-determination. Continuous monitoring and surveillance can intrude on privacy, and deviations from typical behaviour require human interpretation rather than rigid, standardised responses that may constrain individuals. From an international perspective, the impact of these technologies is likely to vary depending on local infrastructures, regulatory environments and cultural expectations. Ensuring that digitalisation supports rather than undermines person-centred care requires careful and context-sensitive implementation.

An important consideration in advancing this theme is the recognition of multiple forms of knowledge. Traditional biomedical and quantitative approaches provide valuable insights, but they may not fully capture the complexity of person-centred care. Qualitative research, participatory methods, and creative approaches contribute to a comprehensive understanding by foregrounding lived experiences and relational dynamics. International collaboration can play a key role in fostering methodological pluralism and in sharing lessons across different contexts. Inter- and transdisciplinary research, practice and policy are needed to advance the field of person-centred care. This means having shared goals and developing

integrated knowledge beyond the reach of traditional disciplines and science. Patients, their carers and other relevant stakeholders should be involved in the development of new practice, policy guidelines and scientific research, ensuring inclusive power dynamics. A Living Lab approach, applying a real-world ecosystem approach, may be useful in accomplishing this.

Ultimately, bridging practice, organisation and governance is not a technical problem with a single solution but a continuous process of alignment and adaptation. It requires engagement across disciplines and sectors, as well as a willingness to address underlying power structures and assumptions within healthcare systems. From an international research perspective, progress in this area will depend on the ability to integrate insights from diverse settings, to develop context-sensitive strategies, and to maintain a focus on the fundamental goal of improving the experiences and outcomes of individuals and communities.

The theme of this conference thus reflects both the achievements and the ongoing challenges in the field of person-centred care. The scientific research presented at the conference aims to advocate inclusive practices and advance the field with new insights and perspectives. It calls for a more integrated and reflexive approach in which practice, organisation and governance are understood as interdependent components of a complex system. Advancing this agenda will require sustained commitment, critical inquiry and collaborative effort at local, national and global levels.

Philip Moons, Professor of Healthcare and Nursing Science, KU Leuven Belgium, University of Gothenburg Centre for Person-Centred Care, Sweden, and University of Cape Town, South Africa

Hilde Verbeek, Professor of Long-Term Care Environments, Maastricht University, Chair of the Living Lab in Ageing and Long-Term Care, the Netherlands, and University of Gothenburg Centre for Person-Centred Care, Sweden

# Keynote Speaker Contributions

The order of the abstracts for keynotes is organized according to the order of presentation in the conference programme.

## What makes us human? …and who cares, in times of global destabilization?

*Bengt Kristensson Uggla, Professor & Philosophical Advisor, Professor of Philosophy, Culture, and Management at Åbo Akademi University, Finland, Philosophical advisor at Gothenburg Centre for Person-Centred Care (GPCC), Sweden.*

In my presentation I will elaborate on four major concepts: polycrisis, destabilization, decentering and personhood. Each of these themes force us to cope with the question: who really cares? The first theme is associated with the societal challenges of the simultaneous occurrence of a series of interconnected global crises that amplify each other with profound effects also for health care systems. The second has more specifically to do with the serious consequences of the cognitive destabilization, generated by the new digital information system but also reinforced by authoritarian political leadership, which has ruined the preconditions for science and democracy. What will happen to health care if science is being undermined? Who really cares in a post democratic society? The third theme raises questions about what it means to be human considering the extremely polarized landscape of philosophical anthropology and even sharpened by the successful development of Artificial Intelligence. In an age when health care is increasingly carried out by technological-based processes, the technological development needs to be an integral part of what it means to be human. Today we experience the dark sides of the grand success story of globalization, and simultaneously an unprecedented pace of technological development offering ever new medical treatments we never thought would be possible – but also critical challenges we are not yet prepared to cope with.

So many things we have taken for granted are being challenged today, yet the most crucial has to do with what it means to be human. But instead of an exceptionalist view, where the "true" human condition is recognized as a person separated from technology, person-centered care offers an ethical approach where AI can be an integral part of a profound recognition of who the patient is as person and who the person is who cares.

*Bengt Kristensson Uggla is Amos Anderson Professor in Philosophy, Culture, and Management at Åbo Akademi University (Finland), philosophical advisor and for many years visiting professor at Gothenburg Centre for Person-Centred Care (GPCC), Sweden. He has developed the field of cross disciplinary hermeneutics, mainly inspired by the work of Paul Ricoeur and is the author of fifteen books and his latest book published in English is Science as a Quest for Truth: The Interpretation Lab (2024). In 2026 he was awarded the H.M. The King's Medal of the 8th size in the Order of the Seraphim ribbon.*

## Making integrated people-centred care an everyday reality

*Niamh Lennox-Chhugani, PhD, Chief Executive and Director of Research at the International Foundation for Integrated Care (IFIC)*

People-centred, or more importantly people-driven care, is a core component of integrated care. Integrated care is care that is coordinated, continuous and centred around needs of the individual in their situation and enables them to live the life that they want as part of their community. There are many overlaps between integrated care and people-centred care but you can have one without the other. Only when our health and care systems use both as fundamental design principles, will we deliver the 21st century care that our populations need. That requires a fundamental shift in how we practice as policy-makers, health and care providers and members of society. I will explore those changes, some of which are already happening in my presentation, challenging all of us to think and act differently to make integrated people-centred care a reality.

*Dr Niamh Lennox-Chhugani is Chief Executive of the International Foundation for Integrated Care. With her background as a clinician, academic and consultant, she is an*

*integrated care researcher and implementer in an international context. She is a regular speaker at conferences, on panels, has authored peer-reviewed papers and book chapters, led and contributed to health system reviews and integrated care evaluations globally. She has a PhD from Imperial College London in organisation change in healthcare. She is on the editorial board of the International Journal for Integrated Care and sits on the advisory board of numerous integrated care research programmes.*

## Listening Beyond Speech: Communication, Narrative and Person-Centred Care

*Juan Bornman, Professor, B(Logopeadia); M(Communication Pathology), PhD Augmentative and Alternative Communication (AAC), Professor in Augmentative and Alternative Communication at Stellenbosch University, South Africa.*

Person-centred care is commonly articulated through three interrelated tenets: initiating the partnership through the patient's narrative; working the partnership through shared decision-making; and safeguarding the partnership through documentation that ensures continuity of care. Central to all three is the assumption that patients can readily articulate their experiences, values, and goals. For many individuals – including persons with communication disabilities, children, and those navigating linguistic, cultural, or power asymmetries – this assumption does not hold.

Drawing on research in augmentative and alternative communication (AAC), and informed by perspectives from the global South, this keynote argues that access to narrative is not a given but a communicative right that must be actively enabled. In many African contexts, where oral storytelling traditions remain strong, narrative is foundational to identity, meaning-making, and relational care – yet is often marginalised within biomedical systems. Using examples from health and rehabilitation contexts, the presentation illustrates how AAC principles can be used to elicit and co-construct patient narratives following stroke, in paediatric care, and in multilingual settings where shared language is absent.

The keynote further demonstrates how AAC-informed practices support equitable partnerships and shared decision-making, and how documentation of narratives and preferences can safeguard continuity of care across settings.

Ultimately, the presentation reframes person-centred care as unattainable without deliberate, culturally responsive communication access.

*Juan Bornman is Professor of Augmentative and Alternative Communication (AAC) at Stellenbosch University and a speech-language therapist and audiologist. Her research spans more than three decades and is grounded in a rights-based commitment to communication as a fundamental human need and human right. Central to her scholarship is the ethical and methodological imperative to elicit the perspectives, lived experiences, and narratives of children and adults with severe communication disabilities themselves, as a cornerstone of person-centred care. Her work advances the use of AAC to enable meaningful participation across education, health, and criminal justice contexts, particularly in the global South. Through academic publications and applied research, she challenges exclusionary practices that silence individuals with communication disabilities and reframes inclusion as relational, contextual, and collaborative. Her scholarship consistently bridges theory, policy, and practice, foregrounding communication access as essential to dignity, agency, and social participation.*

## Measuring and improving person centred care: patient experiences past, present, and future

*Chris Graham, CEO of Picker, a leading international charity that exists to promote and improve person centred care. Faculty member at the National Institute of Health Research (NIHR) and a non-executive director at the Professional Records Standards Body (PRSB). Part of the NIHR Quality, Safety, and Outcomes of Health and Social Care Policy Research Unit.*

Over the last 30 years the measurement of patients' experiences of care has developed from a niche area of study into an everyday part of services around the world. A key goal of this measurement has been to empower patients; to give them a voice in assessing the quality of services; and, ultimately, to make person-centred care a reality.

We now enjoy a much richer understanding of how people's experiences are associated with different elements of service delivery and healthcare quality. But in practice, an intense focus on measurement has not always led to the expected improvements in the quality of care. This has led to both

challenges and innovation – with new tools being used to develop and interpret patient experience insight.

In England, patient feedback is collected at incredible volume and frequency – and there are expectations that this will continue to grow in the future. The natural challenge is to ensure that the information gathered is informative, useful, and advances person centred care – challenges that will likely require a plurality of approaches to be used in harmony.

This session will explore the learning from three decades of patient experience measurement in England – drawing out lessons of international relevance, as well as examining the questions that will shape the measurement and use of patient feedback in the future.

Overall, we will consider the evolving role of patient experience – and ask what it will take to deliver the highest quality person-centred care for all, always.

*Chris is the CEO of Picker, a leading international charity that exists to promote and improve person-centred care. A researcher by background, Chris has particular expertise in measuring, understanding, and using people's experiences of health and care and has worked with partners around the world to develop approaches to gathering feedback from patients, service users and staff. This has included extensive work on the development of the NHS Staff and Patient Survey Programmes, two of the largest programmes of their kind anywhere in the world.*

*As well as his work at Picker, Chris is a National Institute of Health Research (NIHR) faculty member and a non-executive director at the Professional Records Standards Body (PRSB). He is also part of the NIHR Quality, Safety, and Outcomes of Health and Social Care Policy Research Unit. Chris studied Experimental Psychology at Pembroke College, University of Oxford.*

# "Making the jump" from a possibility in principle to possibility in practice: Transforming and developing person-centred practice within health and social care organisations

*Erna Haraldsdottir, Professor, BSc, MSc, PhD Nursing, Professor in Nursing at the Queen Margaret University, Edinburgh, UK. Deputy Head of Queen Margaret University's Nursing and Paramedic Science Division and Director of the University's Centre for Person-centred Research.*

It is the possibility of possibility, Søren Kierkegaard tells us, that leads to the somewhat paradoxical condition of feeling dizzy with anxiety yet having the pulsating desire to jump into the unknown. For transformation to happen, the gap between possibility in principle and possibility in practice needs to be bridged. The possibility gap in relation to transforming and developing person-centred practices is that most health and social care system strategies and policies have person-centred principles at their heart. However, translating them into practice remains a challenge.

In my presentation I will, through the lens of Kirkegaard, focus on how teaching and learning needs to intentionally include the gap and 'the jump' that needs to happen to transform and develop practices and care into being truly person-centred.

I will highlight several of my research projects focusing on the development of person-centred practice through education and learning programs and demonstrate the philosophical underpinnings of these, practical application and outcomes. I will bring to light the real learning from these projects in terms of methodology and provide examples of methods used.

The core challenge we are facing as leaders, practitioners and academics, with invested interest in person-centred health and social care practice, is to truly implement person-centredness into practice. In order to do that, we need to make the jump.

Ref: Kierkegaard S (1989) London, Penguin Group.

*Erna has worked in palliative care since the late 1980s. She was instrumental in developing and setting up a palliative care service within the National Health Care system in Iceland between 1990 and 2000. Erna is professor in nursing, deputy head of nursing and director of the Centre for Person-centred Practice Research at Queen Margaret University. Erna has extensive experience and knowledge in person-centred palliative care. She has been involved in person-centred practice development, education and research in various health and social care settings including hospices, care homes and within the national health care system in UK. She serves on several development groups in relation to person-centred practice and palliative care education and research and has published widely in palliative care research journals. She has also taken part in developing and delivering national and international teaching and learning programmes in palliative care including Iceland, the UK, Serbia, Uganda and India.*

## Kaleidoscopic views of person-centred care: a global perspective of included and excluded populations

*Swarup Sarkar, MD, MS, Senior Researcher; University of Gothenburg, Sweden; Ambassador, Global Health Security Network, Sydney, Australia; Ex CG Pandit National Chair, Indian Council of Medical Research and Ex Director / Senior Adviser WHO, UNAIDS, UNITAID, GFATM, ADB and CARE International*

Person-centred care is possible only when people are meaningfully included and when health services are available, accessible, affordable, and of assured quality. While these conditions are often unmet in many countries of the Global South, people in the Global North also experience exclusion for a variety of reasons, despite overall system capacity.

This keynote examines how these dynamics operate across both high-income and low- and middle-income settings, leading to the exclusion of individuals and groups. Failures arise at the macro level due to inadequate resources and weak regulatory frameworks, and extend to the micro level when service delivery mechanisms and service packages are designed without sufficient attention to peoples lived realities.

Creating an enabling environment—through the active involvement of communities and community-based organisations, particularly those representing marginalised populations—can help bridge the gaps between

availability and accessibility, and between inclusion and exclusion. Drawing on both positive and negative lessons from past epidemic responses to COVID-19 and AIDS, this keynote address makes the case for establishing a mandatory role for governments in funding and sustaining user-group initiatives, rather than relying on ad hoc or voluntary participation and feedback at individual level.

Community voices, representing coalitions of groups experiencing different forms of marginalisation and diverse lived experiences, must be supported and systematically integrated into planning, design, implementation, and service delivery at all levels. Evidence demonstrates that such approaches can be adapted to different political systems, levels of resource availability, and health-care delivery models.

Finally, the presentation highlights the critical need for real-time, disaggregated data—or appropriate proxy indicators—to make visible who receives services, when they receive them, and where gaps persist. Without these foundational elements, person-centred care remains a stated principle rather than a practical reality.

*Distinguished epidemiologist and physician with extensive experience in global health and its role for marginalised population. Expert in formulating and leading health policies and programs, with a special focus on pandemic preparedness, outbreak control, and disease elimination. Highly skilled in integrating community insights into public health strategies and leadership curriculum development evidenced by key leadership advisory roles in various national and international health organizations, universities, UN agencies and civil society organisations. Award-winning contributions recognized by WHO and global health communities.*

## Applied AI for Person-Centred Care – Global Insights from Practice, Management, and Innovation

*Nasim Bergman Farrokhnia, Professor, BSc, MSc, PhD Nursing, MD, PhD, Industry Director*

As the healthcare sector rapidly evolves, artificial intelligence (AI) is reshaping clinical practice, care delivery and patient outcomes. In this

keynote, Nasim Bergman Farrokhnia—Industry Director at Microsoft's global healthcare and life sciences team—will share a unique perspective shaped by years of hands-on clinical practice, executive management, and international collaboration across EMEA's diverse cultures and regulatory environments. Drawing on a background as a physician, a PhD, and an affiliation with the Karolinska Institute, as well as leadership roles such as chair of eHealth doctors within the Swedish Medical Association and former head of Northern Europe's largest emergency department, Nasim brings an ecosystem-wide perspective to the discussion.

This session will focus on the GCPCC conference's core theme: bridging practice, organization, and governance in person-centred care. Nasim will share personal experiences, best practices, and concrete use cases from clinical settings and management roles around the world, illustrating how applied AI can be harnessed to advance person-centred care at scale.

Key topics include:

- **Forces Driving the AI Revolution in Health:** Insights into the incentives and needs accelerating AI adoption, illustrated with real-world examples from different healthcare systems.
- **AI for Prediction and Precision Health:** How predictive analytics and precision health models support clinical decision-making and proactive prevention, with practical cases from Nasim's work in emergency medicine and digital health.
- **Professional and Societal Responses:** Reflections on how the medical profession is reacting to AI, including scepticism and concerns, and strategies for building trust and ethical governance.
- **Agentic AI and New Players**: Exploration of agentic AI's potential to empower patients and clinicians, and the impact of new entrants like Neko Health on resource allocation and the broader ecosystem.
- **Governance, Incentives, and Alternative Payors:** Lessons learned from implementing innovative care delivery models and alternative payor systems, with examples of successful adoption and scaling.

Attendees will gain actionable insights from Nasim's international experience, clinical expertise, and leadership in digital transformation—

learning how to integrate AI and digital solutions into person-centred care frameworks while preserving the human touch at the heart of healthcare.

*Nasim Bergman Farrokhnia is a seasoned healthcare executive with extensive experience in internal medicine and digital healthcare innovation. Currently part of Microsoft's Global Healthcare and Life Sciences team, she is focused on digital transformation in healthcare and has contributed significantly to various healthcare organizations in Sweden. Professionally, Farrokhnia has held leadership roles in notable digital healthcare providers such as Mindler and Kry/Livi, overseeing quality and research initiatives while expanding services in primary care psychiatry and digital healthcare. She holds a PhD from Uppsala University and has been recognized as one of the top influencers in Swedish tech. Farrokhnia is also a co-founder of a national research network on digital healthcare services and serves in various thought leadership roles within the healthcare sector.*

# Workshops & Panels/Symposia

The order of the abstracts is organized according to the order of presentation in the conference programme, which means that the abstracts for workshops and panels/symposia are mixed.

## Invited Pre-Conference Workshops

### Workshop 1: Methodologies for equitable people-centred health measurement and analysis

*Jae-Yung Kwon[6], Ava Mehdipour[4], Richard Sawatzky[1, 2, 3, 4, 5] & Kara Schick-Makaroff[3]*

[1] Trinity Western University, School of Nursing, Canada

[2] Centred for Advancing Health Outcomes, Canada

[3] University of Alberta, College of Health Sciences, Faculty of Nursing, Canada

[4] University of Gothenburg, Institute of Health and Care Sciences, Sahlgrenska Academy, Sweden

[5] University of Gothenburg Centre for Person-Centred Care (GPCC), Sweden

[6] University of Victoria, School of Nursing, Canada

Theories and practices of person-centred care emphasize the importance of research on equity and individual differences as foundational to understanding mechanisms and person-centred outcomes in diverse populations. The goal of this workshop is to provide practical guidance on approaches to equitable, people-centred measuring and analysing health and quality of life. This guidance will draw on key theoretical perspectives underlying idiographic versus nomothetic measurement, person-centred versus variable-centred analysis, intersectionality research, and realist

methodologies for theory building. The workshop will include practical examples of approaches to unbiased measurements and analyses in diverse populations, including the use of: 1) Psychometric methods (e.g., item response theory and latent variable mixture models) to reduce biases in measurements of patient-reported outcome and experiences, 2) Statistical models (e.g. multi-level and latent class models, dynamic structural equation models) to reveal individual differences in health and quality of life trajectories, 3) Qualitative approaches including the development of personas to understand individual differences of diverse people, and 4) Realist designs to build theories about programs explaining what works, for whom, in what circumstances, and why to promote person-centred health care. The workshop will be delivered at an introductory level, covering key theoretical perspectives and methodologies relevant to person-centred research. This will include interactive learning through demonstrations and small group discussions. Participants will have the opportunity to consider how these theories and methodologies can be applied to their current or proposed research projects. Each group will report back on shared learnings and outstanding questions for full group discussion. Resources will be provided for further self-directed in-depth learning. Target group: Researchers, analysts, trainees, and users of research interested in methodologies for equitable people-centred health measurement and analysis with the goal of promoting person-centred outcomes in diverse people.

## Workshop 2: Health Economic Evaluations of Person-Centered Care: From Evidence to Study Design

*Hanna Gyllensten[1,2] & Pia Johansson[3]*

[1] Centre for Person-Centred Care (GPCC), Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden.

[2] Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden.

[3] School of Public Health and Community Medicine, University of Gothenburg, Gothenburg, Sweden

The first session presents an overview of the methods and the current research frontiers of health economic evaluations of person-centered care. The seminar starts with a general overview of health economic evaluations and their use with priority-setting and decision-making. The presentations then continue with a focus on the methods applied to person-centered care -supplying answers to queries such as: what is known about the cost-effectiveness of person-centered care? Which revisions of standard methods are needed, and why, to create relevant evidence on the costs and benefits of person-centered care? This session also includes participant discussions on specific themes such as identifying costs, valuing patient benefits, and the need for subgroup analyses. A key aim of the discussion will be to ensure participants have an understanding of how the evidence applies to their own country and setting, and the challenges and possibilities of research into health economic aspects of person-centred care. This introductory session requires no preparation or materials. Just bring your curiosity, everything you need will be provided. Target group: Anyone interested in or involved in health economic studies in the field.

The second session is built as a workshop allowing participants to work on own projects, based on a structured project planning tool and with the assistance of experienced health economists. Participants will discuss and illustrate, based on their own projects, how health economic research questions can be included in research applications, study protocols, and the reporting of study results. The workshop thus focusses on enhancing participants' practical skills in designing a health economic evaluation of a person-centered intervention. The overall goal of the workshop is that participants leave with a drafted plan for a health economic evaluation of their own project. Please bring a laptop to the workshop, as the session includes hands-on exercises. We also encourage you to bring a project idea that you would like to develop into a health economic evaluation plan. If you do not yet have a project in mind, no worries; we will provide example cases that you can work with during the session or you can join one of the other

participants in discussing their project. Target group: Anyone planning or conducting a health economic study in the field, we recommend coming to the introductory session before attending the workshop).

## Workshop 3: Relational Practices for Person-centred Cultures and Leadership - Elevating Lived Experience and Meaningful Engagement

*Jana Bergholtz[1] & Brendan McCormack[2]*

[1] University of Gothenburg, Centre for Person-Centred Care (GPCC), Sweden.

[2] Susan Wakil School of Nursing and Midwifery, Sydney

In this workshop, we will delve into the concept of person-centred cultures and examine the robust evidence base that highlights the vital role culture plays in sustaining person-centred care. These cultures are essential for fostering care practices that are collaborative, inclusive, and participatory for everyone involved. Yet, we recognize that cultivating such cultures is both complex and challenging, and that conventional education and training approaches often fall short. Central to the existence of a person-centred culture is 'respect for all persons' and so in this workshop, we meld and blend perspectives on lived experience and meaningful engagement as a healthy tension that needs to be navigated in healthcare relationships and systems. A variety of principles, frameworks and participatory methods are being used to include perspectives of people with lived experiences in healthcare development globally. We will explore a range of methodologies, guiding principles and frameworks to support the development of relational practices that focus on ensuring all voices are heard in the development of effective person-centred services and the systematic implementation of patient and public involvement (PPI). Our intention is to share learning and practices that can overcome systemic barriers to meaningful engagement and participation of all interested parties. Target group: Those who are interested in developing person-centred cultures and have responsibility for doing so – e.g. healthcare leaders; implementation scientists; practice development

facilitators, health service evaluators; academics engaged in culture change; patient and public representatives; people with lived experience.

## Workshop 4: Feel, Share, and Understand Experience: How to Co-design with Patients and Staff

*Tomas Edman*[1] *& Kajsa Westling*[2]

[1] Experio Lab, Founder and National Coordinator

[2] Karlstad universitet Samhällsnytta AB, Karlstad University, Karlstad, Sweden

This workshop equips participants with both theoretical frameworks and practical methods for using co-design to engage patients, staff, and other stakeholders in developing and delivering person-centred healthcare. We introduce a service-logic perspective that places not only patients' needs but also their capabilities and resources at the centre of value creation for health and wellbeing. You will learn approachable co-design tools for development work, but also how to build engagement and shared understanding around co-design—for example creating an inclusive, equitable environment that enables co-design, framing problems with stakeholders and prototyping and testing ideas. We will also cultivate curiosity and empathy, exploring how lived experience can inform improvement and innovation. The session blends theoretical perspectives with hands-on activities to help you translate concepts into practice in your own context. Above all, expect a creative and exploratory workshop where we learn with and from one another—and have some fun along the way. Welcome! Target group: Professionals, patient partners, leaders, and researchers working in healthcare or adjacent fields where co-design is applicable.

# Workshop 5: Sahlgrenska hemma — Person-centred Hospital@Home: from pilot to sustainable operations

*Karin Ahlberg[1], Sofia Ekdahl[2], Kerstin Ulin[3] & Emma Vasell[4]*

[1] Professor, Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg; Sahlgrenska at Home, Sahlgrenska University Hospital, Västra Götaland Region, Sweden

[2] Chief Physician Internal Medicine and Head of Department at Medicine Geriatrics and Emergency Care Östra; Project Manager of Sahlgrenska at Home, Sahlgrenska University Hospital, Västra Götaland Region, Sweden

[3] Vice Head of Education and Associate Professor, Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Sweden

[4] Specialist Nurse in Internal Medicine, Medicine at Medicine Geriatrics and Emergency Care Östra, Sahlgrenska University Hospital, Västra Götaland Region; PhD-student, Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Sweden

What happens when hospital-level care moves into the home? In this hands-on workshop, Sahlgrenska hemma shares lessons from designing and scaling person-centred Hospital at Home services in a large region. We put the patient narrative and shared decision-making at the core, showing how mobile teams and tight collaboration with primary care and municipalities can create safety, quality, and efficiency. Participants follow a full patient journey - from inclusion to discharge - focusing on safety, medicines, self-care, and family support. We guide you through what it takes to start, scale, and embed home hospital services: competencies and staffing, referral pathways, digital decision support, documentation, and information-sharing across settings. Special attention is given to equity, ethical considerations, and genuine partnership with patients and families. We also discuss commissioning, reimbursement, and legal enablers for sustainable operations and fair access, and how everyday data can power continuous learning and improvement. You will leave with a first implementation sketch and a

toolbox ready to adapt to your context. Format: Short inputs, real cases, small-group exercises, and joint reflection. The workshop connects directly to the GCPCC theme by bridging practice, organisation, and governance for person-centred care at home. Target group: Service/department managers, ward/unit managers, clinical leads, nurses, physicians, physiotherapists, occupational therapists, pharmacists; leaders in primary care and municipal home care; quality improvement and patient safety professionals; digital and data analytics teams; commissioners/payers; regional and municipal decision-makers.

# Main Conference Workshops & Panels/Symposia

## Panel: Possibilities and Challenges in trials: A Panel discussing practical aspects of remote Person-Centered Care [PCC001]

*Inger Ekman[1, 2, 3], Jesper Poucette[4], Joanne M. Fuller[2, 7], Carl Johan Orre[5] & Vasiliki Mylonopoulou[2, 6]*

[1] University of Gothenburg, Institute of Health and Care Sciences, Sweden.

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[3] Region Västra Götaland, Sahlgrenska University Hospital/Östra, Department of Medicine, Geriatrics and Emergency Care, Sweden

[4] Region Västra Götaland, Närhälsan, Ågårdsskogen Medical Center, Sweden.

[5] Malmö University, Department of Computer Science and Media Technology, Sweden.

[6] University of Gothenburg, Department of Applied IT, Sweden.

[7] Department of Clinical Neuroscience/Ophthalmology, Institute of Neuroscience and Physiology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

As health systems embrace remote care, both calls and digital contacts, evaluating their real-world effectiveness and patient experience is essential. This panel examines the opportunities and challenges of conducting trials in remote person-centred care, some of which are unique to this type of

intervention where co-creation and personalized pathways are central. Bringing together researchers, clinicians, and patients, the discussion will cover opportunities, challenges, and methodological considerations related to participation, intervention design, digital literacy, and maintaining engagement at a distance. Attendees will gain practical insights into designing and running rigorous studies that advance remote person-centred care. The panel will be moderated by Hanna Gyllensten, Associate Professor, involved with the GPCC's focus area directed towards Development, adaptation and evaluation of person-centred care; who will guide the discussion to highlight key learnings, gaps, and future directions. Perspectives include Inger Ekman, RN, Professor at University of Gothenburg, brings experience of initiating and leading several trials examining the effects of remote person-centred care. Zahra Ebrahimi, RN, PhD, brings experience of conducting remote person-centred care with older persons living with frailty. Jesper Poucette, MD, brings the perspective of a healthcare professional and experiences of using remote support both in direct contact with patients and in team both for planning in care and treatment. Carl-Johan, Assistant Professor, brings the experience of being both a researcher and a patient representative involved in developing and evaluating remote care initiatives. Vasiliki Mylonopoulou, Associate Professor, with a background in Human-Computer Interaction and a focus on the inclusion of relevant actors in the design of digital health applications and services, brings her perspectives from international, local, and interdisciplinary projects on the subject. The panel will open with brief introductions, followed by a moderated discussion on the practical steps, opportunities, and challenges of conducting and evaluating remote person-centred care trials, from multiple perspectives.

## Workshop: Core components and challenges in co-designing person-centered integrated services with older people and staff from social and primary care [PCC002]

*Sara Cederbom[1], Christofer Lindgren[2], Emma Granström[3], Helena Strehlenert[4], Caroline Wachtler[5], Charlotte Klinga[6], Ida Goliath[7] & Maria Flink[8]*

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[3] Research and Development Unit for Older Persons (FOU nu), Stockholm Health Care Services, Stockholm, Sweden; Department of Learning, Informatics, Management and Ethics, Karolinska Institutet, Stockholm, Sweden

[4] Stockholm Gerontology Research Center, Stockholm, Sweden; Department of Learning, Informatics, Management and Ethics, Karolinska Institutet, Stockholm, Sweden

[5] Academic Primary Health Care Centre, Region Stockholm, Sweden; Division of Family Medicine and Primary Care, Department of Neurobiology, Care Sciences and Society, Karolinska Institutet

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All stakeholders – both users and providers - should have a voice and the opportunity to contribute in the development of person-centered, integrated services. Therefore, co-design is increasingly used to support the goals of the Swedish Social Service Act and the national initiative "Good quality, local healthcare". However, there is limited practical guidance for health and social care providers on how to co-design integrated services together with older people. This workshop draws upon the KOMPASS project that aims to develop and test a practical guide for how staff and older people can collaboratively create person-centered integrated services. This workshop will address core components and challenges in co-designing person-centered integrated services. Introduction (10 min by MF, HS): Presentation of core components for successful co-design, and practical challenges identified in KOMPASS. Results are based on studies of co-design processes, observations and interviews with staff, managers and older people in Stockholm. Workshop (35 min by MF, SC, HS, CL): Vignettes illustrating

complex co-design scenarios will be used for group work. Participants will be divided into moderated small groups to reflect on key themes that are important yet often challenging in practical co-design: Meaningful involvement. How can stakeholders from different organizations meaningfully involve and collaborate with older people in the co-development of integrated services – ensuring that their experiences and knowledge are valued throughout the process? Anchoring co-production in organizations. What is needed to ensure that co-designed outcomes truly reflect organizational priorities and lead to real-world implementation? Ethical considerations. How can facilitators and participants work together to uphold ethical principles – ensuring respect, inclusion, and transparency? Summary (15 min by CL, SC): Workshop leaders will briefly present key insights from the group work to the full audience and invite a joint discussion on core components that enable co-design of person-centered, integrated care with and for older people.

## Panel: Person-centred care in rural Sweden [PCC003]

*Anette Edin-Liljegren[1, 2], Sarah Persson[2, 3], Lina Ärlebrant[1, 2], Annica Westberg[4] & Andreas Lundqvist[2]*

[1] Department of Epidemiology and Global Health, Umeå University, Umeå, Sweden

[2] The Swedish Centre for Rural Health (SCRH)

[3] Department of Food, Nutrition and Culinary Science, Umeå University, Umeå, Sweden

[4] Department of Medical and Translational Biology, Umeå University, Umeå, Sweden

This symposium will present the rural and sparsely populated region of northern Sweden and the challenges faced by the rural population when it comes to accessing health care, and how it can be done, including a person-centred care perspective. The presentations start with setting the scene and why it is important to do research in SPR, an area located in more than 60 % of the world, by Anette. Video consultations (VC) are becoming a widely adopted alternative to face-to-face interactions and offer a safe and accessible solution; however, their impact on the quality and personalization of care

remains underexplored, particularly in dietetic practice. Sarah has explored person-centred care in video consultations from the experiences of Swedish dietitians and their patients during the COVID-19 pandemic, with a specific focus on person-centred care using a mixed-method design. In rural and SPR, there is a lack of physicians, and sometimes the only way to meet a doctor is via VC. Lina will present patients' experiences of VC with a physician. The patients are living in home-based settings and receive home healthcare or reside in nursing homes. The results of the thematic analysis reveal insights at a micro, meso, and macro level regarding feelings, healthcare-professional relationships, and technology. Medication-related problems (MRPs) are common among home-living rural older adults who often face barriers to access healthcare, such as long distances to healthcare services and poor continuity of care. Annica is developing and evaluating a tele-pharmacy service in primary care in Northern Sweden's rural areas as a single-arm, non-randomised, interventional pilot study. The aims are to develop and evaluate this service regarding MRPs, medication adherence, beliefs about medicines, and quality of life. These studies have been performed by the Swedish Centre for Rural Health, which will be further presented by its manager, Andreas Lundqvist.

## Workshop: Two decades of delivering Care and Support Planning for people with long term conditions. Learning for person centred care and application in Sweden [PCC004]

*Stina Mannheimer[1], Nick Lewis-Barned[2] & Lindsay Oliver[2]*

[1] GPCC, Institute of Health and Care Sciences, University of Gothenburg, Gothenburg, Sweden

[2] Year of Care Partnerships Programme, Northumbria Healthcare NHS Foundation Trust, UK

Long term conditions (LTC) care, and especially care for people with multiple LTCs, represents the biggest challenge facing healthcare in developed countries across the world. Huge national financial demands are

projected, as well as health and personal costs to patients. We present and share a person-centred approach that can potentially provide significant mitigation of this, as well as improving citizen experience, health outcomes and staff satisfaction. For almost 20 years the Year of Care Partnerships Programme has developed, delivered, tested, and refined a programme to implement person-centred care for people with single and multiple LTCs, known as Personalised Care and Support Planning (PCSP). Built around annual LTC reviews, it is based on strong theoretical principles and integrated into routine care. PCSP has been adopted by several hundred GP practices in England and Scotland and has been delivered to thousands of patients annually over multiple cycles. A range of evaluations have demonstrated that this approach is welcomed by patients who see it as transformational to their experience, and by healthcare staff who find it much more satisfying professionally. It supports relational engagement between people with LTCs and health professionals and improves both personal and health outcomes. The benefits persist where fidelity to the principles and processes of PCSP are sustained. The programme is adaptable to local circumstances, can be applied flexibly in different settings, and works across a lifetime. It streamlines care for people with complex health needs. This workshop will share PCSP principles and the work that is needed for clinical teams to put it into practice. We will also outline plans to make use of these principles in a Swedish primary healthcare setting. There will be opportunities to explore how participants could make use of this approach in their own practice.

## Panel: Measuring Person-Centred Care: A Panel discussion [PCC005]

*Maria Santana[2], Eskil Degsell[1, 3], Helena Fridberg[1, 4], Nina Ekman[5] & Peter Hagell[6]*

[1] University of Gothenburg, Centre for Person-Centred Care (GPCC), Sahlgrenska Academy, Gothenburg, Sweden

[2] Departments of Pediatrics and Community Health Sciences at the Cumming School of Medicine, University of Calgary, Canada

[3] Karolinska Institute and Karolinska University Hospital, Stockholm, Sweden

[4] Department of Community Medicine and Rehabilitation at Umeå University, Sweden
[5] Institute of Health and Care Sciences, University of Gothenburg, Gothenburg, Sweden
[6] Faculty of Health Sciences, Kristianstad University, Kristianstad, Sweden

In this panel, we bring together researchers involved in measuring person-centred care from different perspectives and context. The panel will open with brief introductions, followed by a moderated discussion on the opportunities, challenges, and methodological considerations related to measuring person-centred care. The panel will be moderated by Lena Rosenlund, from The University of Gothenburg Centre for Person-centred Care, GPCC, and the Regional Cancer Centre in Stockholm, she will guide the discussion to highlight key learnings, gaps, and future directions. Invited panel members:

Maria Santana, Dr. Santana is a Patient-Reported Outcome Measures methodologist working to implement previously developed high quality person-centred care quality indicators to measure person-centred care across the continuum of care. She is also studying the role of Patient-Reported Outcome Measures in the routine clinical care.

Peter Hagell, Professor Caring Sciences at the Faculty of Health Sciences, Kristianstad University, Sweden. Research group leader for PRO-CARE and head of subject (health sciences) at Kristianstad University. Coordinator of PMhealth (Network for Psychometrics and Metrology in the health sciences). Research areas include outcomes measurement and assessment, psychometrics, person-centred care, and observational and experimental clinical studies.

Helena Fridberg, Dr Fridberg is a postdoctoral fellow at Umeå university, Sweden. She also works on the research project IMPROVE – Implementation of Person-Centred Care: Process Evaluation of Strategies, Leadership, and Health Economics, evaluating a patient-reported measure for person-centred care.

Nina Ekman, Dr Ekman is a lecturer at the Institute of Health and Care Sciences, Gothenburg university. In her research, she has focused on observable indicators of person-centred care and designed a tool for the purpose of direct observation for assessing competency in delivering person-centred care.

Eskil Degsell, is a caregiver and vice chair of the Swedish Brain Tumour Association. He is a member of The GPCC Person Council and involved in several projects and research. He is also affiliated to the Karolinska Institute and Hospital in Stockholm, Sweden.

## Workshop: Reaching Consensus on the Purpose of Person-Centered Care: A Real-Time Delphi Workshop [PCC006]

*Lina Emmesjö[1, 2, 3], Hanna Gyllensten[1, 2] & Carl Johan Orre[4]*

[1] University of Gothenburg, Sweden

[2] Gothenburg Centre for Person-Centered Care (GPCC), Sweden

[3] University of Skövde, Sweden

[4] Malmö University, Sweden

How can we use consensus techniques to explore the true purpose of person-centered care? In this interactive workshop, participants will engage in a real-time Delphi process to explore this question, while simultaneously learning about the method itself. The Delphi method is a structured approach to reaching consensus among experts through iterative rounds of scoring and feedback. It maintains anonymity to reduce the influence of dominant voices and encourages thoughtful reflection by allowing participants to revise their responses after viewing group results. Workshop participants will take on the role of "experts" in person-centered care, selecting from perspectives such as researcher, healthcare professional, patient, next of kin, or other. The process consists of three rounds: Round 1: Participants are presented with a range of statements on the purpose of person-centered care, based on a literature review, and are invited to suggest additional perspectives. Round 2:

Participants score each statement (1–9) based on how well it captures the purpose of person-centered care. Round 3: Participants review aggregated scores from their selected expert group and others, then re-score the statements with the benefit of this shared insight. The session concludes with a presentation of the final results and a group discussion on how this method—and the insights gained—can inform research and practice in person-centered care. This workshop will be conducted in the digital platform eDelphi, where the participants will use their own smartphones or laptops. The workshop offers not only a collaborative space to reflect on core values of person-centered care but also a hands-on introduction to a method for inclusive, evidence-informed consensus-building.

## Panel: Improving the Patient's Medical Home: Implementing PC-QIs in Primary Care in Alberta [PCC007]

*Matthew Luzentales-Simpson[1], Kalpana Thapa Bajgain[1], Marina Rosa Filezio[1], Paul Fairie[1, 2], Kimberly Manalili[2] & Maria Santana[1, 3]*

[1] University of Calgary, Department of Community Health Sciences, Canada

[2] University of Calgary, Department of Family Medicine, Canada

[3] Alberta Strategy for Patient-Oriented Research, Patient Engagement Team, Canada

Background: The Patient's Medical Home (PMH) is a Canadian model for high-functioning primary care, emphasizing Person-Centred Care (PCC) as a core objective. The PMH underscores continuous quality improvement (CQI) as an essential mechanism for enhancing care quality, patient safety, and system performance. Here, we highlight our quality implementation program, which incorporates CQI into primary care. Our team co-developed, validated, and prioritized Person-Centred Quality Indicators (PC-QIs) through national collaboration with patients, communities, decision makers, and providers. PC-QIs are measurement-based quality improvement (QI) tools that compare a patient's actual primary care experience to an ideal, person-centred care experience. PC-QIs are derived from patient's experiences, obtained systematically through Patient-Reported Experience

Measures (PREMs). Lower PC-QI scores have been associated with additional unplanned care use following in-patient discharge, demonstrating potential to identify opportunities to improve patient outcomes and system performance. Implementation: Implementation plans were co-designed with six primary care, using the Quality Improvement Framework, which describes steps towards high-quality implementation. Barriers and enablers to implementation were identified through semi-structured interviews with decision makers, using the updated Consolidated Framework for Implementation Research, then matched to implementation strategies using the Expert Recommendations for Implementing Change tool to adjust implementations, locally. Partnerships: To facilitate and sustain implementation, we partnered with the provincial health quality organization to administer their primary care PREM, enabling routine capture of patient-reported experiences. We also partner with patients, via the PC-QI Patient Advisory Council to integrate patient perspectives into the implementation. Training: In partnership with local QI staff, patient partners, and primary care providers, we have co-developed a "Train-the-Trainer" style program, which is predicted to support provider understanding and adoption of PC-QIs. We will evaluate provider perspectives of the program using semi-structured interviews, and surveys. We also reflect on the challenges encountered and we will present evaluation findings to date.

## Workshop: From participants to partners: Strengthening the role of older adults as research partners [PCC008]

*Ann-Therese Hedqvist*[1, 2]

[1] Linnaeus University, Kalmar, Sweden

[2] Region Kalmar, Ambulance Services, Västervik, Sweden

While policy and funding frameworks increasingly call for public involvement, older adults remain underrepresented in roles that shape research priorities, methods, and knowledge production. So how can we meaningfully involve older adults as active co-creators in research, rather

than passive participants? This workshop invites participants to explore strategies for strengthening the role of older people as research partners in health care. The workshop builds on insights from an ongoing mixed-methods study focused on the involvement of older adults as research partners. Together, we will explore how person-centred values can guide the design of inclusive and equitable research partnerships. The workshop draws on real-world examples and invites reflection on structural, relational, and practical conditions that enable or hinder meaningful involvement. Participants will engage in: A short framing presentation (10 minutes) introducing key findings from the umbrella review and early insights from the Delphi study. A collaborative mapping exercise (30 minutes) where small groups identify barriers, enablers, and innovative practices for involving older adults as partners across different research contexts. A plenary discussion (20 minutes) synthesising group insights into guiding principles and strategies for more inclusive research. Guiding questions include: What values, attitudes, and practices enable meaningful partnerships with older adults in research? What structural, relational, and practical conditions support or hinder co-creation in research? How can we move from tokenistic involvement to genuine shared ownership in the research process? Designed for researchers, older adult representatives, healthcare professionals, and policymakers, the workshop aims to foster mutual learning, surface tensions, and co-develop principles that can guide future research and policy. Participants will leave with practical ideas for strengthening partnership-based research involving older adults.

## Panel: Making an iMPAKT: utilising person-centred nursing & midwifery KPIs and digital technology to transform healthcare environments [PCC009]

*Val Wilson[1, 2, 3, 4], Tanya McCance[1], Karen Tuqiri[2, 4], Mary Mulcahy[2] & Deborah Muldrew[1]*

[1] Institute of Nursing and Health Research, Ulster University

[2] Prince of Wales Hospital, SESLHD

[3] Nursing & Midwifery Research Allaince, SWSLHD

[4] School of Nursing, University of Wollongong

Globally, health authorities increasingly expect person-centred care, yet its meaning and implementation remain misunderstood. To address this, innovative strategies are needed to support healthcare professionals in embedding person-centred practices. This symposium presents a set of eight Person-Centred Nursing and Midwifery Key Performance Indicators (KPIs), and a validated measurement framework tested internationally across diverse settings. These KPIs have been integrated into the iMPAKT App, which collects, manages, and analyses patient experience data. The App also helps nurses and midwives translate insights from the data into meaningful practice improvements. This symposium will demonstrate how the KPIs and iMPAKT App enhance the quality and safety of person-centred nursing and midwifery care. Three interlinked presentations will highlight this International Research Programme focusing on outcomes of the work, how the App is used in practice through an organisational case study and the challenges in ensuring sustainability of iMPAKT. Presentation 1 Wilson V & McCance T: This presentation will provide an overview of iMPAKT and the implementation and evaluation studies that have taken place globally. We will showcase the outcome of the iMPAKT programme in terms of research, development and practice. Presentation 2 Tuqiri K, Wilson V & Mulcahy M: Prince of Wales Hospital in Sydney is the first to implement the iMPAKT App organisation-wide, across 29 clinical units—including inpatient, ambulatory, community, and virtual services. This presentation will highlight the critical enablers of success: strong leadership at all levels, dedicated iMPAKT champions, targeted facilitation for nursing staff, celebrating progress, and a robust governance structure. Presentation 3 McCance T, Wilson V & Muldrew D: This presentation will chart the journey of advancing the research program into the innovation domain, ensuring the technology stays current and widely accessible. The associated challenges for sustainability and scalability globally will be explored, alongside the benefits for commercialisation.

# Workshop: Digital Storytelling as a Qualitative Research Method for Patient and Public Involvement in Health Research [PCC010]

*Sandra Munro[1], Sadia Ahmed[1], Paul Paul Fairie[1] & Maria Santana[1]*

[1] University of Calgary, Alberta SPOR SUPPORT Unit, Patient Engagement Team

This workshop introduces Digital Storytelling (DST) as an arts-based qualitative methodology that supports meaningful Patient and Public Involvement (PPI) in health research. DST involves the creation of short, multimedia first-person narratives that integrate voice, image, and sound to convey lived experiences in a nuanced and impactful way. It has been increasingly applied across the research lifecycle, including data collection, analysis, knowledge translation and reflective learning. The session will begin with an overview of the 7-step DST methodology, followed by examples of digital stories created by individuals with lived experiences in health and healthcare. These examples will illustrate how DST can communicate emotions, insights, and context in ways that compliment and enrich traditional research methods. Participants will engage in structured small-group discussion to reflect on the stories and explore how DST can inform person-centred care. A hands-on activity will guide attendees in developing a research design using DST, focusing on the research goal, intended audience, and rationale for selecting this methodology. Emphasis will be placed on ethical considerations when using digital storytelling in health research, including issues of story ownership, authorship, and the practice of living consent- an ongoing, relational approach to consent that acknowledges the evolving nature of participants' comfort and agency. The workshop will also highlight the importance of co-creation when working with Patient Partners, ensuring that their contributions are not only acknowledged but actively shape the research process. This includes involving Patient Partners in the design, production, and interpretation of digital stories, as well as in the development of knowledge translation outputs. The workshop will conclude with a group discussion on potential applications of DST, including its use in co-developing knowledge translation outputs and fostering

equitable research partnerships. Participants will leave with a foundational understanding of DST and resources to support its integration into their own research.

## Invited Panel: Patient and public involvement structures and practices impacting person-centred healthcare and research (global perspectives) [PCC011]

*Brendan McCormack[1], Vincent Dumez[2] & Jana Bergholtz[3]*

[1] Susan Wakil School of Nursing and Midwifery, Sydney, Australia

[2] Centre of Excellence on Partnership with Patients and the Public (CEPPP)

[3] University of Gothenburg, Centre for Person-Centred Care (GPCC), Sweden.

Patient and public involvement (PPI) is increasingly implemented in healthcare organisations and research, and regarded essential in person-centred care. However, supportive structures are lacking in most countries and implementation varies world-wide. This panel discussion proposes to learn from good examples and articulate needs for further development. In this panel, we will discuss the following questions:

- What are purposeful structures for patient and public involvement in healthcare and research? What is the impact thereof?
- How to create and make use of synergies and links between patient and public involvement in healthcare and research?
- Impact of PPI processes, culture change and impact/outcome for patients?
- How to enable the inclusion of marginalised groups and people whose voices tend to be hidden?
- Are there features of patient and public involvement that support person-centred care? If so, what features?
- How can patient and public involvement become transformative in health care?

The panel will be moderated by Maria Santana, Professor in public health at the University of Calgary and provincial director in Patient Engagement for the Alberta Strategy for Patient-oriented Research, Canada.

Invited panelists:

- Jana Bergholtz, patient partner at the University of Gothenburg, Centre for Person-centred Care (GPCC). She studies PPI in healthcare and research and works to reduce tokenism in involvement practices.

- Vincent Dumez, founding member of the Centre of Excellence on Partnership with Patients and the Public (CEPPP), has played a leading role in advancing patient partnership in healthcare, education, and research in Canada and internationally.

- Brendan McCormack, Head of School and Dean, The Susan Wakil School of Nursing and Midwifery and Head of the CARE Program, Sydney Policy Lab, The University of Sydney, Australia. Brendan has a long history of leading collaborative research and development that is participatory and inclusive.

## Workshop: Designing digital health that works for everyone: a practical workshop on the Picker Principles of Digital Health [PCC012]

*Jenny King[1], Chris Graham[1] & Molly Hopson[1]*

[1] Picker Institute Europe

As digital health continues to expand it is important that the use of digital technologies supports the provision of person centred care. This is where the Picker Principles for Digital Health come in. Developed from a review of the literature and engagement with service users and professional stakeholders, they define what matters to most to people and guide providers and commissioners to deliver digital health services that respect peoples'

preferences, needs, and values. The principles cover themes such as data security, clinical safety, inclusivity, and transparency. In this interactive workshop, we'll introduce and discuss the Picker Principles of Digital Health—a set of values that define what people should experience when using digital health services. After a short presentation from JK to introduce the principles, we'll use a live poll (via Mentimeter) to explore questions such as which principles participants find most important, which would make the biggest difference, and which are the hardest to design and implement. Then, in groups facilitated by the other authors, we'll look at scenarios involving digital health use (e.g., booking an appointment, remote consultation, using a health app etc). Groups will be given a realistic but flawed digital health journey and asked to identify which principles are being violated. That is where the user experience breaks down and falls short of what people should reasonably expect. We'll then ask the groups how they'd reimagine the scenario, redesigning the experience to better reflect the principles and meet people's needs. We will use pens and post-its to record the discussion. Finally, we'll reconvene to one group providing feedback in a plenary discussion. This session is designed for anyone looking to make digital health more person centred and inclusive.

## Invited Panel: Home dialysis as a logistical hub in resilient healthcare – person-centred care by design

*Amir Khorram-Manesh[1], Emma Spak[2] & Håkan Hedman[3]*

[1] Associate Professor of Surgery, Sahlgrenska University Hospital, University of Gothenburg, Gothenburg, Sweden

[2] Director, Nationell samordning och planering, NSPL

[3] University of Gothenburg Centre for Person-Centred Care (GPCC), Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

How can healthcare systems remain functional during crises, war and disruptions to infrastructure and supply chains without creating one model for ordinary times and another for emergencies? This seminar explores how person-centred care can serve as the foundation for a healthcare system that

is resilient by design, with home dialysis as a concrete and compelling example. Home dialysis shows how advanced care at home can be organised around the capabilities, needs and resources of patients and families, while also strengthening the system's overall resilience and surge capacity. By reducing reliance on hospital-based treatment and enabling more care to be delivered safely outside hospital walls, home dialysis can help create capacity within the healthcare system when demand rises sharply or services are disrupted. In this way, surge capacity is not only a matter of beds, staff and emergency plans, but also of designing care models that are flexible, distributed and sustainable in everyday practice. Through robust logistics, secure access to medicines and consumables, support for self-care, digital monitoring, home preparedness and close coordination between patients, healthcare providers, pharmacies and public actors, care can remain safe, continuous and adaptable across both ordinary conditions and exceptional circumstances. In this perspective, resilience is not a parallel system activated only in crisis. It is an integrated feature of person-centred healthcare itself. The home becomes not only a place of care, but part of the healthcare system's infrastructure and capacity. Home dialysis can therefore be understood as a model for how person-centred care can strengthen continuity, support patient autonomy, expand surge capacity and reduce pressure on hospitals under stress. The seminar brings together perspectives from policy, healthcare, innovation and person-centred care to discuss how home-based care models can support a more resilient healthcare system for both everyday delivery and exceptional circumstances.

## Panel: Chronic pain and person-centered care: A panel on what we can learn from the EAPER-trial [PCC013]

*Åse Lundin[1, 2], Veronica Lilja[1, 2], Mari Lundberg[2, 3], Vivi-Anne Segertoft[4] & Sara Wallström[1, 2, 5, 6]*

[1] Institute of Health and Care Sciences, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

[2] University of Gothenburg Centre for Person-Centred Care (GPCC), Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

[3] Department of Health Promoting Science, Sophiahemmet University, Stockholm, Sweden

[4] Patient research partner

[5] Region Västra Götaland, Sahlgrenska University Hospital, Department of Forensic Psychiatry, Gothenburg, Sweden

[6] Centre for Ethics, Law and Mental Health (CELAM), University of Gothenburg, Gothenburg, Sweden

Chronic pain is a growing global public health challenge, the leading cause of years lived with disability and significantly impacts various aspects of life, including participation in working life. The EAPER-trial evaluated the efficacy of a person-centred intervention at home, consisting of a combined telephone support and eHealth platform, persons on sick leave due to chronic pain. Despite having to end the trial before reaching the targeted number of participants, results were significant, favoring the intervention. This panel brings together researchers and a patient research partner that have worked on the EAPER-trial to explore what made the trial show significant results when so many similar person-centered interventions have struggled to do so and what we can learn and bring to future projects. The panel will be moderated by Lilas Ali. She has been involved in the design and evaluation of several previous person-centred interventions. This experience will guide the discussion to draw out key learnings, gaps, and future directions that can be brought into person-centered research. Presentations include: Mari Lundberg has extensive knowledge of chronic pain and experience of being the PI for several person-centred interventions for people with chronic pain. She will present insights and key learning from these. Sara Wallström is the PI in the project will present about the project and previous interventions she has been involved in, which the project was inspired by. Åse Lundin was actively involved in conducting the EAPER-trial and will share lessons from this as well as results from the trial. Veronica Lilja will present findings from process evaluations and collaboration with research partner in the EAPER-trial. The panel will conclude with a moderated discussion on experiences from the intervention and what we can learn from it and bring into the design of future intervention.

# Panel: Exploring the Possibilities and Challenges of Researching Person-Centered Care at the Governance Level: A Panel on Implementation Research [PCC014]

*Lina Emmesjö[1, 2, 3], Malin Tistad[4], Markus Sarajärvi[5], Jenny Wising[1, 2, 3] & Theresa Larsen[6]*

[1] University of Gothenburg, Centre for Person-Centred Care (GPCC), Sahlgrenska Academy, Gothenburg, Sweden

[2] University of Gothenburg, Sweden

[3] University of Skövde, Sweden

[4] Dalarna University, Sweden

[5] Karolinska Institutet, Sweden

[6] Gothenburg Region, Sweden

While person-centered care (PCC) has been widely studied at the micro level, significantly less attention has been given to its development and implementation at the meso and macro (governance) levels. However, sustainable transformation toward person-centered systems requires engagement and evidence-building across all levels of the healthcare system. This panel brings together researchers working within various governance-level implementation projects at the Gothenburg Centre for Person-Centred Care (GPCC) to explore the opportunities, challenges, and methodological considerations of researching PCC at this level. The panel will be moderated by Hanna Gyllensten, Associate Professor in Health and Care Sciences, with expertise in health economics and governance research. She has been involved in all the featured projects and will guide the discussion to draw out key learnings, gaps, and future directions for governance-level PCC research. Presentations include: Malin Tistad, Associate Professor in Care Science, Dalarna University, will present research from a region in Sweden on how political directives can shape and influence person-centered practices at the governance level. Markus Sarajärvi, researcher at Karolinska Institutet, will share lessons learned from a national implementation program aimed at embedding sustainable, person-centered care for young people. Jenny

Wising, PhD candidate at GPCC, will discuss the implementation and evaluation of a leadership program aimed at promoting person-centered practice in social and healthcare settings. Lina Emmesjö, postdoctoral researcher at GPCC, will share insights from governance-level implementation of policy lab methodologies to foster person-centered innovation. Theresa Larsen, PhD candidate at GPCC and project leader at the Gothenburg Region, will describe the design, implementation and evaluation of a web-based PCC education program for municipal care professionals The panel will conclude with a moderated discussion on cross-cutting themes, practical implications, and future research needs at the intersection of governance and person-centered care.

## Workshop: Sexual Expression in Persons Living with Dementia [PCC015]

*Karen Rennie[1], Erna Haraldsdottir[1] & Duncan McKellar[2]*

[1] Queen Margaret University

[2] The Hammond Centre for Dementia and Palliative Care

Sexuality, intimacy, and sensuous expression remain important aspects of identity and personhood throughout the lifespan, including for older adults living with dementia in care homes. Yet, these expressions are often ignored, misunderstood, or suppressed within institutional care settings. This interactive workshop invites participants to engage with findings from a PhD study, the first of its kind to include the voices of people living with dementia in nursing homes, focusing on the meaning and importance of sexual expression in later life. Drawing on rich narratives and lived experiences, we will explore how sexual expression contributes to wellbeing, personhood, and dignity in care. Through facilitated discussion, reflective exercises and group work, participants will examine their own values, beliefs, and assumptions around sexuality and ageing. We will consider how our individual perspectives shape the ways we engage with residents' needs, and how we can foster a more inclusive, person-centred approach to care that acknowledges the full humanity of those living with dementia. Key themes

will include: The significance of sexual and sensuous expression in later life and dementia care. The impact of institutional culture and staff attitudes on residents' sexual autonomy. Emotional and ethical dimensions of supporting sexual expression as a healthcare practitioner or caregiver. Practical strategies for integrating sexuality into holistic, person-centred care. This session offers a respectful, open space to discuss a sensitive but vital aspect of dementia care. Participants will leave with a deeper understanding of how acknowledging and supporting sexual expression can enrich the lives of residents and strengthen the quality of person-centred healthcare practice.

## Panel: From Vision to Reality: Navigating the Challenges of Developing a Person-Centred Culture at a University Hospital in Denmark [PCC016]

*Bibi Hølge-Hazelton[1, 2], Elizabeth Emilie Rosted[1, 2], Mette Kjerholt[1] & Brendan McCormack[1, 2, 3]*

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At Zealand University Hospital in Denmark, we are committed to a person-centred vision for how we provide healthcare. Over the past five years, we have worked to embed this vision at micro, meso, and macro-levels of our organization. Our efforts have included piloting an intensive staff and leadership program at the department level, fostering and evaluating person-centred capacity among leaders at the organizational level, and working with global leaders in person-centred healthcare to inform, guide and support our initiatives. This Panel aims to provide a comprehensive exploration of our journey, highlighting the progress we've made, the challenges we have encountered, and the strategies we have developed to overcome them. We will share our experiences at the micro, meso, and macro levels, offering valuable insights that can benefit other organizations striving to cultivate a person-centred culture. By sharing our initiatives and their outcomes, we

hope to inspire others in their efforts to develop person-centred cultures. Outline of panel- 60 minutes Introduction and Overview (10 minutes): Brief introduction to the panelists and an overview of the session's objectives. Panel Presentations (40 minutes): Each of the four presenters will share their insights and experiences: Presentation 1: Overview of organizational-level initiatives and their impact. Presentation 2: Learnings from the department-level intensive program. Presentation 3: Reflecting on providing mentorship, support and external facilitation through the lens of global leadership. Presentation 4: Analysis of the micro, meso, and macro-level processes and outcomes and their broader implications. Discussion and Q&A (10 minutes): The session will conclude with an open discussion and Q&A, allowing participants to engage with the panelists and explore how these insights can be applied in their own contexts.

## Workshop: Embodied Experience of Health History Narration, Mindfulness as a New Approach to Care [PCC017]

*Anne-Marie Cote*[1]

[1] Simon Fraser University

In this workshop we will be using a visualization exercise, thread-and-paper model, to serve as a metaphor for how patients curate their health narratives and how healthcare practitioners can engage more ethically with the patient to increase understanding of the body's complexity. Following the paper and thread exercise, the group will explore the potential of mindfulness and narrative-based care in healthcare, challenging the conventional Western medical model that views the body as a fixed entity with an idealized past to return to. Through the lens of ontogenesis and embodied awareness, the workshop attendees will learn that the body is not static but in constant flux, and that healing should focus on supporting the body's evolving identity rather than restoring a former state. Drawing on the theories of Dr. Erin Manning, Rita Charon, Byung-Chul Han, and Anil Seth, the work emphasizes the importance of touch, attentive listening, and narrative in the

therapeutic process. Using clinical case studies to illustrate how simple therapeutic touch and mindful presence can lead patients to rediscover their bodies in transformative ways, revealing the emotional and sensory layers often hidden beneath symptoms. This workshop aims to critique the reduction of patient health histories into isolated data points, advocating instead for a narrative-based understanding of health that values the full context of a patient's lived experience. Finally, we will introduce mindfulness techniques as tools for both practitioners and patients to remain present with the body as it is, not as it was, thereby facilitating ongoing self-discovery and growth. The work concludes that cultivating this embodied, non-judgmental awareness not only enhances therapeutic outcomes but also honors the deep humanity at the heart of care. Ultimately, this approach supports both patient and therapist in co-creating a space for healing that embraces potentiality over prescription, and presence over pathology

# Oral Sessions

The order for the abstracts for oral sessions is organized into topics.

## Co-creation

### Cultural activities and patient empowerment created through co-operation [PCC020]

*Maria Linderström*[1]

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Sweden among other countries has challenges: increasing stress related illness, mental unhealth, lack of existential health and social isolation. Cultural and outdoor activities can be powerful tools among other treatments, but it can be difficult to find models healthcare can implement. Arts on prescription can be seen as sending a more paternalistic as well as pathogenetic value of the patient, which the model invented in Region Östergötland has been conscious to avoid. To put patients in action, let care givers be heard and cultural actors engaged the model was created by co-operation: patients, caregivers and cultural actors were invited and reinvited to create and improve a model for patients with anxiety, pain and stress-related illnesses. The ongoing intervention since 2012 involves activities such as art, craft and forest bathing. They are led by professionals and focus on process and creativity in order to give the participants a safe space in which they can change mindset. The activities take part in groups consisting of 8-12 participants to create social coherence. The model is an example on how to involve art and nature in healthcare as well as to involve the target groups itself. The main success-factor of the model is the cooperation of perspectives. Anchoring all parts was a base in designing the model: all

stakeholders were included as reference groups; participants (patients), caregivers, actors within the cultural and outdoor sector. After 12 years of ongoing the evaluations show all through good results for participants (improved wellbeing), caregivers (a useful tool) and actors (a new area). With similar challenges, the regions benefit from cooperation. During 2025 the Region Dalarna and Region Uppsala are piloting the model. More regions are welcome to join the network to exchange experience.

## Working Together: Lessons Learned from an Inflammatory Bowel Disease (IBD) Patient Research Council [PCC021]

*Sandra Munro[1], Jessica Cromwell[2], Justin Mikhail[2], Amanda Pounder[1], Sophia Khan[1], Kaylee Janse[2], Melissa Fox[2], Kendall van Diepen[2], Kaitlyn Chappell[2] & Karen Wong[2]*

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Inflammatory bowel disease (IBD), comprising Crohn's disease and ulcerative colitis, are lifelong illnesses, often diagnosed in young adults. Managing and monitoring IBD requires multidimensional care, yet resources to support both medical and psychosocial needs are limited in Alberta, Canada. To address these gaps, we are co-developing MYIBDToolkit, a digital health intervention designed to support both patients and providers through enhanced communication and self-management tools. To ensure the intervention reflects patient priorities, a Patient Research Council was formed in June 2023. The council includes seven Patient Research Partner (PRPs), a gastroenterologist, dietician, project manager, and academic researchers. Monthly meetings and collaborative working groups were established to co-create research protocols, educational content, nutrition and mental health pathways. All members have equal access to shared materials and contribute through synchronous and asynchronous formats. A Patient Engagement Evaluation conducted in August 2024 identified areas for improvement, including communication, role clarity, and study timelines. In response, we implemented changes such as assigning a communications

lead, forming smaller working groups, and creating a shared document outlining roles and milestones. Evening meeting-times and flexible scheduling supported consistent participation. Training provided by AbSPORU's Patient Engagement Team—including sessions on patient-oriented research and qualitative methods—enabled PRPs to co-lead a focus group study. Five PAC members completed research ethics certification (TCPS 2: CORE 2022), further supporting their leadership roles. This collaborative, person-centred approach ensures that the lived experiences and insights of individuals with IBD shape the development of MYIBDToolkit. By integrating patient voices throughout the research process, we aim to create a tool that is responsive, accessible, and meaningful, ultimately improving quality of life and care for people living with IBD.

## Bridging the Gap Between Cancer Care and Civil Society: A Realist Evaluation of a Patient-Led Social Innovation in Sweden [PCC022]

*Frida Smith[1, 2], Johanna Hök Nordberg[3], Andreas Hellström[2], Patrik Alexandersson[2], Eva Dieker[4], Sara Riggare[4], Erik Eriksson[5] & Therese Scott Duncan[4]*

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Cancer rehabilitation in Sweden is fragmented and unequal, leaving many patients and their families without adequate support after clinical treatment ends. This ongoing study evaluates Kraftens hus (KH), a patient-led social innovation designed to complement traditional cancer care by offering emotional, social, and practical support through civil society engagement. Using a modified realist evaluation framework, we investigate how KH functions across micro, meso, and macro levels, and under what contextual conditions its mechanisms lead to beneficial outcomes. Data collection includes qualitative interviews, surveys, document analysis, and focus groups

across four KH sites (Borås, Göteborg, Stockholm/Gotland, Östersund). At the micro level, we explore how KH supports individuals in navigating fragmented care systems and enhances their sense of coherence and self-efficacy. At the meso level, we examine the organizational model of KH and its capacity to foster cross-sectoral collaboration. At the macro level, we assess how patient involvement and co-production contribute to system-level change and sustainability. Our initial program theory suggests that KH improves quality of life for cancer-affected individuals by activating mechanisms of peer support, empowerment, and resource integration. The organizational model is expected to facilitate trust and legitimacy among stakeholders, while patient-driven processes enhance relevance and responsiveness. This empirical study contributes to the growing field of social innovation in healthcare by demonstrating how civil society plays a complementary role in rehabilitation. It will also offer a transferable model for other patient groups and health systems seeking to address complex needs through inclusive and sustainable approaches.

# Digitalisation & eHealth

## From interviews to insights in long-term care: AI models for thematic, sentiment and summarization of interviews to support quality of care [PCC023]

*Sil Aarts[1], Mohammad Fayazi[1] & Katya Sion[1]*

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In long-term care (LTC), interviews with clients, their families, and care professionals are essential for understanding and improving care quality. Manual analysis of these interviews is labor-intensive and time-consuming. This study presents an AI-approach, using natural language processing (NLP), to automate: 1) thematic analysis, 2) sentiment detection and 3) summary generation. Using 470 interviews (125 manually labelled by experts

as reference) we applied discourse-aware segmentation and contrastive machine learning for context-rich textual understanding. Structured prompting ensured coherent, accurate summaries. The NLP models substantially improved the efficiency and consistency of identifying key themes and sentiment from the interviews. Expert evaluations rated the NLP summaries as coherent and factual. Quantitative evaluations, comparing manual expert analyses to NLP, will be presented at the time of the conference. As an open-source tool, this approach facilitates evidence-informed decision-making in daily practice. Moreover, this model is easily transferable to other types of qualitative data, offering broad applicability across healthcare and research contexts

## Digital twins to support person-centred care [PCC024]

*Sandra Saade[1], Susanna Nordin[1], Kevin McKee[1], Marie Elf[1] & Johan Borg[1]*

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Health and social care systems are facing substantial challenges. Demographic shifts, with a growing proportion of older adults and a shrinking proportion of working-age adults, coincide with aging in place policies. This results in more older adults living at home with complex needs while healthcare systems face staff shortages. Digital health technologies offer opportunities to strengthen integrated, person-centred care. A digital twin for homecare will be developed, drawing on sensor data from older adults and their homes, GPS data on staff driving routes, and daily surveys capturing perceptions of care from both older adults and staff. This dynamic, individualized representation may support tailored care planning, proactive decision-making, and mutual insight into needs and preferences. Before entering the development phase, individual interviews and focus group discussions have been conducted with older adults receiving homecare services and homecare staff from two municipalities in Sweden, to explore their perspectives on digital twins and their potential use in homecare. Semi-structured interviews and two focus group discussions were held with 14

older adults, with diverse living and housing situations and diverse homecare needs. These data underwent reflexive thematic analysis. Four focus group discussions were conducted with 31 professionals occupying various roles within homecare services, and these data were analysed using content analysis. The results indicate that older adults perceived digital twins as a potential means to make homecare services more responsive to their needs, enhance their safety through monitoring and predictive functions, and to support staff continuity and scheduling. Homecare staff anticipated that digital twins could support more proactive and needs-based homecare, facilitate assessment and planning, and contribute to a better work environment with less stress. Both older adults and staff revealed a limited understanding of digital twins and expressed ethical and social concerns, and lacked a deeper understanding of the concept.

## Wearable sensors for fall risk screening – Insights from older persons [PCC025]

*Madelene Törnblom[1], Kari Rönkkö[2], Kerstin Ådahl[2], Staffan Karlsson[1, 3], Ulrika Olsson Möller[1, 4, 5] & Anna Nivestam[1]*

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Background: Falls are a major health concern among older persons, and wearable sensors offer promising opportunities for fall risk prediction in real-world settings. However, the acceptability and user experience of such technologies among older persons in their daily lives remain understudied. Understanding the experiences of older persons is essential for the successful implementation of wearable sensor-based fall risk screening. Methods: In 2024, a qualitative study was conducted in Sweden with 21 community-dwelling older persons (13 women and 8 men) aged 77–81 years. Participants wore a thigh-mounted wearable sensor for one week to screen for fall risk in

daily life. Individual interviews were held 9–89 days after sensor use (median: 15 days) and analysed using conventional qualitative content analysis. Results: Older persons' experiences with wearable sensor-based fall risk screening were explored through the overarching theme 'Being an older person in a fall screening process'. Despite the standardised procedure of the screening, they all had unique experiences reflecting a diversity of perspectives. While the sensor was generally experienced as easy to use, some encountered challenges during wear, such as losing the sensor. The older persons emphasized that screening results must be personally meaningful and actionable for health improvement, expressing a desire to actively use the information to support their health goals. Conclusions: The older persons described diverse and unique experiences of wearable sensor-based fall risk screening in their daily lives. The wearable sensor was perceived as an acceptable tool, emphasizing the value of further research into fall risk technology to enhance the accuracy of fall risk assessments in daily life. The results of this study highlight that the screening results should be presented in a person-centred way, ensuring that the older person can understand and, if they wish, use the information to actively support and improve their health.

## The Influence of Artificial Intelligence on Person-Centred Care: Insights from AI-Assisted Triage in Primary Care [PCC026]

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Artificial intelligence (AI) is increasingly shaping healthcare by processing large data volumes, improving decision-making, and streamlining workflows. At the same time, person-centred care (PCC), which emphasizes individualized, empathetic, and context-sensitive healthcare, is widely recognized as a gold standard. While AI-based digitalisation and PCC are often seen as operating under distinct logics, this study explores how AI may

influence the practice of person-centred care in clinical settings. The aim of this study was to explore how AI-assisted triage influences the delivery of PCC in primary care. Drawing on 39 semi-structured interviews with healthcare leaders, professionals, and patients, and guided by theoretical framework on PCC, we conducted an abductive qualitative content analysis. Interviews took place between November 2022 and May 2023, focusing on participants' experiences with AI in clinical settings. Findings indicate that AI-assisted triage can support PCC by reinforcing clinical judgment, facilitating patient narratives, and enhancing both safety and accessibility. Patients valued AI's objectivity and its capacity to assist in articulating health concerns yet underscored the irreplaceable value of human interaction. Trust, transparency, and clinician oversight emerged as critical conditions for AI to support PCC, with participants expressing caution regarding AI's autonomous application. AI was found to shift traditional patient-provider dynamics, promoting patient responsibility while also introducing challenges related to self-diagnosis and rigid AI questioning. Participants consistently emphasized that AI should serve as a complement, rather than a substitute for human interaction, to preserve empathy, transparency, and individualized care. In conclusion, AI has the potential to support PCC by amplifying patient voices, enhancing access, and informing clinical decisions. However, its impact is contingent upon thoughtful integration, cultivating of trust and transparency, and incorporating diverse user perspectives in the design and deployment of AI systems. Additionally, training healthcare professionals for AI-supported environments is crucial to realizing these benefits.

# Disasters and Time-Critical Events

## Person-Centred Care for Crisis Preparedness: Building Resilient Healthcare Under Exceptional Circumstances [PCC027]

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How can person-centred care become a key strategy to strengthen healthcare system resilience in crises, disasters, and within the context of total defence? Drawing on lessons from the pandemic, current research, and experience in preparedness planning, we show how person-centred approaches can help safeguard continuity of care and patient participation even under extreme conditions. By integrating person-centred principles into preparedness plans, more robust systems can be built to withstand pressure. The lecture offers practical insights and tools to apply in your own organisation.

## Person-Centered Care in Emergencies and Mass Casualty Scenarios [PCC028]

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While person-centered care aims to influence policymakers' rules and regulations to improve the care of individuals worldwide, there is a notable lack of exploration of this concept in the context of Disaster and Public Health Emergencies (DPHE) as an alternative ethical approach. In this study, we provided a nuanced understanding of the advantages and challenges associated with various ethical approaches in emergencies and mass casualty scenarios to enhance patient care. The ethical approaches examined included Mechanistic Medicine, Utilitarianism, and Person-Centered Care. A survey, developed through several rounds of the Delphi

methodology, consisted of 22 statements and was administered to 39 expert participants from nine different countries. The results of the questionnaire, along with participants' comments, were analyzed. The findings indicate that practitioners tend to employ a combination of diverse ethical approaches when managing victims of disasters and public health emergencies. The choice of approach is context- and situation-dependent, often responding primarily to the nature of the underlying etiology, which allows for the integration of diverse approaches, including individualized care. The outcomes of this study will contribute to future ethical discussions surrounding person-centered care in situations with limited resources and will aid in the development of essential ethical and educational guidelines.

# Health Equity/Women Health

## Person-Centered Care during Antenatal, Intrapartum, and Postnatal Care: analysis of data from Ghana and Kenya [PCC030]

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Background: Person-centered maternal health care (PCMHC)—responsive, respectful, and supportive care across the pregnancy, childbirth, and postpartum continuum—is essential to achieving maternal and neonatal outcomes. We sought to examine the extent of PCMHC and associated factors using recently validated tools for person-centered antenatal care (PCANC) and person-centered postnatal care (PCPNC), in addition to the well-established person-centered maternity care (PCMC) scale for intrapartum care Methods: Data are from cross-sectional surveys with 2000 women within 12 weeks postpartum in Kenya and Ghana (1000 each). Outcome measures are summative scores generated from a 36-item PCANC scale, a 30-item PCMC scale, and a 38-item PCPNC scale, each with three sub-scales for dignity and respect, communication and autonomy, and

responsive and supportive care. Each score is standardized to range from 0-100, where zero is the worst, and 100 is the most person-centered care. Results: The average standardized scores were 68.8(SD=15.78) for Kenya and 74.2(SD=16.48) for Ghana for PCANC; 71.6(SD=14.80) for Kenya and 71.8(SD=15.61) for Ghana for PCMC; and 69.4(SD=14.19) for Kenya and 72.3(SD=17.32) for Ghana for PCPNC. The lowest subscale scores across all outcomes were in communication and autonomy, with scores ranging from 54.9 for communication and autonomy during childbirth in Kenya to 70.1 for communication and autonomy during ANC in Ghana. The highest scores were for dignity and respect, with responsive and supportive and supportive care scores in between. On average, women of higher socioeconomic status have higher PCMHC scores at each phase. PCMHC is also higher in health centers and private facilities than in public hospitals. Conclusion: Person-centered care is sub-optimal at various stages of the pregnancy, childbirth, and postnatal continuum, with communication and autonomy as the lowest-scoring domain. The most vulnerable women receive the worst care. Interventions are needed to improve person-centered care during the maternal health continuum and to address the inequities.

## Disparities in autonomy in decision-making during pregnancy in Canada: Findings from a national survey of patient-reported experiences [PCC031]

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Autonomy in decision-making during pregnancy is a key component of person-centered care, yet little is known about autonomy experiences of perinatal service users in Canada. We conducted multivariable regression analyses, using the validated My Autonomy in Decision-Making scale (see Table 1) as the outcome variable, and maternal characteristics as the independent variables. We controlled for pregnancy year, repeat observations, and gravidity and stratified by the healthcare provider type whom people rated (midwives or physicians). 5389 participants reported on 7049 interactions with healthcare providers between 2009 and 2022 as part of a national participatory action study. Midwifery clients reported very high autonomy scores, on average, while those who rated physicians were less likely to experience autonomy, although physician scores increased over time. For women who rated physicians, the adjusted odds of high autonomy were significantly lower among young mothers (AOR=0.58, 95 % CI: 0.43-0.78); people with less education (AOR=0.67, 95 % CI: 0.49-0.91); respondents with insufficient income to meet financial obligations (AOR=0.49, 95 % CI: 0.36-0.68) and those with a very weak sense of belonging to their communities AOR=0.19, 95 % CI: 0.12-0.30). For people who rated midwives, the adjusted odds of experiencing autonomy were significantly lower among newcomers to Canada (AOR=0.34, 95 % CI: 0.15-0.77), respondents who needed social services during pregnancy (AOR=0.35, 95 % CI: 0.16-0.79), people with high risk pregnancies (AOR=0.59, 95 % CI: 0.41-0.86), and those with a very weak sense of belonging (AOR=0.57, 95 % CI: 0.34-0.94). Several factors were linked to higher odds of autonomy, including early entry into prenatal care, and sufficient time during prenatal appointments. The ability to lead decisions during pregnancy, birth and the postpartum period, is a reproductive right, yet minoritized communities reported significant loss of autonomy. Differences persisted across models of care, pointing to structural inequities in patient-led decision-making during pregnancy.

Table 1: My Autonomy in Decision-Making (MADM) Scale items and proportion of participants who agreed or strongly agreed with each item, stratified by provider type

| | | Family Doctor (n=1245) | OB (n=2218) | Midwife (n=1938) |
|---|---|---|---|---|
| 1 | My provider asked me how involved in decision making I wanted to be. | 485 (39.1) | 734 (33.2) | 1372 (71.0) |
| 2 | My provider told me that there are different options for my maternity care. | 442 (35.8) | 591 (26.8) | 1631 (84.7) |
| 3 | My provider explained the advantages/disadvantages of the maternity care options. | 387 (31.3) | 605 (27.5) | 1511 (78.3) |
| 4 | My provider helped me understand all the information. | 565 (45.8) | 945 (42.9) | 1608 (83.6) |
| 5 | I was given enough time to thoroughly consider the different care options. | 528 (42.8) | 797 (36.1) | 1611 (83.6) |
| 6 | I was able to choose what I considered to be the best care options. | 619 (50.4) | 957 (43.5) | 1640 (85.1) |
| 7 | My provider respected my choices. | 803 (65.2) | 1256 (57.2) | 1670 (86.6) |

*Response options: 1- Strongly disagree, 2- Disagree, 3- Somewhat disagree, 4- Somewhat agree, 5- Agree, 6- Agree Strongly*

## Patient-Centered Care in Question: A Qualitative Study of Power Imbalances in Obstetric and Gynecological Violence in Québec [PCC032]

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Research on obstetric and gynecological violence has expanded considerably in recent years. Inspired by feminist mobilizations in South America, this phenomenon has gained international recognition as a form of gender-based violence, with documented prevalence and consequences underscoring its significance. This partnership-based study from Québec (Canada) applies a patient-centered analytic framework to explore how power inequities shape experiences of disrespectful sexual and reproductive health care reported within the last seven years. We conducted ethically supervised, in-depth interviews with 35 participants who shared accounts of violent or disrespectful encounters. Through reflexive thematic analysis, we show how

clinical encounters are situated within hierarchical structures of power and expertise. These hierarchies operate both in patient–provider interactions and within interprofessional relationships, producing contexts in which experiential knowledge is marginalized despite its perceived importance for high-quality care. Participants also described how partial or incomplete communication of information fostered doubt, eroded trust, and constrained their ability to engage meaningfully in decisions about their care. The analysis additionally highlights a persistent tension surrounding expectations of deference to medical authority and the normative role of the "good patient." Participants navigated these expectations either to maintain harmonious interactions or to optimize perceived clinical outcomes. Taken together, these findings call into question the practical realization of patient-centered care, revealing systemic shortcomings that inhibit respectful and equitable care delivery.

# Implementation & Knowledge Translation

## The Determinants of Implementing Patient-Centered Care in Developing Countries: A Case Study of Kahama Municipal Hospital in Tanzania [PCC033]

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Background: Patient-centered care is a cornerstone of healthcare quality and one of its six key dimensions. Despite its well-documented contribution to improving service delivery and health outcomes, patient-centered care remains inadequately implemented across many health facilities in low- and

middle-income countries. This study examined the determinants influencing the effective implementation of patient-centered care among healthcare providers at Kahama Municipal Hospital in Tanzania. Objective: To explore and analyze the factors that facilitate or hinder the effective implementation of patient-centered care among healthcare providers at Kahama Municipal Hospital. Design: A qualitative research design was adopted, involving 21 healthcare providers purposively and conveniently sampled. Data were collected through Focus Group Discussions together with Key Informant Interviews and were analyzed thematically using content analysis. Results: The study identified a combination of individual and institutional determinants influencing patient-centered care implementation. Provider-related factors included limited knowledge and understanding of patient-centered care, low motivation, excessive workloads, inadequate professional competencies, and suboptimal communication practices. Organizational barriers encompassed the absence of ethical and policy frameworks, a lack of a supportive institutional culture, and insufficient leadership commitment to patient-centered values. Conclusion: While patient-centered care is acknowledged at Kahama Municipal Hospital, its implementation is impeded by policy gaps, workforce shortages, leadership limitations, and weak institutional mechanisms. To strengthen patient-centered care practice, health sector policymakers and hospital administrators should: (1) develop and operationalize comprehensive patient-centered care policies and guidelines, (2) institutionalize a patient-centered culture within leadership and governance structures, (3) address human resource deficits, (4) enhance continuous professional development on patient-centered care, and (5) strengthen staff motivation and recognition systems. Implication: Institutionalizing patient-centered care within Tanzania's health system will enhance care quality, accountability, and patient trust, while accelerating national progress toward equitable, people-centered, and resilient healthcare delivery.

## "What's stopping us?": Using implementation science to act on patient experience data [PCC034]

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Background and Objectives: Using patient experience data (PXD) to improve healthcare quality is gaining interest, but it rarely translates into improvements in patient care. Recognizing the organizational challenges (e.g., competing priorities, data interpretation uncertainty) to collecting and actioning PXD, we aimed to understand related facilitators and barriers to identify strategies to overcome these hurdles in a hospital setting. Approach: Our team conducted a qualitative descriptive study with 23 participants (10 patient and caregiver partners, 13 hospital staff) from a multi-site, urban hospital in southern Ontario, Canada. Interviews and focus groups were held. Interview questions were guided by a four-part schematic created by our team outlining a potential strategy to action PXD. The five domains of the Consolidated Framework for Implementation Research (CFIR) were used to develop our codebook and guide analysis: Innovation, Outer and Inner Setting, Individuals and Implementation Process. Results: Participants provided reflections on the PXD strategy. Our findings were organized using the CFIR domains. For Innovation, participants identified the need to have clear goals and outcomes. For Inner and Outer Setting, participants emphasized the importance of understanding how external (e.g., seasonal illness, policy changes) and internal constraints (e.g., accreditation, staff burnout) affect implementation. At the Individual level, the perception among staff that implementation was not feasible in their day-to-day work was a barrier. Participants emphasized the co-collaboration between patients, caregivers and hospital staff (e.g., leadership, front-line staff, service workers) to implement improvement initiatives as a key facilitator for the Implementation Process. Conclusion: The CFIR constructs served as a useful analytic frame for identifying factors that support acting on PXD to create a more responsive, person-centred healthcare system. This requires a strong organizational commitment, a concrete strategy, a culture that values

patient experience, meaningful collaboration, and clear accountability. Our findings can be further tested in a future implementation study.

## Culture of Compassionate Collaboration: Organizational responsibilities in sustainable implementation [PCC035]

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Background: Person-centered research has advanced science and practice, highlighting the crucial role of organizational management, values, and structures in implementation. To safeguard the rights and dignity of persons with Serious Mental Illness (SMI) in Supported Accommodations (SA), robust programs are essential for regulatory compliance, ethics, evidence-based practice, adaptability to resident sensitivities and preferences, staff resource management, program fidelity, high quality collaboration, fostering compassion, etc. Given health inequities and the low status of residents and staff in SAs, Everyday Life Rehabilitation (ELR) was developed and evaluated to provide integrated, long-term, collaborative person-centered rehabilitation, focusing on personal recovery through meaningful activities. Methods: Alongside a four-year pragmatic cluster-RCT, showing strong effects of ELR on recovery and quality of life (Sjöberg, Liv & Lindström, 2025) and cost-effectiveness (submitted), we examined implementation strategies within 14 participating municipalities. Process data were collected from senior- and housing managers. Results: Implementation efforts varied widely among the municipalities. Eight elements were identified as critical for successful implementation of ELR: (1) management signaling values and long-term goals of implementing ELR; (2) organizing steering groups with clear timeframes and responsibilities; (3) leadership commitment and support; (4) monthly staff reflection sessions for collegiate learning; (5) dialogue on roles and expectations aligned with program components; (6) structures and prerequisites for person-centered and intersectoral collaboration; (7) recognition of `Culture of Compassionate Collaboration´

(CCC); and (8) continuous dissemination of best practices. Conclusions: Despite strong effects and cost-effectiveness of ELR, organizational responsibility is critical for long-term implementation success. Findings emphasize the need to create and sustain a Culture of Compassionate Collaboration (CCC) through collegiate learning and leadership support.

Reference: Sjöberg A, Liv P & Lindström M. Effect of Everyday Life Rehabilitation on recovering quality of life in individuals with serious mental illness in supported accommodation: a pragmatic cluster randomised controlled trial. BMJ Mental Health, 2025; 28(1).

## From words to action – implementing person-centered transitional care for adolescents with long-term conditions: the STEPSTONES research consortium [PCC036]

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Background: During the transition to adulthood, adolescents with long-term conditions need to take over responsibility for their care. Considering their unique developmental needs, adolescents are exposed to challenges and risks, and inadequate preparation for self-management can negatively impact long-term health outcomes. In addition, their follow-up care is transferred from a pediatric to an adult setting. Person-centered care is essential to address these critical challenges, with the STEPSTONES transition program being fit to cater these needs. Although mounting evidence for the effectiveness of transition programs, these are rarely implemented in practice. Objectives: To implement, adapt and evaluate the STEPSTONES transition program for adolescents with congenital heart disease, type-1 diabetes and, neurodevelopmental disorders in pediatric health services. Methods for implementation: A multi-faceted approach, combining stakeholder engagement, patient and public involvement, and facilitation of new practices, is employed to explore facilitators and barriers to implementation, as well as to examine how the STEPSTONES transition program can be sustained within each setting. The implementation and adaptation are conducted across six university hospitals, along with habilitation services in two healthcare regions in Sweden. Methods for evaluating implementation: The effectiveness is evaluated using a non-inferiority design where evaluation of both clinical effectiveness and implementation strategies employed will be carried out. Patient-reported outcomes will be compared to results from previous STEPSTONES RCTs, focusing on empowerment, health outcomes, and transition readiness. Participants' and healthcare professional's experiences of person centeredness during the transitional phase are investigated. In addition, we are exploring contextual mechanisms of impact and normalization of the transition program into standard care. Expected outcomes: The implementation of these projects will accelerate the translation of evidence into clinical practice by implementing an on-demand model of care. Furthermore, the research can provide evidence of which implementation strategies are successful in the implementation, adoption, and maintenance of person-centred transitional care.

# Learning & Education

## In charge of personcentred fundamental care: An action research approach in a surgical department [PCC037]

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Background: Research in surgical care has highlighted the need to improve the delivery of person-centered fundamental care. The inCHARGE programme—Innovations to Utilise Nurses' Competence and Achieve Person-Centered Care: Fundamentals of Care Goes into Practice—is a research program aimed at identifying and co-creating interventions to promote person-centered fundamental care in a surgical department. Aim: The aim is to describe the processes within the programme and how its outcomes inform clinical practice and enhance the delivery of person-centered fundamental care to patients. Methods: The program adopts an action research approach. Since 2022, the research team has collaborated with nursing staff and leaders across three surgical wards in a university hospital in Sweden, to design actions and interventions that influence the direction of nursing practice. Initially, nursing staff participated in interactive workshops that included education on person-centered fundamental care, professional role responsibility, and leadership. Data collection includes measures of missed nursing care, person-centered climate, and patient preferences for participation, alongside patient interviews, written reflections, and focus groups. The Fundamentals of Care framework serves as the overarching theoretical framework. Results: Findings show multifaceted factors that enable or hinder nursing staff in delivering person-centered fundamental care. These include the need for a culture of daily mentorship to ensure adherence to person-centered routines and to embed

person-centered care into everyday thinking and practice. Results from the programme's sub-studies have guided the development and (re-)implementation of person-centered routines across the three wards. The presentation will provide a snapshot of these results and outline the collaborative process. Conclusion: To support the delivery of person-centered fundamental care and facilitate changes in clinical practice, this action research programme offers a promising design and content. The results can be used to demonstrate the need for change and to navigate the complex implementation of person-centered fundamental care in clinical settings.

## Creating conditions for flourishing and growth: experiences of using a concept of person-centred workplace learning in practice [PCC038]

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Background: Some years ago, the Nursing Development Unit of the City Hospital Zurich, a Swiss tertiary hospital, developed a concept for person-centred workplace learning based on the Clinical Nurse Specialists' (CNS) shared values and principles of personcentredness. The concept was widely used for ongoing workplace learning with Registered Nurses (RN). Due to organisational challenges and changes, the members of the Nursing Development Unit felt a strong need to revise and adapt the concept. Methods: The concept was revised in an inclusive, collaborative and participatory way. An iterative process was used including revisiting literature, engaging with the two models of workplace facilitation "critical allies – critical friends" (Hardiman & Dewing 2019) and the concept of active learning. Critical-creative dialogues accompanied the process of revising the concept in all stages. Senior members of the CNS team who have advanced facilitation skills supported the implementation of the revised concept using creative methods and critical dialogues. Results: Feedback from both CNS and RNs were quite positive. RNs enrolled in workplace learning felt

empowered and in a safe space. However, critical dialogues also showed that especially the junior CNS needed additional support in using active learning methods in practice. Further, communication with nurse managers appeared to be challenging as they had different expectations to workplace learning than the CNS. Conclusions: The revised concept seems to support the creation for conditions to flourish. Yet, it is vital that junior CNS are supported in using the concept for offering them also conditions for flourishing and growth. Open communication is key. It is eminent to be transparent against all interested parties about what we are doing and listen to their needs and ideas to gain mutual understanding.

## Integrating Indigenous Knowledges into Nursing Curricula: A Strategic Approach to Improving First Peoples' Health [PCC039]

*Brendan McCormack[1] & Roianne West[1]*

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Improving the health and wellbeing of Aboriginal and Torres Strait Islander peoples in Australia requires a systemic transformation in nursing education—one that privileges Indigenous knowledges, person-centred care, and cultural safety. This presentation shares a transformative curriculum approach that supports this goal by embedding Indigenous-led knowledges and culturally safe pedagogies across all years of nursing education. Despite national accreditation requirements mandating Aboriginal and Torres Strait Islander health content, many institutions continue to rely on isolated units rather than holistic integration. At the Sydney Nursing School, we are addressing this gap through the co-design and implementation of an Integrated Indigenous and Person-Centred Theory (IIPCT) and its companion Curriculum Framework (IIPCCF). These innovations serve as culturally responsive mechanisms to shift paradigms in nursing education. We will present the IIPCT's philosophical and theoretical foundations and describe how the IIPCCF operationalises these principles throughout the curriculum. This includes how these frameworks advance student capability

in cultural safety, relational accountability, and Indigenous governance in education and health. We will discuss the pedagogical and institutional challenges of this work, and highlight how this approach is equipping future nurses to be leaders in equity-focused and culturally safe care. We will particularly focus on the pedagogical challenges posed by introducing this new theory and the culture change needed to operationalise it in teaching practices. We will highlight the theory-informed strategies we are using to prepare nurses who will be leaders in developing sustainable practices to reduce health inequities and improve the wellbeing of all persons.

## Evaluating the Normalization of Person-Centred Practice Following Leadership Education: A Longitudinal Mixed Methods Study [PCC040]

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Background: Leadership plays an important role in driving the integration of person-centeredness across all levels of healthcare organizations, an effort increasingly seen as essential to meet global challenges. In Sweden, a leadership program in person-centred ethics was developed to support this. Although educational initiatives are widely promoted, it remains unclear whether leadership education supports the normalization of person-centred

practices in everyday work. Aim: This study aims to evaluate the normalization of person-centred practice from the perspective of leaders, up to six months after their participation in a leadership program. Method: This explanatory sequential mixed methods study is guided by Normalization Process Theory (NPT). Leaders in diverse Swedish healthcare settings admitted to the program (n=43) were invited to participate. Data are collected at baseline, follow-up 1 (after program completion) and follow-up 2 (6 months post-graduation, September 2025), assessing normalization with the Swedish NoMAD instrument (S-NoMAD). Inclusion required program completion, resulting in 33 eligible participants. Quantitative data will be analyzed using descriptive and inferential statistics. Semi-structured interviews will be conducted in autumn 2025 to explore perceived normalization of person-centred practices, analyzed using directed content analysis. Findings: Preliminary analyzes of baseline and follow-up 1 data (n=29) shows significant increases in coherence and reflexive monitoring, suggesting improved shared understanding and evaluation of person-centred practices. No significant change was observed in collective action or cognitive participation. Before the conference, follow-up 2 and interview data will be integrated into the results that are presented. Conclusion and Contributions to practice: Leadership education may enhance key aspects of normalization of person-centered practice, particularly how it is understood and assessed. Further data will provide a fuller picture of how such programs influence implementation of person-centered practice over time. These findings can inform the refinement of leadership programs and support healthcare organizations in advancing person-centred practice through targeted educational strategies.

# Art, Media & Performance

## Bridging Realities, Building Futures: Lived Experiences of Person-Centred Practice as the Artistic Foundations for a National Research Network [PCC018]

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Abstract : This art exhibition is a collaborative creation by multiple research groups across the Netherlands, together with regional workplace partners, service-users, teachers, curriculum developers, and students. It explores person-centredness as a guiding principle in professional and educational practices within healthcare and social domains. Through a diverse collection of artistic expressions, the exhibition illuminates lived experiences that reveal both the successes and the challenges of bringing person-centred values to life in everyday care, work, learning, and research relationships. Developed as a catalyst for the establishment of a platform within a new national network for practice-based research on person-centredness in Dutch healthcare contexts, the exhibition marks an important starting point. The platform aims to foster the development of person-centred professionals by strengthening professional identities and supporting the transformation of curricula and workplaces. In doing so, it seeks to bridge practice, organisation, and governance—reflecting the central theme of the 2nd Global Conference on Person-Centred Care. Participants are invited to engage creatively and critically with the works on display, using them as prompts for reflective analysis. This process will help inform the platform's ongoing strategies, ensuring they are enriched by

multiple ways of knowing and shaped by the perspectives of an international community committed to the principles of person-centredness. The exhibition thus serves not only as a space for artistic encounter but also as a living forum for dialogue, co-learning, and the continued development of person-centred care in theory and practice.

## Why Women Get Sick Differently – And Why It Matters (performance/song and discussion) [PCC019]

*Mirjam Kaijer*[1] *& Mariette Reineke*[1]

[1] Voices for Women Foundation

We warmly invite you to an eye-opening lecture by Dutch journalist, author, and former nurse Mirjam Kaijer, who shares a powerful personal and professional story that resonates with women across the globe. For ten years, Mirjam suffered from unexplained health issues. Her symptoms were vague and often dismissed as stress or psychological distress. After countless visits to specialists and years of self-doubt, the real cause was finally found: a benign tumor on her parathyroid gland—a small diagnosis with life-changing consequences. Her experience led her to a shocking discovery: 80% of all patients with medically unexplained symptoms are women. And that is not a coincidence. Medical research has historically been centered on the male body. Women have long been excluded from clinical trials because their hormonal cycles were considered "too complex." As a result, diagnostics, treatments, and medication dosages are still largely based on male biology. Women's complaints—especially when they don't fit a standard medical model—are too often minimized or misunderstood. To challenge this inequality, Mirjam founded the Voices for Women Foundation, a platform for patients and professionals, and launched a national reporting center where thousands of women have shared their stories. She will present key insights from this unique data: a collective testimony of women who feel unseen, misdiagnosed, and passed from one specialist to another—often told it's "just stress." This lecture is not just about women's health. It's about

rebuilding trust in medicine, improving care, and recognizing the urgent need for gender-sensitive healthcare. Join us for this inspiring and important talk—and be part of the change.

## From Confusion to Clarity [PCC041]

*Anna-Greta Ledin[1] & Marlen Nilsson[1]*

[1] The Swedish Dementia Association

Theme: How to stay related while performing tasks Aim: Giving participants space to explore how essential principles of communication support personcentred care Presentation: Anna-Greta Ledin will act as the moderator of the workshop. Marlén Nilsson will introduce the video based Marte Meo Core Program (MMCP) in dementia care. Anna-Greta Ledin will show the 1st film from a case study in the Marte Meo Core Program (MMCP). Group work: Exploring the 4th film in the case study. Participants will work in seven groups. Groups will explore different tasks related to essential principles of communication in the film. Groups will be guided how to share their results. Anna-Greta Ledin and Marlén Nilsson will take turns in guiding groups in their sharing. Time for reflections, questions and answers will be allocated to each group after their sharing.

## Don't look for it there. The key is with me [PCC042]

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This interactive mixed-media installation investigates the boundaries between what can be accessed through clinical practice and what remains solely within the person's own authority. At the centre of the work is an anonymised photographic portrait positioned within a large wall installation. Surrounding the portrait is a constellation of small handcrafted wooden

doors, each representing a different dimension of the individual's inner and outer life—identity, memory, embodied experience, emotional landscape, and medical reality. Several of the doors are intentionally designed to be opened by participants. Behind them, viewers encounter de-identified fragments of clinical material: portions of laboratory reports, medication charts, imaging snippets, and reduced clinical notes. These open doors symbolise the aspects of a person's life that healthcare professionals typically access, interpret, and document through biomedical and diagnostic frameworks. Other doors remain locked, with no keys provided. Beneath the central portrait, a single sentence reads: "The key is with me." The juxtaposition between what can be opened and what cannot invites reflection on the ethical dimensions of person-centred care. While clinical knowledge can illuminate biological patterns and measurable markers, there are personal truths—histories, meanings, vulnerabilities, and values—that remain inaccessible unless the individual chooses to reveal them. By requiring a large-scale wall installation, the work creates an immersive environment that asks viewers to navigate curiosity, uncertainty, restraint, and respect—mirroring the relational dynamics of therapeutic encounters. Participants are encouraged to experience both the permissions and the limits embedded in the artwork, recognising that genuine person-centred care depends not on accessing every door, but on acknowledging the person as the primary holder of their own keys. This installation shifts focus from "discovering the patient" to honouring the patient's agency, boundaries, and sovereign right to decide which doors may open—and which remain closed.

# Disasters and Time-Critical Events

## Violence in War and Armed conflicts as experienced by older persons: A Meta Ethnographic Study [PCC043]

*Elisabeth Lindberg[1], Maria Claesson[1] & Åsa Israelsson-Skogsberg[1]*

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This meta-ethnographic study addresses the need for development of strategies to sustain person-centred care close to the older person during extra ordinary situations such as war or armed conflicts. As these situations escalate, much of the focus has been placed on acute emergency responses. However, there is a pressing need for more long-term strategies targeting older persons. Older adults often stay in conflict zones, placing them at risk of becoming victims of violence and war crimes. This meta-ethnographic study aims to review and synthesise research on violence in contexts of war and armed conflicts as experienced by older persons and explore how violence in war and armed conflicts affects the health and well-being of older persons. Databases were searched for studies with a qualitative approach and participants aged ≥ 55 years. Twenty qualitative studies were included, describing experiences of persons from seven countries. Guarding the past and ensuring a future was established as an overarching metaphor in a lines-of-argument synthesis, accompanied by five themes: To endure a violent situation; Home - the heart of existence; To witness a fragile family line; Alienated and abandoned by society- adding insult to injury and maintaining normality in an abnormal situation. Findings indicate that separation from loved ones, the breakdown of healthcare services, and remaining in conflict areas significantly increase vulnerability. The knowledge generated through this project contributes to preparedness for extraordinary events. A deeper understanding of the challenges associated with person-centred care for older adults during war or armed conflicts can support the development of a more resilient society. Furthermore, when the health and well-being of older adults are prioritised, they themselves can become valuable resources in times of societal crisis.

# Understanding the contexts and mechanisms that lead to the natural disaster preparedness of long-term care facility stakeholders: A realist review [PCC044]

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Objectives: Disaster preparedness has become a priority for stakeholders of long-term care facilities (LTCFs). However, the process by which these stakeholders prepare for natural disasters remains unclear. This realist review aims to theorise the process of describing under what circumstances, and what works for LTCF stakeholders in preparing for natural disasters. Methods: Guided by the Realist And Meta-narrative Evidence Synthesis; and Evolving Standard (RAMESES), we used the following steps: (1) literature review and search for evidence, (2) study selection, (3) data extraction, (4) data synthesis, and (5) development of an initial programme theory (IPT). Databases including MEDLINE, CINAHL, PsycINFO, Scopus, Web of Science, and grey literature were used for the search between September 2023 and February 2025. Realist analysis was used to generate context-mechanism-outcome (CMO) configurations, which were validated by an expert. Results: Based on the 41 included documents, the six IPTs were developed: (1) obtain cooperative support systems from the public sector; (2) cultivate mutual help with community members; (3) build multiple evacuation options with various LTCFs; (4) assess residents' abilities and utilising them; (5) improve staff and facility preparedness using iterative drills and education, and (6) develop and refine disaster plans for quick response and recovery. Conclusion: Daily disaster preparedness practices should include coordinating with local stakeholders, assessing residents' abilities in detail for

using them in disasters, and implementing iterative and complementary processes between drills and revisions of disaster plans. Recommended policies should involve examining the transferability of IPTs to countries with similar contexts and incorporating measures aimed at improving staff outcomes into guidelines. Further research is required to test and refine these theories. Publication and Note:

> Our review protocol was published elsewhere http://dx.doi.org/10.1136/bmjopen-2024-087837. Ongoing process of this review will be presented in another conference, and full results and conclusions will be added in the GCPCC 2026.

# Health Equity

## Values-based practice in health and social care: fairness and equity as conceptual tools for mobilising social justice for underserved communities [PCC045]

*Kirstie Allen[1], Nasreen Ali[1] & Yannis Pappas[1]*

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Background: Health and social inequality mandate UK care providers to deliver transformative and inclusive services within a challenging fiscal context and sociopolitical climate. To meet the needs of underserved populations, the future workforce requires competent, skilled graduates in approaches to achieve fairness, equity and social progression within marginalised groups. This study seeks to examine the educational requirements of health and social care students in achieving person-centred care, by conceptualising the experiences of care recipients and providers of fair and equitable service provision. Methods: This project utilises a multi-stage approach to examine the perspective and experience of service users, clinicians and pre-registration students of the requirements for achieving fair and equitable health and social care for underserved and superdiverse communities. Constructivist grounded theory is adopted for the exploration

of fairness, equity and social justice within care provision. Co-production has been utilised throughout the project with stakeholders from community groups, academics and students to assure a collaborative and culturally competent approach. Results: The study conceptualises fairness and equity, and activities required of care providers to attaining these principles within integrated and person-centred practice across health and social care within the UK. Such commitment to addressing inequality through person-centredness enables culturally competent methods to be exercised for the improvement of care for diverse communities. The qualitative findings will be consolidated into an instructive educational model for application to health and social care training curricula, enhancing graduate practice of the future workforce and the mobilisation of social justice. Conclusion: This project expands understanding of fair and equitable health and social care through a social justice lens and examines principles of person-centred practice in contemporary service delivery. Future work provides practical application of this new understanding to training curricula, alongside opportunities to influence policy and workforce development agenda in accordance with values-based practice.

## Legitimizing user knowledge in mental health services: Epistemic (in)justice and barriers to knowledge integration [PCC046]

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In 2022, a research study was published in Frontiers of Psychiatry by Dr. Katarina Grim and others, which examined collaboration processes between psychiatric/social psychiatric services and user organizations. The study was unique in its kind as it was planned, carried out and published by six

researchers from different universities in Sweden together with seven representatives of the user umbrella organization NSPH. The study interviewed 28 people who work with user influence in various roles in Sweden. The study identified a number of gaps in the collaboration structures between user representatives and officials. It also highlighted successful strategies that can bridge these gaps and create more equal and efficient work processes. On the basis of these experiences, a working material has been developed in collaboration with Karlstad University and the user organization NSPH. We would like to present the experiences from the study together with the working material and a checklist that can be used when starting/evaluating collaboration processes with service user representatives. We used Miranda Fricker's framework for epistemic injustice to understand and develop the working material. Epistemic injustice is about different kinds of knowledge not being used in an equal way, depending on who is the sender. This can be expressed by certain knowledge not being considered as credible compared to others, it is not understood and it is not included in an equal way as other forms of knowledge. The working material presents three types of epistemic injustices, together with nine discussion questions to managers and officials who work in collaboration process with service user representatives. These topics and discussion questions highlight how you can create more epistemic justice and create more equal encounters in collaboration processes.

## Identifying measurement biases is foundational to person-centred practice in diverse populations: Insights from the measurement of emotional wellbeing [PCC047]

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Aims: Ensuring unbiased measurements that represent the perspectives of diverse people is foundational to person-centred practice, organization and governance. As part of our research on "Equitable People-Centred Health Measurement" (https://www.healthyqol.com), we examined emotional well-being and the extent to which: a) responses to emotional well-being items are heterogeneous, and b) social determinants of health (SDOH) and health-related variables explain measurement bias. Methods: Data were obtained via an online survey of 10,076 adults in Canada. The questionnaire included: a) the "Emotional Well-Being" item bank (43 items) of the CAT-5D-QOL; b) The "Screening for Poverty and Related social determinants to improve Knowledge of and links to resources" tool to collect information about SDOH, including demographics (e.g., immigration, gender identity, racial background), social needs (e.g., finances, housing, social isolation, transportation) and disability; and c) health-related variables (health conditions, healthcare utilization, medications). Latent variable mixture models were used to examine heterogeneity in measurement model parameters across latent classes. Measurement bias was estimated as the differences between standardized emotional well-being scores from a 1-class model (no heterogeneity) and a k-class model (accommodating heterogeneity). Multivariable regression was used to explain measurement bias. Results: The sample was heterogeneous, with optimal results obtained for a 4-class model (class proportions = .09, .08, .41, and .41; entropy = .88). For 41% of the sample, measurement bias was positive (ranging from 0.01

to 0.54 for the 10th and 90th percentiles), with SDOH and health-related variables explaining 17% and 10% of the variance. For 59% of the sample, measurement bias was negative (ranging from −0.01 and −0.31 for the 10th and 90th percentiles), with SDOH and health-related variables explaining 5% and 4% of the variance. Conclusions: Ignoring SDOH and various health-related differences could result in biased measurements of emotional well-being, leading to some people's perspectives of their emotional well-being being misrepresented.

## PRIDE project - Person-centred, Resilient and Inclusive Healthcare DEsign with Aging/Older Gay men [PCC048]

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Background: Older gay men face unique health challenges shaped by the intersection of ageing, sexual orientation, and systemic discrimination. Despite advances in LGBTQIA+ rights, health and aged care systems often remain ill-equipped to provide inclusive, person-centred support. There is limited research that actively involves older gay men in designing healthcare responses tailored to their lived experiences. Aim: This project aims to co-design a person-centred model of care with older/ageing gay men, ensuring that their health needs, values, and priorities directly shape future health and aged care policies. Methods: Guided by the Person-centred Practice Framework (McCance & McCormack, 2021), a co-design workshop was held in December in New South Wales, Australia with 12–18 gay men aged 45 and over. A participatory action research approach was used to ensure inclusivity, equity, and community ownership. The workshop structure included: (1) sharing lived experiences of ageing and health, (2) identifying health concerns and barriers to care, (3) prioritising needs through group dialogue, and (4) co-creating solutions for more inclusive healthcare pathways. Data captured through notes, visual artefacts, and audio

recordings, followed by thematic analysis in partnership with participants, highlighted key issues for co-designing more inclusive health systems for older gay men. Results: The workshop identified priority health needs in areas such as physical health, mental health, sexual wellbeing, social connection, and experiences of discrimination. The outcomes include a co-created set of principles and pathways for inclusive healthcare. Developing the PRIDE model of care is the next phase of the study, an overview of which will be included. Conclusion: This study generated actionable insights to strengthen health equity for older gay men and inform a model of care with direct relevance for policy, education, and service design. By placing lived experience at the centre, it advances both person-centred practice and LGBTQIA+ health inclusion internationally.

# Illness Communication

## Patient-centred Health Care Service – From Theory to Practice. Do Patients Feel the Change? [PCC049]

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Background/Problem: Curatio is an out-patient clinic that mainly serves insured patients from a private insurance company and is very busy (around 500 unique patients per day). The backbone of the clinic is our 55 family doctors, who do both on-site and telephone visits. The clinic regularly reviews patient complaints and classifies them by type. Recently, we noticed more so-called "communication complaints", when under limited time resources, doctors were more focused on solving clinical problems and less on person-centred aspects. Intervention: The project started in May 2023 and was planned for 1 year. We developed unique Patient-Centered

Questionnaires separately for clinic visits (11 questions) and telephone visits (10 questions). An outsourcing company conducted patient surveys before and after the project. The percentage of positive answers to these questions was defined as the main outcome indicators. Based on Smith's Patient-Centered Interviewing principles, we created a Patient-Centered Communication Standard, describing in detail the skills, how to use them, and in which order. The draft was sent to the family doctors for their comments. We divided the doctors into 3 groups. Each group attended initial training, which included a theoretical presentation and role-plays. Knowledge was tested before and after the training. After 6 months, smaller refresher trainings were held, focusing on discussing difficult cases using role-play. Outcomes/Results/Lessons learned: We saw improvement in both the theoretical knowledge of the doctors and in patient experience (shown by survey results and by the decrease of communication complaints). However, we believe maximum results are not yet reached. Implications for Person-Centred Care: Even in a high workload clinic, it is possible to introduce person-centred care, meaning that patients feel respected, fully informed, and encouraged to take part in managing their own health. Patient feedback can be used both as a quality indicator and as a collaborative tool for improvement

## Integration of person-centred palliative care in hospitals – how can palliative care consultation teams drive practice change? [PCC050]

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Early integration of person-centred palliative care within disease-oriented care is advocated but the question of how this is best accomplished remains. A practice-driven quality improvement project was introduced in a surgical cancer care context whereby palliative care consultations were offered early in the disease trajectory for patients with pancreatic cancer. Within this study, a qualitative interpretive description design was applied, focusing on the integration and collaboration between the actors involved in the quality improvement project. The aim of the study was to examine a practice-driven change for the early integration of person-centred palliative care within surgical cancer care. Seventeen study participants (healthcare professionals, managers and patient association representatives) were interviewed. The interviews were complemented by observations and a constant comparative analysis was applied. The main finding was that the success of the quality improvement initiative was influenced by the way in which healthcare professionals perceived the concepts of palliative care, integration and roles, as well as differences in palliative care practices and organisation. In conclusion, within practice-driven person-centred palliative care integration initiatives, perspectives on what, when and how to integrate person-centred palliative care, variations in palliative care practice, and specific needs of the patient group in relation to the surrounding palliative care system must be disclosed and addressed when initiating collaboration between palliative care consultation services and specialist hospital teams. Behind the barriers disclosed in this study is a need for a supportive policy for palliative care consultation services that includes how to contextually adapt and tailor it.

## What Matters Most: BRCA Carriers' Views on Person-Centred Care [PCC051]

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Background: Women diagnosed with a BRCA gene mutation face increased lifetime risks of breast and ovarian cancer, prompting complex decision-

making around surveillance, preventive surgery, and fertility. While care trajectories are medically individualized, many women report their lived experiences are marginalized - particularly due to the absence of a cancer diagnosis. Yet, living with inherited cancer risk brings ongoing psychosocial challenges, highlighting the need for person-centred care (PCC) that addresses meaning, identity, and long-term decision-making beyond clinical management. Aim: To identify which aspects of PCC women with BRCA mutations prioritize in their care, and how these perspectives vary within the population. Methods: We applied Q-methodology with 23 Dutch BRCA carriers; a participatory method increasingly used for healthcare priority setting. Participants ranked statements based on the Picker Institute's PCC dimensions according to personal importance and elaborated during interviews. Factor analysis identified shared perspectives, complemented by qualitative interpretation. Findings: Three distinct perspectives on PCC emerged, each emphasizing different dimensions. (1) 'The Informed Journey' prioritized clear information, education, and communication to support understanding and decision-making. (2) 'Care Rooted in Compassion' centred on emotional support, empathy, and respect, fostering trust and psychological safety. (3) 'Acknowledging Intimacy and Loss' highlighted attention to physical needs, addressing embodied impacts of genetic risk. Across perspectives, effective treatment by trusted professionals was a shared priority. Notably, priorities were shaped less by clinical history than by personal values and social context. Discussion: This study reveals the heterogenous care experiences of BRCA carriers and pinpoints priority areas for advancing PCC in women's health under conditions of long-term risk. Showing how gendered experiences of uncertainty and vulnerability shape care preferences, we outline how PCC can be adapted to the realities of women navigating complex choices over time. Our findings offer practical strategies for integrating female-specific priorities into care, enabling responsive support in risk contexts.

## Sleeping Beauty Awakens: ICU Patients' Narratives and Implications for Person-centred Care [PCC052]

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What does it mean to be cared for as a patient in the intensive care unit (ICU)? We investigated former ICU patients' experiences and perspectives of the intensive care period. Six narrative interviews were conducted, revealing 35 narrative sections addressing this phenomenon. Drawing on Polkinghorne's (1998) narrative analysis, findings are presented through both narrative and paradigmatic lenses. The emerging plot is conceptualized as a narrative inspired by the famous ballet 'Sleeping Beauty'. Princess Aurora symbolizes the ICU patient, facing critical illness, helplessness, and uncertainty in this unfamiliar realm. The lilac fairy, her loyal companion, represents the ICU nurse, a guiding presence who facilitates the patient's reconnection to personhood. Two possible endings highlight the diversity of patient's experiences: For some, the narrative concludes in tragedy, not being perceived as person, solely treated as cases, leading to post-traumatic stress or prolonged recovery. For others, a sense of self and relational being is restored in an encounter and relation resulting in a more reconciliatory resolution, the comedic ending. Our broader study is aiming for an understanding of person-centred practice in the ICU. It is philosophically underpinned by McCance & McCormack's understanding of Person-centredness, emphasizing the relational and contextual nature of personhood in care and further enriched by Levinas's Ethics of Radical Alterity, highlighting the ethical significance of encountering the Other. Findings of this part of the investigation demonstrate that the quality of interpersonal encounters in the ICU plays a decisive role in shaping patients' sense of self. Recognizing and responding to the patient as a person emerges as a critical factor in supporting recovery and mitigating long-term (psychological) consequences. Caring for a person in the ICU is not solely a clinical matter but is fundamentally ethical and relational, contingent upon the presence and actions of practitioners who engage with patients as persons not cases.

# Informal Care & Support

## Rooted in Care: Impact of Community-Led Home-Based Daycare on Children's Wellbeing [PCC053]

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In low-income urban communities in Bangladesh, access to affordable and quality childcare remains scarce, placing children's development at risk and limiting women's participation in the workforce. The lack of safe-care options forces many mothers to leave children in unsafe environments or exit paid work altogether. In response to this critical gap, BRAC piloted a community-led, home-based daycare model to provide structured care within caregivers' homes, grounded in proximity, trust, and cultural familiarity. This study examines the piloted daycare model's impact on the emotional and social wellbeing of children, while also exploring its influence on women's ability to engage in paid work. The intervention trained local women as caregivers, equipping them with knowledge in mental health, early childhood development, responsive caregiving, and play-based learning. Ongoing psychosocial support was provided through Paracounsellor-led home visits, and skill refreshers. A mixed-methods evaluation was conducted to assess outcomes. Quantitative tools included the Kessler-10 Psychological Distress Scale for 262 mothers, and the KAP survey for 150 care entrepreneurs. Child development and behavior were assessed for 1,014 children using the ASQ-3 and SDQ. In-depth interviews were held with 15 mothers to assess their mental wellbeing. Findings indicate improvements in children's emotional regulation, social skills, and attachment. Caregivers reported increased confidence and skills in supporting children's emotional needs. Mothers noted reduced stress, greater trust in the care setting, and, in some cases, the ability to resume or extend work hours. However, challenges such as caregiver fatigue, space limitations, and resource constraints

persisted. This model demonstrates the potential of home-based daycare as a low-cost, scalable solution for urban informal settlements. By investing in community women as caregivers, such programs can promote child development, enhance women's economic participation, and foster collective wellbeing through localized, relationship-based care. Key Words: Home-based daycare, Child development, collective wellbeing, Emotional support, women empowerment

## Navigating the Fundamental, Relational, and Spatial-Temporal Dimensions of Being Relative in Institutional Long-Term Care [PCC054]

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Relatives of nursing home residents frequently inhabit a complex, multi-dimensional institutional context, navigating a delicate balance between personal connections and institutional demands. Existing research often adopts a role-based perspective, insufficient to capture the full scope of their experiences and the inherent ambiguities of "Being Relative." Based on 30 participatory observations, this qualitative study explores the "being relative" process from a person-centred perspective. We conducted a reflexive thematic analysis, revealing three core meta-themes that describe this navigation process. First, the Navigating Fundamental Dimensions of Being Relative meta-theme involves managing a Liminal Positioning in the Institutional World, experiencing Ambiguity in Institutional Situations, and dealing with Navigating Power Asymmetries in Institutional Life. Second, the Navigating Relational Dimensions of Being Relative meta-theme highlights the search for meaningful connections, including Seeking Resonance Amid Institutional Alienation, Co-Creating Relationships

Through Recognition, and experiencing Moments of Genuine Encounter. Finally, the Navigating Spatial-Temporal Dimensions of Being Relative meta-theme focuses on how relatives navigate the physical and temporal constraints of the institution, including Navigating Institutional Space and Navigating Temporal Rhythms. Our findings present "Being Relative" not as a static role, but as a continuous, active, dynamic process of meaning-making and adaptation across these three fundamental dimensions. These insights are vital for developing truly person-centred care models that recognise and support the complex realities of relatives, moving beyond a one-dimensional view to a holistic understanding of their unique personhood.

## Strengthening Mental Wellbeing Among Informal Carers and Long-term Care Workers: Insights from Swedish expert interviews in the EU WELL CARE Project [PCC055]

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Background: Across Europe, 6.3 million people work in the long-term care (LTC) sector, which faces significant challenges related to staffing, workload, and sustainability. In parallel, an estimated 52 million people provide informal care to relatives or friends. The EU Care Strategy (2022) underlined that the wellbeing of both groups is interdependent and vital to ensuring high-quality care. Building on these priorities, the Horizon Europe-funded research and innovation project WELL CARE (2024–2027) seeks to identify, evaluate, and promote effective practices that enhance mental wellbeing and strengthen collaboration between formal and informal care. This presentation draws on empirical findings from the Swedish policy and practice context. Objectives: To explore how policies, care frameworks, and funding schemes address the mental wellbeing of informal carers and LTC

workers. Specifically, the study explored stakeholders' perspectives on current policy responses, examining how they envisioned future directions and the development of support structures that could strengthen the mental well-being of these groups. Methods: Eight national experts were purposefully selected and interviewed, representing academia, trade unions, patient and carer organisations, employer organisations, and professional associations. The data were analysed using thematic analysis (Braun & Clarke, 2006).Results: Preliminary findings reveal both visions and tensions in the policy landscape for supporting informal carers' and LTC workers' mental wellbeing. Participants identified a need to strengthen coherence between national and local levels. Key risks and opportunities emerged, particularly regarding the decentralised Swedish governance model. A recurring theme was the expectation that care should be State provided; unmet expectations were perceived as a source of stress for informal carers, described by several informants as the "disappointment of rising expectations." These findings highlight how cultural, and policy contexts shape the experiences of care, providing insights for policymakers seeking to enhance mental wellbeing and person-centred care provision across Europe.

## Good practices to support the mental health and resilience of informal carers and long-term care workers, and to foster care partnerships [PCC056]

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Long-term care (LTC) workers and informal carers are the backbone of LTC for millions of people with health/care needs across Europe. However, their demanding roles risk negatively impacting their mental health and well-being. Moreover, despite shared responsibilities, the integration and collaboration between these groups is rare, and a missed opportunity to foster mutual

support and more person-centred care. The EU Horizon Europe-funded WELL CARE project (2024–2027) addresses these needs by identifying, evaluating, and promoting good practices that support carers' mental well-being and foster care partnerships. Researchers and advocacy organisations from Germany, Italy, the Netherlands, Slovenia, and Sweden conducted a comprehensive review of scientific and grey literature published between 2013 and March 2024, following PRISMA guidelines. Searches across eight multidisciplinary scientific databases yielded 16,357 potential good practices; after rigorous screening and quality assessment, 134 remained. Grey literature, and consortium partners' input added 103 more, and interviews with 23 experts contributed 14 additional practices. In total, after removing overlaps and applying selection criteria, 170 good practices were identified. After a systematic ranking process, 40 top-ranked practices were selected. Key findings from the analysis of the top 40 good practices highlighted that the majority focused on informal carers, while fewer addressed LTC workers, although 34 practices had the potential to foster care partnerships. Care recipients were predominantly older adults, followed by working-age adults, often living with cognitive decline or mental health conditions. Most practices occurred in ordinary home settings, followed by digital environments, and the majority of the collected practices included training initiatives or organisational/management approaches. Examples of good practices, representing different typologies and countries, will be showcased during the presentation. Delegates will gain insights into good practices that enhance mental well-being, resilience, and care partnerships among LTC workers and informal carers, paving the way for more integrated, person-centred care across Europe.

# Learning & Education

## Designing for reflexivity: Provotypes as an educational tool for promoting norm awareness in child healthcare participation [PCC057]

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Children's participation in healthcare is highly dependent on care professionals' attitudes and contextual, socio-technical norms. This paper addresses the call for educational methods that promote reflexivity and an awareness of norms. It describes a novel tool, grounded in a norm-critical design methodology and workshop-based learning, designed to facilitate reflexive discussions among nursing students and care professionals. Both the development of the tool and insights from a feasibility study with target groups are described. The tool includes a set of provotypes (provocative prototypes) that incorporate and problematise identified barriers to child participation in healthcare. Accompanied by conversation questions, these provotypes are intended to promote discussions on how socio-technical healthcare norms affect children's opportunities to influence their care. The output was tested with nursing students, design researchers, teachers, and care professionals to arrive at an applicable tool for nursing and care education.

## Growing Research, Growing Care: A Person-Centred Approach to Research Capacity Building in Nursing and Midwifery [PCC058]

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Background: Engagement in research by nurses and midwives is associated with improved patient outcomes. However, limited time and organisational

support often prevent clinicians from building research capacity. In 2022, a Quarantine Research Time Program (QRTP) was co-designed across a Sydney health district with nurses, midwives, researchers, community members, and administrators. The program is grounded in the Person-Centred Practice Framework McCance and McCormack (2021), recognising that enabling professional development is essential to cultivating person-centred cultures. Methods: The QRTP adopts a person-centred approach by focusing on the unique needs, values, and aspirations of each participant. Reflecting the framework's emphasis on prerequisites (professional competence, interpersonal skills, clarity of beliefs and values), the program provides academic mentorship, leadership sponsorship, and protected time (one day per fortnight over three months). Research topics are chosen by participants and aligned with clinical priorities. Consistent with the framework's care processes and macro-context, follow-up continues post-program to maintain support, address barriers, and sustain engagement. Results: From May 2022 to December 2024, 48 nurses and midwives were nominated; 41 (85%) completed the program. All participants undertook structured training; 83% developed research protocols and ethics submissions; 49% submitted manuscripts to peer-reviewed journals; and 12% enrolled in higher degrees. Participants reported increased confidence, autonomy, and connection to their practice through research. Conclusion: The QRTP demonstrates how a person-centred approach to professional development can foster a research-engaged nursing and midwifery workforce. By aligning with McCormack and McCance's framework, the program supports individuals holistically recognising that empowered, well-supported professionals are central to delivering compassionate, evidence-informed care.

Reference: McCance, T.; McCormack, B. The Person-Centred Practice Framework; McCormack, B., McCance, T., Martin, S., McMillan, A., Bulley, C., Eds.; Fundamentals of Person-centred Healthcare Practice Wiley: Oxford, UK, 2021

# Towards a Competency Model for Person-Centredness in Undergraduate Nursing Education: Lived Experiences of Students and Educators [PCC059]

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Background: As part of the Erasmus+ project PerCen NursEdu, we aim to anchor person-centeredness as a key competence in undergraduate nursing education in German-speaking countries. To this end, the initial project phase focuses on the development of a competency model grounded in high-quality data, whose relevance is informed by the perspectives of key actors, namely students and educators. Aim: As the first step in the project, the aim was to generate a comprehensive corpus of lived experiences and perspectives that should provide a holistic understanding of person-centered competencies within the context of undergraduate nursing education. Methods: The first step involved collecting written accounts of students' experiences through the lens of "Person-Centred Moments" by McCormack and colleagues. These accounts were then shared anonymously with educators, who reflected on them in writing. The moments and corresponding reflections formed the bases for further exploration in subsequent focus groups with students and educators. This approach aimed to foster a deeper understanding of students' person-centred competencies. In addition, it was intended to shed light on the necessary conditions for

learning and teaching, such as elements of a person-centred teaching and learning culture, and the knowledge, attitudes, and skills required by educators. Data set: The empirical material from Austria, Germany, and Switzerland comprises 119 "Person-Centred Moments" written by students and 55 written reflections of educators on selected student moments. Additionally, five focus groups were conducted with a total of 44 students and five focus groups with 23 educators, each lasting approximately 1.5 hours on average. Current state: Data analysis is in the initial stage. The presentation will focus on the results of the lived experiences of students and educators. They will provide the basis for the competency model, which will be further developed in a co-creative process across the four involved countries (including South Tyrol, Italy).

## Beyond Checklists: PROMs as Relational Tools for Person-Centred Practice in BSN Programs [PCC060]

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Background: Integrating patient-reported outcome measures (PROMs) into baccalaureate nursing (BN) education can contribute to advancing equitable person-centred care, yet these tools remain underutilized in nursing curricula. When nursing students learn about assessment, limited attention is given to gathering data on the patient's perceived health-related concerns and priorities, with an overreliance on clinician-reported assessment tools. Preparing nursing students to think critically about PROM is essential for equity-oriented person-centred care. Aim: This study evaluated the impact of incorporating PROMs into BN courses and explored faculty and student experiences of using PROMs as relational tools to facilitate person-centred communication and assessment. Method: Guided by implementation science, a sequential mixed-methods design was used to assess PROM integration across one BN program. Participants included faculty teaching

nursing courses (n=19) and students enrolled in those courses (n=204). Quantitative data were collected through pretest-posttest surveys measuring factors influencing PROM uptake. Qualitative data were gathered through faculty interviews and student focus groups to capture perspectives on equitable person-centred assessment. Findings from both components were analyzed separately and then integrated to address the research questions. Results: Results of faculty and students' experiences will be presented at the conference. These findings will generate evidence on the impact of teaching and learning about PROMs for fostering patient engagement and holistic assessment. They will also identify barriers and enablers to PROM adoption, highlighting their role as catalysts for meaningful dialogue and as complements to patient narratives. Conclusion: Embedding PROMs in BN curricula can prepare future nurses to deliver relational, person-centred care by bridging the gap between objective measures and patients' lived experiences. When teaching assessment of persons and their conditions, educators should ensure a balanced approach that captures both subjective experiences and clinician judgment. Findings inform curriculum redesign and faculty development strategies to advance PROM use and increase adoption in future practice.

## Achieving consensus on curriculum components for person-centered leadership development [PCC061]

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The creation of person-centred cultures within healthcare settings is a pre-requisite for person-centred care. Healthcare leadership is necessary to cultivate such cultures and leadership should be based on the same values set. Whilst an empirically informed theoretical model for person-centred leadership exists, and many organisations are offer leadership development programmes for person-centred practice, there is a lack of evaluation studies. To evaluate such leadership development programmes the assumption is that

these are based on the same set of curriculum components. The absence of a person-centred leadership development curriculum framework was the instigation for this delphi study. A modified delphi study using anonymous/confidential surveys was used to seek consensus for a curriculum framework. The initial curriculum framework consisted of 16 component parts and 6 guiding principles for the delivery of a person-centred leadership development program. This was based on findings of a literature study and consultations with members of the Person-Centred Practice International Community Of Practice (PCP-ICOP) with experience in delivering leadership development programmes. Participants for the delphi study surveys were also recruited within and via the PCP-ICOP but excluded those members who had contributed to the initial curriculum framework development. Consensus was sought using a 5 punt Likert scale. The twenty five participants could also leave comments and suggestions for each item. Round 1 acheived the pre-determined 70+% (strongly)agree cut-off for all items. Collected comments and suggestions were used to refrase several items and formulate two new components. Round 2 acheived 80+% consensus on all items, thereby eliminating the need for a third round. We can now publish an internationally agreed curriculum framework for person-centred leadership, with content component parts and guiding principles. We are curious for feedback from a wider audience within the person-centred practice community

## Strategies to become, and be, a hospital of choice for patients and staff - Managers' perspectives [PCC062]

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Introduction: Previous research has demonstrated a positive association between person-centered care (PCC) and improved patient outcomes. Hospitals that emphasize high-quality care tend to achieve better results compared to those that do not. However, implementing PCC within hospital settings requires substantial commitment from both leadership and healthcare professionals. Consequently, it is essential to investigate how hospital management strategically plans to establish and maintain an environment that is preferred by both patients and staff. Aim: The aim of this study was to explore and describe the perceptions of hospital management staff regarding their efforts to align with their mission statement in becoming and being a hospital of choice for patients and staff. Methods: Data were collected using the nominal group technique (NGT). Five consenting members of the hospital's management team participated in a structured group session. The NGT data collection process followed five recommended steps: 1) presentation of the opening statement; 2) silent generation and recording of ideas; 3) sharing of ideas in a round-robin style; 4) group discussion; and 5) ranking and voting of ideas. Results: During data collection, six themes were identified: hospital infrastructure, hospital environment, quality of service delivery, care outcomes, communication, and professional identity. Each theme was associated with two to six strategic actions, which were prioritized by the participants. Conclusion: Hospital managers play a pivotal role in fostering a PCC culture through visible and values-driven leadership. Their ability to communicate a clear vision, build trust, and prioritize quality outcomes is essential to deliver a holistic, patient-centered care beyond physical needs. Moreover, cultivating an environment that supports staff collaboration and professional development is critical for sustaining such care practices.

# Embedding Person-Centred Care through Nursing Leadership: The Clinical Leads Program at Prince of Wales Hospital [PCC063]

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The Clinical Leads Program at Prince of Wales Hospital is a strategic initiative within the hospital's Quality Safety Culture Framework, designed to enhance person-centred care practices by engaging clinical nurses to collaborate on quality improvement in eight domains of clinical practice, aligning with National Standards. The program cultivates future nursing leaders, builds workforce capability, and fosters a culture of safety, quality, and continuous improvement. Its three core objectives are: to improve person-centred approaches to patient safety outcomes and reduce hospital-acquired complications (HACs); to enhance the capacity and capability of frontline clinical nurses in quality improvement and risk management; to empower Clinical Nurse Leaders to lead quality improvement and research, while mentoring junior staff and modelling best practice. In 2025, the program evolved to include a robust governance structure, with executive sponsors assigned to each clinical domain and a structured educational framework. Quarterly workshops, facilitated by the Expert Facilitators, guide and mentor Clinical Leads through domain-specific data analysis, innovative project design implementation, evaluation and peer education. This structure ensures alignment with hospital priorities and supports sustained, evidence-informed improvements in clinical practice and person-centred care. Over 100 nurse-led ward-level quality improvement projects have been completed to date. These projects are informed by ward culture maps and developed collaboratively by clinicians, ensuring clinical relevance and ownership. Initiatives range from educational innovations, visual communication tools such as posters through to partnering with families in developing personalised delivery of care. The program has fostered strong interdisciplinary collaboration, and many projects have been identified for transferability and scalability, amplifying their impact hospital-wide. This

presentation will share insights from the program's evolution, highlighting how structured leadership development and governance can embed person-centred care processes across complex health systems. Practical strategies for replication and scalability will be discussed.

## Enhancing Person-centred Neuro-Oncological Cancer Care - Beyond Borders and across disciplines [PCC064]

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This presentation aims to inspire colleagues to advocate for person-centred and family-focused care within their field, recognising that global, interdisciplinary collaboration is key to meaningfully addressing the needs, values, and lived experiences of individuals and families affected by serious illness. Through an ongoing interdisciplinary collaboration led by a dedicated group of nurses and allied healthcare professionals, we have successfully

developed a strong international network within neuro-oncology via the European Association of Neuro-Oncology (EANO). At the heart of this collaboration lies a deep commitment to person-centred care, ensuring that the voices, values, and lived experiences of individuals affected by brain tumors and their families are central to all our efforts. This shared ambition has grown steadily over the decades, culminating in the establishment of the International Nurse & Allied Health Professional (AHP) Committee (NAC) in 2021. https://www.eano.eu/about/about-us/committees/nurse-allied-health-professional-committee-nac/. We have achieved the following milestones: Established an international Patient Advocacy Committee, ensuring patient voices shape our work Created a LinkedIn community of over 300 members to foster global dialogue. https://www.linkedin.com/groups/12675762/ Led scientific meetings, highlighting family-focused and person-centred approaches Hold leadership roles, influencing strategic directions Sponsored networking events to build inclusive, collaborative spaces Teach at the EANO School, embedding person-centred principles in education Organise and chair webinars Secured funding to recognise excellence through awards, prizes, and scholarships Contribute to global educational master class Launched a mentorship programme for nurses and AHPs Led international research, resulting in peer-reviewed publications and editorials Facilitated PhD courses, exchanges and collaborative clinical studies Invested in capacity building Nurses and AHPs from the United States and Australia have recently joined the network, and we are actively reaching out to the neuro-oncological society in Asia and Africa. International working groups have been created e.g the International Neuro-oncology Caregiver Consortium and The Response Assessment in Neuro-Oncology (RANO)-Cares.

# Organisational Governance

## When Integration Meets Person-Centred Care: Learning from the NICHE Anchor Institute [PCC065]

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The Norfolk Initiative for Coastal and rural Health Equality (NICHE) Anchor Institute, at the University of East Anglia, brings together integrated care system partners to address health inequalities across rural and coastal communities. NICHE aims to 'ignite' creative, person-centred mindset; 'innovate' place-based initiatives, and 'embed' critical and creative approaches that catalyse transformations within compassionate communities located across rural and coastal communities. Now in its evaluation phase, NICHE offers insights into sustaining person-centred principles within evolving integrated care systems. Our evaluation explores the tension between system-level integration driven by organisational reform and person-centred practice grounded communities where people live and work. Integration prioritises productivity, organisational alignment, and outcomes; while person-centred care emphasises relationships and sensitive responsiveness to what matters locally. We use a critical realist and practice development framework (McCormack & McCance, 2021), with participatory evaluation methods prioritising co-created meaning, local context, and ripple effects beyond service delivery. Emerging themes show person-centred redesign can both enable and constrain integration. Grassroots employment pathways, interprofessional reflective rounds, and cultural transformation initiatives illustrate how relational practices foster shared purpose and enhanced wellbeing, yet also clash with integration's standardised pathways and performance metrics. Governance arrangements linking NHS organisations, the university, and community partners provides legitimacy and intellectual resources, yet also surfaces trade-offs between corporate

accountability and responsiveness to lived experience. NICHE's experience offers an embedded, context sensitive approach to innovation. It helps bridging practice, organisations, and governance, offering lesson suitable for an international audience. This presentation shares the evaluation framework, practical learning, and lessons on sustainability, offering a grounded account of how anchor institutes can navigate, rather than resolve, the tensions between integration and person-centred care in coastal and rural communities.

McCormack, B. and McCance, T. (2021) The Person-centred Practice Framework. In: McCormack B et al. (eds.) Fundamentals of Person-centred Healthcare Practice. Chichester, UK: Wiley-Blackwell.

## Who do you say I am? Language, Culture and their Intersection with Quality in Residential Aged Care [PCC066]

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This study investigates the shift in language from "person-centred care" to "consumer-directed care" in Australian aged care policy, and its implications for the implementation of person-centred care models aimed at enhancing the lived experience in residential care settings. Motivated by first-hand experiences this research sought to understand the ways in which language–particularly how the older person is referred to, such as "care-recipient", "consumer", "person", and "participant", in policy documents and research–influences residential aged care providers' culture and practices of person-centred care. Using an explanatory mixed-methods approach. The quantitative phase involved content and sentiment analysis using Leximancer across major national reviews and inquiries into aged care (2011–2021), revealing a marked shift in policy discourse towards "consumer-directed care". These findings informed the qualitative phase, which included 46 semi-structured interviews with CEOs, cultural change facilitators, academics and researchers. The qualitative component identifies how

terminology from policy documents influences practices in residential aged care, particularly the implementation of person-centred care models aimed at improving the quality of care and life for older people. It finds that while terminology matters, the way terms are interpreted is even more significant. The research highlights a critical confusion in the sector, especially in how residents are described, whether as "consumers" or within the framework of "person-centred care". This conflation is examined through the lens of Bourdieu's social practice theory. By exploring the intersection of language and culture–how language shapes organisational culture and influences care delivery–the study reveals how linguistic choices can unintentionally impact the quality of care. By unpacking these linguistic subtleties and their practical effects, the study offers fresh insights into implementation approaches to promote more respectful and compassionate practice environments. By highlighting the unintended consequences language can have on care quality, these findings are especially timely, as Australia is implementing new human rights based legislation.

## Co-designing Safety and High Reliability From Breakthrough to Zero Harm with Patients, Families and the Frontline [PCC067]

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Introduction: While there are numerous reports in the literature of reduction of preventable harm events, sustainability to zero harm remains elusive with isolated approaches. We present our 10-year journey to patient safety by building a holistic scalable model to a culture of high reliability driven by transformational leadership, empowered frontline and patient engagement. Methods: We assessed our existing organizational culture of safety framework for NYU Langone Long Island Children's services in 2014 and

identified multi-tiered strategies for our 10 years culture transformation journey. Major key drivers included: designing programs to embed high reliability organization principles from leadership to frontline, data-informed governance, building Quality Improvement capacity and co-production with our patients and families. Central to our interventions are: 1. The Key Card Change Program - the program leverages the "kamishibai" lean management method to design visual cue cards as a tool for frontline and family partnership in the reduction of hospital acquired conditions (HACs) and driving highly reliable processes for safe care, 2. The deployment of our "people" bundle - HRO training, leadership methods and empowering our team with advanced QI capability 3. In alignment with the Children's Hospitals Solutions for Patient Safety, ramping up utilization of proactive safety strategies for the past 2 years. Results: We have achieved > 70% reduction in hospital acquired conditions from hospital acquired infections, harms from falls and pressure injuries and unplanned extubations from 2014-2024. With scaling up of our HRO journey with proactive safety culture strategies, we are seeing an improvement in our Serious Safety Events rate for CY 2025. Conclusion: Culture of Safety is an evolution, not a destination - by investing in our people to enable transformational leadership and new competencies, co-designing solutions with our families and the frontline and leveling up approaches to proactive safety we have developed a scalable model towards achieving Zero harm.

## Transforming Healthcare for Changing Lives [PCC068]

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Introduction: Over the past decade, there has been robust transformation in healthcare delivery systems worldwide driven by the need to prioritize person-centeredness and achieve safer, higher quality care. Despite this

trend, emerging economies like the Philippines have fallen behind due to a fragmented system, under-resourced infrastructure, lag in digitalization, policy gap and culture. We present a framework for leveraging High Reliability Organization (HRO) and Person Centered Care (PCC) principles as a foundational lever for healthcare transformation (HCT) for an emerging tertiary healthcare institution. Methods: A multi-disciplinary leadership team was chartered to form the Institute for Advancing Care Transformation (i-ACT) in Manila, Philippines . Literature, expert guidance and conceptual framework for PCC, HRO and Governance were reviewed. Key pillars of Clinical Effectiveness, Quality and Patient Safety, PCC, Innovation/Digitalization, Service/Advocacy and Principled Governance were established. An inter-disciplinary team for each pillar defined the Structure, Process and Outcome to guide operational readiness. Results: Key interventions to date included: Development of a culturally adaptive patient experience survey tool and obtaining baseline data to inform process design from the ground up. Establishment of Patient and Family Advisory Council to co-design processes, services and patient facing tools with patients and families. Partnering with physician leaders to define digitalization roadmap. Enabling transformational leadership through active learning workshops and seminars focused on HRO, PCC and governance, and collaborating with experts to leverage lessons learned from global transformation. Conclusion: i-ACT is the first institute in the Philippines dedicated to advancing HCT. This presents a model for redesigning HC systems from inception to build a culture that will support a safer, higher quality, truly person-centered healthcare for all. The organization will embed PCC and HRO principles to "hire-for-culture" fit as the next step, co-create the culture we desire with patients and providers and blend local innovation with international expertise.

# Patient & Public Involvement

## Furthering the Role of Patient and Family Advisory Councils in Person-Centred Healthcare Organizations, Institutions and Research Programs [PCC069]

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Patient and Family Advisory Councils (PFACs) are increasingly being recognized and valued as an effective way to integrate patient and family perspectives and priorities into health research, clinical practice, and decision-making within healthcare organizations and institutions, thereby advancing person-centred care. Integrating lived experience expertise enhances the quality of research evidence by grounding priority setting, conduct, dissemination, implementation, and evaluation in what matters most to patients and families. This helps ensure that healthcare policies and practice remain responsive to diverse patient and family needs, ultimately supporting better informed and shared decision making at all levels – individual, family, organizational and more broadly. This oral presentation will share examples of two PFACs – one informing a European pediatric healthcare institution and a second informing a Canadian program of research. We will briefly outline their background and purpose and describe membership, work to date and aspirations for going forward, illustrating how PFACS can inform research agendas and program development, fostering collaborative approaches to improving care. We will highlight five evidence-based key considerations and best practices for PFACs including: 1) designing membership to reflect multiplicity of backgrounds; 2) using inclusive and sustainable engagement approaches; 3) co-determining meeting schedules, timelines, formats and terms of references; 4) establishing equitable approaches to compensation; and 5) identifying and supporting additional engagement opportunities including co-authorship and evaluation of the patient and family engagement. PFACs are no longer a nascent practice but recognized as an effective way to centre patient priority and experience in the co-production of the health research evidence that can inform more person-centred health care policy and practice. It is therefore important that spaces are made for open discourse and conversation to continue advancing evolving theories and practice of PFACs. In addition to the presentation, we are hoping for an opportunity to have some time for Q&A and exchange.

# From Selfcare to Meta-Selfcare in Chronic Conditions: The Evolution of Patient Expertise [PCC070]

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As healthcare systems grapple with the increase in chronic conditions, attention is turning to how patients themselves develop the knowledge and skills needed to live well over time. Traditionally, clinical practice as well as research on selfcare have emphasized compliance with professional guidance and the performance of daily management tasks—taking medication, monitoring symptoms, adjusting diet or exercise. Yet many people living with long-term conditions go far beyond this. They experiment, evaluate outcomes, share insights, and iteratively refine their strategies. This higher-order capacity can be described as meta-selfcare: the reflective and systematic process through which patients do selfcare and learn from, optimize, and evolve it. Meta-selfcare reframes chronic illness management as a dynamic learning practice rather than a set of fixed routines. It encompasses processes such as self-observation, hypothesis testing, adaptation, and knowledge sharing, activities that parallel scientific reasoning on a personal scale. Understanding meta-selfcare invites a conceptual shift from viewing patients as followers of care plans to recognizing patients as experts in the making of and as contributors to collective knowledge. It bridges experiential learning, personal science, and participatory health, highlighting the epistemic value of lived experience. Moreover, it clarifies that patient expertise complements and strengthens, rather than replaces, professional care. This means offering insights that can improve safety, personalization, and sustainability of health systems. In our session, we will present an emerging framework to provide a lens for rethinking chronic care as co-evolution between patients and healthcare systems. In the framework, we will articulate the logic and mechanisms of meta-selfcare and invite patients and family caregivers,

clinicians, policymakers, and researchers to join us in moving beyond "supporting selfcare" toward co-creating meta-selfcare. Together we can foster environments where patients can reflect, experiment, and share the knowledge that keeps them well!

## Active involvement of persons with intellectual disabilities in health research; the ACCESS project [PCC071]

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Persons with intellectual disabilities have a higher risk of mental and physical ill health, more non-communicable diseases, and shorter life expectancy than the general population. These disparities stem partly from unhealthy lifestyle habits and partly from unequal access to health-promoting services, while tailored, person-centred lifestyle interventions remain insufficient. Although persons with intellectual disabilities often express a desire to participate in research concerning their health and well-being, they are frequently excluded from health research. A central premise of the ACCESS project is therefore that persons with intellectual disabilities should not merely participate in research but in collaboration with researchers. The lived experiences and perspectives of persons with intellectual disabilities are essential for developing knowledge that is relevant, accessible, and grounded in the realities of their everyday lives. The overall aim of the ACCESS project is to enhance access to person-centred lifestyle counselling for persons with intellectual disabilities, including the development of a digital screening tool that supports participation and self-determination in lifestyle habits assessments. At the same time, the project seeks to contribute to methodological development by demonstrating how research can be conducted in genuine collaboration with persons with intellectual disabilities,

representing an important step toward more inclusive and equitable health research. Therefore, a competence group comprising persons with intellectual disabilities is actively involved in the ACCESS project to ensure participation, equality, and a holistic perspective. The competence group contributes to the design, implementation, as well as interpretation of the results and findings, thereby serving as co-creators in the research process. In this way, the project becomes a shared learning journey in which academic and experiential knowledge meet on equal terms. The process with the competence group, as well as the researchers' and the competence group's experiences from this process, will be the focus of the presentation.

## Patient and Caregiver Engagement in an Era of COVID-19: What did we learn and how do we move forward? [PCC072]

*Kerry Kuluski[1, 2], Michelle Marcinow[1], Carol Fancott[3], Maggie Kerestecí[4] & G. Ross Baker[2]*

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Background: Patient and caregiver engagement is a core component of high quality health care systems. The Covid-19 pandemic revealed the fragility of patient and family engagement that was not as firmly rooted in the health system as expected. Objectives: To identify key enablers to sustaining patient engagement activities during times of high health system stress (e.g., the COVID-19 pandemic). Methods: A series of case studies were conducted across 5 Canadian provinces and included both health service delivery and social care organizations at local, regional, and provincial levels, as well as health organizations that support improvements in care and patient engagement. 1-1 interviews were conducted with patient partners and organizational leaders from each of the case sites. An inductive thematic analysis was conducted to identify core themes (enablers) to sustaining

patient engagement activities during the pandemic. Findings: The following themes represent key enablers to sustaining patient engagement activities during the pandemic: 1) Strong Connection between Organizational Leaders and Patient and Care Partners; 2) Maturation of Context including Entrenched Philosophy of Patient and Family Centred Care; 3) Giving Patient and Care Partners the Space to Lead, Build and Sustain Relationships; 4) Willing Partnership through Meaningful Activities; and 5) Creating New Mechnisms for Engagement. Conclusions: The Covid-19 pandemic challenged the culture that patient engagement efforts require to thrive and revealed the tensions that exist in creating person-centred policies and practices during times of crisis. We have learned from many organizations where not only engagement practices and philosophies survived but were able to thrive. Moving forward, we can consider engagement capabilities in the broader ecosystems of health where engagement needs to grow. We can seek to understand the instrumentality of engagement efforts but also the democratic forces of engagement and dialogic understanding brought about through opportunities for learning and unlearning.

# People of Old Age

## Supporting Autonomy in Later Life: Care Structures in Long-Term and Community Care [PCC073]

*Inhye Jung[1] & Hyo Jung Lee[1]*

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Autonomy in later life is often examined through independence in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), or framed as decision-making capacity—an important but partial dimension. These approaches do not fully capture the lived experience of autonomy in everyday aging and care. For older adults receiving daily support, autonomy is shaped or constrained by the care structures in which they live. Because national policy frameworks mediate these dynamics, the Korean case is

salient. South Korea introduced long-term care insurance in 2008 and piloted community-based integrated care in 2019, with nationwide implementation planned for 2026. Within this evolving context, examining how care structures support autonomy is crucial. This study builds on prior work, including a phenomenological analysis of lived experiences of autonomy and a social network analysis of care arrangements. Abductive reasoning is applied to integrate these findings with ecological systems theory and the concept of relational autonomy, drawing on person-centered care as a guiding framework. Data consist of in-depth interviews with nine older adults receiving daily care and 13 caregivers, with analysis ongoing and recruitment continuing. Preliminary findings suggest that autonomy is sustained through care structures operating at three levels. At the existential–practice level, routines that acknowledge bodily change and temporality help preserve agency. At the relational–network level, reciprocity and negotiated roles foster self-expression. At the lifeworld–system level, accessible community resources and responsive institutions enable participation and voice. Together, these insights highlight autonomy as integral to realizing person-centered care. The study advances an emerging framework toward a mid-range theory that reframes autonomy beyond functional independence and decision-making, offering conceptual implications for strengthening long-term and community care systems.

## The daily life of people with dementia in different care environments: a comparison between care farms and regular nursing homes [PCC074]

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Introduction: The physical, social, and organizational environment plays a crucial role in the daily lives of people with dementia. A stimulating

environment can enhance quality of life. Green care farms offer an alternative to regular nursing homes by providing a distinct physical, social, and organizational setting, with person-centered care and a meaningful daily life as primary goals. Regular nursing homes tend to be more clinically oriented, offering less scope for individual variation. This study examines how the daily lives of residents with dementia differ between care farms and regular nursing homes. Methods: In this cross-sectional study, 226 residents from four care farms and five regular nursing homes were observed. Using the MEDLO tool (Maastricht Electronic Daily Life Observation), residents' activities, locations, social interactions, physical effort, and mood were recorded. Each resident was observed once in the morning, afternoon, and evening, resulting in 36 observations per resident. Multilevel regression analyses were conducted, adjusting for age, gender, cognitive status, and ADL dependency. Results: A total of 10,053 observations were collected. Residents of care farms spent more time outdoors (10.6% vs. 2.5%) and were more frequently engaged in physical and household activities than residents of regular nursing homes. Passive or purposeless activities occurred less often on care farms than in regular nursing homes (36.3% vs. 45.9%). Differences in location further suggest that organizational and operational factors also play a significant role. Additional analyses are currently underway, with results to be reported later. Conclusion: Residents of care farms spend more time outdoors, are more active, and more engaged. These differences indicate that care farm environments may better support meaningful daily life and overall engagement for people with dementia. The observed differences in passivity highlight the potential value of rethinking the design and organization of care environments to promote more active and fulfilling daily routines.

## Using saliency and tacit knowledge for person-centred care, a two-phased qualitative study on patient and family involvement in residential care. [PCC075]

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Background: Since workforce shortages are increasing, collaboration between care recipients, their significant others and care professionals (triad) should intensify to guarantee person-centred care1. Such care, that aligns with personal preferences, needs and values, requires saliency and sharing of tacit knowledge of parties involved2. This study (2022, 2024) explored 1. how saliency based on tacit knowledge for the personhood of a care recipient informs person-centred responding of care professionals and 2. how a person-centred learning culture can be fostered in which tacit knowledge is shared in triads. Methods: Both study-phases took place on residential wards for people with dementia and somatic care. Narratives of successful examples and best practices of using tacit knowledge were collected via observations and interviews. Based on these insights and in co-creation with all stakeholders, an innovative tool was developed which consists of a seasonal calendar and card game, enriched with eight elaborated practical examples. The tool facilitates dialogue and reflection, enhances saliency and encourages using tacit knowledge in daily life-experiences of residents. Results: Findings show that saliency informed by tacit knowledge often leads to person-centred care. Nevertheless, chances for sharing tacit knowledge in a triad are missed due to prevailing task-oriented routines. The study highlights the importance of a continuous dialogue on values and priorities, and the need for reflection-in-action and on-action. The knowledge gained and the tool increases awareness and engagement, although a sustainable organisational embedding remains a challenge. Conclusion: Saliency and using tacit knowledge of parties cooperating in a triad are essential for person-centred care. Facilitating dialogue and reflection strengthens such collaboration. Concrete examples of best practices and narratives of successful communication supports a person-centred learning climate.

# Facilitating person-centred oral healthcare in home care: the GAPA model as a bridge between dental and municipal services [PCC076]

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Objective: To present a work model for person-centred oral healthcare in home environments of older adults, combining clinical practice, organisational collaboration, and co-designed digital infrastructure. Background: Older adults with complex care needs risk losing access to dental services, resulting in undetected oral health problems and declining wellbeing. To address this gap, a new collaborative model was developed within a cluster randomized project involving 480 older individuals. The new work model bridges over boundaries of dental care and municipal care and gives improved oral health through shared planning, decision support, and

joint home visits, ensuring tailored care aligned with each person's daily life. Materials and Methods: Oral health planning was structured through decision coaching, facilitating learning between older adults, dental and municipal care professionals. Dental care delivery includes assessments, preventive measures, extractions, and prosthetic adjustments during home visits. A digital platform, co-designed with older persons, care staff, developers, and researchers, supports coordination, documentation, and communication across services. Proposed to be integrated into routine workflows, the platform reflects the needs of multiple users. Projected Results: The intervention is designed to strengthen interprofessional collaboration, support person-centred care planning, and enable contextually adapted dental services within municipal care. The digital platform is expected to facilitate continuity and provide the basis for mapping oral health status among groups typically absent from national data collections. Anticipated Conclusion: The GAPA model positions oral health as a shared responsibility in integrated home care. Practice-based innovation combined with organisational coordination and digital infrastructure offers a scalable pathway to sustainable, person-centred oral health care practice. Success is contingent on co-design, contextual fit, leadership and measured implementation fidelity.

# Tools & Assessments

## Conducting inclusive quantitative research on person centred care [PCC077]

*Molly Hopson[1], Amy Tallett[1] & Jenny King[1]*

[1] Picker Europe

To champion the best possible person centred care, it is essential that we hear from diverse individuals and communities with varying views and experiences, to ensure that data reflects the overall population as best as possible. This presentation will focus on inclusion in quantitative research on person centred care and share best practice and guidance using real

examples from our work, including: Embedding the patient voice in research methods (co-development) Engaging patients, service users and wider stakeholders in the development of self-reported care experience surveys. For example, using semi-structured in-depth interviews and stakeholder events to inform survey content, and inviting relevant audiences to review draft questionnaires. Inclusive design Using cognitive interviews to test survey questions before launch to ensure they are accessible to and understood by the relevant audience. Ensuring surveys are accessible to people with differing needs, by offering translations into different languages, versions in braille and easy read, and ensuring online surveys are screen-reader friendly. Utilising different survey modes Catering for preferences, for example offering online and paper survey response modes. Creating survey versions for various audiences, e.g. adapting children's survey designs to suit different age groups Offering telephone helplines to support participants completing the survey. Utilising promotion methods to maximise survey response Working with community groups to promote engagement with lesser heard populations. Engaging audiences through different mediums i.e. social media, invite letters (postal, SMS, email), infographics, and utilising existing networks to help reach people to invite to take part in surveys. Clear representation of findings Ensure that the dissemination of survey findings on person centred care is accessible to respondents e.g. by using plain English and engaging designs, as well as offering language translations and easy read. This can be tailored according to the population and the available budget.

## Measuring What Matters: A Delphi Study to Define Quality Indicators for Person-Centered Care [PCC078]

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Background: Person-centered care (PCC) is increasingly viewed as a foundation of high-quality healthcare. However, there is still no shared understanding of how best to measure it. Existing quality indicators often focus narrowly on specific diagnoses or fragmented elements of PCC, and they rarely align with the European standard for patient involvement or the Swedish patient law. This limits the health system's ability to assess, compare, and meaningfully improve PCC across care settings. Aim: This study seeks to identify and develop a set of consensus-based quality indicators for person-centered care that reflect a broad and holistic view, enabling systematic evaluation across Sweden's healthcare landscape. Method: A comprehensive literature review laid the groundwork by identifying key domains of person-centered care from previous research and policy documents. Based on this, a Delphi study was launched involving stakeholders from four key groups: healthcare professionals, managers, patients, and informal caregivers. Through multiple rounds of structured questionnaires, participants rated and refined proposed indicators, contributing both expert knowledge and lived experience to the process. Findings: Findings will be possible to present from all four round of the data collection at the time of the conference. Conclusion: This research is generating a validated, stakeholder-informed set of quality indicators that can meaningfully capture person-centeredness in healthcare. The emerging indicators aim to bridge gaps between policy ideals and measurable practice, offering decision-makers actionable tools to evaluate, compare, and strengthen person-centered care across regions and sectors.

# Exploring the Internal Dynamics of the Person-centred Practice Framework: A Cross-cultural Structural Evaluation [PCC079]

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Background: The Person-centred Practice Framework (PCPF) is a widely adopted model guiding person-centred healthcare delivery (McCance & McCormack, 2021). Despite its conceptual strength, few studies have rigorously examined the framework's internal structure or tested the relationships among its constructs. Aim: This study explores the internal coherence of the PCPF, focusing on inter-construct and inter-domain relationships within its three core domains—Prerequisites, Practice Environment, and Person-centred Processes—across multilingual and multicultural settings. Methods: A secondary dataset (N=3773) was collated from eight studies using the Person-centred Practice Inventory – Staff (PCPI-S), translated into six languages and spanning seven countries. Bayesian correlation and structural equation modelling (SEM) were used to examine construct-level and domain-level relationships. Confirmatory factor analysis was conducted to test the theoretical structure of the PCPF across language groups. Results: Bayesian correlation analysis showed strong intra-domain and moderate to strong inter-domain construct correlations (Tyagi et al 2025). Structural equation modelling demonstrated excellent model fit (RMSEA=0.047, SRMR=0.057) and confirmed that the Prerequisites domain significantly predicts both the Practice Environment ($\beta = 0.67$, $p < 0.001$) and Person-centred Processes ($\beta = 0.80$, $p < 0.001$). Surprisingly, the Practice Environment did not significantly predict Person-centred Processes. These findings underscore the foundational role of practitioner attributes and highlight the mediating (but not direct) influence of environmental conditions. Conclusion: This is the most comprehensive empirical test of the

PCPF to date. The findings reinforce its internal logic, confirm cross-cultural validity, and offer robust evidence to support its use in education, workforce development, and policy implementation. Importantly, the study advocates for dual investment in both staff development and organisational environments to meaningfully embed person-centredness in healthcare systems globally.

References: McCance, T., McCormack, B., 2021. The person-centred practice framework. In: McCormack, B., McCance, T., Martin, S., McMillan, A., Bulley, C. (Eds.), Fundamentals of Person-Centred Healthcare Practice, vol. 2021. Wiley, Oxford, pp. 23–32. https://www.perlego.com/book/2068078/fundamentals-of-personcentred-healthcare-practice-pdf

## Co-development and Evaluation of a Train-the-Trainer program to support physician knowledge and use of PC-QIs in continuous quality improvement [PCC080]

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The Patient's Medical Home (PMH) is a Canadian vision for primary care that describes the foundations of a healthcare system to achieve Person-Centred Care (PCC). In addition, the PMH also describes the importance of continuous quality improvement (QI) and continuing professional development to improve patient safety and enhance the quality and delivery of care. Person-Centred Quality Indicators (PC-QIs) are measurement tools that were co-developed, validated, and prioritized in partnership with decision makers, providers, patients, and community partners. PC-QIs compare patient's actual experiences, collected systemically using patient-

reported experience measures, to the ideal, person-centred care experience. This work describes the implementation of a training program for PC-QI use in primary care, which includes indicators for overall experience, trust in providers, communication, and shared decision-making. Our research team is engaging with patient partners, local QI staff, and primary care providers to co-develop a "Train-the-Trainer" style program, which is composed of 2 phases (Researcher to QI training, and QI to Provider training), including evaluation modules before and after both phases of the training program (Figure 1). This program will specifically train physicians on the use of 3 specific PC-QIs: Overall Experience, Trusting Relationships, and Communication. The program is predicted to support physician understanding, adoption, and maintained use of PC-QIs in their annual quality improvement efforts. Using a mixed methods approach, we will evaluate the effectiveness of the training program, as it relates to physician learning and the appropriate use of PC-QIs using pre- and post-training tests, self-evaluations, and interviews to capture both provider and QI staff perceptions of the program. We will be delivering and evaluating the training program across four academic teaching clinics before the end of the calendar year, and we predict that the evaluation of the pilot training program will inform the implementation of primary care training programs in the future.

# Art, Media & Performance

## A Box of Memories: Documentary Music Theatre as a Catalyst for Person-Centred Dementia Care [PCC081]

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This presentation explores the development and presentation of A Box of Memories, an original documentary musical that uses story, music, and theatre to promote person-centred care for people living with dementia. Co-created by a daughter-father creative team, the work draws on lived experience and clinical insight to illuminate emotional, relational and systemic dimensions of dementia care. The musical follows three characters: Lizzy, a woman navigating the challenges of diagnosis and change; Sonia, her daughter grappling with caregiving and grief; and Jeremy, a medical specialist rediscovering empathy through his engagement with Lizzy's story and experience. Through these intersecting narratives, the show invites audiences to reflect on their own relationships with dementia, whether personal, professional, or societal. Using performance video extracts and behind-the-scenes reflections, the presentation will illustrate how the show's autoethnographic practice fosters emotional resonance and audience identification to promote attitudinal transformation. The presentation will also provide insights from audience evaluations demonstrating the show's efficacy in shifting perspectives on dementia, personhood and care. By integrating artistic practice with clinical and community engagement, A Box of Memories demonstrates how documentary musical theatre can be a powerful tool for raising awareness, challenging stigma, and cultivating empathy, promoting greater person-centredness in care for people vulnerable to marginalisation. This session will be of interest to creative and health practitioners, researchers, and advocates seeking innovative approaches to person-centred practice. It will offer insights into the potential of the arts to transform attitudes and deepen understanding of complex human needs, leading to greater application of person-centred philosophy and practice.

## The Power of Person-Centred Moments: A Nurse's Patient Journey [PCC082]

*Ruth Smoother*[1]

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Person-centred care is the foundation of meaningful healthcare—and its presence or absence can shape a patient's entire experience. This 10-minute first-person monologue shares the story of a nurse with over 30 years of clinical experience who unexpectedly becomes a patient after suffering a heart attack. Told from the patient's perspective, the narrative explores how moments of connection and disconnection within the hospital environment impacted her sense of safety, dignity, and identity. It recounts a prolonged period in the emergency department without a diagnosis, during which she chose not to inform her family—missing her niece's wedding and receiving her diagnosis at the exact moment her niece walked down the aisle. The story highlights how not only interpersonal interactions, but also systemic factors—such as wait times and communication—play a critical role in shaping a person's experience of care. These elements can either reinforce or undermine a sense of being seen, heard, and valued. This experience profoundly reshaped her understanding of person-centred care and its delivery. Now working as a nurse educator, she uses her story to highlight the importance of embedding compassion, presence, and attentiveness into clinical practice. The monologue invites reflection on how person-centred care must be supported not only in individual interactions, but also through organisational culture, leadership, and governance. By bridging personal experience with professional insight, this performance challenges healthcare professionals and leaders to consider how systems, behaviours, and values align to support truly person-centred care.

## The Impact of a Patient Engagement Podcast: A Tool for Inclusive Knowledge Translation [PCC083]

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Background: Knowledge Translation (KT) is an iterative process that incorporates various perspectives, making research findings accessible, meaningful, and applicable across diverse populations. Inequitable information access can hinder diverse groups from benefiting from research.

This presentation showcases podcasting as a collaborative tool for engaging with patients, families, and community members, in co-creating and sharing information, reaching a potential podcast audience reported to be 584.1million in 2025. General Methods: The Patient Engagement Podcast (PEP Talks), was co-developed in 2020 in response to the COVID-19 pandemic to facilitate inclusive online collaboration for knowledge sharing. Producers and hosts invited patient, family and community research partners and academic researchers as guests through their networks, to co-create and share culturally sensitive, relevant research knowledge. Recordings were conducted online via Zoom, edited using Garage Band and reviewed by guests before release. Episodes are available on various podcast platforms including, Spotify, YouTube, SoundCloud, and BuzzSprout. Results: PEP Talks has published 35 episodes, featuring patient, family, and community research partners, academic researchers, clinicians, and senior leaders, as guest speakers. This podcast has garnered 16,382 unique plays globally. Statistics have been retrieved from podcast platforms SoundCloud, Buzzsprout and YouTube. Podcast guests, patient partners, and academic researchers have reported sharing the episodes as KT products for educational purposes, on websites, with personal and professional networks to enhance understanding of their research. Additionally, PEP Talks has been used as a resource for graduate students and has been featured at international conferences. Conclusions: Podcasts are a great option for disseminating evidence-based research methods, results, and processes to a broader audience, including the people who research is intended to impact; patients, families and communities.

# Comprehensive & Integrated Care

## Packing for the Journey: Quality and Practice Development in Person-Centred Digital Counseling [PCC084]

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Introduction: Digital technologies offer new opportunities to support family caregivers - a growing priority in aging societies. Alles Clara, a digital service in Austria, leverages these possibilities and offers individual counseling provided by nurses and psychologists. Central to its effectiveness is a person-centred approach to counseling. This project set out to explore core elements of high-quality, person-centred online counseling and to chart a path for its continuous growth and refinement within Alles Clara. Methods: We embraced practice development as a transformational journey in three phases: (1) Setting the Scene – analyzing the app-usage and counseling characteristics through in-app tracking and user feedback; (2) Encompassing Change – co-creating a quality framework through a participatory approach together with online counselors (n= 10) and a newly-introduced practice facilitator; and (3) Packing for the Journey – defining strategies to enable and sustain high-quality, person-centred counseling in Alles Clara. Results: Baseline data from 1,263 family caregivers and 342 counseling sessions highlighted the heterogeneity of users and their needs. Requests varied widely, reflecting the diverse demands placed on digital counseling. Applying the Practice Development Framework (Garbett & McCormack, 2002) to Alles Clara led to the creation of our 'Compass of Change', a structured model for defining quality through shared values and vision within the team, and explicit requirements regarding the counseling and workplace culture. The model integrates context-specific strategies and tools, underscoring the interplay of knowledge, time, and attitude. This approach fosters continuous quality improvement, ensuring that person-centred digital counseling is not a static benchmark but a dynamic and evolving process. Conclusion: High-quality digital counseling requires moving beyond fixed standards toward practice-driven, relational, and reflective development. Through ongoing facilitation, and systematic evaluation, quality becomes an active force - empowering counselors to provide person-centred counseling, ultimately enabling them to go the extra mile for those seeking support.

# Artificial Intelligence and Person-Centred Practices: A Critical Person-Centred Reflection [PCC085]

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Artificial Intelligence (AI) is rapidly transforming healthcare, offering new possibilities for efficiency, personalization, and clinical decision support. However, AI raises profound questions about ethics, depersonalization, and the preservation of humanistic values in care. This communication critically examines the intersection of AI and person-centred practices using the Person-Centred Practice Framework (PCPF) as an analytic lens. Each domain of the PCPF was explored in relation to emerging evidence on AI integration in health systems. At the Macro Context, AI has the potential to reduce inequities and improve resource allocation, but policies often prioritize efficiency over dignity, and relational care. Within the Prerequisites domain, AI can enhance professional competence through data-driven insights and training, yet it challenges practitioners to retain empathy, ethical clarity, and self-awareness. In The Practice Environment, AI offers opportunities for workload optimization and decision support, but risks eroding collaboration and autonomy if imposed without consultation or transparency. Most critically, within Person-Centred Processes, AI can support personalization and shared decision-making, yet it cannot replicate authentic presence, empathy, or holistic understanding. The relational depth of care remains a uniquely human responsibility. Outcomes associated with

AI adoption must therefore move beyond biomedical indicators to incorporate person-reported experiences, dignity, and participation. This reflection concludes that AI can strengthen person-centred practices if guided by values of equity, inclusivity, and relational ethics. However, without intentional alignment to person-centred principles, AI risks reinforcing technocratic and depersonalized models of care. The challenge is not whether AI will be used in healthcare, but how it will be designed, implemented, and evaluated to ensure that technological innovation amplifies rather than diminishes our shared humanity. In this presentation, we will discuss how AI interacts with each domain of the PCPF, highlighting opportunities and risks, and reflect on how person-centred principles can guide the responsible design and implementation of AI in healthcare.

## Implementing Virtual-4-part meetings across sectors to support person-centered care: Barriers and facilitators [PCC086]

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Background: Transitions between healthcare sectors are critical moments for patients and families, particularly those living with complex and multimorbid

conditions. Fragmented communication and lack of coordination can result in medication errors, misaligned care plans, and emotional stress for both patients and relatives. Virtual-4-part (V4M) meetings hold the potential to improve continuity, coordination, and shared decision-making, while supporting the involvement of patients and families as active participants in care. Objective: This study explores barriers and facilitators to implementing V4M as a tool to enhance person-centered care across sectors. Methods: We conducted two interdisciplinary workshops at two emergency departments (ED). Participants included healthcare professionals and leaders from hospitals, general practice, municipal nursing, and nursing homes (12 to 25 participants, respectively). Using the SWOT framework, data were collected via audio recordings and written notes, and analyzed using the Consolidated Framework for Implementation Research (CFIR). Results: There was strong engagement and commitment across sectors to co-create solutions that support continuity and person-centered care. Emerging findings point to determinants across all five CFIR-domains. Innovation level: Barriers included differing expectations and a lack of consensus on patient selection. Facilitators were strong user involvement, shared care planning, and improved patient pathways reducing unnecessary ED visits. Inner setting: Key barriers were time constraints in the ED; facilitators included agreement on shared goals and structured scheduling with GPs. Outer setting: Barriers involved incompatible IT systems, GDPR concerns, short ED stays and overlapping initiatives. Facilitators included integration with GP financial agreements. Individual level: Barriers comprised limited V4M competence and challenges in patient selection. Facilitators involved engaging relatives remotely and empowering patient participation. Implications: Understanding implementation challenges and enablers is crucial for embedding V4M in practice. The next phase will evaluate V4M, aiming to improve coordination, shared understanding, and continuity of care for patients and families across healthcare settings.

# How Can Measuring and Using Data from an App Strengthen Person-Centred Care? [PCC087]

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Over the past decade, our international research program has focused on one central question: How can we meaningfully measure person-centred care from the consumer's perspective? A key outcome of this work has been the development of a validated set of Person-Centred Nursing and Midwifery Key Performance Indicators (KPIs). These have been rigorously tested in multiple studies across Europe and Australia. Building on the success of these KPIs—and the strong engagement we've seen from staff—we created the iMPAKT App. This digital tool was designed to make the process of collecting, collating, and reporting data faster, easier, and more scalable. Ongoing feedback from real-world implementation has helped us refine the app and enhance its usability. In this session, we'll introduce you to the iMPAKT App and show how it can be used in a range of clinical settings from acute clinical settings, care homes, virtual care and in the community. You will experience how data is entered and turned into clear, meaningful feedback reports. We will use an iMPAKT report example to explore questions like: What does this feedback tell us? Which areas of care need more attention? What actions can we take forward as a team? And how do we care for ourselves while caring for others? While person-centred care is often talked about, it's not always easy to embed in high-pressure environments. And while many systems collect data, few show us how to actually use it in a way that drives change. The iMPAKT approach bridges that gap. It turns feedback into meaningful conversations, strengthens team connections, and supports compassionate, sustainable improvements in care. Most importantly, it works across all levels, from individual units to whole

organisations, to broader systems, helping shape a more person-centred future for nursing and midwifery

# Digitalisation & eHealth

## Illuminating person-centred processes through lived experience [PCC088]

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Person-centredness is a global movement in healthcare that prioritises the human experience. It challenges healthcare organisations to think beyond the effective and efficient completion of tasks and to consider the overall experience of care on the person and their wellbeing. The Person-centred Practice Framework (PCPF), of McCance and McCormack (2021), profiles person-centred practice as a whole-systems issue and through the articulation of the key constructs, emphasises the contextual, attitudinal and moral dimensions of humanistic caring practices. This mid-range theory is viewed as a means of operationalising person-centred care in any context, and highlights the attributes of the practitioner in creating meaningful engagements with patients and families. The essence of person-centred care is a way of being, and focuses on creating connections between persons in any one caring moment. In this presentation we illuminate the person-centred processes through storytelling that reflects our lived experiences of care. As the original authors of the PCPF, over the past 25 years we have been committed to working with healthcare teams and organisations to develop contexts that enable the delivery of person-centred care. Yet we continue to experience care that is inconsistent as reflected through the person-centred processes. Our positionality as leaders in this field, gives us a privileged position of power to give voice to our concerns and to elevate the issues for policy and practice. Our stories, like many others, are a salutary reminder of the vulnerability experienced by persons across healthcare

systems and the potential for practitioners to 'leave a person-centred imprint' among those with whom they connect.

Reference: McCance, T. & McCormack, B. (2021). The Person-centred Practice Framework. In: McCormack, B., McCance, T., Martin, S., McMillan, A., Bulley, C. (Eds.), Fundamentals of Person-Centred Healthcare Practice, pp.23-32. Wiley, Oxford.

## Looking through the magnifying glass: discovering and uncovering workplace culture using a person-centred observation tool [PCC089]

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Background: Workplace culture impacts fundamentally on the provision of person-centred care. Taking a closer look at the workplace culture gives insight into and helps understanding how things are and how they are done in a particular setting. As workplace culture at the micro level directly influences the care provided, this is a vital step in transforming a culture towards person-centredness. Instruments support structuring this process and offer opportunities to include team members. Aim: Assessing the current workplace culture was the first aim of my PhD research on person-centred culture in a Swiss cancer outpatient clinic: A participatory inquiry. Methods: Data were collected through sequences of workplace observations using the Workplace Culture Critical Analysis Tool revised (WCCAT-r) (Wilson et al. 2020). In a second step, semi-structured conversational interviews taking up findings from the workplace observations completed the assessment of the current workplace culture. The observational data were analysed using a participatory creative hermeneutic approach involving the co-researchers (healthcare professionals and service users) enrolled in the PhD research. Analysis and findings from the conversational interviews are presented in a separate presentation. Findings: Two overarching themes - interpersonal

relationships and competence - with four subthemes each, were found, describing person-centred aspects of the current culture. Conclusions: Workplace observations guided by the WCCAT-r offer insights in, and support describing the current workplace culture in terms of person-centredness. The experiences made by using the WCCAT-r are helpful for future use of the instrument in the same or different settings.

## Examining the Impact of Person-Centred Climate on Nurses' Turnover Intention Using Structural Equation Modelling [PCC090]

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Background: A supportive practice environment is essential for effective person-centred care. When nurses are not enabled to act according to their professional values, they may experience moral distress, potentially leading to disengagement and increased turnover intention. Although the impact of the practice environment on nurse outcomes is well documented, the pathways linking person-centred climate to turnover intention remain underexplored. This study aimed to test theoretical models linking these factors. Methods: We conducted a cross-sectional study of nurses (n=573) from multiple acute care hospitals and long-term care facilities within a major healthcare organization. Validated instruments were used to assess key constructs. Model A posited that nurses' prerequisites, the practice environment, and person-centred processes predict the perceived person-centred climate. Model B examined whether person-centred climate influences turnover intention, mediated by moral distress, cool-out, and job satisfaction. Model B was cross-validated in a second sample (n=593) with shortened instruments. Structural equation modelling was performed using

the lavaan package in R. Results: Both models showed acceptable fit after minor, theoretically justified modifications (Model A: CFI=0.930, RMSEA=0.060; replicated Model B: CFI=0.951, RMSEA=0.049). In Model A, predictors explained 51.8% of the variance in person-centred climate. The practice environment emerged as the sole significant predictor of a person-centred climate ($\beta$=0.74, $p<0.001$) and mediator ($\beta$=0.50, $p<0.001$) between nurses' prerequisites and person-centred climate. Model B replicated well, with consistent structural relationships, explaining 59.4% of the variance in turnover intention. Person-centred climate was indirectly associated with lower turnover intention via job satisfaction ($\beta$=-0.42, $p<0.001$) and, to a lesser extent, via both job satisfaction and cool-out ($\beta$=-0.17, $p<0.001$). The indirect path through moral distress was negligible and non-significant ($\beta$=-0.007, p=0.757). Conclusions: Fostering person-centred environments is important to support nurse retention. Future research should further explore mediating mechanisms to inform retention efforts.

## The role of profession in associations between person-centred care and work-related health in primary care [PCC091]

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Background: Worldwide, the healthcare sector faces challenges in retaining healthcare professionals, often driven by work-related health factors such as job dissatisfaction and stress of conscience. Person-centred care (PCC), rooted in ethical principles, promotes collaborative care co-created by HCPs and patients, may help address these issues, though its impact across professional groups needs further attention. This study aimed to determine the association between perceived PCC and the experience of stress of conscience among primary healthcare professionals and whether this association is mediated by job satisfaction and moderated by profession. Methods: A cross-sectional design with a moderated mediation analysis was conducted using baseline data from the longitudinal PCC@Work project. A questionnaire on PCC and work-related health was distributed among registered nurses, physicians, psychologists, midwives, assistant nurses and other professions in western Sweden. Results: The results showed that among the 560 respondents, the different professions' scores were relatively close, but modelling all concepts revealed variations in their relationships. Profession moderated these associations, slightly reducing the strength of the relationship between PCC and job satisfaction (b= 1.02 to 0.98), while nearly halving the overall strength of associations between PCC, job satisfaction, and stress of conscience (b = –1.44 to –0.79), indicating varying impacts across professions. Conclusion: Type of profession significantly moderated the association between PCC and stress of conscience and job satisfaction. This may point at a need for tailored implementation strategies to optimize PCC's impact in primary care. Various professional groups experienced PCC's effects differently and customized approaches may also be needed to support their work-related health effectively.

# Health Equity

## Equitable people-centred analysis to identify social determinants of health classes [PCC092]

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Aims: Healthcare systems increasingly recognize the role of social determinants of health (SDOH), the conditions in which people live in shaping health outcomes. This study aimed to identify latent SDOH classes among a diverse Canadian sample and examine differences in self-reported mental and physical health across these classes. Methods: We conducted a secondary analysis of 2024 data from the Equitable People Centred Health Measurement study. Participants (N = 9,446) completed the Screening for Poverty And Related Social Determinants to Improve Knowledge of and Links to Resources (SPARK) tool, which measures various SDOH including demographics and social needs. Self-reported mental and physical health were each measured using a single 5-point Likert item (1 = excellent, 5 = poor). Latent class analysis was used to identify the SDOH classes, and chi-square tests were used to assess associations with health outcomes. Results: A five-class model best fit the data (entropy = 0.83; Vuong-Lo-Mendell-Rubin LRT for 4 vs 5 classes $p < 0.001$). The "multibarrier and materially insecure" class (12.5%) had high rates of recent immigration, low education, food/housing insecurity, disability, and social isolation. The "racially diverse with multiple disadvantages" class (7.2%) experienced moderate-to-high hardship across multiple domains. The largest class, "materially stable with high unemployment" (46.7%), had secure housing and food, strong social

support, but high unemployment. The "secure and affluent" class (20.7%) had high education, employment, and home ownership, with minimal barriers. The "racially diverse yet materially stable" class (12.8%) also had housing and food stability but had greater racial diversity, more recent immigration, and slightly lower home ownership and social support. Mental health and physical health differed significantly across these classes, with small-to-moderate effect sizes. Conclusion: This study identified intersectional latent SDOH classes linked to health outcomes, offering nuanced insights into the diverse needs that shape health in Canada.

## Improving person-centred communication in primary care using data-driven personas [PCC093]

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Aims: Patient experience surveys are often used for purposes of quality improvement and governance of person-centred practices. Reporting results of patient surveys typically foregrounds the average experience. Consequently, experiences of some members within diverse populations may be rendered invisible or misrepresented. Personas (hypothetical representation of patients) are a tool to help amplify hidden voices by relating responses to patient experience measures to patients' life stories. A mixed-methods approach to creating data-driven personas (Figure 1) was used to better understand and attend to unique primary care communication experiences identified through latent class analysis. Methods: A latent variable mixture model (LVMM) was applied to examine heterogeneity of responses to six communication-related questions from 3,539 people across Alberta. Measurement bias was taken as the difference in factor scores

between a model accounting for heterogeneity and a model not accounting for heterogeneity. Sixteen diverse respondents belonging to the class with the greatest measurement bias were invited to participate in an interview, five of whom identified as Indigenous. A constellatory approach was used for the preliminary mapping of six unique personas. Acknowledging that Indigenous experiences are often less attended to, interviews with Indigenous patients were foregrounded as the core constellation of four personas. Results: The LVMM resulted in improved fit for a 2-class compared to a 1-class model. Class 2 consisted of 24% of survey respondents who responded to communication questions more negatively, relative to class 1. The latent class information and interview experiences informed the creation of six interactive visual personas. Figure 2 provides an initial visual of Jesse (persona 1) to better understand experiences of chronic pain management in rural primary care. Conclusions: Personas can be used as practice-based scenarios to support healthcare practitioners in applying person-centred care principles. This can ultimately tailor care to individual needs that have historically received less attention.

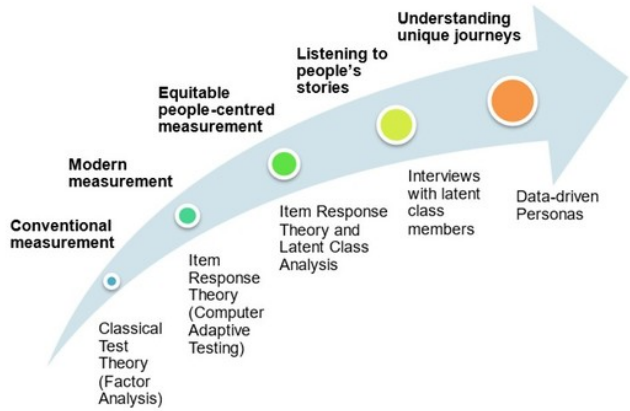


**Figure 1: Vision for measuring experience**

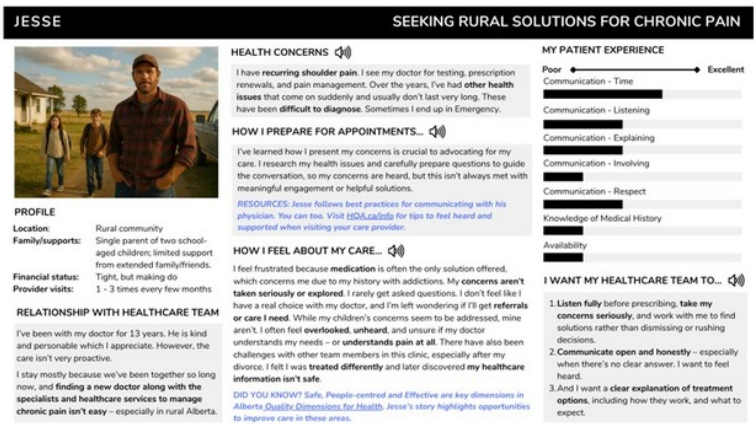


**Figure 2:** Visual of persona 1

# What do we mean by "improvement" when considering trajectories of depression? [PCC094]

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Background: People living with kidney failure have a complex, unpredictable burden of illness, including depressive symptoms. To detect improvement in depressive symptoms when an intervention is provided, it is imperative to articulate what we mean by "improvement" to inform person-centered practice. Further, patient-reported outcome measures are often regarded as screening tools to inform interventions or evaluate outcomes depicting improvement. Purpose: Our purpose was to examine how improvements may be conceptualized when considering trajectories of depression symptoms for people receiving dialysis treatment. Methods: A realist analysis was undertaken drawing on 30 theory-based documents and interviews with seven therapists to identify ideas about how cognitive behavioral therapy (CBT) as an intervention might support improvements for people undergoing dialysis. This analysis was contextually supported by 258 people receiving dialysis who were invited to report on their depressive symptoms via the PHQ-9 every 2 weeks over 6 months. Three different methodological approaches were undertaken to examine how improvements may be considered based on changes over time in PHQ-9 scores: variable-centered, person-centered, and person-specific. Results: Theoretically, CBT is assumed to promote adjustment to chronic health conditions and other life stressors through cognitive restructuring. Response shift, a change in meaning or evaluation of depressive symptoms, may be an outcome reflecting improvement due to adjustment processes. Variable-centered approaches depicted an average trajectory of no change over time and assumed to be representative of the overall sample. Person-centered approaches (e.g., latent class growth models) revealed different trajectories with no to minimal

change over time for several homogeneous sub-populations. And person-specific approaches (e.g., dynamic structural equation models) further disentangled heterogeneity by revealing intra-individual fluctuations that were otherwise unaccounted for in the other two approaches. Conclusion: To inform equitable people-centered healthcare, improvement may not be revealed by average decreases in PHQ-9 scores but rather by intra-individual differences.

## Understanding of palliative care influences preferences for end-of-life care and place of death: results from a population-based survey [PCC095]

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Background: Person-centred palliative care emphasizes aligning care with individuals' values and preferences, including how and where to receive care and die. This approach is a core component of national policy. Dying in one's preferred place is associated with enhanced wellbeing and sense of dignity.

Preferences are shaped by various factors, including individuals' understanding of goals, services, and benefits of palliative care. Aim: To investigate preferences for place of end-of-life care and place of death in the Swedish adult population and explore factors associated with these preferences, and to identify how preferences vary across subgroups characterized by differences in understanding of palliative care. Design: A cross-sectional population-based survey. Latent class analysis was used to identify subgroups based on participants' understanding of palliative care. Setting and participants: A random sample of 3,750 individuals aged 16 to 90 years, from the Swedish population register were invited. Results: A total of 1,752 persons responded to the questionnaire (48% response rate). Overall, 59.6% preferred end-of-life care at home, and 54.2% preferred to dying home. Five subgroups with dissimilar understandings of palliative care were identified, ranging from comprehensive understanding to misunderstanding (Figure 1). The comprehensive understanding group included more women (57.6%), older participants (Mean age 57 [SD 17]), and a higher proportion with university education (48.2%). Comprehensive understanding, e.g. believing that palliative care supports families and reduces suffering, was associated with a preference for home or hospice care. Misunderstanding, e.g. the belief that palliative care hastens death, was associated with a preference for hospital or care facility. Conclusion: Most respondents preferred home as the place for end-of-life care and death. Preferences were significantly influenced by understanding of palliative care. The results underscore the importance of person-centred care practice and governance approaches that enable for people to make informed choices, and that strengthen opportunities for home-based care.

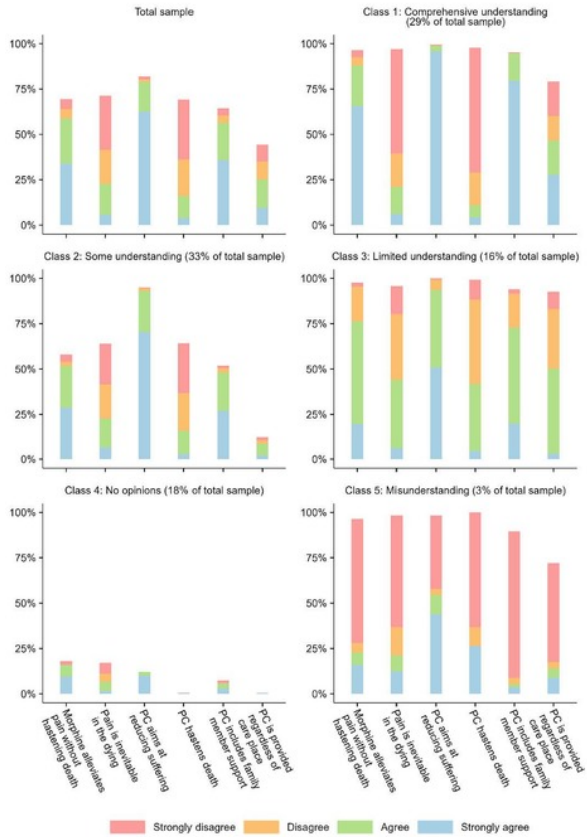


Figure 1. Visualisation of the total sample and classes 1-5's understanding of palliative care based on latent class analysis, excluding responses marked as `no opinion´.

# Organisational Governance

## Mapping Convergences between One Health and Person-Centred Practice [PCC096]

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Contemporary health challenges, such as climate change, zoonotic diseases, and growing social inequities, demand integrative frameworks that connect human and planetary well-being. This communication explores the convergence between One Health and Person-Centred Practice (PCP), highlighting how their complementary perspectives can enrich both conceptual and practical approaches to health. One Health underscores the interdependence of human, animal, and environmental health, while PCP emphasises dignity, relationships, and the care experiences of individuals. Through conceptual analysis, key areas of overlap are identified. Both paradigms share commitments to relational ethics, environmental and contextual awareness, and collaboration. One Health advances ecological and systemic determinants of health, while PCP offers structured insights into personhood, care relationships, and enabling environments. Their convergence opens possibilities for transdisciplinary education, integrated policymaking, and innovations in clinical practice that attend simultaneously to personal and ecological well-being. Case examples illustrate partial but

fragmented integration, such as zoonotic disease surveillance initiatives that combine ecological and community engagement, and long-term care models that connect person-centred values with environmental design. However, systematic operational bridges between the two paradigms remain underdeveloped. Real integration requires participatory research agendas, inclusive policymaking, and educational reforms that prepare professionals with ecological literacy, ethical depth, and relational competence. In this presentation, we will examine the conceptual and practical intersections between One Health and PCP, illustrate points of convergence and fragmentation through case examples, and discuss how integrating these paradigms can support resilient, just, and compassionate health systems that care for both people and the planet.

## Person-Centered Practice in Portugal: Insights from the Macro Context of the Healthcare System [PCC097]

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Background: The growing recognition of person-centered practice as a central element of health systems worldwide is driving reforms and reorienting public health policies. However, its integration into daily clinical practice remains complex and uneven. The Person-Centered Practice

Framework underscores the macro context as crucial for sustainability, encompassing the political, structural, and strategic conditions that shape healthcare. Objective: To describe how person-centered practice is outlined in the macro context of the Portuguese healthcare system. Methods: A qualitative, descriptive, and retrospective documentary analysis study was conducted. Documents were retrieved from the official websites of entities responsible for the definition, orientation, and regulation of healthcare in Portugal. The textual analysis was guided by the theoretical conception of the Person-Centered Practice Framework regarding the macro context domain and was conducted using IRAMUTEQ software. Results: The lexicometric analysis allowed the emergence of two thematic clusters, integrating the respective classes: Structural and organizational determinants of person-centered practice, comprised the classes: Systemic vision and integrated response; Organizational culture and participation; Digital transformation and information management; and Political vision and governance structures; and Operationalization of person-centered practice, was represented by the class Care approach, given its thematic specificity. Factorial analysis revealed distinct and weakly connected discursive patterns, associated with different system levels. Similarity analysis identified a central focus on the health–care–person triad, connected with service organization, care integration, and person participation, although with dispersed terminology suggesting a misalignment between policy and practice levels. Conclusions: The Portuguese macro-level discourse demonstrates significant progress in positioning person-centered practice as a political and strategic priority, reflected in commitments to humanized care, health literacy, digitalization, and Integrated Care Pathways. Nevertheless, the absence of structured educational guidelines, the persistence of biomedical dominance, and the lack of evaluation mechanisms sensitive to care experiences continue to restrict translation into practice.

# Bridging the gap: collaboration between local care entrepreneurs and a long-term care organization [PCC098]

*Danaé M.L. Smeets[1, 2], Jill Schneiders-Bindels[3], Bram de Boer[1, 2], Patrick Vermeulen[4], Daisy J.A. Janssen[1, 2, 3] & Hilde Verbeek[1, 2]*

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Background: Long-term care (LTC) organizations are under pressure as ageing populations increase demand while workforce availability declines1. There is an increased need for integrated approaches that focus on participation of formal and informal networks1,2,3. One initiative emerging in the Netherlands is the Powered by concept, in which a LTC organization collaborates with local care entrepreneurs to facilitate them in providing accessible, high-quality and personalized care to older people within their own community. Aim: This study aims to describe the Powered by concept and define its physical, social and organizational components. Methods: An exploratory-descriptive qualitative design was utilized, combining document and website analysis, interviews with organizational stakeholders, and a focus group with care entrepreneurs. Data were analyzed iteratively and triangulated across sources. Findings: The Powered by concept includes 25 care arrangements, mostly offering residential care (n=20). In physical and social environments, much variation could be noted across care arrangements, indicating freedom in shaping these environments. In the organizational environment, key components of both parties and their collaboration were identified. A complementary partnership, based on mutual trust and a shared passion for care and well-being, is indicated. Key

components of the LTC organization include: system-level expertise and resources, fluidity in control, and adaptability. Key components of care entrepreneurs include local embeddedness, intrinsic motivation, reflectivity, and entrepreneurial drive. Conclusion: The Powered by concept is an alternative way of organizing LTC for older persons. It facilitates a dynamic collaboration between centralized expertise and locally rooted entrepreneurship, allowing for high-quality care delivery tailored to the community.

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## Organisational and environmental support for person-centred care are associated with lower stress of conscience among health and social care staff [PCC099]

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Background: Stress of conscience is prevalent among health and social care staff and associated with factors such as burnout, intent to leave, reduced job satisfaction and quality of care. One approach proposed to potentially reduce stress of conscience is person-centred care (PCC), but there are few studies with large sample sizes and persons of various health and social care occupational groups. Aim: The aim of the study was to assess the association of perceived PCC with stress of conscience among health and social care professionals in hospital and municipal care settings. Methods: This newly published cross-sectional study is based on a web survey sent to 11,554 hospital and municipal care staff in western Sweden, yielding 1671 responses (1). To measure the exposure variable, the Person-Centred Care Assessment Tool (P-CAT) was used, including its subscales 'Extent of Personalising Care' and 'Organisational and Environmental Support'. The Stress of Conscience Questionnaire was used to measure the outcome variable. Bivariate correlations were calculated, and multivariate linear regression analyses were executed. Results: Health and social care staff who reported lower levels of stress of conscience also reported significantly higher levels in the total P-CAT score (B = −1.16), and the Extent of Personalising Care subscale (B = −0.8). The strongest association with stress of conscience was identified in the Organisational and Environmental Support subscale (B = −3.14). Conclusions: The results indicate that organisational and work environmental factors could be of importance for lower stress of conscience. Supportive efforts in factors such as staffing, funding, and training from senior management and first-line managers, and conducive psychosocial

work environments could be enablers for applying PCC and reducing stress of conscience. However, longitudinal research is needed to better determine the causal relationship.

Reference: Gustavsson K, et al. (2025). BMC Health Services Research. https://doi.org/10.1186/s12913-025-13077-x

# Poster Session 1

## Digitalisation & eHealth

### Moving Forward: Embedding Person-Centred Care at the Core of Operations in Long-Term Care [A001]

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Background: Person-Centred Care (PCC) remains a critical challenge for long-term care (LTC) providers. Translating PCC principles into routine practice requires systemic strategies and innovative approaches. This pilot study explores an integrated implementation pathway combining blended training, structured follow-up, digital tools, and a new procedural framework—the Life Project Support Plan (LPSP)—within Spain's largest LTC provider (DomusVi). Methods: A quasi-experimental pilot study involved 233 healthcare professionals across multiple units, analyzing 640

PCC cases. The intervention included blended learning (face-to-face and online), biweekly coaching, and a portable digital platform to support documentation, alongside co-creation of LPSP with the person at the center of care. Pre- and post-intervention measures assessed PCC practice scores and LPSP adoption using paired t-tests, two-way ANOVA, correlations, and effect sizes. Results: PCC practice improved significantly (Pre = 3.78, Post = 4.03; $t(232) = -3.395$, $p < 0.001$, $d = -0.315$). Technology-enhanced groups showed greater gains ($\eta^2 = 0.063$). LPSP adoption rose sharply (Pre = 0, Post = 13.2; $p < 0.001$, $d = 1.239$). Positive correlations between technology use and LPSP uptake highlight the synergistic effect of digital integration and training. Conclusions: Comprehensive training combined with digital support accelerates PCC implementation and fosters organizational change. This multi-component approach to Person-Centred Care (PCC) in long-term care settings integrates blended professional training, structured follow-up, digital tools, and the co-created Life Project Support Plan (LPSP). By embedding measurable Person-Centred Care practices through co-created LPSP and digital support, this model bridges practice, organization, and governance toward sustainable cultural change. Future research should evaluate long-term impact and cost-effectiveness.

## Exploring Person-Centredness in Technology-Based Gait Rehabilitation after Stroke: A Framework-Based Analysis of a Scoping Review [A002]

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Stroke is a leading cause of disability worldwide, frequently resulting in gait impairments that compromise independence and quality of life. Technological innovations have expanded rehabilitation strategies, but their alignment with person-centred care principles remains unclear. This study explores the extent to which technology-based interventions for gait rehabilitation in stroke survivors reflect the domains of the Person-Centred Practice Framework (PCPF). A scoping review was conducted, guided by Arksey and O'Malley's framework and reported in line with PRISMA-ScR guidelines. A comprehensive search across four databases (MEDLINE, CINAHL, Nursing & Allied Health Collection, and Cochrane Central) retrieved 775 records, of which 22 randomized controlled trials met the inclusion criteria. Interventions were analysed for their alignment with PCPF domains. The review identified six categories of technology-based interventions: auditory stimulation, visual and multisensory feedback, electrical stimulation, robotic-assisted gait training, stabilization training, and vibration therapy. Evidence of person-centredness was most apparent in the Person-Centred Processes domain, where interventions incorporated individualised adjustments, feedback mechanisms, and motivational strategies. Outcomes such as gait performance, balance, autonomy, and quality of life were also reported, though inconsistently. Professional competence reflected the Prerequisites domain, while aspects of The Practice Environment were occasionally described through specialised settings and equipment. However, no study explicitly addressed the Macro Context domain, and relational or organisational dimensions of care were rarely considered. In this presentation, we will examine how technology-based gait rehabilitation after stroke demonstrates implicit but inconsistent integration of person-centred principles. We will show how personalisation often emerged as a functional necessity rather than a deliberate commitment to person-centredness and discuss how adopting the PCPF prospectively as a

design and evaluation framework can ensure that technological innovation enhances both functional recovery and positive outcomes for all actors involved.

## AI-based tool for healthcare professional training in person-centred conversations [A003]

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Background: Conversations between patients and healthcare professionals is fundamental to person-centred care. This approach requires healthcare professionals to be skilled in active listening and able to adapt to both the clinical setting and the individual needs of the conversation partner. However, there is a lack of specific training opportunities in person-centred conversations. Artificial intelligence (AI) offers new opportunities for realistic scenario-based training with individualized performance feedback. An AI-based tool for training person-centred conversation targeting healthcare professionals is currently under development within an innovation project. An interdisciplinary team conducts research on the development as well as explores the relevance and usability of the tool. The

focus of this presentation is the co-design and iterative evaluation of this AI-based training tool. Method: The design and evaluation follows the ADDIE model for instructional design and The UK Medical Research Council's structured framework for developing and evaluating complex interventions, comprising three phases: development of realistic patient cases and AI-generated feedback; usability testing; and evaluation of effect. Tool development is user-centred and conducted in collaboration between tech developers, researchers, healthcare professionals and patient representatives from three care settings. This presentation will focus on the first two phases. Results: Fifteen patient cases have been developed, aimed at conversations in primary health care, psychiatric care, and palliative care settings. Initial testing with healthcare professionals and patient representatives indicates that the patient cases are perceived as authentic and realistic. However, refinements are needed, including adjustments in complexity and sequencing. This presentation will highlight the development process and preliminary findings from the usability testing phase. Conclusion: AI-based communication training shows promise in meeting the need for realistic training opportunities in healthcare. The tool has the potential to enable safe practice of difficult conversations.

## Clarity, Autonomy, and Guidance in Internet-Based Pain Interventions: A Reflexive Thematic Analysis of Participants Learning Experiences [A004]

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Background: Internet-based interventions are increasingly used for chronic pain and migraine, yet little is known about how different forms of content shape participants' engagement, understanding, and learning. Even though patients are the main agents of change in digital treatment, few studies have examined differences between explicit, psychoeducational formats and experiential, metaphor-rich approaches in terms of their impact on engagement and learning. Understanding more about the content and learning processes may help optimise design and delivery, and improve relevance, adherence, and outcomes. Aim: This study explored how participants learned and engaged in two internet-based pain interventions, and how content and format shaped these experiences: one self-guided psychoeducational program for chronic pain and one therapist-supported CBT/ACT program for migraine. Method: Fourteen participants (self-guided: n = 8; therapist-supported: n = 6) were interviewed. Data were analysed using reflexive thematic analysis within a critical realist framework. Results: Two overarching themes were developed. The first concerned the importance of clarity: explicit explanations, structure, and visual or metaphorical material helped participants understand, stay motivated, and engage. An experiential sense of clarity, combining explicit understanding with emotional engagement and coherence, appeared relevant. The second theme was the balance between autonomy and guidance. Preferences varied, but participants stressed the need to grasp the rationale and to receive flexible support for sustained involvement. Conclusions: Clarity seems to be central to engagement and learning in digital pain interventions. Combining explicit information with visual and metaphorical material in a flexible, structured framework may strengthen both cognitive and experiential learning, enhance motivation, and support adherence.

# A critical discourse analysis of person-centred dialogues in a remote intervention with and for older persons living with frailty [A005]

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Background: Person-centred care is increasingly recognized as essential in healthcare. Person-centred dialogues are central to this approach, yet little is known about how these discourses are constructed in practice. Aim: To critically analyse how person-centred conversations are constructed and negotiated in remote dialogues between healthcare professionals and older persons living with frailty. Method: A total of 18 person-centred dialogues between healthcare professionals and four older persons living with frailty, who had participated in the IHOPe randomised controlled trial were selected [1]. The intervention was a remote person-centred intervention via telephone conversations and a digital platform. A critical discourse analysis was conducted on approximately 10 hours transcribed dialogues using Fairclough's three-dimensional model [2]. Results: Three themes were formulated: (1) Patient-driven narratives of constant struggle with bodily limitations and inaccessible care; (2) Healthcare professionals' strategies to apply person-centred ethics through active listening, affirmation, and co-creation; (3) Tensions and structural barriers that hinder full realization of person-centred ethics, including digital exclusion and responsibility shifts. Conclusion: Person-centred dialogues are necessary but insufficient without organizational and policy-level reforms to ensure equity and continuity in care for older persons living with frailty. Points for discussion: How is person-centred care constructed and negotiated in remote dialogues with older persons living with frailty? What opportunities and barriers arise in the

application of person-centred ethics in these dialogues? In what way does societal structures influence person-centred dialogues?

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## The interpersonal patient–nurse relationship as experienced by remotely monitored patients [A006]

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Aim: The aim with this review was to map what has been published on patients' experiences of the patient–nurse relationship, in a remote patient monitoring setting. Background: In person-centered care interpersonal relationships are considered a foundation. As remote patient monitoring is increasing within healthcare there are potential relational impacts to be considered. However, there is limited knowledge on patients' experiences of the patient–nurse relationship during remote monitoring. Method: A scoping

review was conducted, including searches in four databases. During the initial screening, 9,001 abstracts were reviewed. A total of 31 studies were finally included in the review, representing four continents. A thematic analysis was performed, resulting in three main clusters with underlying themes. Results: The results showed that generally, remote monitored patients had a positive experience of the patient–nurse relationship. An active and present nurse facilitated this and made the patients feel safe, supported and recognised. Responsibility was perceived as something being shared between the patient and the nurse, making them a team. However, there were also some negative experiences, such as dependency on the caregiver, lacking guidance and even feeling lonely. In addition, ending the monitoring could bring stress to some patients. Conclusion: Even though remote patient monitoring is based on technology, it is most definitely an activity dependent on the human-to-human relationship. Remote monitoring can be person-centered, if delivered with consideration. Health care professionals and organizations should be aware of how to integrate person-centered care within remote patient monitoring, but also how remote monitoring itself can benefit person-centered care.

## Supporting person-centred chronic pain care: Co-designing a digital self-monitoring tool PAS-SAP (My Pain Survey- for Support and Partnership) [A007]

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Background: Chronic pain affects approximately 20 % of Europe's population and has major individual and societal consequences, including reduced quality of life, psychological distress, and long-term sick leave. Effective management requires a person-centred care approach. Digital tools can play an important role in supporting person-centred communication about the impact of chronic pain on daily life between healthcare professionals and patients. Aim: To develop and feasibility test a digital self-monitoring tool for chronic pain from the patient and healthcare professional perspective. Methods: "PAS SAP" is a research and innovation project conducted at the Specialist Pain Clinic, Department of Anaesthesiology, Intensive Care Medicine and Pain Medicine, Sahlgrenska University Hospital, since 2022. Using a co-design approach, patients and healthcare professionals have participated in interviews, focus groups, and workshops to identify communication needs in chronic pain care. A self-monitoring tool, integrated into the regional IT healthcare architecture, was co-developed in 2024–2025. The tool features questions on pain, stress, sleep, physical activity, and medication use selected in partnership as per patient need. Self-monitoring data entered by patients are visualised for healthcare staff to support dialogue and shared treatment planning. The feasibility study will be conducted at the Specialist Pain Clinic, and in primary care (autumn 2025–December 2026). The feasibility study will explore usability, acceptance, and perceived value among patients and clinicians, with a focus on communication, engagement, and person-centred care processes through interviews, focus groups and quantitative data collections. Findings will guide a decision for a potential regional scale-up across all care levels and adult patient groups. Expected results: Through participatory development and digital innovation, this project aims to strengthen person-centred pain management by enhancing mutual understanding, supporting shared decision-making, and promoting continuity of care as data can be shared across care levels. Preliminary results of the feasibility study will be presented.

# The therapeutic alliance in Internet-Delivered CBT for Non-Cardiac Chest Pain: A Qualitative Interview Study [A008]

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Background: Non-cardiac chest pain (NCCP) is common, disabling and costly, yet patients often report feeling dismissed and receive little support. Internet-delivered cognitive behavioural therapy (iCBT) can increase access to care, but little is known about how a therapeutic alliance (TA) is formed when contact is text-based and focused on reinterpreting bodily sensations. Aim: To explore how participants in an iCBT programme for NCCP experienced the TA, and how these accounts align with or challenge established models. Methods: This qualitative study was embedded in a randomised controlled trial of an 8-week iCBT programme targeting cardiac anxiety in NCCP. Twenty-two participants who completed the programme were interviewed using a semi-structured, theory-driven guide based on research on digital alliance. Audio was transcribed and analysed with reflexive thematic analysis, using a deductive, latent approach. Results: Participants described a helpful alliance, experienced as a negotiated process rather than a static quality. Three themes were generated. (1) Agreement on goals and tasks involved "recognising utility" in the programme and balancing personal relevance with sufficient challenge, with the therapist scaffolding this process. (2) The emotional bond centred on the therapist as a "human professional" who combined warmth with structure, responded promptly, and flexibly adjusted tone and intimacy to preferences, including repairing strains in the relationship. (3) Acceptability of the digital medium encompassed modality, platform and content. When these were perceived as secure and trustworthy and, they receded into the background, while a skilled therapist could compensate for shortcomings. Conclusions: The TA in iCBT for NCCP is best understood as a negotiated process in which therapists

bridge limitations of digital delivery and support patients' agency in relation to distressing bodily symptoms. Participants' accounts underline the importance of attending not only to goals, tasks and bonds, but also to the acceptability of the digital medium when designing online care.

## Inclusive AI Avatars for Preventive Health Dialogues in a Superdiverse Primary Care Context [A009]

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Digital healthcare is becoming the daily norm, from booking visits to engaging in e-health services, with new initiatives being conceptualized continuously. While digitalisation may improve accessibility, reduce waiting times, and optimize care, it also risks deepening existing healthcare inequalities and reinforcing stereotypes if solutions are not designed with diversity and inclusion in mind. This is particularly important in a time of global superdiversity, where person-centred care requires meeting people where they are: personally, but also linguistically and culturally. Digital tools can help bridge these gaps, and the responsibility for overcoming language and cultural barriers cannot rest solely on individuals. This multidisciplinary project, grounded in diversity, equity, and inclusion (DEI) explores how generative AI avatars could support preventive health dialogues in Swedish primary care, through the overarching research question: In which situations might individuals prefer a conversation with an AI avatar rather than with a human healthcare professional, and why? Embedded in this are further questions about trust, multilingualism, intercultural communication, and what "person-centered" truly means in digital care. Focus is placed on user perspectives on communication and the multimodality of embodied conversational agents; how they speak, move, and gesture; and how these design choices can be made culturally sensitive, norm-aware, and linguistically accessible to a superdiverse population. Taken together, the project examines how technology could strengthen person-centered care by

enabling more tailored, supportive, and empowering conversations. We hope that this work can contribute to digital care solutions that support accessibility, participation, and trust, through providing DEI-based recommendations for future preventive health interventions. Expected outcomes include guidelines for culturally inclusive communication and encounters, and strategies to reduce digital exclusion, aiming to help shape a digital future where care feels personal, respectful, and reachable for everyone, thus contributing to a more sustainable, equitable primary care system.

## "It Just Hangs There": Smart Sensor Technology and the Missing Dialogue in Nursing Homes [A010]

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This poster presents findings from a case study examining how a smart sensor system shaped everyday care in a Dutch nursing home. The study took place in a small-scale ward for 32 residents with psychogeriatric conditions. In each apartment, a ceiling-mounted sensor with a camera-based contour recognition function was installed. When certain movement patterns occur (e.g., getting out of bed, possible falls), the system sends alerts and a live video feed to staff phones, enabling them to assess situations at a distance and reduce unnecessary room checks, contributing to a calmer environment. Observations, interviews and a focus group were thematically analyzed into a narrative that provides an insight into an ordinary day on the ward, showing how the sensor influenced everyday care decisions. While the sensor was often valued by staff for providing oversight and helping to prioritize care, one resident expressed discomfort by saying: "I'm still independent; I just don't want that camera turned on." For a health care worker however, the sensor had come to feel like an ordinary part of the care environment: "It's like a pink wall. The wall is pink, so the sensor is just part

of the room." These examples show that the sensor could be experienced as supportive, intrusive, and routine, depending on personal needs and values. Yet these differences were not always discussed together. Opportunities for shared decision-making about whether, when, and how the sensor should be used were limited. Staff also explained that the sensor requires a period of baseline learning to recognize individual movement patterns, and the current system makes it difficult to adjust settings per resident, which restricts the possibility of tailoring use to personal preferences. These findings highlight the need for clearer dialogue and organizational support to strengthen shared decision-making in the implementation of smart sensor systems.

## Exploring Person-Centred Care in Video Consultations: Experiences of Swedish Dietitians and Their Patients During the COVID-19 Pandemic [A011]

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Background: The COVID-19 pandemic prompted a rapid shift in healthcare delivery, with video consultations (VCs) becoming a widely adopted alternative to face-to-face interactions. While VCs offered a safe and accessible solution, their impact on the quality and personalization of care remains underexplored, particularly in dietetic practice. This study investigates how Swedish Registered Dietitians (RDs) and their patients experienced and perceived VCs, with a specific focus on person-centred care. Methods: A mixed-methods study was conducted between 2021 and 2023, involving surveys, semi-structured interviews, and observational data from clinical settings. Participants included Swedish RDs and patients who had engaged in VCs. Quantitative data were analysed using descriptive statistics, while qualitative data were examined

through thematic analysis to identify recurring patterns related to the use and perceptions of VCs and their influence on care relationships, communication, and care quality. Results: VCs were generally perceived as contributing to good and close healthcare, offering flexibility, accessibility, and continuity during uncertain times. However, the choice of consultation modality was often made by the RDs, with limited patient involvement. While RDs consistently acted in the patients' best interest, they did not always actively seek or incorporate individual preferences or perceptions into the consultation process. Patients appreciated the option of choosing VCs when it aligned with their needs and the consultation agenda. These findings reveal a gap between professional intentions and the practical realisation of person-centred care in remote settings. Conclusion: To enhance the quality of remote dietetic care, healthcare providers must prioritise individual considerations and foster shared decision-making. Enabling patients to choose their consultation modality—whether face-to-face or video—can be viewed as an initial and essential step toward person-centred care, even before treatment begins.

## Why do managers of care facilities use humanoid robots in elderly care? A qualitative analysis in Germany [A012]

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The use of humanoid robots in inpatient care facilities is increasingly being discussed - both in principle as a technical innovation and regarding structural challenges of elderly care and the acceptance of the people involved. The aim of this research is to investigate the reasons that guide the decisions of German institution managers, as representatives of middle management, regarding the acquisition and use of humanoid robots. Based on 23 qualitatively evaluated media articles, possible motives were identified using content analysis and integrated into an interview guide. With the help of this guide and in order to take into account the missing scientific basis of the articles, semi-structured interviews were conducted with three managers

of facilities that already work with humanoid robots in their inpatient care facilities. This was followed by another qualitative evaluation using a content analysis approach. The resulting category system distinguishes between three superordinate categories — strategic-organizational, practical-functional, and symbolic motives — which comprise four, six, and two subcategories, respectively. Overall, the results show that the decisions of institution managers as representatives of middle management are shaped by various framework conditions, including both active strategic objectives and structural requirements. The functions of the robot play just as much a role as hoped-for reduction in workload or symbolic effects. The research contributes to a better understanding of the introduction of humanoid robots in the inpatient care sector and the underlying decisions. It also illustrates the central role of middle management and structural framework conditions for the implication of new technologies in inpatient care facilities in Germany. (This work is based on the author's master's thesis, which was submitted to Koblenz University of Applied Sciences in 2025.)

## Person-centred virtual care: A digital homecare team and care users' experiences of video visits [A013]

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This paper examines how increased digitalisation and welfare technologies impact person-centred care. In 2023, a Swedish municipality introduced video visits for home care users, but its implications for person-centred care remain unclear. On the one hand, video visits have been described as a way for health-care organisations and municipalities to increase time and cost efficiency, and concerns have been raised regarding whether the quality of care is being compromised. On the other hand, video visits have been described as having the potential to both facilitate and strengthen person-centred care and hence increase the quality of care. The concept of person-centred virtual care is used to highlight the special conditions for practicing person-centred care via video visits. Person-centred virtual care refers to adapting person-centred practices for video visits. This paper examines a digital homecare team (first-line

managers, coordinators, development manager, system technician, and care staff) and care users' experiences of video visits. It is based on 48 qualitative interviews, conducted from June 2023 to January 2025. As part of a pilot project, the digital home care team explored which home care services could be delivered via tablet, such as medication reminders, checking before and after showering or walking, wellness checks, and short conversations about how they are doing and their plans for the day. Over time, offerings expanded to include online grocery shopping, online group talks, and online group exercise. It was optional to try video visits, and early care users helped to both refine and promote the digital home care. It is not possible to perform practical tasks via tablets, such as doing the dishes. The result shows that this 'limitation' makes it easier for care staff to focus on the care user, and they tend to get the role of supporting and encouraging care users to perform tasks independently.

## Nurses' Expectation of Artificial Intelligence to Analyse Patient Stories to Improve Person-centred Nursing: A Qualitative Study [A014]

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Background: In previous work, eight Key Performance Indicators (KPIs) and an associated measurement framework were developed to provide a new perspective on nursing quality. Patient stories are one of four tools used to generate data to evidence the KPIs. To streamline data collection, the iMPAKT app was developed, which automatically transcribes the stories, with nurses manually analysing the stories to identify which KPIs are present. This process is time-consuming, and there is potential to automate it using Artificial Intelligence (AI). Aims: The aim of this study was to explore the potential of AI to capture patient experience through stories, applied directly

to the iMPAKT app. Methods: In this qualitative study, data were collected in focus groups with nurses with either expertise in informatics or working with patients to identify criteria for an AI model capable of semantic search and text mining in collaboration with users. Data from the focus groups were analysed using reflexive thematic analysis. Results: Five themes and four principles were identified. Participants emphasised the importance of enabling all patients to participate in data collection, while ensuring the solution is user-friendly and considers patient needs. Although participants expressed trust in AI and a desire for a high-level of automation, they stressed the importance of maintaining a human-in-the-loop approach, involving both nurses and patients. Ethical considerations, such as anonymising stories and obtaining informed consent, were highlighted to safeguard patient safety and foster a psychologically safe work environment. Participants also discussed the potential for AI to identify disturbing incidents within stories, while recognising associated organisational responsibilities. Conclusions: The findings demonstrate a clear intention to develop an inclusive, AI-driven system that removes barriers to patient engagement and highlights the potential for nurses to contribute significantly to AI development. Ethical responsibilities surrounding AI development remain critical, as AI presents opportunities and challenges.

## Leveraging Natural Language Processing to Identify Information Gaps and Common Challenges in Online Cancer Forums [A015]

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Background: Patient-centered cancer care requires a clear understanding of what patients and caregivers find most confusing, frightening, or difficult, many of which may remained unnoticed in clinic visits because of time pressure, stigma, or uncertainty. Online cancer forums offer a space where

people can describe their experiences more freely. By analyzing these posts, we can uncover explicit questions and "latent" informational needs for future supportive resources development. Methods: We conducted a content analysis of posts from the r/cancer subreddit (August–November 2025). OpenMed disease NER was used to identified posts with a specific cancer diagnosis and grouped them into broader cancer categories, focusing on the three most frequently mentioned cancers. A rule-based pipeline applied regular expressions and keyword lists to identify challenges in seven core domains and parallel information-need themes. Posts were coded as having explicit information needs if they contained question marks or advice-seeking phrases. Results: Among 1006 posts with an assigned cancer diagnosis, 397 concerned lymphoma, breast, or colorectal cancer. Diagnostic and staging challenges were common across these cancers (76.7%, 84.8%, and 87.1%), followed by treatment decision/burden challenges (64.7%, 59.8%, and 78.0%) and side-effect/symptom challenges (33.1%, 35.6%, and 37.1%). Overall, 71% of posts contained at least one explicit information need, yet theme-specific information seeking was lower than the corresponding challenge burden. Diagnostic/staging questions appeared in 28.6%, 39.4%, and 56.1% of lymphoma, breast, and colorectal posts, treatment decision questions in only 2.3%, 1.5%, and 6.1%, and side-effect management questions in a small minority of posts despite frequent reporting of side-effect burden. Conclusions: Even when patients and caregivers do not explicitly ask for information, their posts describe confusion and distress about diagnosis, staging, treatment choices, and side-effect management. These findings highlight informational needs and underscore the importance of patient-centered communication to address common challenges outside the clinic.

## Can perceptions of physical activity be a key in lifestyle-related diseases? [A016]

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Swedish healthcare and national strategies advocate person-centred care (PCC), emphasising partnership and individualised communication. For lifestyle-related diseases such as knee osteoarthritis, physical activity is a cornerstone of treatment. Yet, how patients perceive physical activity remains underexplored, despite its potential impact on adherence and outcomes. This study applies a phenomenographic approach to examine perceptions of physical activity among 20 participants in a digital osteoarthritis programme. Interviews explored how patients define physical activity and assess their own activity levels. Data analysis is ongoing, and full results will be presented at the conference. Preliminary findings indicate diverse perceptions, with most participants associating physical activity primarily with exertion and strenuous exercise. This contrasts with scientific definitions, which often include all bodily movements resulting in energy consumption or any daily activity. The discrepancy may result in misunderstandings and affect how patients respond to advice and create barriers to effective self-management. Such discrepancies, underscoring the need for tailored communication that aligns with individual understanding. Understanding these different perceptions of physical activity is critical for implementing PCC in practice. Tailored communication strategies that reflect patients' perceptions could enhance engagement and improve outcomes. These results will inform future research and policy initiatives aimed at integrating PCC principles into digital health interventions for lifestyle-related conditions.

# Digitalisation in Home Nursing Project: Strengthening Person-Centred Care [A017]

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Digitalisation will transform home nursing services, offering new ways to support patients and improve the quality of care. This project will examine how technology will strengthen person-centred nursing without replacing the essential human aspects of care. While digital tools will enhance efficiency, accessibility, and communication, they will need to complement - not supplant - the physical presence, empathy, and relational dimensions that will continue to define nursing practice. Person-centred care will be understood as seeing the whole person and recognising individual needs, preferences, and life context. The integration of welfare technology, digital communication tools, and assistive devices will improve continuity, safety, and patient autonomy when applied in a holistic and ethical manner. However, increasing reliance on technology will raise important questions about how digital solutions will affect the nurse – patient relationship, physical touch, and the sense of connection that underpins quality care. This study will investigate nurses' experiences of digitalisation in home nursing and how they will balance technological use with compassionate, hands-on care. Using a mixed-methods design, it will explore the opportunities and challenges associated with digital tools, the competencies that will be required for their effective use, and how person-centred values will guide the digital transformation of municipal health services. The findings will contribute to developing sustainable, ethical, and person-centred digital practices in home care — where technology will support, rather than replace, human care and physical presence. The project will demonstrate that digitalisation and person-centred nursing are not opposing forces, but complementary elements of high -quality, future - oriented healthcare.

# Person-Centred Prediction of Illness Experience Through Symptom Clusters: The Digital Person Project Protocol [A018]

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Background: People undergoing systemic cancer therapy frequently experience multiple interconnected symptoms that shape day-to-day functioning and quality of life (QoL). The Symptom Science Model 2.0 positions symptom clusters as complex phenotypes that can support anticipatory, person-centred care when integrated with organisational processes and clinical decision-making. However, current practices rarely link symptom-cluster insights to care pathways or governance structures in routine oncology services. Objectives: This three-phase funded programme aims to: (i) synthesise evidence on symptom-cluster patterns during active cancer treatment; (ii) develop and validate a short-term predictive model of QoL decrease using longitudinal electronic patient-reported outcomes (ePROs) and cluster-based features; and (iii) co-design and prepare the organisational integration of multidisciplinary, cluster-focused needs assessment and management. Methods: Phase I is a scoping review following PRISMA-ScR. Phase II uses retrospective, de-identified electronic patient-reported outcomes and electronic health record data from adults receiving outpatient cancer treatment. These include sociodemographic and clinical characteristics, treatment information, and repeated reports of symptoms and quality of life. Symptom clusters will be identified by examining how symptoms co-occur over time, and early changes in these patterns will be used to predict short-term quality-of-life decline within a treatment cycle (≈7–28 days). A silent-mode pilot will assess how the predictive model fits routine practice without influencing care. Phase III consists of co-design

workshops with nurses, oncologists, and people undergoing treatment to translate the model into cluster-focused assessment and care processes aligned with existing outpatient workflows and organisational structures. Discussion: Digital Person bridges practice, organisation, and governance by linking lived illness experience to interpretable digital phenotypes and embedding these into service-level decision processes. The project advances precision health within a person-centred paradigm by supporting anticipatory, nurse-led multidisciplinary responses to evolving symptom burden. Outcomes will contribute to integrated oncology pathways that align technological innovation with ethical, organisational, and experiential dimensions of care.

## Patients' perspectives on person-centered participation in remote patient monitoring [A019]

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Introduction: Person-centred care is increasingly recognized as vital for ensuring high quality outcomes, especially for individuals with long-term conditions. Digital health solutions, such as remote patient monitoring (RPM) are often promoted for their potential to support person-centeredness. However, there remains a knowledge gap as for whether and how RPM facilitates person-centered patient participation, and the mechanisms involved. This study investigated whether and how patients associated RPM with their participation in health and healthcare within primary healthcare. Methods: In this qualitative study, 12 patients with asthma or hypertension who had utilized RPM shared their experiences of RPM and their participation in health and healthcare. Results: RPM could facilitate communication, and foster a mutual relationship with healthcare professionals, thus reinforcing patient participation. Patients emphasized

that the relationship and communication with healthcare professionals was key for experiencing participation. While the RPM was a tool for managing self-care, it was more often perceived by the patients as a way to facilitate healthcare staff, rather than directly benefiting the patient's own health. Patients primarily used to report symptoms and measures, delegating decision-making for further actions to healthcare professionals. Conclusion: RPM can influence patients care and treatment, though they may not view this as participation. Simply providing access to RPM does not guarantee improved patient participation. To fully realize the potential of RPM for enhancing health outcomes, it is essential to explore how it can better support person-centered participation.

# Patient & Public Involvement

## Person-Centred Culture in a Swiss Cancer Outpatient Clinic: A Participatory Inquiry [A020]

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Background: Persons undergoing cancer treatment spend a lot of their time in cancer outpatient clinics. It is important that they feel safe and comfortable during their visits. A person-centred culture proofs to be beneficial for service users' and healthcare professionals' well-being. Aims: The aims of this doctoral research were to assess the current workplace culture in relation to person-centred practice at the Cancer Outpatient Clinic, develop a shared understanding of person-centred culture and identify areas of practice to further develop to enhance the person-centred culture. Methods: The research was a multi-method participatory inquiry following principles of person-centred research. It took place in the Cancer Outpatient Clinic of the City Hospital Zürich, Switzerland. Ethical approval was obtained by the respective ethic committees. Healthcare professionals and service users

from the Cancer Outpatient Clinic of the City Hospital Zürich, site Triemli participated as co-researchers in data collection and analysis. The current workplace culture and what matters most to service users when they stay in the outpatient clinic have been assessed using workplace observation and conversational interviews. In creative workshops and critical dialogues, co-researchers were invited to explore what person-centredness means to them and to identify areas of action to enhance and promote person-centred practice. To ensure rigour, reflexive methods were used. Findings: The assessment of the current workplace culture revealed that a person-centred culture is present. To further develop it, it is crucial to sustain the attributes of the co-researchers' shared understanding of a person-centred culture which are offering a comprehensive, individual and empathic care, appreciation, mutual respect and competence. Conclusion: Exploring person-centredness together with the ones affected by it, was a valuable experience for all involved. The challenge now would be to preserve and promote what we have created.

## There is a lot of heart in it: a qualitative inquiry exploring what matters most to service users when they stay in the cancer outpatient clinic [A021]

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Background: Persons diagnosed with cancer spend a lot of their time in cancer outpatient clinics. It is important that they feel welcomed, safe and secure. There is much known about symptom management and patient reported outcomes related to cancer therapies. But little is known about what matters most to service users when they stay in the cancer outpatient clinic and how they experience their stays. However, this insight would be helpful in promoting person-centred care and offers valuable information to describe the current workplace culture. Aim: This inquiry, which is part of a

participatory PhD research about person-centred culture in a Swiss cancer outpatient clinic, aimed to explore these questions using conversational interviews. Methods: Nine service users undergoing cancer treatment participated in the conversational interviews. The interviews were analysed by the lead researcher and the co-researchers (healthcare professionals and service users) enrolled in the PhD research in a participatory way, using a hermeneutic approach and critical dialogues. Findings: There is not "the one thing" that matters most to the service users when they stay in the cancer outpatient clinic. For most of the service users, staying in the cancer outpatient clinic is a good and appreciative experience. Feeling safe and secure, being perceived as person and the healthcare professionals' competence stands out. However, some of the participants perceived communication and organisational aspects as challenging. The positive experiences were confirmed by the service user co-researchers. Both experience and what matters most might correlate with personal strategies of coping with the illness. Conclusion: Conversational interviews help gaining in-depth insights in how the care is experienced. Adding critical dialogues amongst the co-researchers to the hermeneutic analysis process offers another twist in evaluating the findings and shows which additional factors influence the service users' experiences in outpatient cancer care.

## Systematic implementation of Patient and Public Involvement (PPI) at the University of Gothenburg's Centre for Person-Centred Care (GPCC) [A022]

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Background: International declarations have long called for strengthening democratic and ethical values in healthcare and research, while grassroot public movements have reinforced these. Consequently, research funders increased requirements for PPI, and in 2024 WHO adopted a resolution on social participation, creating even stronger incentives for systematic PPI. However, political shifts and resource constraints complicate implementation, underscoring the need to embed PPI in meaningful ways and assess how it brings value. PPI implementation at GPCC: GPCC began implementing PPI shortly after its launch with a patient (HH) joining GPCC's steering group. In 2016, a Person Council was established to facilitate further dialogue with patients and family carers. In 2021, a patient with research background (JB) was recruited, later added to the steering group, and tasked with strengthening PPI implementation. An internal survey identified challenges including compensation, recruitment and sustained engagement, unclear roles, and time constraints. In response, a PPI policy was co-developed with administrative staff, patients, and researchers. Preparatory work included contacting HR departments at 19 other Swedish state universities. None reported comparable routines; one was exploring the issue, and several expressed interest. The GPCC PPI policy specifies role descriptions, agreements, compensation aligned with national guidelines, insurance coverage, and clear ways to monitor progress. GPCC researchers can also apply for supplementary PPI funding. JB offers drop-in support for GU researchers and PPI contributors seeking advice. Discussion: Inclusion in decision-making and institutional policies are first steps in resolving barriers. However, evidence on the effectiveness of PPI remains inconclusive due to inconsistent definitions and reporting, while evidence on cost-efficiency is sparse [1,2]. GPCC therefore combines implementation with research into both the potential and limitations of PPI, contributing to a more evidence-informed understanding of its role.

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# Rethinking Representativeness in Patient and Public Involvement: A Small-World Network Hypothesis [A023]

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Background: A persistent challenge in patient and public involvement (PPI) is the representativeness of PPI contributors. Maguire & Britten (2017) identified multiple co-existing and often conflicting understandings of what it means to "represent" others [1]. Patient organisations often face tensions between democratic legitimacy and practical constraints in acting as representatives [2]. Guidance on representativeness emphasises that demographic mirroring is rarely achievable or appropriate [3]. Aim: To propose a small-world network hypothesis that offers an alternative, scientifically grounded understanding of representativeness in PPI. Hypothesis: The representational value of PPI contributors can be derived primarily from their structural position and relational connectivity within health, social and community networks, not from demographic proportionality. Small-world network research shows that a limited number of well-positioned bridging nodes can efficiently connect diverse clusters and enable broad informational flow across a system [4,5]. Implications for PPI Practice: Experienced PPI contributors frequently occupy such bridging roles, drawing on informational flow of lived experiences from a variety of clinical and social care settings as well as from support networks with diverse demographics. Assessing representativeness through relational and structural diversity may therefore be surprisingly more effective than relying on demographic matching alone. Conclusion: A small-world network perspective offers a testable and conceptually coherent reframing of

representativeness in PPI. It clarifies who can legitimately contribute and why, opening new directions for empirical research and practical guidance.

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## Exploring Key Themes of Patient and Public Involvement (PPI) in Swedish Health Research Documents [A024]

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Introduction: Patient and Public Involvement (PPI) has become an important part of health research, yet the existence of many different frameworks and terms, combined with a lack of consensus, has led to uneven implementation. In Sweden, there are currently no national guidelines for PPI in health research, and the lack of common guidance may lead to inconsistencies in practices and tokenistic PPI. Aim and methods: This study aimed to create an overview of key themes in PPI-related documents created by actors that govern, finance and influence the process of health research in Sweden, with the goal of identifying similarities and differences, as this may support the development of national guidelines. A strategic sampling strategy was utilized, and 23 documents were included in the thematic analysis that was conducted. Results: Five themes were identified: the entanglement of culture and structure within PPI, the importance of flexible systematic procedures, laying the foundation for collaboration, the appraisal of knowledge and education and ethical aspects of PPI. Differences included terminology for collaboration and PPI itself, varying emphasis on ethics depending on actors and differing guidelines for financial compensation.

Discussion: These findings may guide future research and contribute to initiatives for national guidelines. The themes demonstrate that despite differences, many shared values and procedures exist, which is promising for creating shared guidance for PPI. At the same time, identified differences highlight the need for flexibility so that guidelines can be adapted to diverse health research contexts. Conclusion: Overall, the results suggest that effective guidelines for PPI in health research should be adaptable to different contexts, include unified yet accommodating terminology and structures, and foster a culture of trust and respect for different types of knowledge.

## Validation Practices in the Clinical Applications of Quality-of-Life Assessments Tools in Palliative Care [A025]

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Quality-of-life (QoL) assessment tools, such as patient-reported outcome measures (PROMs) are increasingly used in palliative care (PC) to reflect patients' voices. Contemporary measurement validity theories suggest that validation practice involves accumulating and synthesizing evidence to support interpretations and actions based on measurement scores. Measurement validity theories have been developed more often for psychometric purposes, including aggregate-level interpretations of scores, in education and psychology. Therefore, a knowledge gap exists for the clinical applications of QoL assessment tools, including in PC. The study aimed to understand how patients and PC professionals enacted validation practice in the clinical applications of QoL assessment tools in PC. Using an interpretive description approach, we observed participants using QoL assessment tools during routine care, and we individually interviewed eight patients living at home with life-threatening illnesses and six PC

professionals. The data were analyzed diffractively to tell parts of a story about validation practice in the clinical applications of QoL assessment tools in PC. Validation practice is not a homogeneous phenomenon. Validation practices can be enacted by the relational use of QoL assessment tools; by focusing on an ongoing reflective dialectical interpretation of the scores with patients; by ascertaining with patients which priorities are most important to them; by skillfully using relevant metaphors to recognize the patient as a person; and by asking further questions to determine the patient's goals of care. As a boundary object with agency, a QoL assessment tool collaborates with people to create practice-based validity evidence. Diffractive analysis of socio-material practices enabled the observation of interference patterns and the consequences of using these tools. Validation practices are important for a person-centred approach to PC. Without a person-centred approach to using QoL assessment tools in PC, professionals risk intervening (or not intervening) based on assumptions rather than justifications.

## Promoting older persons' relationships in a care home: A participatory, action-orientated study [A027]

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Background: Evidence suggests that older people who live in care homes commonly experience feelings of loneliness and social isolation. Older people seek reciprocal relationships with care home staff and peers; however, these types of relationships are rarely realised and there is limited evidence on how to effectively promote these relationships. It was a priority for the care home partner to address issues of loneliness and promote social connectedness in the care home. Aim: This research aimed to promote older persons' relationships in a care home by co-creating an action plan with staff and residents. Methodology: A participatory, action-oriented methodology was used. The methodology was underpinned by John Macmurray's philosophy of friendship and community. Methods: Evidence was collected

through interview conversations with 9 older person residents and critical consciousness raising workshops with 9 staff members. The interviews and critical consciousness raising workshops encouraged care home staff and residents to become aware of the relational needs of older persons' and propose actions that could improve their relationships. The evidence was analysed using a participatory method with co-researchers and an action plan was co-created from the evidence. Findings: Participatory analysis revealed key themes and issues affecting older persons' relationships in the home, which related to: communication, attitudes, feedback, choice, activities, conflict, death, environment. The action plan addressed specific issues and contained mutually agreed upon solutions. From this research, a model has been developed to promote friendship in a care home community. Conclusions: This participatory, action-orientated study facilitated the creation of an action plan that reflected the needs of staff and residents. The action plan raised consciousness about issues affecting older persons' relationships in the care home and encouraged actions that could improve older persons' relationships in the home.

## Understanding Support Needs for Sustainable Work: Perspectives from Adults with ADHD and/or Autism [A028]

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Background: Adults with neurodevelopmental conditions often struggle to find a work situation that is sustainable over time without risking illness and exhaustion. They frequently do not receive the support they need to manage work in a way that promotes long-term health and stability. We aimed to identify what support adults with attention-deficit/hyperactivity disorder (ADHD) and/or autism spectrum disorder (ASD) believe that they need to create a sustainable work situation. Method: A sample of Swedish adults with ADHD and/or ASD identified by medical records (N = 515) completed a web-based questionnaire with questions about their experiences and wishes regarding support to obtain or maintain work. We used content analysis to identify what type of support the participants had received, and what support they felt they needed, to reach a sustainable work situation. The questionnaire also included open-ended questions, allowing participants to elaborate on their personal experiences and reflect on what had helped or hindered them in previous work settings. Results: Preliminary results indicate that participants had received support consisting of predefined, typical interventions, that were not necessarily individualized. In contrast, their subjective needs involved gaining a better understanding of one's own needs, encountering tolerance and understanding, and being offered flexibility and continuity at work and in other areas of life. These needs were often described as essential for maintaining both mental health and long-term work ability. Conclusions: The preliminary results indicate a great difference between received and desired support. In particular, the results encourage more individualized, person-centered interventions, and identify a need to pay special attention to the timing, continuity, and flexibility of support. A better alignment between formal support structures and individual needs may contribute to more sustainable employment outcomes.

## Barriers and facilitators for patient involvement and engagement in health research and development- An interview study with key actors [A029]

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Previous research indicates that patient involvement and engagement can improve care quality, self-management, and patient– care provider relationships. At the same time, structural barriers, power asymmetries, and the complexity of involving multiple actors across diverse contexts continue to challenge the meaningful implementation of Patient and Public Involvement (PPI). The present study aimed to explore key actors' perspectives on the barriers and facilitators to patient involvement and engagement, with particular attention to the factors influencing involvement and engagement at the meso- and macro-levels. Semi-structured interviews were conducted with 29 participants representing patients, healthcare, research, industry, and public authorities. All had prior experience with PPI, and data were analysed using qualitative content analysis by Graneheim & Lundman. The analysis of the interviews resulted in the identification of barriers and facilitators linked to the following themes: Acknowledgement of Power and Responsibility, Structure and Regulation, Patient Representative – a Role with Internal Contradictions, Expectations, and Authenticity versus Tokenism. Interview findings suggested that barriers and facilitators were primarily relational in nature, closely linked to power dynamics between key actors. These dynamics were also shaped by the varying conditions that different actors face, depending on their contexts and the institutional frameworks guiding their PPI-related activities. For more effective PPI activities it is essential that relational dynamics and power relations are made explicit and addressed with transparency. Clearly articulating expectations regarding roles and responsibilities can further facilitate this process and, in turn, support the development of more robust structures to advance involvement and engagement while reducing the risk of tokenism. Adopting a person-centred approach to PPI might be one way to ensure that PPI activities are not only systematically implemented but also experienced as meaningful.

# Creating Space for Personhood: Lessons Learned from PPI with Women Experiencing Homelessness, Violence and Comorbidity [A030]

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Abstract: This participatory research project explores lessons learned from conducting patient and public involvement (PPI) with a marginalized group of women experiencing homelessness, comorbidities, and deep mistrust in institutions, care systems, and themselves. Often excluded from traditional structures of influence, these women face overlapping cognitive, psychological, physical, and social challenges, making their participation in research both vital and complex. Based on 15 sessions with a co-creative working group, this work underscores the importance of flexibility, relational ethics, and environment when involving individuals whose lives are far removed from mainstream society. Anchored in a person-centred approach and influenced by the relational philosophies of Martin Buber and Carl Rogers, our work emphasizes the power of genuine dialogue and the need to meet people as whole, complex human beings—seeing participants not merely through the lens of problems or diagnoses. The process illuminated how consistent structure, shared routines (e.g., communal meals), and respect for each woman's unique rhythm of engagement fostered a sense of safety and belonging. Over time, participation enabled the women to renegotiate their self-image and sense of capacity. Through relational experiences and creative expression, new personal narratives emerged—allowing for complexity, contradiction, growth and agency. Key lessons include the need for non-linear, creative methods to support diverse forms of expression; the importance of acknowledging power imbalances; and the ethical balance between personal transformation and the research agenda. For PPI to meaningfully contribute to person-centred care, it must resist becoming standardized or uniform. Instead, it must allow for multiplicity and be grounded in lived experience—especially the voices of those furthest from care, power, and trust.

# The involvement of persons with aphasia in shared decision-making following cerebrovascular accident(s) across clinical contexts [A031]

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Background: Shared decision making is a collaborative process, built on the notion of co-construction and person centered care, that involves both client and clinicians in making health-related decisions through the incorporation of research evidence, clinician expertise, and preferences of the client themselves, in this case, persons with aphasia (Hargraves et al., 2021; Hoffmann et al., 2022). Rationale: Research exploring the involvement of persons with aphasia in decision-making remains scattered across the knowledge base. As such, they synthesis of current research surrounding the involvement of adults with aphasia in decision-making was crucial - given the vulnerability of the population in involvement. Methodology: A scoping review guided by Arksey and O'Malley's six steps was used. Following comprehensive searches, screening by two reviewers, and the use of PRISMA-ScR, N=15 records remained for data extraction. Data was then extracted and mapped. To conclude, the results were socially validated by persons with aphasia themselves and speech-language therapists. Results: The involvement of persons with aphasia in decision making is imperative to provide meaningful and person-centred care. Healthcare, however, still tends to follow pathways that centre clinicians as decision-makers - leaving a notable absence in the incorporation of persons with aphasia. While the presence of aphasia may affect the individual's capacity to make decisions or their ability to reveal their capacity to make decisions, it is important to recognise that persons with aphasia can make informed decisions and participate in shared decision making if provided with appropriate strategies and supports. Conclusion: By prioritising the involvement of persons with aphasia in their own intervention processes, their inclusion as both a human right and an essential function of being human is acknowledged and the erroneous assumption that no persons with aphasia can make decisions for

themselves and are thus unable to participate in shared decision making processes can be refuted.

## Coproducing person-centered and cohesive clinical pathways [A032]

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Introduction: Patient participation was mandatory when a National system for Knowledge-based management of healthcare was launched in Sweden aiming to enhance a person-centered learning health system. The patient representatives co-produce person-centered and cohesive clinical pathways in collaboration with professional representatives in national groups to describe assessment, diagnosis, planning and evaluation for a specific condition. The chairperson and process leader in the respective group and the support function for the system, support the process of producing clinical pathways. Healthcare professionals and patient representatives jointly constructing clinical pathways is a significant but less studied strategy. The present study therefore aimed to explore and describe the experiences of patient participation at a national level and in this context. Method: In this qualitative study, patient representatives took part in the planning, analysis, and the final version of publication phase. Individual interviews were conducted digitally with nine patient and eight healthcare professional representatives (process leaders and chairpersons) with experience of participating in producing clinical pathways for acute and chronic conditions, representing 18 national groups. A semi-structured interview guide was iteratively discussed and refined in the research group. The transcribed interviews were analyzed using inductive qualitative content analysis. Results:

Three main categories were identified: Finding appropriate patient representatives – relating to the recruitment process, formal and informal competence and prerequisites and demands. Working methods that facilitate a patient perspective – relating to for example group member interaction, strategies to support participation, meeting forms and learning. Influence of the patient perspective in the clinical pathways processes – including enhancing a patient perspective. The experiences were similarly expressed for both patient and professional healthcare representatives. However, the patient representatives also expressed concern regarding the implementation and utilization of the pathways. Key learnings and practical implications were feedbacked to the National system for Knowledge-based management.

## A Bibliometric Assessment of an Intensive Patient-Led Health Research Training Program [A033]

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Background: Robust patient partnership in health research involves patient partners in all stages of the research cycle from initial study design to final knowledge dissemination. Training programs to augment lived experience expertise with research skills can support patient research partners to work on health research projects in meaningful ways. The objective of this study is to assess the impact of a year-long qualitative health research training program (the Patient and Community Engagement Research (PaCER) program) for patient and community research partners on one approach to knowledge dissemination, namely scientific manuscript co-authorship. Methods: A list of graduates from a one-year training program was gathered from publicly available documents. Google Scholar was reviewed to identify publications co-authored by each of the graduates. Various bibliometric indicators were collected for analysis. Results: 188

graduates of the PaCER program between 2013 and 2024 were identified. Using Google Scholar to identify graduate publications through a retrospective database review, 273 unique peer-reviewed publications were identified, and bibliometric data were extracted, including citation count, article views, and co-authorship information. Descriptive analysis of these statistics reveal that graduates of the PaCER program are frequent co-authors of scientific manuscripts, with at least 75 (40%) of the graduates co-authoring at least one manuscript, and 11 (6%) co-authoring more than 10. These papers are frequently cited (6300+ times) and accessed (more than 550,000 downloads). Co-authorship is generally with senior authors located in Canada, though PaCER graduates have published with many international co-authors, and with many teams beyond their initial PaCER projects. Conclusions: By providing training to patients and community members on qualitative health research methods, the one-year PaCER program, appears to provide a successful launching pad for successful research careers for learners inside and outside traditional academic research spaces.

## Local Collaboration Group for Person-Centred Practice in Uppsala County: A System-Level Structure for Implementation [A034]

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Background: The Swedish national knowledge governance system is designed to ensure evidence-based knowledge is used to provide equitable, high-quality care. The system is organised so that national programme areas develop guidance which regional and local levels adapt and implement. In Uppsala County, a need was identified for a local structure that could uphold a system perspective while supporting the introduction of person-centred practices across the care continuum. This led to the establishment of the Local Collaboration Group (LSG) for person-centred practice in

2024.Organisation: The LSG includes representatives from the county's two hospitals, primary care, municipal health and social care, disability rights organisations, and the Health and Medical Care Department of Region Uppsala. The group is part of the regional knowledge governance system and promotes a shared, coherent approach to person-centred practice. Working Methods: The LSG focuses on several areas linked to person-centredness: strengthening family and next-of-kin perspectives; implementing documented mutual agreements; supporting collaboration through Coordinated Individual Plans (SIP); and developing Living Libraries for citizen involvement. The group also supports regional and local bodies when person-centred and coherent care pathways are introduced. System Level and Function: The LSG operates mainly at the macro level, with attention to system structure, coordination and governance. Its work clarifies responsibilities, improves collaboration and creates better conditions for person-centred practice at the meso and micro levels, where encounters with citizens take place. The group's broad representation contributes to a more coherent system view and strengthens local implementation efforts. Conclusion: Uppsala County has chosen to establish a local collaboration group to support person-centred practice, even though this structure is not included in the national knowledge governance system. The initiative provides a clear local point of coordination and contributes to more consistent, long-term support for person-centred work across different levels of the healthcare system.

## Co-Designing Dialysis Patient Decision Aids: Exploration, Development, and Testing of a Digital Patient Decision Aid Across Nordic Countries [A035]

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Background: Choosing a dialysis modality is a decision influenced by health system issues and healthcare personnel's and patients' personal preferences, and it requires structured shared decision-making. Current practice lacks tools that integrate patient priorities with clinical evidence. Objective: To describe results from a multi-step process aimed at improving shared decision-making for dialysis modality choice in adults with chronic kidney disease. This process included (1) a scoping review to map evidence for person-centred interventions and home-based dialysis (Nygaard-Andersen, 2025), (2) a Scandinavian survey of adults with kidney disease and kidney professionals to capture priorities and perceived challenges, and (3) a design thinking approach including hybrid and online workshops with adults with kidney disease, kidney professionals, and patient associations to identify a decision aid of interest Results: The scoping review, which identified 13 interventions, showed that patient involvement in care and treatment, through shared decision-making, listening to narratives, and building partnerships was emphasised, while involvement in planning and documentation was less common (Nygaard-Andersen, 2025). Survey findings revealed differences between adults with kidney disease and kidney professionals regarding the perceived importance of economic and financial factors, technological complexity, and social relationships in dialysis modality choice. Variations were also observed across Scandinavian countries. The design thinking process identified numerous unmet needs and opportunities for innovative solutions in clinical practice, leading to the testing of a specific digital patient decision aid. Conclusion: Differences in priorities between adults with kidney disease and kidney professionals, as well as variations across health services and settings, highlighted the need for collaborative approaches. Bringing stakeholders together in innovative processes has driven efforts to improve the quality of care and foster solutions that support person-centred dialysis care.

Reference: Nygaard-Andersen B, Torbjørnsen A, Hougaard PF, Leonardsen A-CL, Wolf A, Finderup J. Home-Based Dialysis and Person-Centered Care: A Scoping Review. Nephron. 2025:1-25.

## Involvement, Information and Emotional Support to Cancer Patients with or without an Assigned Care Provider [A036]

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Patient-reported experience measures (PREMs) represent the patient's voice and offer a way to evaluate continuity of care. We used PREMs to investigate the impact of having an assigned care provider on experienced involvement, information, and emotional support in patients recently diagnosed with cancer. We analyzed data from a nation-wide survey conducted in patients diagnosed with cancer 6-10 weeks earlier during 2018-2022. The survey covered 28 different types of cancers. An invitation to answer a web questionnaire was sent by regular mail. A reminder and a paper questionnaire were mailed to the patients if no response was recorded after 3 weeks. Answers were grouped and compared using Pearson's chi-square test. A total of 89% of respondents reported having an assigned care provider. These individuals reported higher levels of involvement, information and emotional support compared to individuals who did not have an assigned care provider. Physicians, contact nurses and other health care staff as assigned care provider were associated with over 80% positive responses in respect of patient involvement and information, whereas patients with no assigned care provider reported only 70 % positive responses in these areas ($p<0.001$). Only 46% of patients with no assigned care provider were positive to the provided emotional support compared to 69-80% for those with an assigned care provider ($p< 0.001$). The profession of the care

provider had little impact. An assigned care provider is important for maintaining continuity of care. This should be encouraged in cancer care as it leads to better patient experience across all investigated domains. The widely spread use of contact nurses in cancer care in Sweden provides a solid ground for such continuity. The continuous use of PREMs captures these aspects and promotes more people-centered health care practices.

## Co-developing the Neonatal Intensive Care Experience Reporting (NICER) Instrument: Content Validation and Pilot Testing [A037]

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Background: Aware of the importance of patient- and family-centered care (PFCC) within the stressful Neonatal Intensive Care Unit (NICU), parents with NICU experience in Alberta, Canada approached the healthcare system and identified the need to evaluate parents' experiences with PFCC in the NICU. To address this parent-identified priority, the Neonatal Intensive Care Experience Reporting (NICER) Instrument is being co-developed. Methods: Parent partners co-lead the research team, working in partnership with researchers and NICU clinicians to make decisions and generate processes. Co-developing the NICER Instrument includes four phases: (1) Defining PFCC principles and establishing items; (2) validating item content;

(3) pilot testing; and (4) assessing additional measurement properties. Results: The NICER Co-development Team defined five core principles of PFCC specific to the NICU and developed initial items (n=72) based on these principles. To validate item content, parent advisors (n=10), NICU clinicians (n=13), and PFCC researchers (n=10) rated the relevance of 72 items based on the NICU PFCC principles. The item content validity index (I-CVI) ranged from 0.54 to 1, and an I-CVI cut-off of 0.85 retained 51 items. Expert feedback and team discussion reduced the items to 49. Parent advisors (n=52) from NICU parent advisory groups in Alberta pilot tested 49 items which took an average of 14.71 minutes (SD=7.49) to complete. Feedback on item clarity, user friendliness, and instrument length was generally positive. Open-ended responses regarding item content and wording informed refinements prior to utilizing the NICER Instrument in NICUs. To further assess instrument reliability and validity, 400 family members across Alberta NICUs are currently being recruited to complete the NICER Instrument. Conclusion: This in-progress research demonstrates how family members, researchers, and clinicians can effectively co-develop a patient-reported measure to ensure that essential patient and family expertise is not overlooked when defining healthcare experiences and conceptualizing care evaluation.

## Co-Designing Digital Health Tools for Inflammatory Bowel Disease (IBD): Insights from a Patient-Led Peer-to-Peer Focus Group Study [A038]

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Inflammatory Bowel Disease (IBD), comprising Crohn's disease and ulcerative colitis, presents complex challenges that extend beyond physical symptoms to affect emotional, social, and psychological well-being. Effective IBD management requires a person-centred approach, one that recognizes

individuals as active partners in their care and values lived experiences. This study explores how people with IBD self-manage their condition, the use of digital health tools, and how their insights can guide the development of more responsive, inclusive health technology. The research was co-led by members of the IBD Patient Research Council, a multidisciplinary team including individuals living with IBD, gastroenterologist, dietician, academic researchers, and a project manager. Four Patient Research Partners (PRPs) from the council co-developed and facilitated a series of online focus groups involving adults living with IBD across Alberta, Canada. Participants shared their experiences using digital health tools, highlighting barriers, facilitators, and desired features for effective self-management. Twenty-two participants, aged 18-65, from diverse geographic and clinical backgrounds, contributed to the study. Thematic analysis of the focus group transcripts revealed 29 themes and 51 sub-themes across three domains: self-management strategies, digital platform features and content, and barriers to use. Key insights included the importance of tracking diet, stress, and symptoms; maintaining physical health; accessing peer support; and ensuring usability, privacy, and meaningful communication with healthcare providers. This study demonstrates the value of co-design and person-centred engagement in digital health research. By integrating patient voices throughout the research process, from design to dissemination, we identified actionable priorities for improving digital health tools that support holistic IBD care. These findings will inform future development of the MyIBDToolkit, a suite of digital tools to enhance communication, accessibility, and quality of life for individuals living with IBD.

## Painful Truths: Common Threads in a Tapestry of Chronic Pain on Identity [A039]

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This patient-oriented qualitative study explores the impact of chronic pain on identity through the arts-based research method of Digital Storytelling. Grounded in person-centred care principles, the projects engaged people with lived experience of chronic pain as both participants and Patient Research Partners (PRPs), who co-designed the research topic, refined methods, and contributed to the interpretation and sharing of findings. Using the 7-step Digital Storytelling methodology developed by the Story Center, USA, eight PRPs created first-person multimedia narratives that reflect their experience of living with chronic pain and identity. The study aimed to: (1) explore how digital storytelling reveals the complex relationship between chronic pain on identity, and (2) co-create research with PRPs to ensure it reflects their insights, values, and real-world impact. Analysis followed a three-stage approach. First, intertextual analysis examined how language, visuals, and tone conveyed meaning and emotion in each story. Second, a thematic analysis identified recurring patterns, concepts, and emotional threads across the stories. Third, each PRP used a structured framework to analyze their own stories, identifying key themes, emotions, and messages, which were then compared with researchers' findings to integrate their unique, contextual, and relevant perspectives. The final overarching themes; Response-Ability, Integrating and Evolving Identities, Complexity of Pain, Pain Processing, were co-developed with PRPs to ensure authentic representation of their lived experiences. This collaborative approach highlighted how chronic pain reshapes self-perception, relationships, and meaning-making over time. Digital storytelling proved to be a powerful tool for capturing the nuanced, emotional dimensions of chronic pain on identity, offering rich insights that extend beyond traditional research methods. This study demonstrates how first-person narratives can deepen understanding, foster empathy, and support more person-centred approaches to care and research.

# Comprehensive & Integrated Care

## Person-centred Literature in Progressive Neurological Physiotherapy Rehabilitation - A Scoping Review [A040]

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Aims: The aims of this scoping review were (1) to identify and profile relevant literature that reports on person-centred Physiotherapy rehabilitation for people with progressive neurological conditions, and (2) to identify, summarise and categorise reported person-centred Physiotherapy rehabilitation approaches for people with progressive neurological conditions. Methods: The scoping review was guided by the framework developed by Arksey and O'Malley, in accordance with the Joanna Briggs Institute guidelines for scoping reviews. Results were reported according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) extension for Scoping Reviews. The scoping review followed the review protocol, papers were identified through: five major databases and snowball searches. Two independent reviewers identified English-language papers on person-centred rehabilitation according to six pre-defined inclusion categories, quantitative and qualitive papers were included as were expert opinion pieces / consensus and book chapters; Descriptive statistics and content analysis were used to synthesize the results. Results: Of the 1123 papers initially screened, 13 papers were included; 5 empirical, 2 RCT's, 1 systematic review, 3 opinion, 1 review and 1 book chapter. Yearly publications were between 2007 – 2024 with the greatest in 2019. Publications were unevenly distributed by countries United States was the highest 46% , followed by UK 31%, the remaining papers were from Asia, Netherlands, and Germany 8% respectively. Most of the papers focused on more than one profession, setting-type, and progressive health condition, in particular Parkinson's Disease, 77% . Finally, empirical papers (n=4) studied the implementation of person-centred Physiotherapy rehabilitation

approaches, including its effect. Conclusion: This scoping review synthesises the key characteristics and emerging categories in the person-centred Physiotherapy rehabilitation literature of people with progressive neurological conditions, an unmapped and rapidly expanding area. This diverse body of literature can establish a foundation for Physiotherapy rehabilitation practices and research, including toward building an integrated multidisciplinary model of person-centred rehabilitation.

## Perspectives on Factors Leading to Acute Admission Among Older People with Frailty – An Interview Study [A041]

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Background: Acute hospital admissions among older people often lead to functional decline, increased vulnerability, and disruption to everyday life for both patients and relatives. Aim This study explores factors leading to acute admission among older people from the perspectives of older patients and their relatives. Methods: We interviewed older people aged 65 and above during their acute admission. Patients receiving home care and home nursing were included, as they are affected by the complexity of everyday life and are considered at higher risk of hospitalisation. Their relatives participated in a telephone interview on collaboration and care before admission. The interviews were analysed using qualitative content analysis. Results: In total, ten patients and eight relatives were interviewed. The analysis yielded three themes: a) Acute deterioration over time: Both gradual and sudden changes in the health conditions of older people can lead to acute admissions.

Distinguishing between these types of changes can be challenging for both older people and their relatives. b) Dilemmas of Delay: Older people and their relatives often hold differing views on the causes of acute hospital admissions and the need for professional care. While some older people downplay or conceal symptoms, relatives must navigate the tension between respecting the older person's autonomy and acting on their concerns—potentially delaying timely intervention. c) Missed Action: Interactions between older people, their relatives, and health professionals are crucial to care quality, yet missed opportunities for timely intervention may stem from unclear communication, a lack of shared understanding, and relatives' perceptions of professional approaches as task-focused rather than holistic. Conclusion: Differences between older people and their relatives in the perception of factors leading to acute hospitalisation were identified, particularly regarding severity and urgency. Health professionals must consider the perspectives of both patients and relatives when assessing the health status of older people.

## "I feel forced to live a life with some risk to get the help that I need": Centring participant experiences of psychedelic-assisted therapy in Canada [A042]

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The current mental health crisis is detrimentally impacting the health of Canadians. With 11 deaths per day by suicide related to unmet mental health needs, mental illness is a leading case of disability in Canada.1 As a response to this need, psychedelic-assisted therapy (PaT) has been gaining traction as a safe and effective treatment for mental illness and distress.2 With recent federal exemptions increasing access to psychedelics for therapy, there remains a lack of evidence informing healthcare providers how they can best provide knowledgeable, ethically-informed person-centred care for this vulnerable population of Canadians receiving PaT. The aim of our study is

to increase the evidence-base of Canadian PaT practices by developing interdisciplinary best practice guidelines that will inform person-centred, knowledgeable, skilled, ethically informed care. Using narrative inquiry, a relational qualitative approach that emphasizes co-created knowledge and centers participant voices, we conducted in-depth narrative interviews with individuals who have undergone and who have delivered PaT in Canada. Data was analyzed using a thematic and a structural analysis to capture each individual's experience. Preliminary findings demonstrate the challenges for patients and providers in navigating PaT within a highly medicalized siloed health system and within the confines of legal structures, and raise questions around what research methodologies are needed to more accurately and fully capture the diversity of participant experiences and outcomes within research settings which, to date, have predominantly relied upon randomized controlled trials. As our study is grounded in centering participant's lived experiences, the findings not only help to inform a person-centred approach to best practice guidelines for PaT but can also shed light on influencing factors that decentre individuals from their own health journey while engaging with this novel treatment.

References: Centre for Addictions and Mental Health. (2024). https://www.camh.ca/en/driving-change/the-crisis-is-real Andersen, K., et al., (2021). https://doi.org/10.1111/acps.13249

## Rethinking seamless care: more collaboration is not always the answer [A043]

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While increased collaboration is often promoted as a solution for fragmented care, it does not automatically result in person-centred or seamless care—particularly for older adults with complex needs. This presentation draws on findings from a doctoral project that explored how inter-organisational collaboration and adaptability shape care coordination in the borderlands between healthcare and social care in Sweden. Across four qualitative and

systems-oriented studies—including ethnographic fieldwork, interviews, and document analysis—the thesis examined discharge processes, care transitions, and adaptive strategies across hospitals, primary care, municipal services, and ambulance care. Findings reveal that collaboration, in itself, is not sufficient. Instead, person-centred coordination depends on the presence of relational continuity, functioning communication pathways, shared accountability, and contextual responsiveness. Effective collaboration occurs when professionals not only cooperate, but also take responsibility and respond to the specific needs of patients—ensuring the right care is delivered by the right actor at the right time. Moreover, system structures and policies often constrain these efforts. Front-line staff are frequently left to bridge organisational gaps through informal practices, workarounds, and trust-based relationships. These relational and adaptive practices are central to delivering truly person-centred care—but are often overlooked in governance and system design. This presentation challenges the assumption that "more collaboration" is inherently better. Instead, it calls for attention to how collaboration is enacted, and whether it enables professionals to act accountably and responsively toward patients. It argues that person-centred care across boundaries requires more than integration—it requires shared purpose, mutual trust, and the organisational space to act. This session will be relevant for researchers, practitioners, and policymakers seeking to understand and support the conditions that truly enable person-centred, cross-boundary care.

## How do paramedics conceptualise and implement person-centredness in the reality of practice: An Integrative Review [A044]

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Background: Internationally, paramedicine has evolved significantly over two decades. As paramedicine moves towards professionalism, enhancing

practical skills and increasing collaborative, respectful partnership working with patients are required. The concept of person-centredness represents a global movement that emphasises the importance of placing the person at the centre of healthcare systems and may offer a helpful framework to develop practice. Aim: To explore international literature on paramedics' conceptualisation and implementation of person-centredness in practice. Method: This integrative review employed a five-layer multi-system approach (Whittemore and Knafl 2005). Five academic databases were searched with no data restriction to unearth studies related to paramedicine and person-centredness. Research papers were screened against agreed-upon inclusion criteria, and data were extracted using quality appraisal and Braun and Clarke's thematic analysis approach. Findings: Seventeen papers of the initial seventy-seven revealed six themes: Lack of shared understanding; Emotional Regulation; The power of powerlessness; Autonomy and engaging in shared decision-making; Being in temporary presence; and Ethical risk management. Discussion: Person-centred practice in paramedicine is poorly understood, with studies melding person-centred care with broader principles of person-centredness. Paramedics view person-centredness as something externally imposed, rather than aspects of the care they intuitively provide. Biomedically-driven assessment prioritises protocols over relational care, creating tension between procedural adherence and patient needs. A paradox emerges where patients seek self-determination yet experience powerlessness, while paramedics navigate conflicts between ethical appropriateness and medical protocols. Conclusion: This review identifies several significant challenges in implementing person-centredness within paramedicine. Despite paramedics instinctively providing aspects of person-centred care, a lack of shared understanding, instinctive relational dimensions, and ethical risk management conflicts provides complexities in the care environment, creating dilemmas related to protocol adherence. A variance in paramedic education and the evolution of practice from pre-hospital to comprehensive out-of-hospital care delivery reveals that further research is required to develop healthful, person-centred cultures.

# Long-Term Care Nurses' Perspectives on Person-Centred Geriatric Care: Strengthening Autonomy, Coordination, and Collaboration [A045]

*Lena Maria Lampersberger[1], Christa Lohrmann[1] & Franziska Großschädl[1]*

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As the world's population ages, the need for long-term care and nurses to provide quality care is increasing. Person-centred approaches are essential to providing sustainable, high-quality care that meets the needs of older people. Little is known about what nurses value in long-term care and how they would strengthen current practice. In a descriptive qualitative study, we explored Austrian nurses' perspectives on what they value in geriatric nursing and their ideas for strengthening care for older people. Using a modified focus group approach that combined freelisting interviews and the nominal group technique, 12 nurses from nursing homes, home care, and community care participated. A combination of convenience and snowball sampling was used. The findings reveal that nurses highly value opportunities to provide individualised, person-centred care, foster older people's self-care abilities and engage with their families and relatives in care processes. Skilled geriatric nursing is associated with qualities such as empathy, sensitivity, compassion and broad professional expertise — all of which align with the person-centred care principles of dignity, respect, and partnership. The nurses prioritised three areas for strengthening geriatric nursing: (1) Promoting older people's self-care abilities through holistic, biography-based care and involving relatives. (2) Improving care coordination across services, with stronger roles for community nurses. (3) Fostering interprofessional teamwork, supported by skill- and grade-mix models. These findings highlight that person-centred care in geriatric nursing is not only about meeting clinical needs, but also about empowering older people, recognizing their preferences, and ensuring continuity of care across settings. Supporting nurses with adequate resources, reduced bureaucracy and recognition of their expertise is essential to sustain person-centred long-term care. Listening to

nurses' voices provides valuable insights for shaping policies and practices that preserve the dignity, autonomy and quality of life of older persons.

## Older people's experiences of person-centred Integrated Care (PCIC) in the Irish National Programme for Integrated Care for Older Persons (NICPOP) [A046]

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Knowledge gaps exist regarding the successful application of person-centredness in integrated care contexts and older people's experiences (Greenfield, 2014; Baxter et al, 2018; Berntsen et al, 2018; Liljas et al, 2019). This study explored older peoples' PCIC experiences in the context of the Irish National Integrated Care Programme for Older People (NICPOP), applying the Person-centred Practice Framework (PCPF) (McCormack and McCance, 2021) as its overarching theoretical framework. Its four research objectives were: i) to explore the nature of relationships experienced within integrated care; ii) to explore the integration of personhood within PCIC; iii) to ascertain the enablers and barriers to the delivery of PCIC; and iv) to identify the outcomes of PCIC. Using qualitative multi-case study methodology, the design consisted of focus groups with three multidisciplinary staff teams using diverse models; staff summaries relating to interventions; 29 semi-structured interviews with 32 older people and carers. Ten themes articulated the experiential dimension of PCIC: 1) Feeling under an umbrella; 2) Being cared for holistically; 3) Knowing that someone has my back; 4) Being able to trust the system over time; 5) Being seen and known in my own home; 6) Being supported to live well independently; 7) Knowing what to expect from integrated care; 8) Feeling involved in my care; 9) Enjoying care; and 10) Being supported as a carer. The six key insights of this study were: 1) Importance of holistic PCIC approaches informed by

lived experience and psychosocial context; 2) PCIC optimises care experiences and supports older people to live well independently; 3) Experiences of coordination and management continuity of care are essential for positive PCIC experiences; 4) Significance of relational care and relationship between staff and older person; 5) Feeling involved and enjoying care as central outcomes of PCIC; and 6) Carers as service users with PCIC needs.

## Experiences of trauma care: identifying improvements in the quality and safety of trauma care from an unseen perspective [A047]

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Trauma is one of the most common causes of death in Sweden and internationally. Trauma care is complex and expensive, requiring the correct combination of expertise, resources and actions at every phase of patient treatment. Patient experiences give a unique perspective of health care services which can identify parts of care process where patient safety and clinical effectiveness are not delivered as planned or as expected. Aim: To describe patients experience of trauma care during hospitalisation. Method: An observational prospective cross-sectional study with a mixed methods approach. Setting and sample: The study was carried out at a specialised trauma ward at a level 1 trauma centre in Sweden during 2023-2025. Subjects were 18 years or over, had Swedish social security number, were admitted after a trauma 1 or 2 according to the national trauma alarm criteria or were transported from other hospitals. Patient experience was measured using the Quality of Trauma Care – patient related experience measure in Swedish (QTAC-PREM Sw) which was translated and culturally adapted for use in

Sweden and has been shown to be valid and reliable for use in Sweden. Results: Descriptive analysis of the responses identified a high overall rating of the acute care during hospitalisation. However, over a third of respondents identified that they wished for more information (explation of injuries, instruction for selfcare after discharge and information on recovery). Half of respondents experienced a lack of help with hygiene and around a quarter felt they were not offered support to discuss emotional needs. Qualitative data from the free text comments, analysed using content analysis, identified improvements were needed around information provision and communication specifically around pain/pain relief, planning treatments and ward rounds. Discussion: National studies using validated experience measures are needed to gain a broader picture of trauma care experiences in Sweden.

## Person-centred care as an ethical framework for the co-development of healthcare navigation service delivery and training programs [A048]

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Introduction: Healthcare navigation represents a person-centred care approach to care that supports individuals in identifying and accessing appropriate care, while enabling them to make informed decisions regarding their well-being and treatment based on their needs, values, and preferences. Healthcare navigation services are especially helpful for individuals experiencing new-to-them diagnoses, chronic complex health conditions and additional equity denying systematic barriers related to the unique physical and sociocultural economic factors they live with. Healthcare navigation programs continue to grow both globally, and in scope of health conditions including cancer care, mental health, Alzheimer's, pediatric care, and others.

Thus, navigation programs and navigator (community, peer, and professional patient navigators) roles and training are increasingly being formalized to ensure consistency and quality of support, and person-centred care must stay foundational to the design, development, delivery, and evaluation of healthcare navigation programs. Methods: This multi-phased qualitative, peer-led project included a team of 12 peer researchers. In Phase 1, they conducted an environmental scan of existing navigation services and navigator training programs in Alberta, Canada. In Phase 2, two groups were created, Navigator and Navigated. Focus groups and interviews were conducted to understand experiences and perspectives from both groups and thematically analyzed to develop key themes. Results: An environmental scan identified 15 navigation services programs for a broad range of health conditions and services, and five navigator training programs. Thematic analysis emerged three key themes for Navigated, four key themes for Navigators, and five recommendations related to experiences, best practices, and gaps in existing programs. Conclusion: In sum, we will describe how a person-centred care framework remains foundational to the design, delivery, and evaluation of healthcare navigation service and training programs. This can ensure improved, equitable healthcare access and health outcomes through identifying and coordinating individual needs, values, and preferences to effectively inform shared decision- making.

## Intersectoral collaboration in the provision of care, support, and participatory opportunities for women in homelessness with co-morbidities [A049]

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Background: Women in homelessness face complex needs requiring coordinated support. Though participation is a legal right, meaningful involvement is challenging. Greater insight is needed to strengthen intersectoral collaboration and support their participation. Objectives: The

aim was to investigate perceptions of the conditions, barriers, and enablers of intersectoral collaboration in providing care, support, and opportunities for participation for women in homelessness from the perspective of professionals. Methods: Twelve individual interviews with professionals in social services, healthcare and voluntary organisations were conducted. Data was analysed with content analysis. Results: Professionals' experience that collaboration for care and support for women in homelessness with co-morbidity often works poorly. Organisations work in isolation without a holistic view; responsibilities are passed around and no one takes a coordinating approach. The woman is not listened to or the centre figure, due to bureaucratic language and that professionals control the agenda. Meetings are planned without regard to the woman's actual life situation with illness, substance abuse and homelessness, which hinders her participation. Professionals also expressed that women are an especially vulnerable group, who experience shame about their situation and may be exposed to violence. The co-morbidity is severe and there is focus on care, but not the violence. For collaboration and participation to work, it is necessary to put the woman at the center, adapt to her needs and situation, with a clear purpose, understandable content and the opportunity for preparation and follow-up. A support person, who helps coordinate and guide through the process, can be crucial. It is also important to create trust, show respect, and build a relationship over time. Conclusion: Intersectoral collaboration in the provision of care, support, and participatory opportunities requires committed, flexible and empathetic professionals, who work together acknowledging all aspects of the individual woman's circumstances - not their own organisational framework.

## Person-centred nursing practice in a Danish cancer setting – a cross-sectional survey among healthcare professionals [A050]

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Background: Person-centred practice (PCP) is widely acknowledged as an internationally recognised approach to care and treatment. However, its implementation in clinical settings remains challenging. This study aims to examine the extent to which healthcare professionals (HCPs) perceive care and treatment of cancer patients as person-centred, and to identify key barriers and facilitators influencing the adoption of a PCP culture. Method: Data were collected from healthcare professionals (HCPs) (n = 228) at the Department of Oncology, Rigshospitalet in Copenhagen, Denmark. Participants represented a range of clinical settings, including outpatient clinics, inpatient wards, and the radiation therapy unit. The Person-Centred Practice Inventory – Staff (PCPI-S) was administered electronically to assess perceptions of person-centred care. Also, the PCPI for service users were collected (n=466). Results: A 64% response rate was achieved (n=145). HCP perceived a high degree of PCP assessed from the domains "prerequisites" (4,19±0,79), "practice environment" (3,82±0,88), and "person-centred processes" (4,18±0,75). Patient data will be presented. Conclusion: PCP is currently embedded in our nursing vision and core values. To truly embed PCP into everyday clinical care, it is essential to create and uphold an appreciative and feedback-oriented culture. Empowering nurses to actively engage in decision-making networks that shape clinical practice is vital—not only to sustain but to evolve this cultural transformation. Their clinical expertise and close patient relationships position them as key drivers of meaningful change.

## Physicians' Clinical Reasoning in the Sickness Certification Process - Integrating the Patient´s Narrative, Work Conditions and Healthcare Structures [A051]

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Assessing work ability is challenging in primary care, and practices vary widely across sickness certification. Such decisions often have major consequences for patients' trajectories and return-to-work prospects. This study explored physicians' clinical reasoning when assessing reduced work ability and recommending sick leave, with the aim of clarifying how person-centred decision-making unfolds in everyday practice. Data were obtained from a survey in which 142 physicians assessed six authentic patient cases and described their reasoning for each case. In total, 925 responses were analyzed using qualitative content analysis, yielding four categories. Assessment of the patient's condition involved balancing medical, functional and social factors in a complex decision process. When objective findings were absent, the patient's narrative became pivotal, requiring clinical experience and judgement. Sickness certification as a process over time reflected views of sick leave as part of rehabilitation, continuously reappraised in relation to recovery and work ability. Work demands and resources captured the person–work interaction—how demands meet the patient's resources and limitations—highlighting the workplace as a key arena for adaptation and participation. External resources and support structures emphasised organizational conditions, including access to rehabilitation resources, clear guidelines, and collaboration with employers and other actors. The results align with the principles of person-centred and integrated care by portraying sickness certification as a relational and continuous process in which the patient's narrative, resources and life situation are central. The assessment is shaped through dialogue between physician and patient, in collaboration with other actors, underscoring the importance of participation, continuity and coordination in rehabilitation. Viewing sickness certification as part of an ongoing care and recovery process is consistent with the pursuit of a more person-centred and sustainable healthcare system.

# Proactive, Person-Centered Self-Management in Everyday life: Experiences of Individuals with long-term health conditions and Healthcare Professionals [A052]

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Background: As healthcare continues to transition toward a more proactive and person-centered approach, there is growing recognition of the importance of empowering individuals to self-manage the consequences of their long-term health conditions in activities of everyday life. However, incorporating such proactive person-centered self-management support that aligns with individuals' needs has proven challenging. For healthcare to succeed in this transition, it is important to improve the understanding of how self-management support is experienced by both individuals living with long-term health conditions and the healthcare professionals involved. Aims/Objectives: To explore the experience of proactive person-centered self-management support for activities in everyday life among individuals with long-term health conditions and healthcare professionals. Methods: A qualitative focus group study was designed. Five focus group discussions were conducted: two with patient organizations and three with healthcare professionals, including managers. Data was analyzed using a focus group analysis to identify shared and divergent experiences. Results: The resulting themes illustrate that both individuals with long-term health conditions and professionals experienced difficulties navigating in healthcare to enable timely self-management support for activities in everyday life. Self-

management support was often introduced late in the disease trajectory and tended to focus on generic, diagnosis-related advice rather than on individuals' specific self-management needs in everyday life. The access to self-management support was hindered by insufficient person-centeredness, absence of systematic routines for identifying needs, limited resources, and insufficient knowledge of available support. Conclusions: The findings highlight the need for healthcare to develop proactive, person-centered processes, including early and individualized screening for self-management needs related to activities in everyday life. Aligning individuals' self-management needs with available support requires better dissemination of information about available self-management interventions to both citizens and professionals. Enhanced access to such information has the potential to facilitate timely tailored self-management support in everyday life.

## A Person-Centred Analysis of a Question on Wishing to Die Across Health and Social Determinants [A053]

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Background: Suicidality reflects the interplay of physical, emotional, social and cultural dimensions of life. A person-centred approach seeks to understand these experiences holistically, moving beyond reductionist models to consider the full spectrum of human complexity and inform the development of tailored care. Aim: To examine differences in wishing to die among people with diverse health experiences and social determinants of

health (SDOH). Methods: Data were obtained via the 2023-24 Canadian Equitable People-Centred Health Measurement survey which included a question on "wishing you were dead and away from it all" (N = 9691). Ordinal logistic regression models were used to examine associations between wishing to die and physical and mental health experiences, emotional wellbeing, and SDOH. Findings: Most participants identified as White (71%), 55% identified as women, 14% reported having difficulty paying for basic needs and 26% had an undergraduate degree or some university. In response to the wishing to die question, 76% of participants indicated 'none of the time', 13% 'a little of the time', 7% 'some of the time', and 4% 'most or all of the time'. Wishing to die was associated with several SDOH, including education, race, and housing situation. For example, having completed no formal school, having any disability, identifying as non-White, and homelessness were associated with increased time spent wishing to die. The odds ratio (OR) of increased wishing to die while having poor or fair physical health, as compared to excellent physical health was 5.0. The OR of increased wishing to die while having poor or fair mental health, as compared to excellent mental health, was 29.7. Conclusion: This study highlights the multifaceted nature of suicidality and the need for person-centered care interventions that address not only clinical symptoms but also pay attention to broader social and cultural contexts of psychological distress.

## Exploring the Current Practices of Person-Centred Care in Emergency Departments: A scoping review [A054]

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Background: While Person-centred care is a cornerstone of high-quality healthcare, its application in a high-pressure environment such as the Emergency Department is consistently challenging. Nonetheless, the majority of Person-centred care models are established in Western healthcare

systems, raising concerns about their universality. This review addresses this gap by synthesising evidence on how Person-centred care is practised and perceived across varied cultural and systemic contexts, particularly within the Emergency Department environment. Aim To explore current Person-centred care practices in Emergency Departments from the perspectives of patients, nurses, and physicians. Guided by the Picker Institute's framework, it synthesises the literature to analyse variations in the implementation of Person-centred care across diverse geographical and healthcare contexts. Methods: This scoping review was conducted in accordance with the Joanna Briggs Institute methodology. Four major databases (MEDLINE, EMBASE, CINAHL, PsycINFO) and grey literature were searched for studies published between 2018 and 2024. A thematic analysis was performed, guided by the Picker Institute's dimensions of Person-centred care. Results: A consistent gap emerged between patient desires for compassionate, inclusive care and the task-focused reality of Emergency Department practice, which is heavily shaped by overcrowding, institutional culture, and burnout. The evidence base is geographically skewed, with most research coming from Western countries whose efficiency-focused systems often conflict with Person-centred care values. Limited evidence from non-Western contexts suggests further cultural restrictions, including hierarchical decision-making and family-centred care dynamics. This review underscores a significant deficiency of patient-voiced evidence from non-Western healthcare systems. Conclusion: Person-centred care is not a universal approach, but a context-dependent practice that must adapt to diverse cultural and systemic realities. Strengthening Person-centred care in Emergency Departments requires bridging patients' relational needs with organisational constraints. Moreover, it requires developing culturally relevant strategies to promote effective communication and compassionate care globally.

## Patients' experiences of receiving care from a mobile care unit – A qualitative interview study [A055]

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Introduction: Demographic shifts have increased the elderly population and chronic diseases, leading to more emergency visits and worse outcomes. Sweden's "Close care" initiative focuses on patient-centered care, including mobile care units, to improve accessibility and satisfaction for frail older adults. To effectively integrate mobile care units into healthcare, it is crucial to gain deeper insights into patients' experiences with this care model. Thus, this study aimed to explore and describe the experiences of patients receiving care from mobile care units in Sweden. Method: Between June 2021 and May 2025, data were gathered through individual qualitative interviews with 17 patients who received care from various mobile care units across different regions of Sweden. These interviews lasted between 12 and 35 minutes and were transcribed verbatim and analyzed using content analysis. Result: The study findings emerged into two main categories and six subcategories. The main categories were: "The home as a care setting", and "Comprehensive patient-centered care". Patients appreciated mobile care for its comfort and the reduced stress of not having to travel to healthcare facilities. The mobile care unit minimized the need for hospital visits, enabling recovery in a supportive environment. Patients preferred mobile care for mild conditions and hospital care for acute conditions. Conclusion: Patients appreciated the person-centered approach and comfort of receiving care at home, which reduced logistical challenges and supported daily routines and independence. However, some participants expressed concerns about the effectiveness of mobile care for more severe conditions, preferring hospital care for its advanced medical resources and 24/7 staff availability.

## Facilitating Shared Decision-Making: Real-Time Nurse-Patient Communication in Primary Care [A056]

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Background: Patient involvement is essential for promoting health literacy and enabling informed decision-making in primary care. When individuals are actively engaged, they are better equipped to manage their health, adhere to treatment, and participate in preventive care contributing to improved quality of life. Aim: The study aims to explore how registered nurses' communication practices support patient involvement in decision-making, thereby contributing to knowledge on person-centred communication in primary care. Methods: This qualitative study is based on the analysis of 148 audio-recorded consultations between patients and registered nurses (n = 30). The analysis was conducted deductively, using a framework of nursing voices, task oriented, nursing, pedagogical, and power voices to examine how nurses involve patients in decision-making during healthcare encounters Findings Preliminary findings indicate that communication between registered nurses and patients plays a significant role in patient involvement in decision-making. In most consultations, registered nurses presented treatment plans without actively engaging patients in the decision-making process. However, the availability of limited treatment options led to mutual confirmation and agreement between the patient and the nurse, rather than shared decision-making. Additional findings will be presented at the upcoming conference. Discussion: The findings from this study underscore the need for a comprehensive understanding of how nurses' communication strategies facilitate patient involvement and shared decision-making, thereby contributing to person-centred care. By examining real-time interactions between patients and registered nurses in primary care, this study adds to the evidence base with high ecological validity and offers insights into everyday clinical communication practices.

# Healthcare Governance

## Towards person-centred fundamental care: Challenged by discrepancies in values, goals and norms and unclear responsibilities within the context [A057]

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Background: Delivery of person-centred fundamental care continues to be challenged by barriers in the care context. The Fundamentals of Care framework has been described by clinical nurses as a practical, easy to understand tool, towards meeting patients' fundamental care needs. Further empirical exploration of what and how contextual factors affect care provision within a complex surgical context is warranted to increase the framework's use in clinical practice. Aim: To explore how factors in the complex aortic surgical care context can affect care provision towards patients' postoperative recovery. Methods: Results about patients' recovery after complex aortic surgery from a patient perspective were presented in focus groups with registered nurses, vascular surgeons and nursing assistants, which explored their experiences with what could improve patient recovery. Data from these focus groups were reanalysed, using reflexive thematic analysis, with the Fundamentals of Care framework as deductive lens, to explore the healthcare professionals' descriptions of contextual factors affecting care provision. Results: Healthcare professionals' described contextual factors at a policy, system and individual level, which resulted in one main theme: Care provision is challenged by discrepancies in values, goals and norms and unclear responsibilities within the context, and two

subthemes: Values, goals and norms determine what care is provided; Taking responsibility for care requires resources, evaluation and feedback. Conclusion: Healthcare professionals describe care provision as affected by a dynamic integration of contextual factors. Healthcare professionals need to be made aware of their own role in this context. Healthcare professionals, leaders and policy makers all have a responsibility to focus on patients' values and goals, and empower adequate care through feedback loops and resource management. Care provision needs to be guided by feedback from patients and healthcare professionals, and work with patients' resources at both an individual, system and societal level.

## Nursing Research on the United Nations Sustainable Development Goals—A Bibliometric Study for Understanding Patients' Unique Contexts [A058]

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Background: The 2030 Agenda emphasizes sustainable development through innovation, science, and collaboration. For nursing, this framework aligns closely with person-centered care, prioritizing equity, health, and quality of life. Yet, the extent to which nursing research addresses the SDGs remains unclear. By applying bibliometric analysis of indexed nursing literature, this study provides an overview of current contributions and identifies areas where nursing can strengthen its role in advancing both sustainability and patient-centered practice. Aim: To explore how nursing research engages with the United Nations Sustainable Development Goals (SDGs), mapping publications to identify trends and central themes. The purpose is to highlight opportunities for nursing to contribute to sustainable health and well-being for individuals, next-of-kins, and communities.

Methods: A cross-sectional descriptive bibliometric design was used to analyze publications indexed in Web of Science (Core Collection). Results: The search identified 131 publications, including 116 articles (89%) and 15 reviews (11%). Compared with adjacent disciplines such as Internal General Medicine (n = 360), Nutrition/Dietetics (n = 171), and Paediatrics (n = 152), nursing contributions were limited. Publications primarily addressed eight SDGs: SDG3 (Good Health and Well-Being), SDG13 (Climate Action), SDG4 (Quality Education), SDG5 (Gender Equality), SDG6 (Clean Water and Sanitation), SDG16 (Peace, Justice, and Strong Institutions), SDG1 (No Poverty), and SDG9 (Industry, Innovation, and Infrastructure). Conclusions and Implications: Nursing research on the SDGs remains scarce and disproportionately focused on SDG3. To realize nursing's full potential, future work must expand to other SDGs while grounding efforts in person-centered care. Aligning global sustainability goals with the needs and preferences of patients and families allows nursing to advance both planetary health and individualized care. Embedding the SDGs more fully into nursing research and practice can strengthen person-centered care while supporting global health equity. Action plans developed by nursing scholars, clinicians, managers, and policymakers are essential to achieve this integration.

## Academic Residential Care Facilities in Sweden: Characteristics and Core Components [A059]

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Background and Aim: High-quality residential care for older adults requires expertise in evidence-based practice, person-centered care (PCC), and sustainability in quality improvement efforts. This is a complex endeavor, as it may require research competence and flexibility to move beyond standardized guidelines. Therefore, collaboration between academia and

clinical practice is encouraged. To address this, several Academic Residential Care Facilities (ARCFs) have been established across Sweden. These aim to strengthen the research profile and evidence base of residential care, while also offering potential to provide a foundation for PCC. However, the characteristics, structure and core components of these ARCFs remain unclear. Therefore, the aim of this study was to describe the defining characteristics and core components of ARCFs in Sweden. Methods: Semi-structured interviews were conducted with 14 key informants from clinical practice and academia at 12 ARCFs, focusing on organization; research; and education. The interviews were analyzed using qualitative content analysis. Results: Findings show that all ARCFs had some level of cooperation with academia, although the structure, nature and frequency of it varied. All ARCFs were involved in different research projects, but only a few as co-creative partners. All hosted students for clinical practice, but differences were found in supervisor training, and the academic environment. Conclusions: The partnership between academia and ARCFs holds strong potential for advancing sustainable, high-quality PCC, research, and education. However, the definition and understanding of ARCFs and their core components vary. Our study shows that while many ARCFs engage with academia through student placements and research participation, the depth, structure and consistency of these collaborations vary across facilities. Strengthening the co-creative partnership between clinical practice and academia is likely a key to realizing the full potential of the ARCF model. To support broader implementation, a clear definition and operational framework are needed to reach full scope of ARCFs.

## Advancing Sustainability and Network Growth in Person-Centred Practice Across Switzerland [A060]

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Background: Since 2015, the Practice Development (PD) methodology and Person-centred Practice (PCP) have been promoted in Switzerland through a network of German-speaking university hospitals. Over 20 foundation and two advanced PD schools have enabled more than 420 professionals to develop their skills based on the International Practice Development Collaborative curriculum. As institutional priorities evolved, a realignment became necessary. Aim: To establish a new network that promotes strategic anchoring of PCP within organizations, supports its implementation in everyday clinical practice and ensures the continued use of PD methodology through educational offerings in German-speaking Switzerland. Methods: Following PD principles, a values clarification process with the founding institutions led to a shared vision for advancing person-centred healthcare. The aim is to empower professionals to build workplace cultures that enhance care quality and staff development. Results: A five-point plan was developed to: 1. integrate PD into strategy and practice, 2. promote mutual learning and exchange, 3. support PD foundation and advanced schools, 4. demonstrate and disseminate PD/PCP outcomes and 5. strengthen interprofessional and international networking. The network now includes four hospitals and one university of applied sciences and welcomes additional partners. Conclusion: This collaborative and participatory approach effectively sustains and expands PCP in Switzerland. The network has established its identity, organized a founding symposium, and submitted PCP to H+ Swiss Hospitals as a recognized quality initiative.

## Lived Person-Centred Care in Long Term Care (LTC): Tensions Between Concept and Reality [A061]

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Background: Health care organizations are urged to treat service-users as

persons who should be involved in co-creating their care, considering their unique perspectives and preferences. A person-centred care approach, which views service-users as persons, partnering and co-creating care with healthcare professionals, is deemed the gold standard of "good" care within healthcare organizations. However, health care organizations, especially nursing homes (NH), face challenges approaching care organization and delivery in this manner, partly due to the diversity of staff and residents. Aim: In our project 'Caring about Diversities,' we aimed to explore nursing home care practices regarding diversity-sensitive care, which we refer to as "good care." Methods: We conducted a qualitative ethnographic study involving nursing staff and residents at a Swiss NH. We achieved 520 hours of fieldwork, producing fieldnotes as data. Data were analyzed using Grounded Theory procedures. Constant comparison and iterative coding were employed to conceptualize types of care practices emerging from interactions between nursing staff, residents. Findings: We generated a substantive theory of basic social processes through which nursing staff work with and achieve "good care" for NH residents. We called it "Crafting Practices". Practicing PCC in nursing home settings with diverse staff and residents is complex, subject to different interpretations, diversities, staff training levels and relationships with residents. Nursing staff demonstrate their creative capacity to produce care that is (or is not) person-centred, hence, PCC is relational and is co-created in the frame of everyday routines, interactions and embodied practices. Conclusion: Nursing staff's micro-level practices, governance and system factors intersect to produce or hinder PCC, which we refer to as "good care". A novel "crafting practices" phenomenon characterises a complex process through which nurses engage strategies, competences and creativity to ensure "good care" for residents.

## Using machine learning to gauge information relevant to a personalized treatment approach when planning psychotherapy [A062]

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Anxiety- and depressive disorders are common, debilitating and associated with a marked decrease in quality of life as well as a large societal cost. Psychological treatments are generally effective but there exists large unexplained variability in treatment effects as well as a general and global shortage of resources allocated to psychiatric care. This makes the identification of predictors that can aid in person centred care approaches not only desirable for increasing quality but necessary for managing resources effectively. Identifying predictors that might inform clinical decisions on who should be offered psychological treatment, how much resources should be allocated to each patient and if treatment should be discontinued has the potential of increasing the quality of care as well as managing resources. Different types of comorbid psychiatric disorders have been proposed as predictors of treatment effect but previous research has identified few consistently replicated predictors. This might be due to shortcomings in previous ways of doing research such as the risk of mass significance problems hampering how many disorders can be tested within the same sample, a general lack of studies testing quadratic effects, use of samples that are not representative of clinical sample, problems with replication due to overfitting of models to sample data and difficulties in testing complex models with many variables that individually have small effects. Method: We have used machine learning algorithm on a clinically gathered outcome data from three psychiatric outpatient clinics in Sweden in order to determine what comorbidities are predictive of treatment effect, if comorbidity profiles influences how many therapy hours are needed before remission and if comorbidity profiles predict occurrence of sudden gain, a well-known within therapy predictor of treatment effect. Results: Several comorbidities explained a significant amount of variance in treatment outcome, sessions needed for remission and occurrence of sudden gains.

# Leading Cultural Transformation in Nursing and Midwifery: A Shared Governance Approach to Embedding Person-Centredness Across an Organisation [A063]

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Person-centred healthcare is fundamental to creating a truly holistic system—one that recognises individual values, beliefs, experiences, and fosters environments where healthful, inclusive cultures can thrive. However, healthcare systems continue to face persistent and complex challenges that hinder the development and sustainability of positive workplace cultures. In response, a collective of senior nursing and midwifery leaders across a health district co-created a person-centred strategic framework, launched in 2024. This strategy identified six key priority areas, Creating a Supportive Practice Environment, Building Research Capacity, Building a Dynamic Workforce, Fostering Leadership at all Levels, Enhancing Digital Informatics and New Technologies and Delivering High Quality, Safe Person-Centred Care through comprehensive stakeholder engagement. Tailored strategic actions were developed to address each priority, ensuring the strategy reflected the voices and needs of patients and staff. To operationalise the strategy, a Shared Governance Framework was

established. This framework supports inclusive leadership, clear accountability, and continuous evaluation, enabling the strategy to be meaningfully embedded. Six dedicated working groups, each co-led by senior nursing and midwifery leaders, were formed to guide the implementation process. These groups ensure that a person-centred ethos underpins all action planning, decision-making, and evaluation efforts. This presentation will outline key elements of the Shared Governance Framework, highlighting how it fosters authentic engagement across all levels of the organisation. Core principle, such as active facilitation, collaborative participation, critical dialogue, shared decision-making, and the celebration of successes will be explored. A robust reporting process has been established to monitor progress, surface challenges, and track outcomes through regular governance meetings. A systematic approach to the implementation and evaluation of this strategy has provided clarity, cohesion, and a roadmap for cultural transformation. As a result, we are beginning to see the emergence of healthful, person-centred workplace cultures where staff, patients, and families alike are supported to thrive.

## Creating a Strategy for Transforming Person-Centered Cultures [A064]

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Person-centred healthcare practice is vital to achieving a truly holistic system where individual values and beliefs are respected and where healthful cultures can flourish. However, there are significant challenges within healthcare systems that impact on the development of healthful workplace cultures. Our presentation explores the use of the Person-Centred Practice Framework and a Practice Development approach with all Directors of Nursing and

Midwifery (DoNMs) to co-create a strategy for nurses and midwives within our health district that will enable the delivery and development of person-centred healthcare practices. Practice Development methodology was the approach used with skilled facilitation adopted to enable the co-creation of a shared purpose of person-centred practice and explore the values that underpin this purpose. Agreed working principles and behaviours supported consensus building methods to co-create draft strategy priorities with DoNMs, further defined by wider stakeholder engagement. Using Collaboration, Inclusion and Participation (CIP), a core foundation of practice development, enabled connection and co-creation throughout the strategy development. Over 390 nurses and midwives at all levels contributed via townhall sessions and focus groups, providing over 2100 items of feedback. Our 5-year strategy was co-created inclusive of seven key strategic priority areas and corresponding strategic actions; Developing Person-Centred Cultures Creating a Supportive Practice Environment Building Research Capacity Building a Dynamic Workforce Fostering Leadership at all Levels Enhancing Digital Informatics and New Technologies Delivering High Quality, Safe Person-Centred Care Together they provide a roadmap for implementation of the strategy across the many nursing and midwifery contexts within SESLHD. This strategy provides a strong foundation, empowering nurses and midwives to reach their potential. It helps them focus on what matters most and encourages innovative approaches to practice. Our strategy acknowledges the influences on nursing & midwifery practice and the need for our care to remain responsive within complex and changing healthcare environments.

## Strengthening Doctor-Patient Relationships through Science Communication Strategies: Beyond Empathy [A065]

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Medical jargon often hinders doctor-patient communication, with 65.4% of Chinese doctors reporting frequent misunderstandings. While empathy is crucial, it cannot fully resolve these knowledge gaps. Science communication (SC) strategies are essential for translating complex medical information into actionable knowledge, thereby potentially improving trust, treatment adherence, and clinical outcomes. This study investigates the application and role of digital AI-integrated SC frameworks in optimizing patient-centered care. Effective SC involves simplifying medical concepts, such as explaining diabetes in lay terms, which research suggests enhances patient trust and improves health outcomes across cultures. Key strategies include providing patients with access to their medical records, which fosters better communication and adherence, and using analogies and visual aids to make information accessible. Digital AI-integrated SC frameworks, such as chatbots and virtual assistants, further enhance communication by offering personalized, real-time explanations of medical conditions and treatments. Studies indicate that AI-powered chatbots have supported pregnant women and post-surgery patients, improving engagement and adherence. Additionally, AI can assist physicians in drafting clear and empathetic responses to patient messages, reducing cognitive burden and enhancing communication quality. Integrating these frameworks into healthcare systems requires careful implementation to ensure accuracy and address diverse patient needs. Incorporating SC training into medical education, supported by tools like virtual patients, is essential for preparing healthcare professionals. Policies, such as the U.S. Health Insurance Portability and Accountability Act (HIPAA), which ensures patients' rights to access their medical records, promote transparency and support SC efforts. In conclusion, digital AI-integrated SC frameworks offer promising strategies to strengthen doctor-patient relationships by making medical information more accessible and understandable. These frameworks complement empathy and address the challenges posed by medical complexity. However, their success depends on training for doctors, supportive policies, and ongoing research to address challenges and ensure patient-centered care worldwide.

# People of Old Age

## Health care professionals' perceptions of participation and mutual learning during mealtimes in nursing homes [A066]

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Background: Mealtimes are a central component of care and according to the Swedish national guidelines for meals in elderly care, a caring meal should be person-centred. One important part in person-centred care is participation, which is also emphasized as a central aspect in the guidelines for mealtimes. During mealtimes in nursing homes, both residents, their relatives and health care professionals could participate and when participating, there could be moments of learning. Aim: To explore healthcare professionals' perceptions of the potential for participation and mutual learning between residents, their relatives and colleagues during mealtime situations in nursing homes. Method: Data was collected through individual semi-structured interviews with 23 health care professionals (nursing assistants, licenced practical nurses and nurses) working in nursing homes in a municipality in south-eastern Sweden. Reflexive thematic analysis was used to analyse data. Result: Three themes were developed, (I) Participation and learning needs prerequisites at multiple levels – at the organisational level, these were influenced by the meal environment and the structure of work. At the group level, team communication and climate were central and at the individual level a person's knowledge and view of humanity were important. (II) Participation and learning could be expressed in multiple ways– these could manifest as the possibility to choose where to sit and what to eat, the possibility to choose to not participate and, to explain and educate one another. (III) Participation and learning as positive yet challenging – both were perceived to contributing to well-being and personal development, but challenges could arise, for example, when the resident´s preferences conflicted with what was considered best for the group.

Implications/conclusions: The result shows that participation and learning between healthcare professionals, residents and their relatives in nursing homes are complex processes, requiring active efforts at all levels of the organisation.

## Perceptions and Experiences of Person-Centered Care in Residential Care of Older People: A Qualitative Interview Study with Residents and Next of Kin [A067]

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Background and Aim: The aim was to explore how residents and next of kin perceive and experience key aspects of person-centered care (PCC), as a foundation for co-creating a sustainable PCC model. PCC emphasizes dignity, respect, self-determination, choice, individualized care, and purposeful living. Despite its central role in care policy, residents in residential care facilities report dissatisfaction with everyday life and the care they receive. There is a need for robust, sustainable models to implement PCC in residential care for older adults. This study is part of the ProFoUND PCC project—Program for User-Based Nursing Development in Person-Centered Care— and explores everyday care experiences, providing baseline insights that will inform the development of a co-created model grounded in real-life care contexts. The study is conducted within two academic residential care facilities (ARCF); facilities that collaborate with universities to integrate research, education and development into daily care practices. Methods: Individual semi-structured interviews were conducted with residents (n=10) and next of kin (n=20). The interview data were analysed using qualitative content analysis. Results: Preliminary findings indicate that residents frequently experience a lack of inclusion in decisions pertaining to

their care. Rather than active participation, residents often convey a sense of passive acceptance concerning both their circumstances and the care provided to them. Next of kin report a general sense of reassurance regarding the safety and well-being of their relatives residing in the ARCFs. Nevertheless, they also express concerns about insufficient involvement in care-related decisions and indicate that their perspectives are not adequately recognized or addressed. Conclusions: Findings suggest that the PCC model should include structures that embed essential components of PCC, such as relational and participatory principles, into everyday practice. These structures should involve both residents and next of kin to have potential to strengthen transparency and trust throughout the care.

## Patients' experiences of orthopedic care for hip fracture in relation to frailty and frailty assessment [A068]

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Background: Frailty is a concept that has been established within healthcare over the past decade and refers to an individual's reduced ability to cope with stressors due to impairments in multiple physiological systems. Validated rating scales exist to assess the degree of frailty. Patients who have sustained a hip fracture are often frail, but there is limited knowledge about how patients themselves perceive the concept of frailty and frailty assessment. Purpose: To describe patients' experiences of orthopedic care for hip fracture in relation to frailty and frailty assessment. Method: A descriptive qualitative design was used. Semi-structured interviews were conducted with 12 patients treated for hip fracture, where frailty assessment was part of the

routine upon admission. The interviews were digitally recorded, transcribed, and analyzed using inductive content analysis. Preliminary Results: Patients' experiences of orthopedic care in relation to frailty were reflected in one main category, 'Being involved matters'. This main category comprised three generic categories: 'Managing care', 'Being frail means being vulnerable', and 'Searching for a shared perspective'. Within these were six subcategories: 'Targeting own goals', 'Submitting to care routines', 'Being fragile', 'Needing extra care', 'Lacking communication', and 'Wanting to be seen and heard'. Discussion: Patients described that frail individuals require extra care but that they did not understand that frailty assessment was conducted. While they expressed that care should be adapted according to the patient's conditions, many reported having to set their own goals due to a lack of support from healthcare providers and that participation on their own terms was not always facilitated. The findings suggest a need for improved communication between healthcare providers and patients, where a shared vision for the patient's ongoing care and rehabilitation is based on the patient's conditions and individual preferences.

## Person-centredness in residential nursing homes: perspectives of older people, their relatives, and healthcare staff [A069]

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The aim was to describe and compare the level of person-centered care climate in residential nursing homes from the perspectives of older people, their relatives, and healthcare staff. Faced with a growing proportion of older people with multimorbidity and dwindling financial resources, a person-centered care environment is described as contributing to the well-being of older people, to the perception of quality of care by relatives, and to the job satisfaction of nursing staff in residential care. The person-centered care approach is created through interpersonal relationships, where the fundamental values are respect and self-determination. Person-centered

climate involves the person's experience of feeling welcome, the recognizability of the surroundings, and the experience of hospitality, security, and safety. From a holistic perspective, it is important to consider older people, their relatives, and healthcare staff, and to integrate relatives into the care process. However, the person-centered climate, as perceived by older people, their relatives, and healthcare staff in residential nursing homes, remains insufficiently explored. A descriptive, comparative cross-sectional design was employed. The study population comprised older people (≥65 years) living in 13 publicly or privately managed residential nursing homes, their relatives, and healthcare staff. Person-centered Climate Questionnaires (PCQ) for patients, relatives, and staff respectively were used to describe person-centered care climate. Participant characteristics included health-related quality of life (EQ-5D-5L), and demographic data. Data analysis will be conducted using non-parametric statistical methods. Data collection will be completed in November 2025, and results will be presented at the conference.

## Developing a Chinese Version of "Adapted Lifestyle Integrated Functional Exercise" as a Falls Prevention Intervention Programme [A070]

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Purpose: Adapted lifestyle-integrated exercise (aLiFE) programme, which seamlessly integrates balance and strength exercises into daily routines, is an alternative exercise intervention for falls prevention. This study aims to develop a Chinese version of aLiFE (CliFE) and test its feasibility. Method: There are four stages in my project. Stage 1 involved focus groups and individual interviews to explore initial perceptions of the aLiFE programme. Stage 2 used an advisory PPIE to draft the CLiFE programme. A four-week pre–post feasibility study, followed by follow-up interviews, was conducted to examine the feasibility and acceptability of the CLiFE programme. Descriptive statistics and content analysis were used. Results: Three focus

groups with 18 older adults (aged 64–87) and three partners (Researcher, Community leader, and Health professional) interviews were conducted in Stage 1. Descriptive analysis indicated good feasibility of performing aLiFE movements within this population. The CLiFE programme was developed following Stage 2 advisory PPIE with seven older Chinese adults. Compared with aLiFE, CLiFE included a Chinese-translated manual, more pictures instead of text demonstrations, group teaching rather than individual home visits, simplified movement difficulty, and an easier daily data collection method. In Stage 3, 15 participants (aged 64–87) completed a 4-week pre–post feasibility test with follow-up interviews. Preliminary findings suggested high acceptability and feasibility of CLiFE among community-dwelling older Chinese adults in the UK. Reported barriers included health-related conditions, memory difficulties, low literacy, and the paper burden of data collection.

## Effectiveness, Feasibility of Integrating Lifestyle Functional Exercise and Its Modified Versions in Falls Prevention Among Older Adults [A071]

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Background: Currently, most fall-prevention exercise programmes are highly structured and often struggle to maintain participants' adherence. The Lifestyle-integrated Functional Exercise (LiFE) programme and its modified versions have emerged as alternative interventions, offering advantages in time flexibility and long-term adherence. This systematic review aims to synthesis the effectiveness of LiFE and its modified versions on fall prevention and risk reduction. It also synthesis qualitative and quantitative evidence on their feasibility and acceptability as fall prevention intervention programmes among community-based older adults. Methods: Studies that implemented the LiFE programme or its modified versions as interventions in community-based settings and were published in English or Chinese were included. No restrictions were applied to study design. Abstract-only papers

and thesis were excluded. Studies reporting fall-related or proxy outcomes were eligible for inclusion. Six databases were searched from inception to May 2025. The Cochrane Risk of Bias (RoB 2) tool and the Joanna Briggs Institute (JBI) Critical Appraisal Tools were used for quality assessment. Meta-analysis and forest plots were applied to examine the effectiveness of falls reduction, while descriptive thematic analysis was used to synthesis data on feasibility and acceptability. Results: A total of 13 studies were included, comprising 547 participants from RCTs and 141 from non-RCTs. The included studies consisted of four RCTs, three single-arm feasibility studies, two mixed-methods studies with single-arm feasibility designs, and two qualitative studies. Preliminary outcomes showed LiFE and its modified versions demonstrated improvements in fall reduction, balance, strength, and quality of life. Participants reported positive experiences; nevertheless, barriers such as paperwork burden and health-related issues (e.g., knee pain) were frequently mentioned. Discussion: The findings suggest that more RCTs with long-term follow-up are needed to strengthen the evidence base. Future studies should also include more diverse ethnic groups to enhance the generalisability of the findings.

## Digital alarm systems with safety sensor and camera in special housing facilities – Supportive or intrusive? [A072]

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Background: As the world's population age at a fast rate, promoting health and wellbeing of older persons is vital and necessitates appropriate care and an enabling environment. The municipalities, responsible for the special housing facilities, face significant challenges in recruiting sufficient social and

healthcare professionals to meet the growing demand of health and social care. Welfare technology may be an important contributor in social and health care provision. The use of welfare technology has often not fulfilled the expectations when implemented in real-world settings, and research on the direct experiences of older persons with these technologies, particularly those living in special housing facilities, is lacking. Objective: To investigate the experiences of older persons utilizing a digital safety alarm system in special housing facilities. Method: A qualitative study based on 17 individual interviews with older persons living in special housing facilities, analyzed with qualitative content analysis. Results: The older persons found digital safety alarm system to involve emotional-, existential- and technological aspects. They found increased security in case of incidents influencing safety in everyday life. They narrated how digital safety alarm system limited one's privacy, and that they learned to live with visibility- They also had a desire to be in control of the surveillance, as they managed the devices. An overarching theme emerged: Balancing inner peace and vulnerability in everyday life. Conclusion: Digital safety alarm system is perceived as a valuable tool for enhancing safety and security for older persons in special housing facilities. However, its use raises questions about privacy and the risk of perceived intrusions into personal space. To ensure the technology is accepted and experienced positively, careful implementation is required, balancing practical safety needs with individuals' rights to personal privacy.

## "We Don't Really Talk About It": Nurses' Perspectives on Discussing Dementia with Patients in Home Care Services [A073]

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Background: Open, person-centred conversations about dementia are essential for supporting autonomy, dignity, and adaptation following diagnosis. However, such dialogue is often avoided in everyday practice. This study explores home care nurses' experiences of engaging in conversations

with people living with dementia about their condition. Methods: An empirical, qualitative study was conducted in two Norwegian municipalities. Five home care nurses participated in semi-structured interviews analysed inductively using qualitative content analysis. The study followed the COREQ guidelines and received ethical approval from the Norwegian Centre for Research Data. Findings: Three main categories were identified: (1) Hesitation despite recognised importance, (2) Barriers to initiating dementia dialogue, and (3) Avoidance driven by euphemisms and fear. While nurses acknowledged the importance of enabling people living with dementia to talk about their diagnosis, they rarely initiated such conversations. Structural factors, including time pressure, task-oriented routines, and unclear role boundaries, reinforced avoidance. Personal uncertainty and fear of causing emotional distress led nurses to use euphemistic language such as "memory problems" rather than explicitly naming dementia. The findings reveal a "silent dialogue" in which both nurses and patients share awareness of the diagnosis but refrain from addressing it openly. Discussion and implications: The study highlights the ethical tension between protecting patients from distress and promoting autonomy through open dialogue. Strengthening organisational and professional support for person-centred communication, including time allocation, training, and reflection, may empower nurses to engage more confidently in meaningful conversations about dementia. Conclusion: Person-centred communication in dementia care requires not only individual competence but also organisational conditions that legitimise and enable such dialogue. Addressing the silence surrounding dementia can enhance relational care and uphold the personhood of those living with the condition.

## Enacting Person-Centred Care in Residential Care: The Perspectives of Social and Healthcare Staff [A074]

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Background and aim: Despite person-centred care (PCC) being a cornerstone of high-quality care, older persons in Swedish residential care facilities (RCFs) report declining satisfaction with their influence and involvement in care decisions. This poses risks to their health and well-being. Staff also highlight unmet psychosocial needs among residents, as routines prioritise medical tasks. When staff are unable to deliver person-centred care, it may lead to job strain and reduced well-being. Currently, there is a lack of validated and sustainable models for implementing PCC in RCFs. This study is part of ProFoUND PCC - a Program For User-based Nursing Development in Person-Centred Care, which aims to co-create such a model together with staff and other stakeholders. The present study explores staff experiences of delivering and enacting PCC in everyday practice, providing baseline insights that will inform the subsequent co-creation of a contextually grounded PCC model. Methods: Semi-structured individual interviews were conducted with social and healthcare staff (n=30) from two residential care facilities. Interviews were conducted in person or digitally, transcribed verbatim and analysed using qualitative content analysis. Results: Preliminary findings indicate that PCC is primarily enacted through everyday routines and interactions rather than through formal plans or documentation. Staff emphasised respect for residents' individuality and autonomy but described challenges such as time pressure, varying competence levels and inconsistent organisational routines. Leadership and workplace culture emerged as important influences for translating person-centred values into daily practice. Conclusions: Preliminary interpretations suggest that achieving sustainable PCC may rely less on individual motivation and more on organisational conditions that enable it. Supportive leadership, opportunities for competence development and a collaborative culture appear essential for fostering person-centred care within RCFs.

# Meaningful connections are person-centred: a qualitative study of care home leaders' perceptions of meaningful connections within care homes [A075]

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Social connection is a public health priority. Connecting meaningfully at an individual level, where a person feels seen, heard and valued, is essential to form social connections, and positively impacts across a person's health and wellbeing, leading to a more enriching life. However, an estimated one in four older adults are socially isolated, and individual, systemic, and structural barriers within care homes limit opportunities for meaningful connection in this population. Aim: To explore care home leaders' perceptions of meaningful connections within their care home, including opportunities for connection, mechanisms to make them meaningful, and the outcomes of those connections. Methods: Qualitative, semi-structured interviews (n=11) were undertaken with a purposive sample of care home leaders across one region of the United Kingdom using MS Teams for audio-recording and transcription. Directed content analysis, based on deductive and inductive coding and guided by the Person-centred Practice framework, was used to analyse the data. Results: Connecting during personal care, reminiscing with the residents and families, connecting within the care home through personalised activities, and building links with the wider community were key opportunities identified for connection. Getting to know and appreciate the person, being present, providing holistic and personalised care, engaging authentically to spark joy, and sharing in decision making to build a sense of belonging and togetherness were central mechanisms to promote meaningful connection among residents, relatives, and staff in care homes. Care home managers perceived those meaningful connections led to positive experiences for residents, relatives, and staff. Conclusion: The most important opportunities for meaningful connections were in the day-to-day personal care, helping to remove some of the barriers reported around lack

of time and funding to organise structured activities. Moving forward it is essential to work with care homes to develop mechanisms to collect formal evidence around the impact of meaningful connections.

## How can digital technologies support meaningful connections in care homes? [A076]

*Deborah Muldrew[1], Rosemary Bradley[1] & Kelly Conway[1]*

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Background: Leveraging digital technology to promote social connectedness has the potential to affect positive health outcomes. The introduction of digital technologies were accelerated into care homes as a result of global restrictions during the Covid-19 pandemic, despite reported systemic and structural barriers. Technology-Supported Interventions can improve Old-Age Social Wellbeing among older adults living in social isolation, however the evidence base within care home environment is not clear. Aim: to identify how digital technologies are used in long-term care settings to facilitate meaningful connections Methods: a scoping review following guidance from the Joanna Briggs Institute was undertaken. Four online databases (CINAHL, Medline, PsycINFO, Scopus) were searched in February 2025 to identify digital technologies which have been used in care homes to support the development of meaningful connections. Grey literature was searched through Google Scholar, and forward and backward citation searching was also undertaken. Result: Forty-two studies were included in the review. Technologies including robotics, virtual reality, mobile/tablet applications, digital devices, and online programmes have been utilised in the care home. Mechanisms through which meaningful connections are made include increased opportunities to connect with family/friends, staff, and the wider community, getting to know the resident as a person, providing a sense of control and autonomy, and sparking joy. Conclusions: Digital technologies are becoming increasingly prevalent within the care home sector beyond passive monitoring through medical devices. Underpinning the application of digital technologies with a person-centred approach, primarily through

getting to know the person as more than their condition, being sympathetically present, and connecting authentically, will enhance physical, psychological and social outcomes for residents, families, and staff in care homes.

## Resource use in Swedish nursing homes over five years: a repeated cross-sectional follow-up study [A077]

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Aim: Nursing homes in Sweden provide housing and care for people 65 years or older who require assistance with everyday activities and care. An increasing number of nursing home residents have cognitive and functional decline, which leads to an increasing need for care time. Nursing home staff also report a lack of time to meet nursing home residents' needs, which may impact perceptions of person-centered care. This study aimed to explore changes in resource use and associated factors in Swedish nursing homes over five years. Methods: This repeated cross-sectional follow-up study used baseline (2013-2014) and follow-up (2018-2019) data from 4599 participants in the Swedish National Inventory of Care and Health in Residential Aged Care study. Time spent assisting nursing home residents' needs was measured using the Resource Use in Dementia scale. Descriptive statistics, t-tests and chi-square tests, and individual multiple linear regression were performed. Results: Resource use increased from 7.15 h/day to 7.83 h/day between baseline and follow-up. Resource use decreased among residents with higher levels of independence in activities of daily living (Personal activities of daily living: -0.31 h/day; Independent activities of daily living: -0.11 h/day; total resource use: -0.61 h/day). The number of residents living in a dementia unit increased from 34.6% to 43% and resource use increased among residents

living in a dementia unit (total: 3.08 h/day). All reported values were statistically significant. Conclusion: Resource use in Swedish nursing homes increased between baseline and follow-up. These findings could help nursing home managers, stakeholders, and municipalities in future decisions regarding policies, financing, and implementation of person-centered care.

## Exploring Relational Engagement in Home-Based Care: Observational Insights Using the Fundamentals of Care Framework [A078]

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Background: Establishing and maintaining a professional nurse–patient relationship is a core dimension of the Fundamentals of Care Framework[1], encompassing trust-building, being present and focused, getting to know the individual, anticipating needs, and collaborative evaluation of the relation. Such a relationship is widely recognised as essential for addressing fundamental care needs through a person-centred approach. However, despite clear conceptual definitions, the consistent integration of these relational elements into everyday nursing practice—particularly in home-based care—remains uncertain. Aim: To explore nurses' activities related to how the nurse–patient relationship is established and maintained in home-based care for older people. Methods: This study is part of a larger project exploring nursing practice, Fundamentals of Care and quality of care. A structured observation protocol based on the Fundamentals of Care Framework was used to support direct observations (N=230) of nurses' home-visits at four home-based care settings in Sweden (Table 1). Data was analysed with descriptive statistics. Results: The most frequently observed activity was nurses engaging in trust-building, which occurred in nearly every observation (Figure 1). This was followed by activities reflecting focus, knowing the older people, and anticipation of their needs. However, nurses'

engagement in anticipating care needs and developing familiarity with older peoples varied across sites. Notably, evaluation of the nurse–patient relationship was observed only once (0,7% of the observations). Conclusion: Nurses predominantly established and maintained the nurse–patient relationship through trust-building, being focused, getting to know the older people, and anticipating their needs. However, the degree of engagement in familiarity and anticipating varied across sites. The near absence of mutual evaluation of the nurse–patient relationship reveals a critical gap in person-centred care and highlights an opportunity for strengthening reflective and collaborative practices in home-based care settings.

**Table 1. Characteristics of observations**

| Characteristics | Observations site 1-4 | Observations site 1 | Observations site 2 | Observations site 3 | Observations site 4 |
|---|---|---|---|---|---|
| Observations* *n* (%) | 230 | 59(26) | 69(30) | 44(19) | 58(25) |
| Older people receiving care *n* (%) | 109 | 23(21) | 22(20) | 23(21) | 41(38) |
| **Length of observations (minutes)** | | | | | |
| -Mean (SD) | 24(19) | 28(25) | 19(16) | 26(19) | 23(12) |
| -Median | 19 | 20 | 15 | 18 | 20 |
| -Min-max | 1–115 | 2–115 | 2–80 | 1–90 | 5–52 |
| **Observed activities related to the nurse-patient relationship *n* (%)** | | | | | |
| Number of observed activities | 796 | 210 | 228 | 141 | 217 |
| -Building trust | 218(27) | 59(28) | 62(27) | 41(29) | 56(26) |
| -Being focused | 210(26) | 53(25) | 63(28) | 39(28) | 55(25) |
| -Anticipate needs | 174(22) | 45(21) | 46(20) | 30(21) | 53(24) |
| -Knowing the older people | 193(24) | 53(25) | 57(25) | 31(22) | 52(24) |
| -Evaluate the relationship | 1(<1) | 0(0) | 0(0) | 0(0) | 1(<1) |
| **Nursing staff part of observations *n* (%)** | | | | | |
| -Registered nurses | 89(39) | 22(37) | 26(38) | 17(39) | 24(41) |
| -Nurse assistants | 141(61) | 37(63) | 43(62) | 27(61) | 34(59) |
| **Team composition in observations *n* (%)** | | | | | |
| -Working alone | 198(86) | 49(83) | 56(81) | 40(91) | 53(91) |
| -Working in pairs | 32(14) | 10(17) | 13(19) | 4(9) | 5(9) |
| **Participants *n* (%)** | | | | | |
| -Registered nurses | 23(50) | 3(38) | 8(62) | 5(42) | 7(54) |
| -Nurse assistants | 23(50) | 5(63) | 5(39) | 7(58) | 6(46) |

*One observation is equivalent to one home visit.

Figure 1. Nurses' activities* related to establishing the nurse-patient relationship in % of observations (*N*=230).


* Activity frequency was calculated per nurse to account for variation in observation counts.

1. Feo R, Conroy T, Jangland E, Muntlin Athlin Å, Brovall M, Parr J, et al. Towards a standardised definition for fundamental care: A modified delphi study. J Clin Nurs. 2018;27(11-12):2285-99.

# Continence care quality from the perspective of older women who receive home care and who reside in nursing homes in Sweden and Canada [A079]

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Background: Incontinence is a common condition among older women receiving home care and residing in nursing homes. Incontinence is a risk factor for social isolation and physical deconditioning, is associated with depression, falls and early mortality, and impairs quality of life. Patients' experiences are one of key indicators of care quality, yet research exploring older persons' perspectives on quality of continence care remains limited. A recent scoping review (submitted) showed that continence care is often not tailored to older persons' needs and wishes. Aim: To examine what constitutes quality of continence care from the perspective of older women receiving home care or residing in nursing homes in Sweden and Canada. Method Older women (65+) with urinary or/and fecal incontinence were interviewed in their homes (n = 23) and in nursing homes (n = 27). Interviews were transcribed verbatim and analyzed by qualitative content analysis. Preliminary results: There is considerable similarity in themes among older women, despite their differing countries. All emphasized the importance of communication and shared decision-making. Intimate care required staff attention to dignity, autonomy, and privacy. Care quality depended on the attitudes of and relationships with the staff. Participants highlighted the importance of comfortable, safe incontinence products and adapted physical environments. Differences between home care recipients and nursing home residents appeared regarding readiness to accept intimate

care from male staff, the need to adapt to staff visiting times, product deliveries and sharing, and bathroom adaptations. Conclusions: There is a need to improve delivery of care to better meet the needs of care recipients. Quality continence care should involve care recipients in decision-making, promote respectful communication, ensure privacy, enable gender-appropriate care, secure product management, provide adequate staffing, continuity, educated staff, as well as adapt facilities.

## Exploring person-centered workplace culture in an inpatient department for older adults with chronic illnesses [A080]

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Introduction: The demographic shift towards an aging population, combined with the rising burden of chronic conditions, places increasing pressure on healthcare systems in high-income countries. In this context, person-centered care has gained prominence, promoted by the World Health Organization and embedded in national health policies, reflecting a global movement to reorient health systems around individuals. However, translating person-centeredness into clinical practice is a gradual and complex undertaking, strongly influenced by organizational culture and the conditions under which care is delivered. The sustainability of person-centered practice, as well as the experiences of inpatients and healthcare professionals, is determined by these contextual elements. Objective: To describe the role of workplace culture in shaping person-centered practice in an inpatient hospital department for older adults with chronic illness.

Methods: The study adopted a qualitative, descriptive, exploratory-observational design. Participant observation, guided by the Workplace Culture Critical Analysis Tool®, served as the basis for data collection. Data was examined through a deductive thematic content analysis, with themes identified and organized in accordance with the Person-Centered Practice Framework, covering the dimensions of prerequisites, the practice environment, and person-centered processes. Results: Themes were identified across all dimensions of the Person-Centered Practice Framework. Variations in subthemes suggested inconsistencies in care delivery, linked to variations among professionals and limited opportunities for multiprofessional dialogue and collaborative decision-making. The analysis revealed tensions between routine-driven tasks and holistic, individualized care planning essential to person-centered practice. Conclusions: Advancing person-centeredness within hospital culture remains a considerable challenge, as routine-oriented tasks frequently undermine efforts to provide individualized care. Strengthening multiprofessional collaboration and integrating reflective practices are key strategies to contribute to the creation of a more supportive workplace culture and to ensure the sustainability of person-centered practice in this context.

## Enhancing person-centred care through older adults' narratives of everyday life [A081]

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Background: Older people who live alone and use home care may be in a vulnerable situation. However, they have often managed their everyday lives for a long time, often while dealing with health challenges. To provide person-centred care, care providers must engage with older home care service users' own perceptions of their strengths and vulnerabilities. In this study, we explored how nine older adults, who live alone, receive home care and are considered to be frail by home care professionals, managed their everyday lives by inquiring into their stories. Methods: We conducted a series of three qualitative interviews with each of the nine participants over a period of eight months, and we analysed the data using thematic analysis and a narrative positioning analysis. Results: Using the concept of resilience as our analytic lens, we identified three thematic threads: continuity, adaptation and resistance. The narrative positioning analysis of three participants' stories revealed that the participants used the processes of continuity, adaptation and resistance strategically and interchangeably. Conclusion: The study provides insight into how older people who live alone and use home care services balance strengths and vulnerabilities in their stories. The results of the study highlight the potential of storytelling in person-centred care. Encouraging storytelling and engaging with older people's narrations might support how older people enact resilience and, in turn, their management of everyday life.

Authors: Kristin Voie, Janine Wiles, Bodil H. Blix, Margrethe Kristiansen, Ann Karin Helgesen og Kjersti Sunde Mæhre. Voie KS, Wiles J, Blix BH, Kristiansen M, Helgesen AK, Mæhre KS. Older people enacting resilience in stories about living alone and receiving home care. Ageing and Society. 2025;45(4) https://doi.org/10.1017/S0144686X23000880

## Involving Stakeholders in Quality Improvement: Communities of Practice in the Care for Older People [A082]

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Interprofessional collaboration is important to address the rising care demands in long-term care (LTC) for older people, as it yields positive outcomes for clients and care professionals. Yet, previous research has shown that clients and family members are insufficiently involved in the design and implementation of interprofessional quality improvement. Given the growing emphasis on relationship-centered care, the lack of involvement of clients and family members in quality improvement initiatives is remarkable. Our action research addresses this gap by involving clients and family members in three quality improvement projects in two LTC organizations through Communities of Practice (CoP). CoPs are a mechanism for interprofessional collaboration that can address complex problems through co-creation and collective learning among stakeholders. Findings show that CoPs are a promising method for quality improvement in LTC. The three projects each address a question regarding better use of quality data with the aim of providing a higher quality of care for the client. It is anticipated that the involvement of clients and family members in CoPs will lead to better outcomes, tailored to their wishes and needs. In this presentation, we will describe the co-creative process of quality improvement in CoPs, making the connection to previous research on barriers and facilitators for interprofessional quality improvement in LTC.

## The impact of the COVID-19 pandemic on older adult experiences with healthcare: a systematic review [A083]

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To implement person-centred care, healthcare practitioners and leaders need to understand the experience of those who are recipients of care. The COVID-19 pandemic worked across multiple levels to impact the patient experience as healthcare systems adapted to provide safe care. Older adults represent an important demographic to understand healthcare experiences, especially in the context of the COVID-19 pandemic. Not only were older adults extremely vulnerable to COVID-19 but they represent a demographic with high exposure and use of healthcare. To understand older adults' experience of healthcare during the COVID-19 pandemic we conducted a mixed methods systematic review using a convergent integrated approach and thematic synthesis. Qualitative, quantitative, and mixed methods studies (2019-2024) of older adults who lived in the community and accessed healthcare services during the COVID-19 pandemic were included. Experiences of those in facilities or residential care were excluded, as were studies not conducted in a peer country to Canada. The 16 included studies described the impact of COVID-19 on community-dwelling people of old age across three themes. Three main themes reflected the experiences of 1) accessing healthcare services and providers, 2) shifting to virtual care, and 3) receiving care, specifically the associated emotional and physical distress, as well as how healthcare providers offered care and support. These findings are discussed in the context of person-centred care with relevant recommendations for health system leaders and care providers. Some older adults' descriptions of care during the pandemic arguably depict person-centred outcomes of well-being and flourishing, while others depict very difficult care experiences where the delivery of person-centred care was challenged. These experiences can be used to point to areas where person-centred can be enhanced and barriers reduced.

# Evaluation of Interventions

## Patient-Reported Outcomes to Monitor Prostate Cancer Treatment - Study Protocol for a Cluster Randomized Controlled Trial (PROMPT) [A084]

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Background: During the past decade, the growing number of treatment options for men with metastatic prostate cancer (mPC) has resulted in longer survival and treatment duration. Both the metastatic disease and the treatments' side-effects may cause distressing physical and psychological and symptoms that lower quality of life. Regularly planned follow-up consultations at an oncology or urology department to monitor such symptoms are standard practice. Patient-reported outcome measures (PROMs) have been broadly incorporated into cancer care during the last decade despite scarce evidence regarding the benefits of using PROMs for men with mPC. Aims: We aim to investigate whether the use of PROM, based on EORTC QLQ-C15-PAL, filled in online prior to the consultation and displayed on a monitor at the consultation, influences the patients' experience of: having an adequate discussion about their most distressing

symptom, and shared decision-making, measured using the CollaboRATE questionnaire Methods: Multicenter cluster randomized trial. Patients with mPC scheduled for consultation at the clinic during the study period will be asked to participate and, if they accept, to fill out forms before and after the consultation. Primary outcome measure will be the proportion of patients who report that their most distressing symptom was inadequately discussed, defined as score ≤ 6 on a 10-point scale reported directly after the consultation. We aim to include 300 patients; this will give 80% power to detect a reduction from 30% to 15% of the proportion of patients who feel their most important symptom was inadequately discussed with a significance level of 0.05. Clinical significance: If the use of PROMs during clinical consultations is shown to enhance symptom communication, this approach should be advocated in clinical practice to improve the care for men with metastatic prostate cancer. If not, the ongoing implementation of PROMs in clinical practice should be reconsidered.

## Bridging the knowledge gap through leadership that encourages inter-professional collaboration [A085]

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Background: Primary health care centres (PHCCs) are the first contact for all people with health-related problems, with the exception of emergency care. The mission of PHCC is to provide tailored, person-centred care where unhealthy lifestyle habits need to be addressed as they affect today's most common non-communicable diseases that cause death and illness. The Act in Time project supported staff and managers at PHCCs in health-promoting

clinical practice through a 12-month implementation intervention. The implementation strategies were based on implementation-research literature and the Astrakan model for leading change. The present study aimed to investigate the experiences from managers, staff and internal facilitators in integrating health-promoting practices into their daily routine work following an implementation intervention. Method: A qualitative study with an exploratory purpose was conducted at five PHCC in Örebro County. Individual interviews with managers (n=9), internal facilitators (n=10) and five focus group discussions with PHCC staff (n=18) representing different professions were conducted using semi-structured interview guides. Data were collected 4 months after the completion of the implementation effort and analysed deductively using Normalization Process Theory. Results: A health promotion approach could be introduced by viewing the task as a shared responsibility and goal for all professional groups but with the managers as leader of the project. The relationship with the manager was important for staff to make the intervention to fit in existing practice. Through inter-professional collaboration a greater understanding of each other's work emerged and made it possible to take advantage of existing competence. Conclusion: Tailored strategies make it possible to introduce a health promotion approach in primary care. The role of the PHCC manager is a key factor that may build a bridge between the goals and what is possible. This needs to be done together with the entire work team to create collective participation.

## Facilitating leaders to create workplaces where healthcare staff want to work [A086]

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Introduction: Staff retention, with its multiple factors and no single solution, is a wicked problem. Of the multiple factors influencing staff intention to stay in health and social care settings, leadership and culture are two areas where a significant impact can be made. Front-line leaders are in an ideal

position to cultivate workplaces where staff want to work. Methods: As part of a two-nation project exploring the impact of various interventions on staff retention, we developed and evaluated a leadership development programme for front-line leaders in health and social care. Two cohorts followed a 12-month programme based on a co-operative inquiry methodology and adult, transformative learning theory. Participants were facilitated in moving through continuous cycles of a) identifying individual or group action, b) executing and observing the impact of their actions, c) sharing their observations and reflecting on the meaning of the observations for leadership intended to encourage staff retention. They self-assessed their transformative leadership development three times during the programme and creatively expressed their development narrative at the end of the programme. Results: In this presentation we share the self-assessment and a participant faction (one fictive narrative based on fourteen participant narratives). As well as increased transformational leadership practice, the narrative reveals development in leading self and others. Skilled facilitation was key and, as facilitators of the programme, we were keen to base the ways we worked on the values underlying transformative and person-centred learning. The leader narrative also demonstrates leadership descriptions that resonate with transformational and person-centred leadership, revealing how participants felt better equipped to cultivate workplaces where staff would want to continue working. Discussion: We conclude that leadership development programmes based on adult, transformative and person-centred learning theory create a learning climate and culture that enables front-line leaders to create workplaces where staff want to stay.

## From Conventional Treatment to Intensive Format: Person-Centred Development of PTSD and CPTSD Treatment [A087]

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Background: Life with Post-Traumatic Stress Disorder (PTSD) or Complex PTSD (CPTSD) often entails intense and challenging symptoms. Conventional treatments are lengthy with high dropouts, which leads to reduce effectiveness and increased costs. This PhD project evaluates an alternative, intensive, short-term treatment and investigates how a person-centred approach informs its planning and delivery. Project aims: To develop and evaluate an intensive eight-day treatment for PTSD and CPTSD with the following objectives: • Enable person-centredness through shared decision-making regarding preferred treatment • Offer an efficient and effective treatment • Reduce dropouts Methods / Development Process In 2021, the intensive treatment was introduced at a psychiatric outpatient clinic in Borås, Sweden. The treatment consists of eight full-day sessions and integrates several therapeutic modalities. Treatment begins with setting trauma-focused goals, where patients specify which trauma events to target. A novel feature is therapist rotation, where patients meet different therapists each session. The treatment is evaluated from multiple methodological perspectives. First results: Feasibility study (n=12): results, no increased suicide-risk. Evaluation of 101 patients: lower dropout rates in the intensive format; patients receiving intensive treatment achieved symptom reduction nearly a year earlier than those in conventional treatment. Active patient participation identified as a key factor in the intensive group. Conclusions: A

person-centred approach appears to enhance patient involvement in the decision-making of preferred treatment. Ongoing studies explore factors influencing patients' decisions to engage in intensive treatment, with a parallel study planned for those preferring conventional treatment. A person-centred approach will continue to guide both the choice of treatment format (intensive vs. standard) and trauma-focus within therapy. Next Steps: Associations between perceived participation and treatment outcomes will be analysed. The innovative element of therapist-rotation will be further examined. The intensive treatment will be implemented as part of standard treatment at Södra Älvsborgs Hospital, Borås, Sweden.

## Ecological reliability of the Gothenburg Direct Observation tool - Person-Centred Care (GDOT-PCC) in clinical practice: Preliminary findings [A088]

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Objective: To examine reliability aspects of the Gothenburg Direct Observation tool-Person-Centred Care (GDOT-PCC) for assessing healthcare professionals' competency in delivering person-centred care (PCC) in clinical practice. Design: Ongoing observational study. Setting: The study was conducted at the Department of Internal Medicine at Sahlgrenska University Hospital/Östra. Participants and methods 50 health professionals (HPs) including nurses, physiotherapists, occupational therapists and physicians were observed and independently rated by two research nurses on the GDOT-PCC while interacting with patients. Directly thereafter, patients and HPs were asked to rate and comment on the HP's PCC competency using an abbreviated version of the GDOT-PCC. Results: Results from

analyses of inter-observer agreement, observer-patient agreement, observer-HP agreement and patient-HP agreement will be presented at the conference. Conclusion: We previously assessed inter-observer reliability of the tool using video-recorded patient-HP interactions. This study will provide additional information about its performance in a more challenging real-world setting. Comparisons between patient, HP and observer ratings are expected to further our understanding of the ecological reliability of the GDO-PCC.

## Partnership of a person-centered rehabilitation program for persons with spinal stenosis undergoing decompression surgery – a mixed-methods study [A089]

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Introduction: Partnership between patients and healthcare professionals can improve physical functioning and activities of daily living. For patients with lumbar spinal stenosis (LSS), the cardinal symptom is neurogenetic claudication limiting walking ability. After surgical treatment most patients stay inactive. Rehabilitation may improve postoperative outcome, thus the person-centered 12-week rehabilitation program Get Back was designed to facilitate increased physical activity. The aim of this study was to evaluate the fidelity of partnership in Get Back. Methods: Twelve inactive patients with LSS scheduled for surgery participated in Get Back guided by two physiotherapists. After completion all patients were asked via questionnaire if they felt involved throughout their rehabilitation. Semi-structured interviews were conducted with all patients regarding their experiences of participating in Get Back. After each treatment session the physiotherapists logged if they had used the three routines of partnership (initiating, working and safeguarding). We used descriptive statistics to analyze quantitative data. Interviews were analyzed qualitatively using deductive content analysis with a predetermined categorization matrix comprising the three routines of partnership. Finally, with convergent mixed methods-design, quantitative and qualitative results were merged. Results: All patients answered "yes" to perceived self-participation throughout the rehabilitation and the physiotherapists reported high usage of the three routines of partnership. These quantitative results concurred with the qualitative results, in which the patients expressed experiences of initiating, working and safeguarding the partnership. However, the patients did not perceive that the health plan was used to plan or document activities; instead, they referred to the activity diary and verbal feedback from the physiotherapists. This may contrast with the physiotherapists' logged use of the health plan. Conclusions: The results of

our study support that a high degree of partnership was present during Get Back. However, there is a need to clarify and facilitate the use of the health plan.

## A comprehensive discussion about medicines and a helpful dialogue with someone who cared for me – experiences of a pharmaceutical care intervention [A090]

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Background: The Motivational Interviewing and Medication Review in Coronary heart disease (MIMeRiC) trial tested a pharmaceutical care intervention over 8 months in a randomized controlled design among 316 patients. More intervention participants were adherent to their medicines at follow-up and they had less concern for their drugs, but there was no difference in treatment target attainment rates. Aim: To 1) evaluate participants' experiences of consultations, perceived effect on reasoning about medicines and perceived effect on medicine-taking behavior, and 2) explore in what way the intervention was experienced as person-centred. Method: Four focus groups were undertaken among intervention participants of different characteristics. The focus groups were transcribed verbatim and analyzed with qualitative content analysis. Participants' experience of the intervention was analyzed on a manifest level by LH and MJÖ, using the three research questions to form an unconstrained matrix in which meaning units were analysed inductively. An inductive approach on the latent level was used by FV and MJÖ to explore the person-centredness of the intervention. Results: Preliminary results indicate that participants experienced the consultation as a comprehensive discussion about medicines and a helpful dialogue with someone who cared for them. That it made them

feel safer with their drugs because it tempered their doubts and made the importance more evident, and that it helped them create and follow new routines and change their mind about using statins. Person-centredness was expressed by the participants in partnership, increased confidence, and the feeling that I matter. Final results will be presented in May. Conclusion: Preliminary results indicate that the effect of the intervention on patients' beliefs and adherence in part was related to the person-centredness created by the pharmacists being trained in motivational interviewing. In this study core elements of pharmaceutical care were applied in a way that was experienced as person-centred care.

## Development of a service evaluation tool to understand personalised care delivery – from the perspective of multiple stakeholders [A091]

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Personalised care is a strategic priority, yet widespread implementation remains slow. Although evidence demonstrates that personalised approaches improve outcomes, experience, efficiency, and equity, healthcare organisations often lack the system-level insight required to understand how personalised care is delivered and what influences its adoption. To address this gap, we developed and tested a comprehensive, system-wide service evaluation tool designed to assess, understand, and monitor personalised care delivery across multiple stakeholder groups. Drawing on the Consolidated Framework for Implementation Research and underpinned by the COM-B behaviour change model, the tool comprises four mirrored surveys for service users, clinicians, service managers, and system leads. An

iterative, exploratory design process, involving service users, public contributors, clinicians, behaviour change experts and system leaders, was used to refine survey structure, content, and usability. The tool was piloted with 24 clinical services across a range of settings; involving 397 service users, 313 clinicians, 73 managers and 40 system leads. Findings highlight consistent gaps between what staff report delivering and what service users experience, particularly in understanding what matters to people, supporting shared decisions, and offering choice. Although most practitioners felt capable of delivering personalised care, many reported lacking the opportunity—time, resources, prompts and supportive systems—to enact these behaviours routinely. Motivation was generally high, but staff described limited habit formation and few external drivers to reinforce practice. These insights have enabled participating services to identify targeted quality improvement priorities, guided by behavioural determinants, and to plan repeat evaluations. This evaluation process offers a scalable, theory-informed method for understanding personalised care delivery within complex systems. By generating system-wide insights into behaviours and their drivers, the tool provides a lever for cultural change and sustained improvement. Future work will focus on validation, impact evaluation, and understanding how the tool can support long-term monitoring and transformation of personalised care delivery.

## What instruments are available to aid or evaluate personalised care delivery? A narrative scoping review [A092]

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Personalised care is widely recognised as a mechanism to support individuals with long-term conditions and to transform health-service delivery, yet systematically evaluating how personalised care is implemented remains poorly developed. This review aimed to map and describe the range of instruments, tools or methods designed to assess, evaluate or measure personalised care delivery from the perspectives of healthcare practitioners and/or service users. A scoping review of literature published from 1990 until December 2024 was conducted, following established methodology for identification, screening, charting and synthesis of evidence. From 3,851 initial records, 172 papers were included—103 reporting the development of a new instrument and 69 describing the adaptation of an existing tool. In total, 101 unique personalised-care instruments were identified. The vast majority (94%) of instruments targeted service-users (patients); with eight focusing on healthcare professionals and one on caregivers. Content analysis of instrument items generated six overarching domains: Understanding the Person; Understanding Capability; Understanding Behaviour; Personalised Care Interventions; Experience of Care; and Wider Determinants. Notably, 81% of instruments were designed for use in a specific clinical population (most commonly diabetes), and 80% focused on supported self-management, with fewer aiming at shared decision-making or broader personalised-care processes. No instrument was found to cover all six domains comprehensively, nor to span multiple stakeholder perspectives or multiple long-term conditions. The review highlights a vast number of condition-specific tools but an absence of broadly applicable, system-level instruments for personalised-care delivery evaluation. Future work should prioritise both instrument development and application; incorporating healthcare professional and system views, and support monitoring of personalised care delivery across whole systems. These findings provide a framework (PCED-6) to guide selection and development of personalised-care evaluation instruments and identify important gaps for further research and practice implementation.

# A systematic review of evidence on the links between patient experience and safety [A093]

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Patient experience and patient safety are two important components of care quality. Traditionally, patient experience and patient safety have been addressed as separate domains and relatively few studies have provided an evidence-based exploration of whether and how they are related. This presentation shares findings from a systematic review that examines the extent, nature, and strength of associations between patient experience and safety. PRISMA guidelines were used to design this review. A search of PubMed was undertaken to identify studies published between 2000 and 2023 that explored links between patient experience and patient safety outcomes, including adverse events, medical errors and avoidable harm. 2925 articles were identified and after screening of abstracts, 117 articles were included for full review, and at time of writing 46 of these are being considered for data extraction. Whilst final results from this review will not be available until Autumn 2025, preliminary analysis indicates that studies span a diverse range of healthcare contexts, including inpatient, maternity and primary care settings. They cover various clinical procedures and specialties, from bariatric surgery and endoscopy to radiological services and care for rheumatoid arthritis. Methodologically, the studies reflect variation, using different quantitative approaches and data sources such as safety indicators and outcomes, and self-report surveys (including on care experiences and perceptions of safety). This diversity reflects the broad relevance of the link between patient experience and safety across different healthcare systems, whilst also highlighting challenges in synthesis due to different data collection methods and outcome measures. This presentation is designed for anyone interested in the intersection of patient experience and patient safety.

# Person-centred goals: connecting practice, guidelines and theory [A094]

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Background: Common goals are important in person-centred partnerships. Yet, research suggests a discrepancy between goals formulated by healthcare professionals and those formulated by patients (1). Further, goal strategies often lack theoretical underpinnings (2). Aim: To, based on a study evaluating goals and goal attainment in a remote person-centred intervention, raise discussion about connecting practice, guidelines and theoretical foundation of person-centred goals. Methods: In the randomised controlled trial Early, accessible, person-centred rehabilitation for people with long-term pain (EAPER-P) people on sick leave for chronic pain were allocated to the control group (n=30) or intervention group (n=29). In addition to usual care, the intervention group accessed person-centred support by telephone and an eHealth platform during six months. In the telephone conversations with healthcare professionals, 28 participants in the intervention group formulated goals. These were documented in health plans

on the eHealth platform. A multimethod study divided the 28 participants into those who achieved goals (n=11) and those who did not achieve goals (n=17). Using descriptive statistics and summative content analysis, the study explored change in self-efficacy and sick leave, as well as the content and attainment of goals. Findings: Less than 20% of the 94 identified goals were attained. The group that achieved goals had a better mean change in self-efficacy (2.30) and sick leave rates (-61.36%) compared to the group that achieved no goals (-1.33 and -25%). Conclusion: The study implies a need for exploring and linking the theoretical underpinnings of person-centred goal setting with guidelines and practice.

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## Building Meaningful Partnerships: Forming & Growing a Patient Advisory Council to Implement Person-Centred Quality Indicators in Alberta Primary Care [A095]

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Person-Centred Quality Indicators (PC-QIs) are measurement-based quality improvement (QI) tools that were co-developed with patients, community organizations, decision makers, and providers in Canada. PC-QIs compare a patient's actual care experience, collected using Patient-Reported Experience Measures (PREMs), to an ideal, person-centred care experience. PC-QI use in primary care will help healthcare QI teams identify areas to improve the

person-centredness and overall quality of the healthcare services people receive. To integrate patient perspectives into the implementation of PC-QIs in primary care in Alberta, we established a patient advisory council (PAC) to work with our research team. To achieve this, we will describe the following aims: Formation and development of the PAC, including recruitment of patient partners, co-creation of guiding documents Evaluate the experiences of patient partners in the PAC, collected using a modified PEIRS-22 tool and semi-structured interviews, analyzed using Braun and Clarke's method of thematic analysis Highlight patient-co-developed recommendations for the creation and development of PACs for future healthcare implementation research projects. This work will reinforce the principles of Patient-Oriented Research and Patient Engagement while providing critical insights into the role of PACs associated with implementation research projects. More specifically, we will describe how research teams can effectively co-develop PACs to engage with research projects in a more collaborative and empowering fashion, strengthening the applicability of research results.

## Effects of a person-centered care intervention on health service use in chronic heart failure: preliminary results of a randomized controlled trial [A096]

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Background: People with chronic heart failure face a complex condition that profoundly affects their health outcomes due to symptom burden and psychological factors. Implementing a person-centered care (PCC) approach involves shifting toward a care model that prioritizes patients' preferences and encourages their active participation in care planning and decision-making. Aims: To evaluate the effectiveness of a person-centered care (PCC) intervention, delivered both face-to-face and by telephone, in addition to standard care, compared with conventional care, on the use of health services among people with chronic heart failure. Setting: Three outpatient heart failure units in Spain. Design: A multicenter randomized controlled trial was conducted following the new MRC framework for complex interventions. The study was guided by a program theory and logic model, and co-created with patients and clinicians. Statistical analyses were performed using linear mixed models (LMM) to assess changes over time and between groups, accounting for individual variability. Point plots with error bars were used to visualize score trajectories across time points (t0, t1, t2), helping to illustrate group differences. Results: The PCC group achieved better clinical outcomes. Unplanned hospitalizations decreased from 18% to nearly zero ($p = 0.007$), and unplanned emergency visits dropped from 40% to almost none ($p = 0.023$). Decompensations also declined significantly at t2 ($p = 0.024$), with greater reductions in the PCC group. Regarding EHFScB-9-based self-care behaviors, both groups improved, but the PCC group showed a stronger increase ($p = 0.001$). Conclusion: The sharper decline in emergency events among PCC participants suggests they were better able to recognize symptoms early, take timely action to manage their condition, and may have developed stronger relationships with their care team. Overall, these findings highlight the potential of person-centered care to enhance clinical stability and empower patients to manage chronic heart failure more effectively.

# Effectiveness of nurses' cultural competence interventions on patient-related outcomes [A097]

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Background: The growing demand for culturally congruent, person-centred care has led to increasing importance of implementation and evaluation of cultural competence interventions across healthcare settings. While evidence indicates that healthcare professionals' cultural competence can reduce racism and healthcare inequalities, as well as improving their capacity to navigate cultural diversity, a gap remains in summarised evidence regarding its impact on patient-related outcomes. Aim: This systematic review aims to assess the effectiveness of cultural competence interventions on patient-related outcomes. Design: A systematic review was conducted. Methods: A comprehensive search was conducted in MEDLINE, Embase, CINAHL, PsychINFO, ERIC, Web of Science and CENTRAL up to September 2023 for studies using a quasi-experimental or experimental design. Two researchers independently assessed the eligibility of the studies and their methodological quality. The quality of experimental studies was assessed using the Revised Cochrane Risk of Bias Assessment Tool for Randomized Trials (RoB 2), and the quality of quasi-experimental studies with the Risk of Bias in Nonrandomized Studies – of Interventions tool (ROBINS-I). Results: Three studies met the inclusion criteria: one randomised controlled trial and two pre-test/post-test studies. The interventions included educational and training activities (e.g., presentations, group discussions and reflective exercises) or technology-based resources (e.g., online databases). Two studies reported on patient satisfaction, finding no significant difference after implemented intervention. One study, assessing the effectiveness of a combination of offline and online training courses reported a significant difference in on client-nurse trust and satisfaction with nursing care. Conclusion: Despite the growing interest in and research on cultural competence in nursing, this review reveals a substantial gap in the literature addressing the effects of such interventions on patient-related outcomes.

This review highlights the urgent need for future empirical research focusing on patient perceptions and experiences within interventions aimed at fostering culturally competent, person-centred care.

## Exploring the benefits and challenges of a person-centred education on the Nordic diet for adults with Type 1 diabetes [A098]

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Background and objectives: The Diabetes Intervention involving person-centred Nutritional Education (DINE trial), is an ongoing project aiming to evaluate the impact of a novel and relatively unexplored person-centred dietary approach, of a sustainable Nordic diet, to people with Type 1 diabetes. Participants' perceptions and experiences of person-centred, nutritional education and the effectiveness of individual health plans will be explored. The research questions aim to bridge the gap between dietary practices and chronic disease management, offering insights into the most effective strategies for enhancing patient adherence. Method: This qualitative follow-up study is part of the DINE trial, conducted at a community hospital in Sweden. After completing the intervention, participants (N=27) from the intervention group will be invited for a semi-structured interview. Focus areas: Patients' experiences and perceptions of: Creation of a partnership by participating in the pre-assessment meeting and sharing their narrative. Creating and using health plans as part of shared goals and decision-making. The perceived effectiveness of health plans. Receiving dietary information and advice based on the Nordic diet, including environmental sustainability. Person-centred nutritional education - exploring perceptions of the intervention and in relation to diabetes care guidelines. Interview data will be analysed using thematic analysis, supported

by the University of Gothenburg's Centre for Person-centred Care model for person-centred care to identify relevant themes and patterns in relation to person-centred approaches. Results: Interviews are planned to commence in December 2025 and continue until June 2027. Conclusion: The DINE trial and the follow-up qualitative study aim to focus on person-centred care, emphasising patient's own resources to enhance self-efficacy and improve dietary advice effectiveness. If successful, this program could serve as a model for other healthcare providers, highlighting patient empowerment and self-efficacy.

## Health plans for patients with Type 1 Diabetes - A qualitative follow-up of the Diabetes Intervention involving person-centred Nutritional Education [A099]

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Background and objectives: Health plans in person-centred care improve outcomes in cardiac rehabilitation (1, 2). However, to understand their effectiveness across care sectors, research is needed to describe and evaluate health plans. This study aims to analyse health plans and interview data from the ongoing DINE trial to identify factors that contribute to health plans' effectiveness in person-centred education on the Nordic diet. Method: Participants must have been part of the DINE trial intervention group (n=27), with documented health plans collected from their medical records. Health plan data includes: The plans the participant wishes to achieve. The participant's resources or capabilities to achieve these plans. Support needs, including who provides support, where, and when. Updates of the health plans during the DINE trial. A retrospective descriptive review of health plans through content analysis will be conducted. To

comprehensively address the research questions, we will cross-verify data from health plans, data from food diaries and food frequency questionnaires, and interviews. This will include information from individual interviews and the development and evaluation of health plans co-created by participants and the dietitian. Results: This is part of the DINE trial, running from May 2025 to June 2027. The analysis is expected to commence June 2027. Conclusion: The intention is to improve the implementation of health plans across the healthcare sector by analysing documented plans, evaluating their alignment with stated goals, and exploring the narratives and partnerships that supported their success.

References: Fors A, et al. Person-centred care after acute coronary syndrome, from hospital to primary care - A randomised controlled trial. Int J Cardiol. 2015 Fors A, et al. Effectiveness of person-centred care after acute coronary syndrome in relation to educational level: Subgroup analysis of a two-armed randomised controlled trial. Int J Cardiol. 2016

## A patient-reported core outcome set for person-centred care [A100]

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Human diversity underscores the need for care to be person centred to be effective and equitable. Reorienting healthcare towards a more person-centred approach and culture requires a common understanding of what person-centered care means and how it should be measured. This study is part of a larger project to identify an agreed minimum of outcomes, a Core Outcome Set (COS), for the evaluation of health care programs. The purpose of this study is to identify patient-reported core outcomes for evaluating healthcare from a citizen and patient perspective by linking the priorities to the respondents' own experiences of healthcare and health and to evaluate variation in preferences and priorities between people with various experience as patient. A secondary aim is to further psychometrically evaluate patient-reported measures for person-centred care. The study employs a quantitative cross-sectional design, utilizing questionnaires for data collection. Individuals with varying experience as a patient with or without chronic or long-term illness and who have visited healthcare in the past year are invited to participate in the study via the Swedish Citizen Panel at the Society, Opinion and Media (SOM) Institute (N = 2000). The study-specific questionnaire are sent out September 2025, and consists of screening questions for healthcare experience and long-term conditions, a section dedicated to prioritizing outcomes that have been identified in earlier research, and questionnaires on health-related quality of life, and experiences with healthcare. Data will be analyzed descriptively and comparatively between groups. The results will contribute to establishing a COS for future evaluations of healthcare from a citizen and patient perspective. The results from the questionnaires will also be evaluated psychometrically to test the ability of items to measure person-centered care.

# Poster Session 2

## Informal Care & Support

### Behind the Mask: Recognising the Person in Relatives of Nursing Home Residents – A Qualitative Meta-Synthesis [B001]

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Relatives are crucial partners in institutional long-term care, but their complex experiences often go unrecognised. This meta-synthesis aims to explore the multifaceted process of "being relative" from their perspective, transcending functional roles to reveal their full personhood. The study uses the metaphor of the "institutional mask" to challenge the reductionist view of relatives as merely functional caregivers. We argue that relatives navigate a complex, dynamic process of adaptation and meaning-making behind this mask. Following the PRISMA guidelines, we systematically searched databases (MEDLINE, CINAHL, Scopus, Web of Science, Psyndex) for

qualitative studies on relatives' experiences in institutional long-term care. Using a reflexive thematic analysis, we conducted a meta-synthesis of 59 studies from seven countries. Our analysis revealed four meta-themes, forming a cyclical "Being relative" model. The first theme, Managing Ambiguity, describes the relatives' continuous process of balancing contradictory emotions, experiencing vulnerability, and finding acceptance and appreciation. The second, Fluid and Overlapping Roles, highlights the shifting between active advocacy and care provision, strategic presence and observation, and coordinating and mediating functions. Third, Dynamic Relationship Development, illustrates the evolution of connections with staff through recognition and relationship challenges. Finally, Negotiating Care Responsibility explains the ongoing adaptation of involvement patterns and balancing care obligations. These themes form a cyclical model illustrating how relatives continuously navigate between institutional expectations and authentic experiences. Our cyclical model challenges reductionist approaches and emphasises the need for person-centred care that recognises relatives as whole persons with complex identities and emotional needs, looking behind the institutional mask to see the individual.

## Informal care within the hospital context: An exploratory study of the experiences of informal caregivers, care recipients, and professionals [B002]

*Benedicte De Koker[1], Ida Walgraef[1], Anja Huion[1], Patricia Van Leerberghe[1] & Deborah Lambotte[1]*

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A hospital admission often represents a turning point, not only for the care recipient but also for their informal caregiver. Informal caregivers take on various roles: they can act as a bridge between the home environment and the hospital, provide reassurance and continuity for the care recipient during their stay, and more. At the same time, hospitalization is often accompanied by stress and uncertainty for both the care recipient and the caregiver. An increasing number of hospitals are developing policies around caregiver

participation and support. This is driven by a growing focus on person-centered care, patient and family satisfaction, and the shortage of healthcare staff. For professionals, involving caregivers is not always straightforward and may lead to role conflicts and new challenges. In this paper, we present the results of a qualitative exploratory study in a regional hospital in Flanders (Belgian) that recently developed and implemented a policy on caregiver participation. How do the three parties in the triad (care recipients – informal caregivers – professionals) experience caregiver participation and support in the hospital context? Through semi-structured interviews with 11 informal caregivers, 9 care recipients, and 13 professional healthcare providers, we mapped perspectives, points of attention, and success factors for triadic working. Based on these results and an exploration of good practices in other Flemish hospitals, we formulate a number of concrete good practices and recommendations for triadic working in the hospital context. The study shows that actively shaping the relationship between care recipient, caregiver, and professional healthcare providers can contribute to a higher perceived quality of care and benefits for all parties.

## Unspoken Expectations and Disproportionate Responsibility: Family Carer Roles in Hospital Discharge [B003]

*Meg Engström Karlsson[1] & Ann-Therese Hedqvist[1, 2]*

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The trend toward early hospital discharge is increasingly shifting post-hospital care and responsibility to the home environment, making informal family carers essential for patient safety and recovery. Despite their vital role, the needs of family carers often go unnoticed or unmet. This qualitative study aimed to explore healthcare professionals' perspectives on the family carer's role during discharge planning and to examine how well carer needs are identified and addressed within the Swedish healthcare system. Data were collected through interviews with 18 healthcare professionals (12 physicians

and 6 nurses) at a medium-sized Swedish hospital. Additionally, eight family carers took part in semi-structured conversations to examine their lived experiences of the discharge process. Data were analyzed using qualitative content analysis. The findings reveal a discrepancy between formal policies and actual practices. While staff noted a lack of formal expectations for carers to take on medical duties, there was a widespread implicit reliance on their efforts, especially when patients declined municipal home care services. Staff from all three clinics reported that carers often assume an overwhelming amount of responsibility, which can sometimes lead to unsustainable home situations or re-admissions. Conversations with carers confirmed these findings; many reported feeling "abandoned" by the healthcare system and pressured into taking on burdensome responsibilities, sometimes at the expense of their own health. Additionally, routines for recognizing and supporting carer needs were generally found to be inconsistent or absent across the clinics. To provide truly person-centered care, family carers must be involved based on their willingness and ability, not on implicit organizational expectations. The findings highlight an urgent need for clearer organizational guidelines, well-defined boundaries of responsibility between hospitals and municipalities, and improved early collaboration. Visibility and proactive support for informal carers are essential to create a sustainable, cohesive care chain and ensure safe, person-centered care transitions.

## Co-designing HELP-F: Using the Double Diamond Model to Develop a Person-Centered Program for Family Caregivers in Primary Care [B004]

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Background: Co-designing healthcare interventions is increasingly recognized as an effective and collaborative approach to ensure contextual relevance and user engagement. This participatory method actively involves end-users from the outset, integrating their experiential knowledge into the design and implementation of health innovations. Despite its potential, co-design remains uncommon in primary care interventions supporting family caregivers of people with advanced chronic illness—a group facing substantial emotional, physical, and social challenges. Objective: To describe the application of the Double Diamond model to co-design the Home-based pErson-centered care to Listen and suPport Family caregiving in advanced disease (HELP-F) intervention; a nurse-led, person-centered programme aimed at empowering and supporting family caregivers providing home care to relatives with advanced chronic illness. Methods: The co-design process followed the four stages of the Double Diamond model. The Discover phase involved narrative interviews with 24 participants caring for relatives with advanced chronic illness. The Define phase integrated these insights with a systematic review and meetings with experts from the University of Gothenburg Centre for Person-Centered Care to create the intervention's logic model. The Develop phase included a focus group with primary care nurses, physicians, and a caregiver representative to refine the intervention's structure and delivery. The Deliver phase will pilot-test its feasibility, acceptability, and preliminary effects in eight primary care centers in Navarre, Spain. Findings: Participants emphasized the need for a person-centered intervention acknowledging each caregiver's perspective and lived experience. The co-design process fostered mutual learning, shared decision-making, and understanding between caregivers and professionals. Consequently, HELP-F emerged as a comprehensive, person-centered intervention addressing emotional, physical, social, and existential aspects of caregiving. Conclusions: Applying the Double Diamond model enabled the development of a feasible, person-centered, and contextually grounded intervention. The co-design process enhanced caregiver empowerment, professional collaboration, and ownership of the HELP-F intervention. Registration: NCT07184216; ClinicalTrials.gov

# Bridging the Gap: Family Involvement in Person-Centred Dementia Care [B005]

*Louise Mayer[1], Bram de Boer[1], Katya Sion[1] & Hilde Verbeek[1]*

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Background: Green Care Farms (GCFs) are an innovative approach to provide long-term care for people with dementia (PwD). They aim to combine agricultural elements with a home-like environment to support an active daily life for their residents. Characteristics of a long-term care setting not only affect the residents themselves but also their family caregivers (FCs). Their involvement in care is considered valuable. However, research on the involvement of FCs of PwD living in GCFs and their satisfaction with involvement is scarce. Methods: A cross-sectional survey compared the involvement and satisfaction with their involvement of FCs of PwD living in GCFs and regular nursing homes (RNHs). The F-INVOLVEMENT and F-IMPORTANCE balance scale (20 items, 4-point Likert scale) measured both actual involvement and individual importance. Congruence scores were conducted for two groups per item. For FCs who rate this item important (FII) and for FCs who rate this item as not important (FINI). Combining the congruence scores of both groups leads to a total congruence score providing information on satisfaction with family involvement in the facility. Results: Overall, FCs found their involvement important regardless of the type of nursing home. However, FCs at GCFs get statistically significantly more opportunities for involvement than those at RNHs. Also, there was more congruence at GCFs indicating that their involvement is more in line with what they consider to be important regarding their involvement. Conclusion: The findings suggest that the residential care environment can influence the care experience of FCs since opportunities for their involvement align more closely with their preferences for involvement at GCFs than at RNHs. Possibly, GCFs focus more on a relationship-centered care approach, contributing to a more meaningful family involvement. This highlights the potential values of innovative care environments for PwD and their FCs.

# Implementation of a family-focused outpatient cancer clinic [B006]

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Over the past decade, a neuro-oncology nursing group at Rigshospitalet has been dedicated to advancing a person-centred and family-focused approach to care for people with brain cancer and their families. Being diagnosed with a malignant brain tumor is a life-altering event that often leads to significant physical, cognitive, psychological, and psychosocial changes for the patient. These changes place increased demands on close relatives, who are often required to take on substantial responsibilities in managing the patient's care and treatment. No two brain cancer trajectories are alike, as tumor location and individualised symptom response result in highly diverse patient profiles. Therefore, it is essential to align care and treatment decisions with each patient's unique needs and preferences, and this must be at the heart of everything healthcare professionals do. This presentation focuses on implementing person-centred clinical practice, exploring both the barriers and facilitators within a multidisciplinary setting. In this presentation, examples of how a family-focused model can be implemented in a large cancer centre will be explored. To tailor guidance and support for these patients and their families, the neuro-oncology nursing group has: Identified patients' and caregivers' needs and preferences longitudinally Implemented Family Conversations in an outpatient clinic. Measured the Caregivers' Role and Responsibility level among the close caregivers Explored caregivers' often hidden and tabooed thoughts when living with a person suffering from personality changes due to a brain tumor. This research, along with insights from clinical practice, will be further explored to inspire colleagues interested in implementing a person-centred care model tailored to the needs of a specific population.

# Care for the Caregivers: Enhancing wellbeing of care providers in Homebased Childcare Models [B007]

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Women providing childcare in low-income urban areas of Bangladesh often face emotional strain due to family stress, lack of household support, financial insecurity, and mid-life challenges. These burdens, combined with the demands of caregiving, can undermine their mental wellbeing and the quality of care they provide. Recognizing this, BRAC piloted a home-based daycare model in informal settlements in Bangladesh, embedding structured psychosocial support for caregivers. This study explores how regular mental health support influences caregivers' emotional wellbeing and caregiving capacity. Community women were trained as caregivers and supported by paracounsellors, who are local women from the community trained in basic counselling skills and psychosocial support. Caregivers received sessions on mental health, self-care, early childhood development (ECD), attachment, stress relief, and anger management. Paracounsellors conducted regular home visits, facilitated training & group reflections, and identified signs of distress to enable timely intervention. A quantitative study was conducted with 300 caregivers using the Kessler-10, Rosenberg Self-Esteem Scale, and KAP surveys to assess mental health, self-worth, and caregiving knowledge. Psychosocial support was provided to 187 caregivers, with fidelity tools assessing emotional wellbeing in 54 of them. Caregivers receiving regular psychosocial support reported reduced stress, increased self-esteem, and improved emotional resilience. These outcomes were linked to more responsive and emotionally engaged caregiving, as observed in practice. Paracounsellors played a preventive and supportive role by addressing early signs of burnout and offering trusted, community-based emotional care. Findings affirm that caregiver mental health is central to delivering quality

childcare in low-resource, home-based settings. Integrated psychosocial support can strengthen caregiver wellbeing and improve childcare service.

## Development of an Internet-Based Support Program for Informal Caregivers in Sweden: A Delphi Study [B008]

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Informal caregivers play a vital role in supporting individuals with chronic illnesses, disabilities, or age-related needs. This study aimed to develop and evaluate the design and content in an internet-based support program tailored to the needs of informal caregivers in Sweden. Utilizing the Delphi method, a panel of experts, including caregivers and caregiver advocates, provided iterative feedback on the program's design and content. The resulting prototype with eligibility, structured over 14 weeks, integrates cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT) to address psychological well-being, stress management, and practical caregiving challenges. Key findings highlight the importance of accessible, flexible, and comprehensive support systems to enhance caregivers' quality of life and caregiving efficacy. The study underscores the need for continued research and development of digital support interventions to meet the diverse needs of informal caregivers.

# Development and Structural Validation of a Family/Friends Version of the Person-Centred Practice Inventory (PCPI-F) [B009]

*Martin Wallner*[1] *& Hanna Mayer*[1]

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Background: Family and friends of nursing home residents, broadly defined to include relatives by blood, by law, and close informal relationships, play an important role in enhancing person-centred care by providing direct support and advocating for residents. While their experiences have received attention, there remains a lack of validated instruments specifically designed to assess person-centred practice from their perspective. This study aimed to develop such an instrument for long-term care. Methods: Drawing on a unified theoretical framework, the Person-Centred Practice Inventory – Family/Friends (PCPI-F) was developed by adapting validated instruments designed for staff and residents. The PCPI-F was designed to capture two distinct perspectives: an "Individual" perspective, reflecting the family member's or friend's own experience (18 items), and an "Advocate" perspective, reflecting their role in representing the resident's interests (15 items). After pretesting and refinement, data were collected via a cross-sectional survey of 461 respondents from 34 long-term care facilities. Both perspectives were tested in separate measurement models using confirmatory factor analysis and reliability analysis in RStudio. Results: Both models demonstrated satisfactory fit and factor loadings after minor, theoretically justified modifications. The instrument demonstrated strong internal consistency and construct validity. One item with a low factor loading was removed from the "Individual" scale, resulting in a 17-item version. In the "Advocate" scale, six items had "cannot judge" response rates of 10% or higher, reflecting varying degrees of care involvement. However, overall model fit and parameter estimates supported retention of all items. Conclusions: The PCPI-F is a structurally validated instrument for assessing the views of family members and friends on person-centred care in long-

term care. It complements existing instruments and fills an important gap in multi-perspective evaluation. Further research is recommended to clarify roles and optimise item relevance.

## Presence and dignity in caring for older persons: Insights for person-centered care from the Mediterranean and Nordic context [B010]

*Lamprini Maria Xiarchi[1], Maria Claesson[1], Lina Palmér[1] & Elisabeth Lindberg[1]*

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Background: Caring for older persons is shaped by societal, cultural and institutional frameworks. In the Mediterranean context, informal caregiving and strong family involvement are dominant, while Nordic countries traditionally function within a universal public care model, though these dynamics are changing. While there is a constant re-evaluation with regard to who is involved in caring, and to what extent, nurses play a pivotal role in safeguarding dignity and holistic care despite contextual differences that occur across systems. Yet little is known about how nurses experience caring across different normative landscapes. Aim: The aim was to describe the meaning of caring for older persons based on the lived experiences of registered nurses in two distinct cultural and healthcare contexts, Greece and Sweden. Methods: A phenomenological approach grounded in reflective lifeworld research guided the overall research. Findings: Caring emerged as a balancing act between organisational demands, ethical commitment, and relational presence, where navigating family involvement, existential concerns, and end-of-life care was essential to sustaining the person's dignity, autonomy, and identity. An authentic embodied presence of the nurse was described as essential in preserving continuity in the person's identity and life story, offering meaning and coherence through time. Caring was closely connected to family involvement, particularly in the Greek context where family is central to caregiving. Nurses reveal both the opportunities and tensions this creates underscoring their crucial role in navigating autonomy, relationships, and trust. Conclusions: Across contexts, caring was revealed as

a deeply relational practice that transcends cultural differences, affirming the universality of dignity and presence in care. The knowledge gained highlights key foundations for person-centered care in community and institutional contexts. These insights can guide nursing education and policy to strengthen holistic, culturally responsive care and to improve the lives of older persons in existentially vulnerable situations.

# Children & Youth

## From ambivalence to agency: parents' conceptions of a theory-based behavioural intervention to prevent dental caries in their preschool children [B011]

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Objectives: To describe the different ways in which parents conceive a theory-based behavioural intervention to prevent dental caries in their preschool-aged children. Methods: Qualitative interview study using phenomenographic analysis in ten public dental clinics in Region Västra Götaland, Sweden (March 2023–July 2024). Ten parents (8 women, 2 men) of 3–6-year-old children at elevated caries risk completed ≥2 counselling sessions with university-trained, health promoters. Interviews (30–60 min) were audio-recorded, transcribed verbatim, and analysed inductively to capture variation in parental conceptions. Flexible delivery (digital/in-clinic)

and interpreter support were available. Results: This study identified three themes tracing a progression from ambivalence to agency. Three subgroups emerged (1) An offer lined with ambivalence, (2) Empowered alliance through personalised support and (3) Active choices through parental agency. These themes coalesced in the synthesis 'From ambivalence to agency: embracing health-promoting behaviour'. Conclusions: Parents conceived health-promoter-led, theory-based behavioural intervention as non-judgemental, culturally responsive, and practically useful. By fostering relational safety and providing actionable tools, the intervention appeared to strengthen parental self-efficacy and catalyse family-level behaviour change. This shift, while modest in scale, may represent a necessary step toward equitable and sustainable oral health promotion.

## Too Far to Care? A cohort study on Travel Distance and Hospital Use in Children living with Respiratory Support [B012]

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Introduction: Children and adolescents (0–18 years) who depend on long-term respiratory support form an expanding patient group with complex needs that extend beyond medical treatment. Their care often requires collaboration across professional boundaries and should be organised in ways that support both the child's health and the family's everyday life. Access to specialised paediatric respiratory care is unevenly distributed,

raising questions about how travel distance affects healthcare use and outcomes. This study explored associations between geographical access to specialised services, healthcare utilisation, and mortality, with attention to family and contextual factors relevant for person-centred care. Methods: We performed a retrospective, population-based cohort study using data from the Swedish Quality Registry for Respiratory Failure (Swedevox) between 2015 and 2021. Multivariable regression analyses were used to examine the relationship between travel distance to specialised care units, healthcare use, and mortality. Results: The study included 600 children (mean age 5.4 ± 5.1 years). Most families (76%) lived within an hour's travel to a specialised unit, while nearly one quarter had considerably longer travel times. Distance to care was not associated with differences in healthcare utilisation or mortality. However, social and contextual aspects influenced care patterns: children of parents with higher educational attainment had more frequent hospitalisations, and children in rural areas had fewer emergency visits. Conclusions: Although physical distance to specialised services was not linked to healthcare utilisation or survival, the findings highlight how family resources and place of residence shape care experiences. From a person-centred perspective, centralisation of specialised services may be justified, but healthcare reforms should be guided by the everyday realities and voices of children and families to ensure that care remains equitable, meaningful and supportive.

## Healthcare professionals' experiences of creating relationships with children with mental ill-health [B013]

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Background: Children's mental ill-health is a growing public health problem that places demands on adults around the child. However, research shows

that healthcare professionals can experience uncertainty when meeting children with mental ill-health. By exploring the experiences of healthcare professionals in primary care working with children affected by mental ill-health, factors influencing relationships and the quality of care can be identified. This knowledge may strengthen both healthcare professionals and other important adults in their efforts to provide adequate support to the child. Aim: To explore Healthcare professionals' experiences of creating relationships with children with mental ill-health. Methods: A qualitative methodology was employed to explore experiences from 16 Swedish health care professionals working in primary care with children affected by mental ill-health. Data were gathered through face-to-face meetings and videoconferencing between February and August 2025, using a semi-structured interview approach. A thematic analysis, grounded in descriptive phenomenology, was conducted. Findings: The data analysis emerged into four primary themes: The physical space of the encounter, Creating a safe space, Communication strategies for interaction and Supporting children's capability. Healthcare professionals perceive encounters with children experiencing mental ill-health as shaped by physical settings and the dynamics between child, parent, and professionals. Establishing a safe space through communication strategies is described as fundamental. Key aspects include building trust, showing empathy, listening without judgment, and supporting the child in making sense of feelings. Professionals emphasize the importance of strengthening children's capabilities and resources, while partnering with parents to ensure sustained support and recovery. Discussion: Creating sustainable relationships requires knowledge of the importance of the child's lived space and communication strategies. A child-centered perspective can guide the development of timely and appropriate support, ensuring care that meets children's needs effectively. The study contributes scientifically by clarifying how healthcare encounters with children experiencing mental illness can be improved.

# Access, usability and use of a digital tool for symptom management in paediatric cancer [B014]

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Yearly in Sweden, approximately 300 children are diagnosed with cancer. Cancer treatments often cause side-effects such as fatigue, pain, nausea, anxiety, sleep disturbance, and depression, which are symptoms that are subjectively experienced by patients and are most accurately assessed through patient self-report. The use of a digital tool facilitates early detection and management of side-effects also within the home environment. The digital tool, Pictorial Support in Person-Centred Care for Children (PicPecc) enables children to self-report side-effects from home and engage in online, chat-based conversations with healthcare professionals, contributing to the child's narrative within person-centred care. The study aimed to describe children´s use of PicPecc at home following cancer surgery or chemotherapy, its usability, and how children, parents, and healthcare professionals experience its access. This study uses a convergent mixed method design, analysing both quantitative and qualitative data. Participating children were encouraged to use PicPecc to report their side-effects for two weeks following cancer surgery or chemotherapy. Data was collected through child assessments, chat logs, structured interviews with children, parents and nurses, and System Usability Scale (SUS) responses which ranges from 0 to100. Data were collected from September 2024 to June 2025. Fourteen

children aged 6-17 years, five parents and five nurses from two paediatric oncology departments in Sweden were included in the study. Preliminary results indicate that children used PicPecc for 1-27 days, and collective completed 1072 assessments. Online chats were either initiated by nurses as follow-up after assessments or by children asking questions about their well-being and their use of PicPecc. The SUS responses indicated that PicPecc had a mean score above 68, indicating good usability. Findings from participant interviews will be presented at the conference. PicPecc meets the criteria for access, usability, and use, thereby facilitating the self-reporting of side-effects among children at home following inpatient oncology treatment.

## Starting digital early parent-directed communication intervention in an on-site group led by speech therapists: perception of parents and nurses [B015]

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Research on the effects of early digital intervention for parents of children with communication disabilities show promising results. This was also seen in a study of the Swedish self-managed digital intervention ComAlong online on 1177, providing parents of young children with identified communication difficulties, knowledge about communication and supportive strategies. However, challenges related to the introduction and independent use was also identified resulting in scattered use. This study explored the effects of introducing ComAlong online during two 2-hour group sessions located at the families' local child healthcare center and led by speech-language pathologists from the central child health care services. During the introductory session the parents were guided in accessing ComAlong online

on their smartphones and understanding the structure and content. This was followed by training in the use of responsive strategies. The second session held one week later included group discussion of the home assignment applying the strategies at home, followed by training of new strategies based on enhanced milieu teaching and the use of pictorial support. Semi-structured interviews with five parents and seven child healthcare nurses, held after about eight weeks, were analyzed thematically. The results showed that the parents perceived the sessions as informative and supported their use of ComAlong online. Another theme focused a feeling of affinity emerging from meeting other parents in a similar situation. Several parents also reported that both their own and their children's communication had been positively affected. The nurses perceived that the introduction facilitated the parents' use of the program as well as their own use of ComAlong online. Both parents and nurses expressed a need for additional support from speech-language pathologists. The results indicate that digital communication intervention is more effective when it is combined with on-site intervention, in this case only two sessions, but that more research is needed.

## Child Health Service nurses' support to parents with overweight in clinical encounters regarding children's overweight - a qualitative study [B016]

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Background: Childhood overweight poses health risks and often persists into adulthood, making early intervention essential. Swedish Child Health Service (CHS) nurses are responsible for addressing this issue, a task perceived as important yet challenging. When giving support to these families a caring and person-centered approach is crucial for their well-being and adherence. Childhood overweight is often associated with parental overweight. Due to the sensitivity and stigma surrounding adult overweight, healthcare professionals may experience discomfort, potentially leading to negatively perceived interactions with patients. Despite these challenges, little is known about how parental overweight influences CHS nurses' approach in encounters regarding children´s overweight. Therefore, this study aimed to explore how CHS nurses support parents with overweight in clinical encounters where children have overweight. Methods: A qualitative design was applied. Semi-structured video interviews were conducted with 14 CHS nurses, and transcripts were analysed using latent, inductive content analysis. Results: Four categories were identified: Feeling insecurity regarding professional role, Focusing on concrete aspects of health, Questioning the parents, and Trying to influence the parent. CHS nurses perceived addressing the child's overweight as their primary duty. They focused on weight-related aspects of the child's health, often emphasising lifestyle advice, while parents' emotions or socioeconomic challenges risked being overlooked. Parental overweight could trigger negative assumptions, including doubts about parents' ability to support their child. When children's weight curves remained unchanged, frustration sometimes led nurses to emphasise parental responsibility or use threats, such as involving child welfare services. Conclusion: This study highlights how CHS nurses perceive both challenges and responsibility in addressing childhood overweight, difficulties that intensify when parents themselves have overweight. The findings indicate that while striving to fulfil their role, CHS nurses' approaches are shaped by weight stigma and by the struggle to balance professional responsibility with maintaining a supportive and respectful, person-centered approach.

# Economic and Person-Centred Implications of Births Before 24 Weeks of Gestation in Sweden [B017]

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Aim: Extremely preterm birth, particularly before 24 weeks of gestational age (GA), is associated with complex health trajectories and lifelong support needs. This study aimed to estimate both medical and non-medical costs of illness in childhood for this population, while considering implications for person-centred and family-oriented care. Methods: We conducted a national, population-based register study including all children born <24 weeks GA in Sweden between 2007 and 2018 who survived beyond their first year. By linking health and social insurance registers, we assessed costs from a societal perspective, covering hospital care, pharmaceuticals, and social support. Results: Among 344 children (56% boys), the mean follow-up was 8.8 years. Expenditures were dominated by hospital-based care during infancy, while family-related and disability benefits became the major cost drivers thereafter. Children born at 21–22 weeks GA and boys showed more

sustained non-medical costs compared with those born at 23 weeks GA and girls. Neonatal morbidities, including bronchopulmonary dysplasia, retinopathy of prematurity, and severe intraventricular haemorrhage, were linked to particularly high long-term support needs. Conclusion: Children surviving birth before 24 weeks GA contribute to substantial and enduring societal costs, shifting from acute medical care in early life to long-term social and family support. These findings underline the importance of person-centred approaches that extend beyond neonatal survival to encompass the lived realities of families. Early identification of needs, coordinated follow-up, and integrated care strategies may reduce fragmentation, support families in daily life, and promote more sustainable use of resources.

## Person-Centered Design and Architectural Inclusion: Advancing Equity for Disabled Learners in Anatomy Education [B018]

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Background: Anatomy education has traditionally relied on cadaveric dissection. Cadavers provide a visual-spatial learning, but in a physically rigid environment. This often proves disadvantageous to students with physical, sensory, or psychological disabilities. The anatomy learning spaces and pedagogical designs remain largely inequitable, despite calls for inclusivity. This study investigates how person-centered pedagogy modules and inclusive architecture can enhance accessibility and engagement for disabled learners in anatomy education. Methods: A qualitative, case-based study was conducted using five representative scenarios depicting challenges faced by students with disabilities in anatomy learning. The participants (medical undergraduates) were asked to write their reflections on the cases presented. The reflections were analysed along with observational audits of dissection hall architecture. A thorough review of Universal Design for Learning (UDL) principles and accessibility standards was performed for. Thematic analysis

was used to identify key barriers and effective person-centered strategies. Results: Two dominant themes emerged: (1) Physical inaccessibility— fixed dissection tables heights, inadequate lighting, and poor acoustics, restricted participation due to large number of students; and (2) Pedagogical inflexibility—visual-dependent teaching, and lack of assistive technology like extended reality, limited equitable engagement. Implementation of adaptive solutions such as adjustable-height tables, tactile and audio-enhanced resources (AR, VR), immersive virtual dissection tools (VR and hololens), and improved spatial layouts will enhance learner participation, confidence, and performance. Inclusive architectural features—such as mobility access, acoustic control, and sensory-safe zones— will foster a more collaborative and psychologically safe environment. Conclusion: Equity in anatomy education can be brought about by merging inclusive architecture with pedagogical inclusivity. By doing this, anatomy education can move from an age-old model to a flexible, human-centered framework. Institutions should sensitize faculty, incorporate accessibility audits and universal design standards into anatomy curriculum planning to ensure all learners can meaningfully engage in understanding the human body.

## Exploring Clinicians' Views on Learning Climate in a Parent-Mediated Intervention Using Self-Determination Theory [B019]

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Introduction: Interventions targeting children with developmental disabilities should be family-centered and promote the family's building of skills and competencies to enhance genuine self-sustainability. This typically puts demands on parents to engage in interventions and to acquire and adapt to new knowledge and insights, thus framing them as learners. However, clinicians may lack pedagogical training and feel uncertain about taking on

the educator role, and associated research is lacking. The Self-Determination Theory is a widely applied framework, where learning, motivation and growth are reliant on fulfillment of three basic, psychological needs: autonomy, competence and relatedness. In this study, we examined clinicians' experiences of creating a supportive learning climate in partnership with parents in a group-based, parent-mediated communication intervention aiming at families of children with developmental disabilities (the AKKtiv ComAlong), through the lens of Self-Determination Theory. Method: A qualitative descriptive design was used. Four focus groups including 13 clinicians (mainly speech-language pathologists) were conducted. All participants were accredited ComAlong-instructors. Self-Determination Theory informed the topic guide. Verbatim transcripts from the focus groups were subjected to practical thematic analysis. Results: Two main themes captured the participants' experiences: "Clinicians strive to create a safe, social environment" (e.g., fostering unpretentiousness and openness) and "Clinicians strive to adjust the teaching to each individual" (e.g., conveying theory in concrete ways and finding relevant angles for each parent). Four sub-themes were defined, and learning-enhancing strategies were extracted and mapped onto the sub-themes. Conclusions: Self-Determination Theory was a relevant framework for examining and anchoring the clinicians' parent-directed educational practices. The results suggest that ComAlong-interventionists view parents' learning as unique processes that require volition and individual meaning-making, which in turn is scaffolded by concrete and open communication and non-hierarchical relationships between parent and clinician. These views align well with concepts of patient- and family-centered care. Implications will be discussed.

## Beyond Curve Correction: Patient- and Surgery-Related Determinants of PROMs in Adolescent Idiopathic Scoliosis [B020]

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Adolescent Idiopathic Scoliosis (AIS) is the most common type of scoliosis in the pediatric population, and its clinical and surgical management can significantly impact patients' quality of life. However, limited research has explored how multiple patient- and surgical-related variables can influence postoperative experiences. This single-center, prospective cohort study analyzed data from 125 scoliosis patients ages 11–18 undergoing corrective spine surgery. We explored associations between patient-reported outcomes (PROMs) and variables including curve severity and correction, body mass index (BMI), brace use, pre-existing mental health diagnoses, length of instrumentation, and postoperative complications by applying the Scoliosis Research Society-30 (SRS-30) questionnaire at four different time points (preoperatively, 3, 6, and 12 months postoperatively). The SRS-30 is a validated questionnaire that focuses on the following five key PROM domains: Pain, Function/Activity, Self-Image/Appearance, Mental Health, and Satisfaction with Management. Findings showed that curve correction over 50% improved postoperative pain outcomes, while greater curve severity preoperatively impacted self-image. Moreover, mental health history and BMI significantly influenced postoperative mental health and satisfaction domains. Patient partners informed variable selection, reinforcing the importance of lived experience in study design and concept. The results of this study reinforce the need for patient-centered care in pediatric scoliosis treatment and illustrate the essential role of PROMs in capturing meaningful patient experiences after surgical processes.

## Person-Centred Care in Child and Adolescent Psychiatry: A Narrative Review Focused on ADHD and Autism [B021]

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Person-centred care (PCC) has become an increasingly central framework within child and adolescent psychiatry, yet its implementation in the care of children and adolescents with attention-deficit/hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) remains challenging. This narrative review synthesises current evidence on how the core principles of PCC—agency, shared decision-making, lived experience, collaborative relationships, and respect for individual preferences—can be effectively adapted for neurodivergent young people and their families. Across recent studies, young people with ADHD and ASD are shown to experience communication differences, sensory sensitivities, executive-functioning difficulties, and challenges in expressing internal states. These factors may complicate traditional clinician-led care models and highlight the need for flexible, individualised approaches. PCC reframes the clinical encounter, shifting the emphasis from symptom control toward meaningful partnership, where the child or adolescent is supported as an active participant according to their developmental capacity. Evidence from qualitative and quantitative research suggests that PCC-oriented practices improve engagement, reduce avoidance of care, strengthen communication between families and clinicians, and increase satisfaction with services. Effective strategies include the use of sensory-informed environments, visual communication tools, flexible interviewing techniques, collaborative goal-setting, and strengths-based clinical formulations. Family involvement, while maintaining a clear focus on the young person's own perspective, is shown to enhance continuity, therapeutic alliance, and ethical alignment. Barriers to PCC implementation include limited time, insufficient training in neurodiversity-informed practice, systemic pressures toward standardisation, and a lack of validated PCC tools tailored for neurodivergent populations. The review concludes that PCC is both feasible and beneficial within ADHD and ASD care but requires organisational support, targeted clinician training, and structured methods to elicit the child or adolescent's own narrative.

# The impact of a person-centred digital assessment tool during chemotherapy treatment [B022]

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Background: In paediatric oncology empathy is vital and nurses highlights the importance of listening to the child and accepting the child as an own person. This is in line with a person-centred perspective. During chemotherapy, symptoms occur repeatedly and are not managed optimally. Consequently, self-reporting of symptoms is needed, otherwise no action will be taken for symptom relief. Digital health innovations can improve children's self-efficacy and outcomes related to disease. The aim of this study was to explore the impact of a digital tool during chemotherapy treatment. Methods: This study is a follow up of an intervention where children with leukemia used a digital assessment tool during chemotherapy. Fifteen children (5-12 years), six teenagers (13-17 years) and 24 parents participated, recruited from seven hospitals in Sweden between 2021-2024. Semi-structured interviews (M=33min) were conducted, and interpretive description was used in the analysis. Results: Children, teenagers and their parents accepted that children/teenagers would not feel well during chemotherapy, but the digital tool helped them map their symptoms. Most were happy to use the tool themselves, as a personal diary, and did not need to call the nurses. The parents could relax because it helped them translate the feelings and symptoms of their child and the digital tool helped them understand how their teenager felt, even though they did not really talk to them. The participants felt safe, and nurses recognized the child's/teenager's needs and preferences. Parents described the experience as coming to a place where they could relax and be taken care of. Conclusions: The digital tool

contributed to a safe and supportive environment where children and parents felt cared for, and nurses could better recognize the child's needs. The digital tool empowered children to map their symptoms independently, providing parents with valuable insight and reducing the need for verbal communication.

# Illness Communication

## Nurses' experiences of wound healing in community healthcare: Trying to be person-centered but seek competence and collaboration [B023]

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Background : Wound healing is a global challenge for both healthcare systems and patients. The costs are estimated to between 2-4% of the total costs in the healthcare system, where 87% of the total cost constitute nurses' worktime. Many of these patients are being cared for in community healthcare and suffer from hard-to-heal wounds. There is a lack of research about how to optimize wound healing in a community healthcare setting which led us to this study. Aim: To identify barriers and facilitators to optimize wound healing among patients with hard-to-heal wounds. Methods: Fifteen nurses working with patients suffering from hard-to-heal wounds in community healthcare in Sweden were interviewed. Qualitative content analysis was used. Results: Study results will be presented at the conference. Working as a nurse in the patients' homes presents both challenges and possibilities when it comes to wound healing, which brings challenges with person-centered care to the forefront. Three preliminary

main categories have however been identified at the time for abstract submission: to deliver person-centered care at home, to have a palette of competences in wound healing, and structure as a way to facilitate wound healing. Conclusions and implications: Although nurses try to work in a person-centered manner with the person with a hard-to-heal wound by listening to their experience and preferences, the partnership is deficient because the nurses' ability to contribute to person-centered care is limited due to a lack of competence and collaboration. The findings from the study will constitute the foundation for a structured intervention, developed in accordance with national guidelines for wound healing. The intervention is anticipated to yield benefits for patients, nurses, and other healthcare professionals by mitigating patient suffering, reducing healthcare-related costs, and increased patient involvement.

## Exploring Person-centred Physiotherapy practice within the context of Huntington's Disease, UK (protocol) [B024]

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This project investigates how Physiotherapists in the United Kingdom understand and deliver person-centred practice (PCP) in the context of Huntington's Disease (HD) and how people with HD and their carers perceive this care. HD is a rare, inherited, and progressive neurological condition that affects movement, cognition, and emotion, creating complex and fluctuating care needs. As people live longer with neurodegenerative disorders, demand for rehabilitation services that can adapt to these evolving challenges continues to grow. PCP forms the cornerstone of effective neurological rehabilitation by prioritising individual values, needs, and lived experiences. Although the importance of PCP is globally acknowledged in healthcare, less is known about how it is conceptualised and applied within progressive neurological diseases such as HD. Existing evidence suggests

that PCP continues to evolve, shaped by both professional practice and patient experience, but gaps remain in the understanding and application of the concept and how peoples' perspectives align within clinical practice. This mixed methods study aims to explore physiotherapists' interpretations of PCP alongside the lived experiences of people with HD and their careers. It encorporates the validated tool of the Person-centred Practice Framework, McCance and Cormack, 2017 adding reliability and validty to the data. By examining this interaction, the project seeks to generate new insights into the delivery of person-centred physiotherapy, contributing knowledge that will strengthen evidenced based Physiotherapy rehabilitation person-centred practices and support the development of person-centred services for individuals and their carers living with and supporting those with a progressive neurological condition.

## How do we understand person-centered care in relation to recovery-oriented services? - An example using Flexible Assertive Community Treatment [B025]

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The Swedish specialist mental health services are striving to shift from a biomedical to a recovery-oriented perspective. Recovery-oriented services provide care and support that help persons in finding meaning in their lives and within their communities, regardless of their mental health needs. It entails a holistic approach towards persons with mental health needs, striving for personal recovery through empowerment and personal growth. Accordingly, the Flexible Assertive Community Treatment (FACT) model is implemented into the Swedish specialist mental health services. FACT is a recovery-oriented and team-based model that offers tailored care and support and works in close collaboration with social services to achieve recovery goals. In alignment with the person-centered approach, FACT

strives to acknowledge persons with mental health needs as being capable. However, person-centred care emphasises initiating and sustaining partnership through listening to the persons narrative and by co-creating an individual plan. While individual plans are an important aspect of FACT, the co-creation of the plan, along with initiating and sustaining partnership is not explicitly stated. Instead, FACT emphasizes team-oriented practices and flexibility in care and support, which include the person with mental health needs. We argue that FACT does not automatically lead to the delivery of person-centered care but rather supports the service providers to develop a person-centered approach. To conclude, we propose that the FACT manual should explicitly incorporate the characteristics of person-centered care. Doing so would enable service providers to fully understand the philosophy behind person-centered practice and strengthen efforts to support persons in achieving a meaningful life.

## Exploring Person-Centred Care Requirements in Early Postoperative Enterostomy Individuals: An analysis of qualitative studies [B026]

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Introduction: The short hospital stay following enterostomy placement limits nursing contact and complicates preparation for altered life situation. In the early postoperative phase, patients report reduced quality of life, marked by bodily estrangement, and lack of self-care knowledge. Person-centred nursing is a promising approach to address these challenges, yet implementation concepts are lacking. This study aims to develop practical nursing approaches for person-centred care of individuals with newly placed enterostomies, based on person-reported experiences. Methodology: Guided by scoping-review methodology, literature was systematically searched in Cochrane, CINAHL and PubMed. Included were qualitative studies published between 2015 and 2025, written in German or English. Studies

focused on person experiences in the early postoperative phase following enterostomy placement. The analysis was guided by the principles of person-centred care as defined by McCormack, providing a structured lens for synthesis. Results: Thirteen qualitative studies were included. Being in relation: Family members offer emotional and practical support, but communication barriers persist. Trusting nurse-patient relationships are hindered by time constraints and lack of continuity. Being in a social world: Stoma-related sounds and odours cause shame and social withdrawal. Lack of peer contact intensifies isolation. Being in place: Home and hospital are perceived as safe spaces, though access to care and resources varies across countries. Being with self: The enterostoma deeply affects body image. Patients report alienation, fear of complications, sleep disturbances, and high care demands. Simultaneously, the stoma is seen as life-saving. Discussion: Each dimension reveals burdens and coping resources. Person-centred care requires consistent nurse-patient relationships, outpatient care-centers, early peer-contact, and integration of personal life stories to foster empathetic care. Conclusion Person-centred care for individuals with an enterostomy must begin by seeing the person behind the patient and considering their individual life circumstances. Initial approaches for clinical implementation have been identified, promoting care that supports patient needs.

## Attitudes and Experiences of Nurses and Carers with the Carer Support Needs Assessment Tool Intervention (CSNAT-I) [B027]

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Introduction/Background: Carers play a crucial role in supporting patients with serious illnesses, yet their own support needs often remain unmet. The

Carer Support Needs Assessment Tool (CSNAT-I) is an evidence-based, person-centred assessment tool designed to identify and address the needs of carers supporting critically ill patients. Aim: This study explores the perspectives of nurses and informal carers regarding the implementation and use of CSNAT-I in palliative cancer care. Method: Semi-structured interviews were conducted with three oncology nurses (via telephone with detailed field notes) and one focus group with four palliative care nurses, alongside five carer interviews. All interviews were audio recorded and transcribed verbatim. Data were analysed using content analysis. Results: Although nurses acknowledged the importance of supporting carers, the integration of CSNAT-I was hindered by time constraints, unclear implementation processes, and limited understanding of its purpose. Both nurses and carers preferred ongoing dialogue and relational continuity over structured assessments. The CSNAT-I was often perceived as a conversation starter rather than a tool to guide support systematically. While some carers received practical help after the assessment conversation, they did not necessarily associate this support with the CSNAT-I. Conclusion with implication for practice (educational and/or clinical): The study highlights key challenges with the CSNAT-I, such as issues related to timing, workload pressures, and limited awareness of its intended purpose. Carers emphasised the importance of continuous support and consistent contact points with healthcare professionals rather than relying solely on structured assessments. While CSNAT-I appears to play a valuable role in legitimising time spent with carers, its full potential is likely to be realised better if it is embedded within person-centred pathways that include clear strategies for implementation and follow-up.

## Caring qualities alleviating suffering and preserving dignity of patients in need of palliative homecare: Nurses experiences [B028]

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Background: As chronic diseases become more prevalent and life expectancy continues to rise, the global demand for palliative care is steadily increasing. Since most patients in need of palliative care remain at home, there is a strong need to develop functional home-based palliative care services. Living with the suffering of a complex illness while facing one's own mortality can deeply affect a person's sense of dignity. Safeguarding patients' dignity remains an essential and ongoing challenge for healthcare professionals worldwide. Aim: The aim of the study was to explore and describe nurses' experiences of caring qualities alleviating suffering and preserving the dignity of patients in need of palliative homecare. Methods: This qualitative exploratory study used in-depth semi-structured interviews for data collection and Graneheim and Lundman's qualitative content analysis for data analysis. The theoretical perspective was based on Eriksson's theory of caritative caring. A total of nine nurses with extensive experience from palliative homecare participated in the study. Results: One main theme and three subthemes were found. The main theme was: Being there for the other alleviates suffering while shaping and reshaping dignity preservation in a process. The three subthemes were: (1) Being a sensitive and compassionate witness who becomes responsible, (2) Having compliance, courage, and perception in a deep presence, and (3) Being calm and patient while having time for conducting skilled practical knowledge. Conclusion: Certain caring qualities are essential in dignity-preserving care for people in need of palliative homecare, with person-centeredness playing a central role in alleviating suffering. Deep, trusting care relationships and nurses' ability to tailor care to individual needs are key to both alleviating suffering and preserving dignity. Future research should explore this topic from the patients' perspective.

# Person-centred care and existential boundary situations during immunotherapy for lung cancer [B029]

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Background: Consolidating treatment with immunotherapy for patients with locally advanced lung cancer has improved survival dramatically. Immunotherapy is administered once monthly for a year after concomitant chemoradiotherapy, involving new symptom experiences and prolonging total treatment length. In transitioning from chemoradiotherapy and during consolidating treatment, little is known about what support patients need and how needs change over time. As immunotherapy extends survival and treatment length, patients increasingly face existential concerns. Aim: To identify vulnerabilities through boundary situations during consolidating immunotherapy in patients with locally advanced lung cancer. Method: Seventeen patients were interviewed about their experiences of undergoing treatment with immunotherapy. The interviews were analyzed deductively, using an analytical matrix based on the existential framework of Yalom and Binder; Death, Meaninglessness, Freedom, Isolation and Body. The results were reviewed for Boundary situations, where a person is exposed to the harshest circumstances of existence. Results: Four contexts where patients face boundary situations were identified: when abiding mortality, in re-orientations, when partnering with healthcare professionals and in guilt and responsibility. Abiding mortality comprises situations where patients face a heightened sense of mortality and immunotherapy as protection against death. Re-orientations refers to situations where patients need to re-negotiate their future, bodily capabilities, relationships and faith. Partnership with

healthcare professionals encompasses existential tensions in healthcare contacts, control, abandonment and the healthcare system as a map of meaning. Guilt and responsibility relate to guilt over past choices and guilt from reduced ability to partake in social activities and how delegated responsibility and participation in medical decisions become difficult to bear. Discussion: The identified boundary situations overlap and interact. Understanding the overlaps can prove useful for health care professionals when using a person-centred framework of care. By recognizing the boundary situations, support to patients can be initiated in time and be more in line with patients needs.

## Existential health in person-centred oncological care [B030]

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In nursing care, existential concerns have been recognized since Nightingale and existential health has been highlighted recently with the Swedish government ordering a report to further national efforts on the subject. There is no consensus in the literature regarding the meaning of existential health, not even in the oncological context where existential concerns are common. Current theoretical perspectives together with person-centred care may guide oncological nursing towards an understanding of existential health that will benefit patients. The literature describes existential health in many ways; opposite existential suffering, a reflexive concept of health, well-being related to spiritual practices or beliefs, the ability to experience health despite hardships and as an aspect of health along physical, mental and social. The arguments of how to conceptualize existential health are primarily made from psychology of religion and existential psychotherapy. Psychology of religion emphasizes meaning and being a part of something greater, while existential psychotherapy emphasizes the adverse aspects of human

existence. However, some consensual features are that existential health is deeply personal, relating to meaning, attitudes towards death and belonging. We propose to understand existential health as a process consisting of the reflexive capacity to feel healthy despite illness and adversity, and the fundamental concerns of human existence; meaning, relationships, freedom, bodily agency, awareness of life and death. In a partnership the person's existential health can be understood through the narrative in hope of cure or in fear of suffering. By approaching the reflexive through the existential concerns in the narrative, caregivers may together with the person identify what in their experience that affects their existential health. A dynamic understanding of existential health will aid health care professionals in supporting patient's overall health despite the many hardships brought by cancer. Further, it may promote a holistic approach to oncological care through person-centredness.

## Lack of person-centredness in end-of-life hospital care during the COVID-19 pandemic: A patient record review study [B031]

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Background: Providing person-centred palliative and end-of-life care was severely challenged during the COVID-19 pandemic due to healthcare strain and infection control measures. Previous studies within the Swedish-Norwegian Palliative Quality Care COVID-19 multicenter project have highlighted these challenges from staff perspectives. However, how patient needs were addressed during their final phase of life in hospitals, irrespective of the cause of death—remains less explored. Aim: To examine the extent and manner in which the principles of good person-centered palliative care were upheld in hospital end-of-life care during the pandemic. Methods: A retrospective patient record review was conducted using a protocol based on WHO's principles of person-centred palliative care, operationalised through the 6 S's model (figure) and Swedish quality indicators for palliative care. From 1,458 hospital deaths (March 2020–February 2022), 150 COVID-19 positive patients were randomly selected and matched by age and sex with 150 COVID-19 negative patients. Data from 254 patients were analysed (114 COVID-19 positive, 140 COVID-19 negative). Results: Of the 254 individuals, 60% were men and 40% women, with aged range 28 to 101 years. Documentation of person-centred dimensions was limited: Self-image 14%, Symptom relief 18%, Self-determination 32%, Social relationships 6%, Synthesis 4%, Strategies 7%, while information about relatives was almost always recorded (98%) (table). Group comparisons showed differences in symptom relief: respiratory symptoms were more frequent among COVID-19 patients, who received more targeted relief. Pain was more often documented and treated among non-COVID patients. Sleep problems occurred in both groups, but COVID-19 patients with sleep problems received less relief. Conclusion: Patients' psychosocial and existential needs were largely unmet, revealing serious deficiencies in providing holistic, person-centred, quality palliative care during the pandemic. Symptom relief varied depending on whether the patient was COVID-positive or COVID-negative: respiratory relief was prioritised for COVID-19 patients, while pain relief was more common among non-COVID patients.

# Development of an implementation strategy for early integration of palliative care in Swedish nursing homes: a pilot feasibility study [B032]

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Background: Most people in Sweden die at an advanced age and thus need palliative care in the last years of their lives, i.e. a person-centred, team-based approach designed to improve the quality of life and wellbeing of the sick person and their families. Although there is currently evidence to suggest the need for the early integration of palliative care in progressive life-threatening conditions, this is not yet routine. This means that desired impact on patients' symptom relief and well-being is not achieved. Aim: To collaboratively develop an implementation strategy for the early integration of palliative care in Swedish nursing homes. Method The study was designed using participatory methods; the implementation strategy was developed in close collaboration with stakeholders (KTA framework). Participants included physicians and nurses in nursing homes, their respective unit manager from regional and municipal primary care, and patient representatives (13). Data were collected through workshops, and individual and group interviews with healthcare staff. Interpretive description was applied in the analysis. Preliminary results: Challenges of conducting development projects within a nursing home setting became clear and especially related to the need for close collaboration between multiple stakeholders. During the study, an overall and increasing awareness of palliative care needs among the old people cared for in the nursing homes was apparent. All participating services adopted the use of medical care plans around palliative care needs and talked about models for serious illness conversations to be valuable. These new routines

were believed to facilitate the integration of palliative care earlier on into their practice. Conclusions: All participants perceived the project as important and relevant, and that it has the potential to contribute to a scalable implementation strategy. The findings from this study will form the basis of a future feasibility study involving a wider range of stakeholders.

## Experiences of daily life among patients with stress-related illness after participating in a person-centred and health-promoting treatment [B033]

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Background: Engaging in meaningful activities may provide health and well-being, but individuals living with mental illness face challenges achieving this in daily life. Stress-related illness is increasing in society and negatively affects the person's ability to be active and experience well-being. In Sweden, treatment usually takes place in primary health care, where health-promoting, person-centred treatment, adapted to the individual's needs, is needed as part of integrated care. Photo-supported conversations, focusing on well-being (BeWell™), is a relatively new health-promoting treatment in primary health care, and its focus is on what contribute to increased well-being in everyday life, despite stress-related illness. BeWell™ consists of 12 individual sessions (in person or virtual) with an occupational therapist. The starting point for dialogues between patient and therapist is the patient's own photographs related to their well-being. The intention is that the treatment would contribute to a sustainable daily life, in which the individual will cope with

challenges, and believe in their abilities to a greater extent. Aim: To explore and describe patients' experiences of daily life, after having participated in the BeWell™. Method: The study have a qualitative approach. Twenty-two women and four men (29–62 years), diagnosed with stress-related illness and having participated in BeWell™, were recruited. The individual interviews focused on their daily life and were carried out six months after completed treatment. The interviews will be analysed with thematic analysis. Expected results: The results are expected to demonstrate the participants' experiences of their daily life after participation in the health-promoting treatment and will provide valuable information from a longitudinal perspective.

## Demystifying Dying in End-of-Life-Care: A Phenomenological Perspective [B034]

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This presentation stems from a research project involving physicians and social workers, focusing on experiences of the process of dying. The empirical material consisted of interviews with patients in palliative care and their significant others, and the analysis was grounded in phenomenology. The analysis highlighted the lived experiences of the participants—embedded in time, identities, social relations, and everyday lives—and showed how the possibility of sense-making was conditioned by the lifeworld. Based on this analysis, we conclude that professionals can and should offer support to patients and significant others, as the end of life often entails multi-faceted suffering. We suggest that this support be understood as reorienting work: helping people when their lines are disrupted or need to be altered. This requires the display of radical empathy, which must be at the core of professional practice and cultivated in the complex, everyday situations of person-centred care.

# Mapping Patient-Generated Index (PGI) Responses to the Kidney Disease Quality of Life 36-Item Short Form Survey (KDQOL-36): A Content Analysis [B035]

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Background and Purpose: Standard quality-of-life tools, like the KDQOL-36, are used in kidney care to assess symptom burden and functional status but may not fully reflect patient-prioritized concerns. The PGI further supports a person-centred assessment by inviting each person to identify, rate and prioritize life areas most important to them. This analysis was related to a broader realist evaluation study exploring how, why, for whom, and what circumstances cognitive behavioral therapy works in dialysis care. Our objective was to describe which priorities identified via the PGI are represented or missing in the KDQOL-36. Methods: We analyzed 203 PGI responses from 47 participants receiving dialysis in Alberta, Canada, using summative content analysis and the NVivo software. The PGI allows participants to list up to five most important areas of their life affected by their health condition (in this case, kidney failure). The KDQOL-36 includes the Short Form-12 general health measures and kidney-specific questions on symptom burden, effects of kidney failure, and perceived life impact. Each PGI response was mapped to one of five KDQOL-36 subscales: Physical Health, Mental Health, Burden of Kidney Disease, Symptoms and Problems, Effects of Kidney Disease on Daily Life, or classified as new categories. Coding frequencies and categories were summarized using word clouds and sunburst. Results: The PGI responses predominantly mapped onto

KDQOL-36 subscales of Effects of Kidney Disease on Daily Life, Physical Health, and Symptoms and Problems, though the other subscales were also represented. Examples of priorities not well-represented by the KDQOL-36 domains include those pertaining to autonomy, lifestyle, leisure, motivation, pet ownership, safety, self-identity, socioeconomic, spirituality, treatment adherence, comorbidity, and grief. Conclusion: While the KDQOL-36 captured structured subscales such as symptom burden and physical function, the PGI responses highlighted priorities closely linked with social determinants of health and other psychosocial aspects central to patient experience.

## Person-Centred Care and Incontinence: An Analysis of Lived Experiences Using McCormack´s Four Dimensions of Personhood [B036]

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Introduction: Incontinence is associated with shame, stigmatisation and daily burdens and reduces quality of life. Experiences go beyond physical symptoms and concern dignity, social participation and self-efficacy. The aim was to synthesise experiences of people with incontinence and identify approaches for person-centred care. Methodology: The methodology is based on a scoping review. A systematic literature search was conducted in PubMed, Cinhal and Cochrane Library between 2015 and 2025, including German and English-language studies on experiences of people with urinary and faecal incontinence. The results were categorised into the four core aspects of personhood according to McCormack (2004). Results: The analysis of ten studies shows that incontinence characterises all four dimensions. Being in relation: Empathic support from carers was valued, while lack of inclusion and not being taken seriously led to feelings of degradation and loneliness. Being in a social world: Shaped by shame and withdrawal, public activities were avoided for fear of stigmatisation. Even

though there was desire for normality, intimacy and belonging. Social support from carers was relieving and helped to break taboos. Being in place: Searching for toilets and adapting the environment shaped experiences. Care homes with "pad-first" strategies were described as degrading, while familiar care relationships provided security. Being with self: Incontinence affected identity and self-image through loss of control, ageing or loss of masculinity. Guidance in pelvic floor training support body awareness, self-efficacy and acceptance. Discussion: Incontinence deeply affects personhood. Caring support is central to strengthening dignity, participation and self-efficacy. Where carers build relationships, enable participation and address needs, person-centredness becomes visible. However, this practice is not consistently implemented. Person-centred care requires taking the voices of those affected seriously and viewing incontinence care not as excretion management but as part of a holistic personhood, followed by the selection of appropriate measures to strengthen such care.

## Person-centered care for people with a tracheostoma in the intensive care unit: A literature research [B037]

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Introduction: Tracheostomies are often performed on intensive care patients to help them survive critical pulmonary situations with minimal sedation. Awake ventilated patients experience anxiety and shame related to the loss of their voice and disfigured body image. The aim of this study is to examine the experiences of affected patients and link them to personhood in order to derive practical implications for person-centered care. Methodology: The study follows the guidelines for scoping reviews. Therefore, a systematic literature search was conducted in the Pubmed via Medline, Cinhal, and Cochrane Library databases between 2015 to 2025. Qualitative articles in German and English were included. The results are classified according to

McCormack's (2004) four levels of personhood. Results: Being with oneself: Patients suffer from feelings of incompleteness, fear, or ugliness due to the loss of their voice and disfigured body image. This can lead to depression or suicidal thoughts. Being in relationships: Due to the limitation of their voice, communication can only be nonverbal. This often leads to misunderstandings with caregivers or relatives. After some failed attempts, they often give up trying to understand and experience communication as failed. Being in a social world: Due to visible changes to their neck, patients often struggle with stigmatization. In acute cases, they are also unable to stand up for themselves so they feel excluded and isolated. Being in one place: The intensive care unit is unfamiliar to patients at first, and the loss of voice means that questions cannot be answered, leading to confusion and fear. Discussion: Staying in an intensive care unit with a tracheostoma affects all dimensions of personhood. Patients want caregivers to be patient and take time to understand their needs and inform them to alleviate their fears. Shared decision-making is also a high priority.

## Medicine Burden in frail older adults - a person-centred measure [B038]

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Background: People are living longer with several chronic illnesses and polypharmacy. Polypharmacy affects older persons through increased risk for side-effects, cognitive/physical impairment, and hospital admissions. Frailty exacerbates these risks. The Living with Medicines Questionnaire (LMQ-3) is a person-centred measure of experienced use of medicines and

related burden. Investigating such burden can inform interventions to reduce risk and improve medicine usage in a person-centred manner. Aim: To evaluate medicine burden and its relationship with demographic and disease-specific variables in frail older people who have sought emergency care without being hospitalised. Method: RCT baseline data from 217 frail elderly in Sweden who completed the LMQ-3 (41 questions, 8 domains, and a score-range from 45 to 205, (higher score --à higher burden)). Descriptive statistics, t-tests, ANOVA and multiple linear regression identified relationships between medicine burden, demographics, frailty, and diseases ($p < 0.05$). 6-month data under collection. Results: 155 patients (71 %) reported a mean total burden of 90.8 (minimal burden). Participants represented FRESH frailty grades: Grade II 45.2%, Grade III 32.3%, and Grade IV 22.6%. A relationship was found between frailty ($p<0.001$), lung disease ($p=0.03$,) and total burden. No statistical significance was found regarding burden and age, gender, or education. However, there were statistically significance between these variables and certain domains. No significance was observed for other disease states. Statistically significance was shown between total burden score and domains for 'impact on everyday life', 'concerns', and 'side-effects'. Regression analyses showed that frailty Grade IV positively affected the total burden ($p \leq 0.001$). Gender, age, education, and background showed no correlation with total burden. Conclusion: Medicine burden among frail older people who visited the emergency department is minimal to moderate and increases as frailty increases. The domains of impact on daily life, concerns and side-effects contribute significantly to the burden, highlighting the need for person-centered care.

# Equity, Justice & Diversity

## Healthcare Navigation in Alberta: a qualitative, peer-to-peer study to inform equitable healthcare navigation program design, delivery and evaluation [B039]

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Healthcare navigation services are essential to individuals needing to access appropriate care in increasingly complex health systems, especially so for those facing systemic and other equity-denying barriers. Understanding the healthcare navigation landscape and experience is important to addressing gaps in service and training programs to improve healthcare experiences and health outcomes. Our Patient and Community Engagement Research (PaCER) team, comprised 12 individuals from diverse backgrounds. We received training, designed and carried out a qualitative study to understand the experiences of both navigators and those navigated in the healthcare system in Alberta, Canada. Methods: Participants were adults, residents of Alberta, and either had been navigated in or with experience as healthcare navigators. COLLECT focus group and interview data were collectively and iteratively analyzed. A thematic analysis approach identified key themes and subthemes. COLLECT participants were invited back to REFLECT focus groups for member-checking. The ethnocultural, linguistic diversity of our research team and trusted community connections meant we could recruit participants who would otherwise be missed in this research. Focus groups and interviews were offered in 11 languages. Results & Impact: The team identified 15 healthcare navigation programs in Alberta. These offered services for: (1) cancer care, (2) diabetes, (3) mental health, (4) disabilities, (5)

life transitions, and (6) newcomers. The Navigated team identified three themes: (1) participants situation and circumstances, (2) navigation experience, and (3) participants perspective. The Navigator team identified four themes: (1) need for healthcare navigators, (2) navigator role, (3) current best practices and challenges, and (4) training and support. Collectively these informed five recommendations related to improving program delivery. Conclusion: Understanding healthcare navigation experiences and perspectives is essential to identifying best practices and gaps. The results of this peer-to-peer study share essential insights from diverse individuals to inform the continued improvement of essential healthcare navigation programs going forward.

## Person-centred, equitable and timely breast cancer prevention in women with intellectual disabilities is long overdue and urgently needed [B040]

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Low uptake of breast cancer prevention in women with intellectual disabilities (ID) leads to higher levels of avoidable breast cancer mortality in this group. Behind the low uptake are practices that are not adapted to the needs of women with ID. To support women with ID in breast cancer prevention, evidence-based recommendations must be followed; the recommendations identified in this assignment are linked to most of the themes found in person-centred and patient-centered care. Further analysis leads to the conclusion that person-centred, equitable and timely breast cancer prevention in women with intellectual disabilities is long overdue and urgently needed.

# Promoting public and community engagement in the topic of equity, diversity, and inclusion in mental healthcare [B041]

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Mental illness is a significant cause of morbidity globally, though rural and remotes communities are disproportionately affected by mental health concerns and face unique barriers. Access to and delivery of quality mental health service is a long-standing challenge in rural and remote areas of Canada. Poorer rural mental health outcomes in Canada may be attributed to a complex interplay of factors including inconsistent funding, disjointed care plans, prioritization of acute management, cultural inequities, socio-economic conditions, and inaccessibility of care centres. Due to the complex nature of mental illness and mental health care in rural and remote Canada, and the limited resources available, our group proposes that treatment and care in rural Alberta follows a model of Person-Centred Care. Our study engages community members in rural Alberta through an adapted Interview Matrix-World Café methodology to explore people's experiences with mental health care in the area. In doing so, we foster a sense of collaboration, involvement, support, and respect for cultural practices and socioeconomic conditions amongst the community. The goal of this project is to determine priority areas for rural and remote mental health research and implementation in Alberta. To achieve this goal, we proposed the following: Host community-based "World Café" events in rural and remote communities Use knowledge translation strategies to inform decision makers, researchers, and healthcare professionals of community priorities for mental healthcare. Our team has so far conducted four World Cafes across rural Alberta, and have reported back to the communities that we have engaged in. We found that Albertans share concerns about the accessibility of mental healthcare particularly for school-aged children, the capacity of

rural mental healthcare services to work with culturally diverse people, and the lack of funding that rural communities face compared to urban counterparts.

## Equitable person-centered measurement of older adults' physical and mental health [B042]

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Aims: Older adults in diverse populations may interpret and respond to patient-reported outcome measures (PROMs) differently depending on where they live and age. Ignoring diversity when analyzing PROMs may lead to inaccurate measurements of their health. This study examined 1) heterogeneity in older adults' responses to a widely used generic PROM, the Veterans Rand 12-item health survey (VR-12), and 2) measurement biases resulting from ignoring heterogeneity. Methods: Older adults (≥ 65 years) across Canada participated in an online survey, which included the VR-12, a PROM measuring physical and mental health (PH and MH), and a tool measuring various social determinants of health (SDOH). A 2-factor Item Response Theory (IRT) model was used to measure the PH and MH dimensions. Latent variable mixture models (LVMMs) were used to examine measurement non-invariance by allowing measurement model parameters to vary across latent classes. Measurement bias was calculated as the difference between IRT scores from a 1-class model (assuming homogeneity) and a k-class model (accommodating for heterogeneity). Multivariable linear regression models were used to examine associations between SDOH and positive and negative measurement bias. Results: Responses on the VR-12 (n=1649) were found to be heterogeneous and best represented by a 2-class model (Class proportions = 0.44, 0.56; Bayesian Information Criterion for 1- and 2-class models=36188 and 35990; Loglikelihood Ratio Test = $p<0.001$). Average positive and negative measurement bias was 0.40 (SD =

0.32) and –0.38 (SD = 0.23) for PH and 0.27 (SD = 0.20) and –0.26 (SD = 0.10) for MH. SDOH explained 4.9% of variance in positive and 11.6% in negative measurement bias for PH, and 14.9% and 7.2%, respectively, for MH. Conclusions: Older adults were found to respond differently to questions about their health, resulting in measurement biases associated with SDOH. LVMMs can be applied to improve equitable measurements of health for older adults.

## Bridging Ideals and Realities: Ethical Insights for Person-Centred Nursing [B043]

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Person-centred care is a normative expectation in nursing, reinforced by the forthcoming EU directive mandating its integration into nursing education from 2026. Yet, organisational constraints, resource scarcity and efficiency demands often make this ideal difficult to realise. Nurses frequently face situations where every choice entails ethical compromise. This paper uses philosophical frameworks to illuminate these tensions and inform practice and education. Drawing on Plato's theory of Forms, we interpret the operating theatre as a metaphorical representation of near-ideal conditions, where the patient remains at the centre: safety is prioritised, tasks are completed thoroughly, and attention is focused on the individual. This is not to suggest perfection in practice, but to use the operating theatre as a conceptual lens for imagining how person-centred nursing might look when organisational structures support its principles. In contrast, home care nursing unfolds on a fragmented stage, marked by time pressure and overlapping responsibilities. Nurses often have to leave patients before tasks are adequately completed—not out of neglect, but due to structural constraints and competing demands. Here, person-centred care often becomes compromised. Using Aristotle's account of tragedy, we frame these situations as moral dramas: nurses act with integrity yet encounter

unavoidable ethical loss. This perspective highlights the emotional and moral labour inherent in care under structural constraints. To address this, we turn to contemporary moral philosophy. Arpaly's concept of blameless wrongdoing offers a lens for recognising nurses' moral effort even when outcomes fall short. Such recognition matters for governance and education: it supports professional autonomy and mitigates unjust moral blame. By staging nursing practice within these philosophical frameworks, we reveal how ideals and realities interact in person-centred care. Ancient concepts, combined with contemporary ethics, provide critical insight into bridging normative aspirations with organisational challenges—informing education and support for nurses under pressure.

## Navigating the Tensions of Patient Reported Outcome Measures: A Simulation-Based Approach to Equitable Person-Centred Care in Nursing Education [B044]

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Patient-reported outcome measures (PROMs) are increasingly embedded in healthcare and becoming more visible in clinical settings, meaning that nurses are likely to encounter and engage with them in practice. PROMs, originating from quality of life assessments, are standardized tools designed to capture patients' health status, functional ability, and wellbeing. Although initially developed for research purposes and quality improvement, they are now applied at the point of care to aid in priority setting and clinical decision making. Because PROMs seek the patient's perspective, they are often linked to person-centred care (PCC). However, their effectiveness in advancing PCC depends on how they are used. When applied uncritically, PROMs can risk reinforcing inequities and lack person-centredness. The intent of this presentation is to argue that undergraduate nursing education must intentionally prepare students to engage with PROMs in ways that are

equitable and person-centred. Achieving this requires not only knowledge of PROMs as assessment tools but also critical awareness of the theoretical and practical tensions they carry. Nurse educators have a unique opportunity to address these tensions through simulation-based learning. Simulation offers a pedagogical space where students can engage experientially with PROM use, critically reflecting on assumptions and interpretations both in practice and during debriefing. By situating PROMs within scenarios that highlight issues of equity, communication, and understanding, simulation can foster reflective and transformative learning. This presentation will be based on a manuscript that positions PROMs within healthcare and nursing, examines their relationship to PCC, and proposes simulation as a strategy to equip students with the skills and perspectives necessary to navigate the complexities of PROM use. In doing so, this work contributes to the broader goal of nursing education: preparing students to deliver equitable, person-centred care across diverse populations and settings.

## Recruiting Hard-to-Reach People: Challenges, Strategies and Determinants of Health for Patients on Dialysis with Depressive Symptoms Considering CBT [B045]

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Background: There is a lack of understanding about recruiting hard-to-reach research participants. We explored this issue by describing the various challenges, strategies, and social determinants of health (SDOH) associated with recruitment of participants into our study of people receiving dialysis for remotely delivered therapist-guided cognitive behavioral therapy (CBT). Methods: Our study used data from 'Re: CBT Dialysis' project. Patients were

invited through indirect recruitment strategies at 25 dialysis sites in Alberta and British Columbia (e.g., letters/posters), through Canadian kidney organizations, and via a previous project. Recruitment challenges were discussed with Community Advisors and site managers; strategies were co-developed. Due to low enrollment, patients were subsequently recruited in-person from 12 (of 25) sites. In-person recruitment challenges and reasons for not participating were recorded; conventional content analysis was used to categorize these notes. A Chi-square test was used to compare SDOH of those eligible to receive CBT but did not participate and those who participated. Results: Initially, indirect recruitment resulted in 58 participants. Subsequently, 2,015 patients were approached in-person. Of these, 1771 were unsuccessfully recruited: 335 were ineligible, 62 incomplete recruitment, 462 other reasons, and 912 declined to join. Top 4 reasons for not joining included: no interest (652), unknown reasons (63), already participating in research (63), too busy (58). To boost recruitment, the inclusion criteria were expanded to include all people receiving dialysis and phone surveys were introduced. Consequently, 168 people joined through in-person recruitment and 162 people joined through indirect recruitment. Of the 221 participants invited to receive CBT, 48 participated. Several SDOH (religion, disabilities, housing, finances, medication access, income, and social supports) were significantly associated with final participation in CBT ($p < 0.05$). Conclusion: There is a great need for additional strategies to improve equitable people-centred recruitment of hard-to-reach research participants, including people receiving dialysis and experiencing depressive symptoms.

## Culturally Sensitive Emotional Well-Being Assessment: Differential Item Functioning Analysis of East Asian Immigrants and White Respondents in Canada [B046]

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Background: The assessment of emotional well-being (EWB) has become increasingly recognized for understanding overall health. An EWB assessment that considers individuals' cultural backgrounds and experiences, particularly those of immigrants, is essential to respecting their unique values within their health care experiences. However, using the same universal assessment measure across cultures may fail to account for cultural diversity, thus hindering the delivery of person-centred care. Therefore, there is a need to examine how EWB measures function among culturally diverse immigrant populations. Purpose: This study aimed to enhance person-centred care by examining measurement bias related to differences in how East Asian immigrants responded to self-reported items for measuring EWB compared to non-immigrant White people in Canada. Methods: The data were drawn from the Equitable People-Centred Health Measurement survey. EWB was measured using the "Feelings" item bank of the CAT-5D-QOL, which consists of 43 items about depressive symptoms, anxiety, and positive feelings. Propensity score matching was used to create a balanced sample of East Asian immigrants and White non-immigrants. Measurement bias was examined with Multiple Indicator Multiple Causes Item Response Theory model to test for differential item functioning (DIF) between the two groups. Results: The sample included 580 White respondents (48.6% male, 51.4% female, mean age=45.3 years) and 580 East Asian immigrants (49.8% male, 50.2% female, mean age=48.6 years). The analysis revealed statistically significant DIF for 21 of the 43 items, indicating that these items do not measure EWB in the same way for East Asian immigrants. The item, "During the past 7 days, how much of the time did you feel that you have a number of good qualities?" showed the significant DIF. Conclusion: This result demonstrates the importance of considering cultural background when using EWB items to ensure culturally sensitive and equitable health that reflects the values of person-centred care for East Asian immigrants.

# Quality of Care in the End-of-Life: An Analysis of Studies Including Data from the Swedish Register of Palliative Care [B047]

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Introduction: The Swedish Register of Palliative Care was established in 2005 as one of several initiatives to enhance palliative care quality in Sweden. To the best of the authors' knowledge, no comprehensive review of articles based on data from the Swedish Register of Palliative Care has been conducted to date. Aim: The aim of the study was to map and interpret how published original articles using data from the Swedish Register of Palliative Care contribute to advancing the understanding of palliative care quality in Sweden. Methods: The study was conducted using an exploratory design that involved content analysis of published original articles based on data from the Swedish Register of Palliative Care. Additionally, to assess the extent to which the included articles are cited in national policy documents on palliative care, relevant guidelines were examined. Results: The content analysis identified 7 distinct themes related to end-of-life quality. Overall, the studies suggested that end-of-life care is both suboptimal and inequitable, with disparities observed between diagnostic groups, across age cohorts and geographic location. Although few studies provided explicit reasoning about quality of care, several suggested future research themes revolved around exploration of general quality improvement and method development in palliative care. Conclusions: The body of research reinforces the perception that palliative care in Sweden remains a neglected area within the healthcare system. If the included studies accurately represent the current state of end-of-life care in Sweden, the need for development is both urgent and substantial.

# Person-Centred Care and Health Literacy: A Scoping Review of the Concepts' Attributes and Interrelationships [B048]

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Background Person-centred care (PCC) builds on understanding the person's narrative, values, and resources, and on forming a partnership that supports shared decisions and active participation in care. Health literacy (HL) refers to how persons find, evaluate, and act upon health information. It extends from the individual level to the organisational level, where it contributes to making care more accessible and actionable. While PCC and HL are often discussed as interconnected, their relationship remains unexplored. This scoping review aimed to describe both concepts and their interrelationship through shared and distinct attributes. Method The methodological framework by Arksey and O'Malley was applied. Two separate searches for each concept were performed by two experienced librarians in the databases CINAHL, PubMed, and Scopus. The scoping considered peer-reviewed articles published between January 2000 and June 2025 that included an analysis, conceptualisation, or theorisation of one of the two concepts. Each concept was summarised based on core attributes, and differences and similarities identified. Results The searches identified 10,284 articles for PCC and 5,513 for HL, of which 17 and 19, respectively,

met the inclusion criteria. The included articles primarily originated from Europe and North America. Eight shared attributes underpinning both PCC and HL were identified: empowerment, meeting persons' needs and addressing everyday life, shared and informed decision-making, effective and tailored communication, functional healthcare systems, supportive organisational structures (leadership, policy, and work environment), cultural competence, and equity. The results are presented in Figure 1. Conclusion PCC and HL share several attributes and strive to empower persons with an equity-driven approach, emphasising communication towards shared and informed decisions. Leadership, policy, and organisational environment were highlighted in both concepts, indicating that person-centred and health-literate care depend not only on individual skills but also on organisational prerequisites. These insights may guide future conceptual work and support development of integrated frameworks.

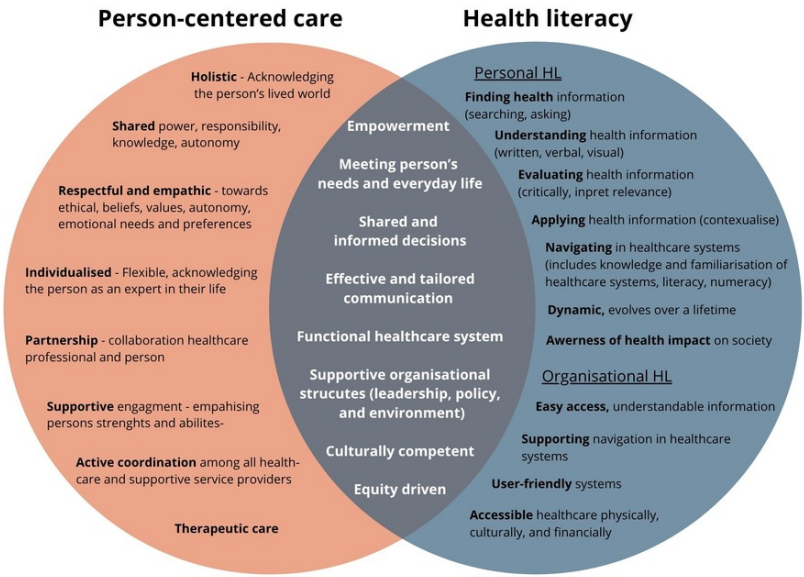


**Figure 1.** Separate and shared attributes of person-centred care and health literacy (HL)

# Healthcare Organization

## Exploring the role of Government Chief Nursing and Midwifery Officers in influencing policy for people centred health systems. A Scoping Review [B049]

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According to WHO (2016) healthcare requires a shift from health systems designed around diseases and health institutions towards health systems designed for people. A renewed focus on service delivery through an integrated and people-centred lens is critical to the delivery of universal health coverage. The State of the Worlds Nursing Report (WHO 2025) notes that building such people centred and resilient health systems heavily relies on the interventions of nurses to ensure that point of care delivery is safe, effective and responsive to need. Nurses often work within or lead multi disciplinary teams who can co create such approaches in practice. However the impact of shortages in the healthcare workforce and its impact on practice and staff is well documented (Kings Fund 2022, Tamata and Mohammadnezhad 2023, WHO 2025). Government Chief Nursing and Midwifery Officers (GCNMOs) are established roles and recognised in many countries globally as the head of the nursing and midwifery profession. GCNMOs have a clear role in influencing health policy and in setting direction for the professional practice and delivery of healthcare in their countries (WHO 2015). This includes leadership and advice on nursing and midwifery workforce policy and the contribution nurses and midwives can make to universal health coverage and people centred care. The rationale for the scoping review is a dearth of evidence of the effectiveness and impact of the GCNMO role. The scoping review was carried out using Joanna Briggs Institute Protocol and was undertaken to Explore and map the existing literature on the roles of GCNMOs in influencing strategic policy

development. Identify key themes and strategies employed by GCNMOs to influence policy. Determine the gaps in knowledge and research regarding the influence of GCNMOs in policy-making. The methodology employed, key themes, findings and implications for people centred healthcare system policy will be discussed.

## First-line managers in home care services and their perspectives on person-centred practice [B050]

*Elisabeth Dal Nyland[1], Elise Johansen[1], Liv Berit Olsen[1] & Camilla Anker-Hansen[1]*

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Background: Empirical knowledge highlights the significant role of leadership in promoting a person-centred approach in healthcare, where leaders act as role models in establishing such practice. Person-centred practice has been shown to improve employee satisfaction and enhance the quality of care. However, despite this knowledge, little research has explored leadership in home care services and how leaders' practice aligns with established frameworks for person-centred practice. Aim: To explore leaders' perspectives on person-centred practice in home care services. Methods: This qualitative study was based on semi-structured interviews with first-line managers in home care services across several Norwegian municipalities. Data were analysed using Braun and Clarke's reflexive thematic analysis, guided by a theoretical framework for person-centred practice. Results: Leaders demonstrated limited knowledge of person-centred leadership. Their facilitation of person-centred practice primarily focused on creating a positive psychosocial work environment and recognising employees as unique individuals. They emphasised being visible and accessible, serving as role models and fostering openness and freedom of expression within the teams. Employees were encouraged to use their skills and exercise autonomy in organising their workday. Time constraints emerged as a major organisational barrier. Most leaders felt they were treated according to person-centred principles by both superiors and employees. However, administrative demands were experienced as

challenging and at times in conflict with person-centred leadership. Conclusions: The findings suggest that although leaders reported limited explicit knowledge of person-centred leadership, their everyday practices reflected many of its core principles, particularly in fostering supportive relationships and positive work environments. At the same time, they described perceived barriers, including limited time and certain administrative demands they experienced as challenging. This study contributes new insights into person-centred leadership in home care services, an underexplored area, and highlights implications for leadership development and organisational strategies to strengthen person-centred practice.

## Staff-reported person-centred practice in Norwegian home care services: a cross-sectional survey using the PCPI-S [B051]

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Background: Person-centred practice is foundational to quality in community care, yet staff-reported PCP in Norwegian home care services is under-described. The Person-centred Practice Inventory–Staff (PCPI-S) aligns with McCormack & McCance's Person-centred Practice Framework and is validated in Norwegian. Aim: To explore staff-based measures of person-centredness in a Norwegian home care district. Methods: We conducted a cross-sectional survey (October 2024) in a home care district in South-Eastern Norway using the Norwegian PCPI-S. N=94 staff completed the questionnaire. Descriptive statistics summarized construct scores; ANOVA tested differences by education level and work experience. $P \leq 0.05$ Results: At the domain level, Person-centred processes scored consistently high (all five constructs ≥4.0), with Having sympathetic presence and Providing holistic care topping the domain (both M = 4.33). Overall, the highest single-construct scores were in Prerequisites; Developed interpersonal skills (M = 4.47) and Being committed to job (M = 4.46). Meanwhile, Care-environment

constructs such as Supportive organisational systems (M = 3.51) and Shared decision-making systems (M = 3.58), and the Prerequisite Clarity of beliefs and values (M = 3.64) were comparatively lower, though all means exceeded the five-point scale midpoint (3.0). Work experience (>5 vs. ≤5 years) showed no significant differences, whereas higher education was significantly associated with higher scores across multiple constructs (Professional competence, Interpersonal skills, Commitment to job, Clarity of beliefs and values, and several Care environment constructs). Conclusions: Although scores were high across domains, Care Environment constructs scored lower than Care processes, while Prerequisites contained the highest single-construct scores. Enhancing supportive systems, team-level decision-making, and professional development may further embed person-centred practice in home care services.

## Implementation of an organisational structure for academic leadership in nursing and person-centred fundamental care. A case study in surgical care [B052]

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Introduction: Highly competent nurses delivering person-centred care, approaches the global challenges of missed nursing care for the patient and high nurse turnover. This study describes the development and implementation of an organisational structure for academic leadership in nursing and person-centred fundamental care. Methods: A descriptive case study design. Data were collected from project records and regulatory documents from the development and implementation of the organisation within a surgical department with nine units at a university hospital. The analysis was performed using content analysis. Results: The implementation of the organisational structure is described in three phases: (I) Evidence mapping, (II) Design, and (III) Establishment. A nursing council and new positions for nursing leadership were developed and filled. PhD-nurses work

to strengthen evidence-based patient care, clinically relevant research, and usage of research results. Specialist nurses perform person-centred nursing rounds for patients with advanced level care needs, mentor younger nurses, and collaborate with surgeons to plan and evaluate care across the department. A model for nursing care and research, guided by the Fundamentals of Care framework, is implemented to guide person-centred fundamental care and research. The development and implementation of the organisational structure were guided by i-PARIHS. Conclusion: The organisational change incorporates key factors for successful implementation and is designed based on evidence to achieve excellent nursing care meeting the individual patient care needs. This approach is promising for long-term sustainability in the nursing workforce and delivery of excellent person-centred fundamental care for the patient. There is a need to scale up the movement of person-centred fundamental care to ensure that the patient's care needs are met. This step-by-step description of the process of developing and implementing the organizational structure - a successful yet challenging endeavor - may support others in initiating similar projects.

## How to promote learning on person-centred leadership: key messages from the Transition towards person-centred care project [B053]

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Background: There is a demand for educational initiatives that support health and social care leaders to facilitate person-centred care (PCC). The TRANSITION research project (2022-2026) addresses this by exploring the shift toward PCC through the development and evaluation of a leadership program grounded in the University of Gothenburg Centre for Person-centred Care framework. Additionally, the project includes a scoping review of international evidence on educational initiatives that facilitate PCC implementation. Aim: To summarise and reflect on key findings from the TRANSITION project, with a focus on how person-centred leadership can be effectively promoted through educational initiatives. Methods: The analysis draws on data from qualitative studies (n=3) with program leaders and participants and a scoping review. Findings are synthesised descriptively with the scoping review providing a frame of reference for interpreting the findings. Interestholders are involved throughout the project. Results: Key findings show that the integration of person-centredness and leadership within the program promotes pedagogical insights among program leaders and supports experiential learning among participants. This learning can enhance the capacity for self-leadership, team leadership, and co-creation of PCC. Contextual factors that influence how managers develop the ability to lead in a person-centred way are identified, highlighting applications of person-centred principles in curricula and how person-centredness is learned across various settings. Comparisons with the findings from the scoping review highlight both similarities and differences in content, methods, and outcomes. Conclusion: The findings reinforce current evidence that the workplace is a critical setting for learning about person-centredness. They also contribute new insights into how the complementary roles of digital and on-site learning activities can be combined to support learning about and through person-centred practice. Further research is needed across health and social care settings in different countries and with different professional groups to develop educational programs that support person-centred leadership and practice.

# Treatment of dental caries in children via a theory-based behavioural intervention led by health promoters: a health economic evaluation [B054]

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Introduction: Dental caries remains a prevalent condition with significant health and economic repercussions. To address persistent oral health disparities and reduce the burden of dental caries among preschoolers in Sweden, this study aims to evaluate the clinical and economic impact of implementing a theory-based behavioural intervention delivered by health promoters in clinics serving children at elevated risk for caries. Methods: A retrospective cohort design was applied, comparing clinics using a theory-based behavioural intervention led by health promoters with clinics using the Recommended Programme for Caries Treatment (RPCT). The cohort were children aged 3–6 years identified as being at increased caries risk in Region Västra Götaland during 2021–2023. Three analytic approaches were employed: (1) budget impact analysis (BIA) to measure net costs and resource shifts; (2) difference-in-differences (DiD) to compare mean decayed, extracted or filled teeth (deft) in intervention versus control clinics; and (3) cost-effectiveness analysis (CEA) to estimate the incremental cost-effectiveness ratio (ICER). Results: The BIA showed that the theory-based behavioural intervention led by health promoters incurred higher initial personnel costs than the RPCT but required fewer clinical hours – an opportunity cost that, if redeployed to clinical activity, could partially offset

these expenses. The DiD showed that, over 3 years, clinics implementing the intervention achieved a statistically significant reduction of 0.26 deft among 6-year-olds. The CEA estimated the ICER to be 2142 SEK (199 EUR) per deft prevented, which improved to 513–810 SEK (48–75 EUR) when the economic value of the liberated work hours was included. Conclusion: A theory-based behavioural intervention led by health promoters reduced caries risk among high-risk preschoolers and may enable improved resource allocation, contingent on the redeployment of freed hours. Despite higher initial personnel costs, the approach demonstrated favourable cost-effectiveness over time, supporting its integration into public dental care systems.

## The Guardians of Personhood: Nurses' Perspectives on Person-centred Care in the Intensive Care Unit [B055]

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The intensive care unit (ICU) is a place where standardized procedures and advanced technology intersect with profound human vulnerability. We explored how ICU nurses understand and enact person-centred care in this context, where protocols, clinical procedures, and machines challenge humanistic engagement. This study forms part of a broader investigation of Person-centred Practice in the ICU, drawing on McCance and McCormack's framework and Levinas's philosophy of the radical Other. Data were collected from 16 ICU nurses working in adult ICUs across three hospitals in Austria. Sources included focus groups, individual interviews, and the collection of person-centred moments. Our analysis identified two strategies that nurses use to shape the care environment; i) 'creating the context'

(grounding values and beliefs to allow personhood to emerge) and ii) 'breaking up the frames' (responding to disruptions through the radical Other to ensure personhood can be valued and sustained). Nurses 'create a context' by adhering to inner credos (guiding values like recognising the person, taking responsibility, and acting ethically) applied in shaping relationships and navigating the patients journey balancing personal, clinical, and technological demands. They understand themselves as guardians of patients' personhood. Person-centred moments emerged from challenging situations. Here, nurses were able to 'break up the frames' - routines, standard procedures, and even personal expectations - by opening to the situation and embracing the strangeness and disruption they faced. By going the extra mile, they created moments in which person-centred care could unfold, generating positive care experiences. Person-centred care in the ICU means caring for the person behind tubes, wires, and machines. It cannot be reduced to checklists or protocols but depends on nurses' ability to pause, notice, and respond, supported by organizational cultures that enable such care. In this way, 'breaking up the frames' is not about dismantling clinical care but expanding it to include the person.

## From Conversations to Care: Person-Centred Nursing in Allogeneic Stem Cell Transplantation [B056]

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Background: Patients undergoing allogeneic hematopoietic stem cell transplantation (allo-HCT) often face complex and evolving needs throughout recovery. Person-centred nursing (PCN) is essential in this context yet remains underexplored in specialised care settings. In Sweden, the Assessment of Rehabilitation Needs Checklist (ARNC) is commonly used in cancer care, but its role in supporting person-centred conversations has not been investigated. Aim: The aim of this study was to investigate how the use of the ARNC as a conversation tool promotes PCN within the allo-HCT context. Methods: This qualitative study was conducted at two major allo-HCT centres in Sweden. Data were collected through semi-structured interviews with patients (n = 16), focus group discussions with registered nurses (RNs, n = 16), and from 30 memos written by RNs. Reflexive thematic analysis was used. Results: Three overarching themes were developed: (1) Letting the Story Emerge, (2) Unmet Needs and (3) Structural Gaps in Practice. The ARNC facilitated individualised conversations and helped identify unmet needs, including sensitive or previously unvoiced concerns. However, lack of follow-up and organisational constraints, such as time pressure and fragmented care settings, limited its capacity to support shared care planning and sustained engagement. Conclusion: When used in dialogue, the ARNC has the potential to support person-centred nursing in allo-HCT by enabling narrative-based, needs-driven conversations. However, its effectiveness depends on structured follow-up and organisational conditions that promote relational care.

## Risk Stratification in Ambulance Service: Describing and Predicting Multi-Level Healthcare Utilization Following Referral to Self-Care [B057]

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Background: Ambulance clinicians increasingly refer patients to self-care, positioning the ambulance service within a complex gatekeeping role. Clinicians must assess whether self-care is a safe option or if further support is needed. Unlike referrals to primary healthcare centers (PHCs), structured follow-up after self-care referrals is often lacking, and the consequences of these decisions remain largely unexplored. This study investigates outcomes and predictors of subsequent healthcare contact and mortality among patients referred to self-care by ambulance services in three Swedish regions. Methods: We conducted a retrospective cohort study of 6,496 ambulance assignments in 2023 that resulted in self-care referrals (970 children, 5,526 adults). The primary outcome was subsequent healthcare contact (including recontact, PHC visits, new ambulance calls, emergency department visits, and hospitalizations) and all-cause mortality within 72 hours and 30 days. Bayesian multilevel logistic regression models were used to estimate the probability of recontact and mortality. Results: Of the 6,496 self-care referrals, 30% resulted in subsequent healthcare contact (adults: 29,2%;

children: 23,7%), most commonly to PHCs (adults: 55,8%; children: 60,3%). Observed mortality was 0,9% within 72 hours and 2,9% within 30 days (adults: 0,9%, 2,9%; children: 0%). Among children, respiratory, infectious, and general medical symptoms were most common; among adults medical, surgical, and neurological symptoms dominated. Predictors of recontact included older age, longer on-scene time, use of Advisory decision support system (ADSS), and distance to hospital. The strongest predictor was the type of complaint, with orthopedic cases showing the highest recontact rates. Conclusion: Nearly one-third (30%) of patients sought additional care within 72 hours of a self-care referral. While this does not necessarily indicate negative outcomes, the lack information follow-up and patient-reported data limits interpretation. Future research should explore patients' perspectives to better understand re-attendance and improve the safety of self-care referrals.

## Health and social care staff experiences of person-centred care related to work-related health and job satisfaction: preliminary focus group findings [B058]

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Background: Current health systems need reforms to sustain a thriving workforce that ensures high-quality care. To support sustainable working

conditions in health and social care, more knowledge is needed about how staff experience their opportunities to apply person-centred care (PCC) and how this relates to their work-related health and job satisfaction (1). Contributing to addressing this knowledge gap (2), the present study integrates staff experiences to inform the shift towards person-centred and integrated care. Aim: To explore how health and social care staff experience PCC in relation to their work-related health and job satisfaction in hospital, municipal, and primary care settings. Methods: This ongoing study applies focus group methodology. So far, three online focus groups have been conducted with thirteen health and social care staff members and more groups are planned. Heterogeneity is sought by recruiting participants of different sexes, ages, years of working experience and occupational groups, while homogeneity is sought by recruiting participants who share similar experiences and work within comparable organisational settings. Results: Preliminary findings indicate that participants experienced PCC as an ongoing and meaningful approach that should be fostered to sustain work-related health and job satisfaction. Having first-line and senior management who understand PCC and support its application was described as a facilitator. However, organisational shortcomings, such as fragmented care processes, staffing shortages, and high work demands, were perceived as barriers that may lead to feelings of frustration and inadequacy. Conclusions: PCC may be experienced as a meaningful process that supports staff's work-related health and job satisfaction. Implementing PCC benefits from supportive organisational structures and leadership, with attention to both facilitators and barriers. More comprehensive results will be presented at the conference.

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## Supporting Person-Centred Care Across Organisational Boundaries: Insights from Research and Practice [B059]

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Person-centred care for individuals with complex needs often requires coordination across multiple providers, including hospitals, primary care, municipal services, and ambulance care. Yet such collaboration is frequently challenged by fragmented systems, unclear responsibilities, and differing organisational logics. This study draws on findings from a doctoral project exploring how person-centred care is enacted across organisational boundaries in Swedish healthcare. Using qualitative and systems-informed methods, the project examined collaboration in care transitions and discharge planning, focusing on older adults with complex needs. Findings show that person-centred care does not emerge automatically through formal structures or increased collaboration. Instead, it often arises in the "borderlands" between systems—through relational work, informal communication pathways, and adaptive strategies developed by front-line professionals. These everyday practices enable professionals to respond to patients' needs in context, ensuring that the right care is delivered by the right actor at the right time. Key enablers of cross-boundary person-centred care include strong interprofessional relationships and trust, clear and flexible communication channels, shared responsibility and accountability for care transitions, and adaptive capacity to address system gaps. Conversely, rigid organisational structures, fragmented governance, and unclear mandates hinder seamless coordination. These findings challenge the assumption that "more collaboration" alone is the solution. Instead, they point to the importance of cultivating the conditions that make collaboration meaningful and effective from a person-centred perspective. This involves governance and leadership approaches that support relational continuity, flexibility, and shared accountability rather than relying solely on structural integration or digital solutions. By highlighting how person-centred care is achieved in practice, this work offers insights into how health and social care systems can better bridge organisational boundaries to meet the needs of individuals with complex needs.

# Exploring the Person-centred Care Practice Patterns of Mental Health Nurses: A Concurrent Mixed Methods Study [B060]

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Aim: To understand the person-centred care (PCC) practice patterns of mental health nurses in one Atlantic Canadian province. Background: There is emphasis on PCC within mental health services, yet, PCC is often poorly understood and operationalized by mental health care professionals. Mental health nurses' person-centred practices remain unclear, as there is limited research on their practices. Design: The Person-centred Practice Framework (McCormack & McCance, 2016) was the theoretical framework for this concurrent mixed methods study. The quantitative portion of the study was a descriptive cross-sectional design and both interviews and participant observation comprised the qualitative portion. Interpretive description, a nursing methodology, guided the qualitative components of the study. In the integration phase, the analytic technique of merging established the alignment among complementary data within the three sets of study findings. Methods: Seventy Registered Nurses across one Atlantic Canadian province completed the survey package consisting of the person-centred practice inventory (Slater et al., 2017) and 13 demographic and work-related questions. Interviews occurred with eight individuals who had received recent inpatient mental health care in the province. Thirty-six hours of participant observation were conducted on three adult inpatient mental health units. The Pillar Integration Process, a four-stage procedure designed to integrate qualitative and quantitative data using joint display tables, guided the integration. Results: Three patterns were developed from the integrated data: 1) mental health nurses maintain a separation from patients and often deliver nursing care from a distance, 2) mental health nurses practice in an organizational culture that supports the status quo, which is not person-centred care, and 3) when mental health nurses and individuals co-engage in person-centred moments, the results are inspiring and foster

hope. Conclusion: Nurses face organizational and personal barriers in their delivery of person-centred care. Although person-centred moments were infrequent, they are valued by those who receive care.

## Applying the principles of adaptive leadership to person-centred care for people with complex care needs [B061]

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Background: Health systems in many countries see person-centred care as a critical component of high-quality care but many struggle to operationalize it in practice. We argue that models such as adaptive leadership can be a critical lever to support person-centred care, particularly for people who have multiple complex care needs. Objective: To reflect on two concepts: person-centred care and adaptive leadership and share how adaptive leadership can advance person-centred care at the front-line care delivery level and the organizational level. Methods: This presentation is based on an environmental scan of the literature on previous studies that have conceptualized and applied the concepts of person centred care and adaptive leadership in the health system context. Findings: The defining feature of adaptive leadership is the separation of technical solutions (ie applying existing knowledge and techniques to problems) from adaptive solutions (ie requiring shifts in how people work together, not just what they do). Addressing adaptive challenges requires identifying key assumptions that may limit motivations for change and the behaviours influenced by these assumptions. Thus, effective care for patients, particularly those with multiple complex care needs, often entails helping care providers and patients to examine their relationships and behaviours not just identifying technical solutions. Addressing adaptive challenges also requires a supportive and enabling organizational context. In this presentation illustrative examples of how adaptive leadership principles can be applied at both the

front line of care and the organization level in advancing person-centred care delivery will be shared. Conclusions: Advancing person-centred care at both the clinical and organizational levels requires a growth mindset, a willingness to try (and fail) and try again, comfort in being uncomfortable and a commitment to figure things out, in partnership, in iterative ways. Patients, caregivers, care providers and organizational leaders all need to be adaptive leaders in this endeavour.

## Person-Centred Leadership [B062]

*Helle Gert Christensen[1], Elizabeth Emilie Rosted[1], Mette Kjerholt[2] & Tina Lanther[2]*

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Background: The Department of Haematology and Oncology collaborated with Professor Brendan McCormack to develop person-centred leadership (PCL). This focus emerged after three years of research into person-centred practice (PCP) in nursing, which revealed that leaders concentrated on patients and staff while neglecting their own leadership practices. To support a multidisciplinary PCP culture, we introduced PCL to all middle managers and department heads. Content: Two joint theme days were held at the end of 2024 and early 2025. These focused on what constitutes a good working life for leaders—how it can be recognised, its link to well-being and job satisfaction, and the core values underpinning effective leadership. The sessions were followed by two 2-hour meetings linked to another leadership course, ahead of the departments' relocation to a new hospital wing. All activities were facilitated by an external consultant. Outcomes: The leadership group formulated shared core values as the foundation of the PCL programme. Through discussions and learning sessions, they explored both personal leadership and leadership practices. The process enhanced awareness of: The link between personal well-being, staff well-being, and patient satisfaction Organisational dynamics and leadership Dilemmas and boundaries in PCL Motivation and authenticity in leadership Conclusion: Leaders tend to prioritise staff and patient well-being over their own. However, a structured, externally facilitated programme can

significantly improve leadership development when time and planning are prioritised. A key motivator for PCL is its positive effect on staff and patient outcomes. Understanding these connections is essential. Overall, we observe a shift toward planning courses and theme days with PCP as a central theme, indicating a growing PCP culture at ZUH and nationally.

## From System Focus to Person-Centred Cancer Care: A Qualitative Study on Healthcare Professionals' Experiences [B063]

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Background: Today's cancer care risks being system-focused, operating in an environment with little regard for patient's life experiences or room for their participation. A person-centred approach, which promotes a continuous, trusting care relationship and considers patients' unique situations, improves the well-being of both patients and healthcare professionals by increasing hope, enhancing communication, satisfaction, and engagement. Aim: To gain a deeper understanding of healthcare professionals' experiences of possibilities and limitations for providing person-centred care, to alleviate suffering among patients within cancer care. Methods: A qualitative and exploratory design was used. Data were collected through four focus group interviews with 15 nurses and physicians from a cancer clinic in Finland. A qualitative content analysis was used to analyse the data material. Results: Healthcare professionals' internal motivation and knowledge are comprehensive. However, their ability to provide person-centred care is limited by organisational structures, such as time constraints, strict management, and resource availability. These issues cause failure demand and limit the ability to create meaningful and long-term care relationships

with patients, and can lead to feelings of powerlessness and ethical stress among healthcare professionals when they cannot provide the care they believe is best for their patients. Conclusions: There is a need for more integration in the healthcare organisation, through better collaboration and flexibility between different instances. This could reduce failure demand and release resources. By gaining a deeper understanding of the problems and addressing them together, healthcare professionals' ability to provide high-quality person-centred care can be enhanced, ultimately reducing patient suffering and improving their well-being.

## From Values to Practice: Development and contextual analysis of a person-centered professional practice model in a home care service [B064]

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Background: In Switzerland, the growing prevalence of chronic conditions leads to care fragmentation, a challenge particularly acute in home care networks with geographically dispersed teams. A unified Professional Practice Model (PPM) grounded in person-centred values offers a strategic solution to bridge practice, enhance care cohesion, and align organisational goals. This study aimed to develop and conduct a contextual analysis for implementation of a person-centered professional practice model for home care services in French-speaking Switzerland. Methods: A multi-method, empirical study was conducted in a large home care service. The PPM was developed using concept mapping, a participatory process involving 157 healthcare professionals. Subsequently, a contextual analysis for implementation was performed using the Intervention Mapping framework, which included focus groups with stakeholders and frontline staff (n=14), and validation through a modified Delphi process. Results: The concept

mapping yielded 14 core values, with "health promotion" (rated 4.4/5) and "patient-centred approach" (4.3/5) identified as most important. "Interprofessionalism" received the lowest rating (3.7/5), highlighting a key implementation challenge. The contextual analysis revealed strong leadership support (83% agreement) and a culture of psychological safety (83% agreement) as critical facilitators. A key finding was the spontaneous alignment of our empirically derived model with McCance and McCormack's Person-centred Practice Framework, providing theoretical validation. Eight concrete implementation strategies were co-designed and validated. Conclusion: This study demonstrates a feasible, staff-driven process to translate professional values into a coherent PPM. The model serves as a practical framework to reduce care fragmentation by establishing shared priorities that bridge practice across a decentralized organisation. This work provides a validated roadmap for knowledge translation, demonstrating how to connect the practice environment with organisational strategy and governance to foster sustainable person-centred care.

## From philosophy, through principles to practice: Leading person-centred culture change by design – lessons from an Australian healthcare scandal [B065]

*Duncan McKellar[1, 2], Erna Harldsdottir[1] & Karen Rennie[1]*

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This presentation explores lessons in leadership, culture and service reform emerging from a major Australian healthcare scandal. The Oakden Older Persons' Mental Health Service was a state-run specialist residential service in Adelaide, South Australia, for people with dementia or an enduring mental health condition. Failures in governance, safety and quality were underpinned by an absence of person-centredness and resulted in public outrage, political fallout and triggered the Australian Royal Commission into Aged Care Safety and Quality. Drawing on lived experience, co-design, reflective practice and embodied scholarship, the presentation presents a

practical framework and actionable tools for leading meaningful, sustained, person-centred culture transformation in health services through a comprehensive, story-informed model that integrates philosophy, principles, and practices. Building on an ontological foundation of personalism, the presentation illustrates the value of an articulated philosophy of person-centredness that is translated into guiding strategic principles. These principles, including cultivating psychological safety, fostering relational presence, supporting work-life integration, promoting workforce democratisation, and balancing quality, safety, and risk, are explored for their leadership relevance and to consider how they inform translation through repeatable, active practices in teamwork and care. The presentation will focus on real-life illustration of the framework, emerging from the reform period after The Oakden Report and subsequent scholarly work, inspiring confidence in practitioners and clinical leaders seeking to achieve similar values-based, person-centred change processes in other service settings.

## Preliminary Validation of an Instrument Measuring the Impact of the Care Environment on Person-Centered Care in Intensive Care [B066]

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Background: This study is part of a project entitled "SoLiDe ICU – Sound, Light, and Design in Intensive Care Units" (https://www.gu.se/en/research/solide-icu-sound-and-light-design-in-intensive-care-units), aiming to improve the care environment and its impact on staff health and well-being. The care environment plays a vital role in supporting healthcare professionals in care delivery. However, it appears to be a lack of knowledge concerning how the care environment may influence

the provision of person-centered care in this specific setting. Although tools exist to evaluate care environments and person-centeredness separately, there is a lack of instruments specifically designed to evaluate how the ICU care environment supports person-centered care. Aim: To validate a questionnaire measuring the impact of the ICU care environment on the provision of person-centered care. Methods: A cross-sectional, quantitative study was conducted. Critical care nurses (n=40) completed a digital questionnaire and provided feedback as part of the validation process. Quantitative data were analyzed using SPSS, including reliability testing with corrected item-total correlation and Cronbach's alpha. Qualitative content analysis was applied to open-ended responses. Results: The questionnaire was found generally relevant and understandable. Although some questions were regarded as irrelevant or less suitable for the context of ICU. Statistical analysis indicated high to very high internal consistency across several domains. The participants indicated that items on work environment and collegial climate need to be added and described comprehensively in future versions of the questionnaire. Conclusion: This study provides preliminary validation of an instrument aimed at measuring how the ICU care environment supports person-centeredness. Further revisions and validation are needed, before it can be considered as a reliable tool for examining the impact of the care environment as an element in providing person-centered care in the context of intensive care. However, the questionnaire shows a potential for evaluating and improving person-centered practices in intensive care environment.

## Cultural transformation in a Swiss acute care hospital: From vision to action [B067]

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Background: In May 2025 the Hospital Dornach, as part of the hospital group "Solothurner Spitäler AG", appointed a new Nursing Officer (NO). The NO met with opposition in her new position - on the one hand there

was a family environment, high patient satisfaction, short official channels; on the other hand silo working, less team spirit and moderate staff satisfaction. She reviewed her impressions and shared her vision of person-centered workplace culture (PCWC) - pertaining to the hospital group's goal of person-centered practice - with her colleagues in the hospital management. In the following, the NO describes the pathway to PCWC within her hospital. Methods: The NO did work-shadowings to observe interactions and to better understand processes and structures. This was followed by dipping into the past and by getting in dialogue, interviewing staff and leaders. This in turn helped to identify pain points in daily practice. Reflections on her insights were discussed with the hospital management. Followingly, several workshops were held to reflect and acknowledge their history, to clarify values and beliefs and to get a vision about person-centeredness within the hospital. Results: The NO engaged with staff by actively using the methodology of practice development. New approaches of the NO were supported by the hospital management e.g. adapting transferal management. The process of defining common values and beliefs was seen as a kickoff for collective leadership and teamwork. By involving staff in addressing pain points, satisfaction increased, and first successes could be celebrated together (e.g. new huddle-board). Conclusion: Based on the experiences to date, a cultural transformation starts by holding a mirror up and by fostering critical self-reflection. A collective first success story is leading the way to retain and win more staff for changes and transformation. Moreover, cultural transformation can be facilitated and realized with advanced facilitators in management positions.

## Registered nurses' experiences of community-based nursing - In a Swedish context [B068]

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Community-based nursing today faces significant challenges regarding the future supply of healthcare professionals, such as registered nurses. It is, therefore, essential to shed light on registered nurses' experiences of their working situation within community-based nursing to identify factors that can create a better working situation. Aim: To describe registered nurses' experiences of the work situation in Swedish community-based nursing. Method: The study employed a mixed-methods design. Data were collected through a) a quantitative sample and b) a qualitative sample of free-text answers to open-ended questions in the questionnaire. The quantitative material was analysed through descriptive statistics, and the qualitative material was analysed with deductive direct content analysis based on the Fundamental of Care framework's three dimensions. Results: The overall experience in community-based nursing was that the registered nurse's work situation within community-based nursing is influenced by factors such as lack of time and understaffing. Lack of time and understaffing affect the possibilities of creating a caring relationship, the integration of care and the context of care. Conclusion: Registered nurses' work situation within community-based nursing is influenced by factors such as lack of time and understaffing. Lack of time and understaffing affect the possibilities of creating a caring relationship with both the person being cared for and their next of kin. In comparison with continuity, good personal knowledge and presence are promoting factors to good caring relationships. The establishment of a care relationship, satisfying basic care and creating organisational conditions take place in collaboration and are the foundations for being able to work person-centred, which also are elements described in the Fundamental of Care framework.

## Person-Centred Care Frameworks as a Catalyst for Proximity, Equity, and Continuity in Danish Healthcare Practice [B069]

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Background: The Danish healthcare system increasingly emphasizes proximity, equity, and continuity to ensure that care remains meaningful, accessible, and coherent for all citizens. In a complex and fragmented landscape, person-centred care (PCC) offers a strategic approach to achieve these ambitions by grounding practice in relationships, co-creation, and meeting patients and families care needs. Three regional initiatives in Denmark illustrate structured, practice-oriented PCC approaches: Person-Centred Practice framework (Zealand University Hospital), Fundamentals of Care framework (North Denmark Region) and Excellent Nursing Care framework (Lillebaelt Hospital). Each region seeks to embed these core principles by anchoring care in holistic, relational, and integrated practice. Aim: To explore how PCC frameworks can advance the goals of proximity, equity, and continuity in clinical practice, and to identify key factors to their successful implementation. Methods: A narrative synthesis was conducted, drawing on research and experiences from clinical leaders, frontline care professionals, students and researchers from the three regions. These were integrated to explore how the PCC frameworks influence practice, and what contextual factors support or constrain their impact. Results: PCC frameworks provide coherence and a shared professional language, supporting care that is closer to patients, more equitable, and better connected across settings. They foster professional identity, reflective team processes, and interdisciplinary collaboration. Yet, despite these benefits, implementation remains challenging. On the micro level, time constraints, staff turnover and competing priorities can undermine PCC. At the meso level, organisational silos and inflexible workflows may hinder collaboration and continuity. On the macro level, policy demands, performance metrics, and resource constraints can conflict with the values underpinning PCC. Conclusion: PCC frameworks act as catalysts for translating healthcare ambitions into coherent, meaningful practice. Successful integration of PCC

requires leadership commitment, continuous organisational investment and strategic alignment across micro-, meso-, and macro-levels of the healthcare system.

## An Organisational Approach to Establishing a Person-Centred Nursing Workforce [B070]

*Karen Tuqiri[1], Professor Valerie Wilson[1, 2, 3], Benjamin Newlyn[1], Melissa Silva[1], Mary Mulcahy[1], Ruth Smoother[1], Natalie Watson[1], Ye Yang[1], Inge Vuuregge[1], Andrew Maxwell[1], Justin O'Hare[1] & Barbara Daly[1]*

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Person-centred nursing practice is linked to improved outcomes for patients, staff, and healthcare organisations. While individual initiatives often support nurses to reflect on and improve their practice, there is limited evidence of how such efforts can influence person-centred care at an organisational level. This presentation shares the experience of a nursing leadership team in a major teaching hospital in Sydney, Australia, who took a systems-level approach to embedding person-centred practice across the workforce. Over several years, a series of integrated strategies were implemented and evaluated to support cultural change and strengthen person-centred values throughout the organisation. Key initiatives included: A redesigned orientation program highlighting hospital values, the nursing vision, and a person-centred model of care A graduate nurse program supporting early career nurses during transition, underpinned by person-centred principles An emerging leaders program focused on developing leadership capability with a strong foundation in person-centredness. Organisational quality and safety initiatives such as annual safety surveys, ward-based quality boards, safety huddles, targeted action plans and showcases. While each initiative offered value individually, their cumulative and strategic alignment created the conditions for meaningful and sustainable change impacting on practice, staff wellbeing and workplace culture. Outcomes to date include improved

graduate nurse retention, reduced vacancies, enhanced staff satisfaction and teamwork, measurable improvements in quality and safety outcomes, enhanced patient experience measures, demonstrated improvements in cultural measures and a more engaged and committed nursing workforce. This work offers valuable insights for healthcare leaders seeking to embed person-centredness at scale, demonstrating that sustained cultural transformation is possible when strategy, leadership, and values are aligned. The power of an intentional, whole-of-organisation approach to cultivating a person-centred nursing culture—where values are lived, not just stated, and where staff at all levels feel valued and are empowered to contribute to better care outcomes will be demonstrated.

## Exploring the Relationship Between Person-Centredness and Patient Safety in Acute Care: A Case Study Approach [B071]

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Background: Globally person-centredness is increasingly recognised as a critical component of healthcare quality and safety. However, the relationship between person-centred practice and patient safety remains underexplored, particularly in acute care settings. This doctoral study aims to address this gap. Aim: To explore the relationship between person-centredness and patient safety in an acute hospital setting, focusing on the role of evidence, facilitation, and workplace culture. Methods: A case study design was used across three clinical units including surgical, medical and rehabilitation at Prince of Wales Hospital, Sydney. Data collection included ethnographic observations using the Workplace Culture Critical Analysis

Tool (WCCAT-R), analysis of existing datasets such as Safety Attitudes Questionnaire (SAQ) findings, person-centred KPIs, quality and safety metrics (e.g. Hospital Acquired Infections), nursing workforce data (e.g. turnover) and semi-structured interviews and focus groups with nursing staff. Descriptive statistics were used to analyse quantitative data and thematic analysis used to analyse qualitative data. These data were then combined for each unit and a cross-case comparison was undertaken. Outcomes: This doctoral study enabled cross-case comparisons to identify contextual factors influencing person-centred care and patient safety. Key findings will highlight common and contrasting processes that support person-centredness, including approaches to engaging with the whole person, understanding and managing risk, and preventing harm. The role of leadership, environmental conditions, and relational dynamics in shaping safety outcomes will be explored. Additionally, the presentation will highlight the types of evidence that engage nurses in evaluating person-centred practice and the facilitation strategies that drive change. These insights offer practical guidance for enhancing person-centred care quality and safety across diverse clinical contexts. Conclusion: The findings of the research will be of international interest to clinicians, managers, researchers, and policy makers and will inform future models of care and organisational strategies aimed at embedding safe person-centred cultures in acute healthcare environments.

## Exploring the potential for implementing a person-centred care educational intervention with Portuguese oncology nurses: A mixed-methods study [B072]

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Person-centred care (PCC) enhances healthcare quality and equity by fostering respectful partnerships between individuals and professionals. While educational interventions such as Mutual Meetings, developed by the University of Gothenburg Centre for Person-Centred Care (GPCC), have shown promise in other contexts, their implementation in oncology nursing and translatability across clinical and cultural settings remain underexplored. This study aimed to explore the potential for implementing a PCC educational intervention with oncology nurses working in a Portuguese healthcare setting, with two specific objectives: a) to assess the acceptability, appropriateness, and feasibility of the Mutual Meetings; b) to analyse participants' sensemaking and contextualisation of PCC in oncology practice. Six oncology nurses from different care departments participated in the Portuguese-adapted Mutual Meetings course, delivered in the three modules: partnership, narrative and documentation. All worked in a tertiary hospital dedicated exclusively to adult cancer care. An exploratory mixed-methods design was used. Implementation outcomes were assessed using validated instruments. The Person-Centred Practice Inventory – Staff (PCPI-S-PT) and an open-ended question about PCC meaning were administered in a before-and-after format to assess changes in perceived PCC perspectives Qualitative data include approximately four hours of transcribed audio-recorded group reflections from the module sessions and final group discussion. This strand is currently under analysis, guided by interpretive description to generate clinically relevant insights. Meetpulp®, an AI-assisted qualitative analysis tool, is being used to organise, code, and explore patterns in the data, while ensuring that interpretive analysis remains grounded in a constructivist lens and the researcher reflexivity. Preliminary findings suggest

high levels of acceptability, appropriateness, and feasibility. Early insights from the group reflections reveal both structural constraints and opportunities for enacting PCC in participants' settings. This study provides initial evidence that a structured educational intervention can support oncology nurses in making sense of and adapting PCC principles to their specialised care environments.

## Co-creating Evidence-based Resources for PROMs Use in Community Mental Health & Substance Use Services: A Path towards Equitable Person-centred Care [B073]

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Background: A previous mixed-method systematic review synthesized evidence on clinicians' experiences with patient-reported outcome measures (PROMs) and factors influencing PROMs integration into practice. To implement this evidence, a researcher-knowledge user partnership was formed within a health region providing community mental health and substance use services. This project aimed to engage stakeholders to co-develop (i) a toolkit for clinical leaders to equip point-of-care staff to integrate the World Health Organization Quality of Life assessment tool into practice, and (ii) resources for managers to address factors influencing the uptake of PROMs by clinicians. Methods: A collaborative partnership, involving researchers, knowledge users (KUs), and a patient partner, was formed based on the principles of Integrated Knowledge Translation and transformational leadership. Two implementation science theories (i.e., Theoretical Domains Framework (TDF) and the Capability, Opportunity, Motivation and Behaviour System (COM-B)) guided all aspects of the project to tailor the evidence to the local context and intentionally select effective

strategies for practice change. Several activities were conducted to involve the practice influencers, such as needs assessments and small group discussions. Results: We identified several resources for clinical leaders and information needs of managers to have conversations with their teams. We developed a Toolkit including six types of practice-based resources designed to meet the needs of end-users by being practical, relevant, and accessible. These resources not only focus on capacity-building but, more importantly, the motivations (beliefs and attitudes) and implementation supports for routine use of the WHOQOL by clinicians. Conclusion: Co-development of KT strategies to implement research evidence by targeting clinical leaders and managers is an important equip point-of-care staff and sustain change at the micro level. These outputs are designed to improve knowledge, shape attitudes, and address environmental supports for knowledge users, thereby fostering equitable person-centred recovery planning for persons living with a mental illness.

# Implementation & Knowledge Translation

## The importance of partnership in chronic pain – co-creation of pain care by working together in research, implementation and knowledge dissemination [B074]

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Chronic pain is a long-term condition that affects daily life, identity, and wellbeing. Despite affecting millions of people worldwide, effective pain care remains limited. Lack of knowledge and awareness among professionals and patients, combined with the invisibility of pain, often leads to disbelief, delayed diagnosis, prolonged suffering, and significant societal costs. Novel approaches are necessary to improve pain care, as most countries' healthcare system are struggling to provide adequate healthcare for people living with chronic pain. In person-centred care, the partnership between patients and professionals is central. We will present concrete examples from the micro, meso, and macro levels to illustrate the unique benefits of collaboration between patient associations, healthcare professionals, and researchers. Co-creating pain care by implementation of research findings and lived experiences in clinical practice. We demonstrate the importance of working together in the development of "The Swedish healthcare pathway for adults with chronic pain - a person-centered and coherent care pathway". Co-creating pain research and innovation with patient representatives as co-researchers. To develop person-centred pain care, patient input is vital to identify gaps in pain care, guide meaningful research and innovation, and highlight the urgency of improving pain care. We present an example from the project "My Pain Survey- for Support and Partnership" (PAS-SAP), for developing and evaluating a self-monitoring tool to support person-centred communication in pain care. Knowledge dissemination. The Societal Impact of Pain (SIP) Sweden is a national platform that brings together patients, researchers and healthcare professionals. We will present how we work together to raise awareness and increase knowledge about pain for healthcare professionals and in society. Collaboration between healthcare professionals, researchers and patient associations is essential to co-create and implement effective pain care, conduct relevant research, to disseminate knowledge and raise awareness of chronic pain in society.

# The effectiveness of Person-Centred Care in South Africa: A Retrospective Qualitative Investigation of Speech-Language Therapists' Perspectives [B075]

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Background: Person-centered care (PCC) is internationally recognized as a gold-standard approach in healthcare, foregrounding the value of the patient's voice. It promotes respect for their unique needs, values, and preferences while encouraging shared decision-making between healthcare providers and patients. In the field of speech-language therapy, PCC is essential for ethical, collaborative, and culturally responsive practice. However, the feasibility of implementing PCC in South Africa, a country characterized by linguistic diversity, systemic inequities, and limited resources, remains underexplored. Understanding how speech-language therapists conceptualize and enact PCC in this context is crucial for developing relevant care models. Aim: This study aimed to investigate the perspectives of South African SLTs regarding the barriers and enablers to implementing PCC within their clinical practice. Methods: A retrospective qualitative design was employed. Phase 1 involved thematic analysis of written field notes collected during a professional debate at a national conference on the feasibility of PCC implementation within a South African context. Phase 2 built on Phase 1 and aimed to further validate and expand these findings through semi-structured interviews with practicing SLTs from both the public and private sectors across South Africa. Purposive maximum variation sampling was used (considering age, gender, experience, setting, etc.) to explore common themes that cut across diversity. Data were analysed thematically, following Braun and Clarke's (2006) six-phase framework. Preliminary Findings: Initial analysis indicated that while SLTs supported the principles of PCC, they encountered challenges such as high caseloads, language barriers, and rigid service models. Enablers for implementing PCC

included interprofessional collaboration, cultural humility, and supportive workplace environments. Conclusion: These findings highlight both the aspirations and complexities of practicing PCC in South Africa. They underscore the need for systemic and educational strategies to enhance clinicians' capacity for ethically grounded and contextually responsive care.

## Serious Illness Conversations and Quality of End-of-life Care in Patients with Hematological Malignancies - a Retrospective Study [B076]

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Introduction: Patients with hematological malignancies frequently receive aggressive, poor-quality end-of-life care. In oncology, person-centred serious illness conversations conducted early in the illness trajectory, focusing on patients' goals, values, and priorities, have been associated with improved end-of-life care and decreased symptoms of anxiety and depression. Yet,

evidence of their impact in hematology remains limited. Aim: This study explores the association between receiving a serious illness conversation and the quality of end-of-life care and the timing of serious illness conversations in patients with hematological malignancies. Materials and Methods: Single-center retrospective study. Data on receipt of serious illness conversations and end-of-life care (hospitalizations, specialized palliative care referrals, place of death, receipt of anticancer treatment) were extracted from electronic healthcare records. Logistic regression, adjusted for sex, age, and diagnosis, examined differences between patients who did and did not receive a serious illness conversation. Setting/participants: The study included patients with hematological malignancies who died between 2020 and 2022 and received anticancer treatment within the last 12 months at a university hospital in Denmark. Results: Among 311 patients (median age 74 years, 43% female), 63 (20%) received a serious illness conversation. Patients receiving conversations had significantly higher odds of referral to specialized palliative care (OR: 2.67, 95%CI [1.44; 4.91]) and lower odds of receiving anticancer treatment within 30 days (OR: 0.19, 95% CI [0.10; 0.37]) and 14 days (OR: 0.21, 95%CI [0.09; 0.46) before death. Conclusion: Serious illness conversations are associated with reduced aggressive end-of-life anticancer treatment and increased referrals to specialized palliative care.

## Implementation of shared decision-making in the multidisciplinary treatment of chronic pain: A developmental project [B077]

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Background: Multidisciplinary treatment of chronic pain involves numerous small decisions made by different healthcare providers, calling for structured

methods to facilitate person-centered care and adequate treatment. Shared decision-making (SDM) is an essential approach to promoting person-centered care and meaningful treatment pathways. Therefore, this development project aimed to develop and implement SDM in chronic pain treatment. Methods: The ongoing project was initiated in 2024 and is taking place at a Danish Multidisciplinary Pain Center, led by a project nurse in collaboration with the Centre for Patient Involvement. Preliminary patient interviews and observations revealed that patients felt little influence over treatment decisions, underscoring the need to treat patients as equal partners. Selected multidisciplinary healthcare providers were trained by the Centre for Shared Decision-making as key figures in the SDM principles and were responsible for teaching their colleagues. As a method to practice SDM, a structured conversation tool was tailored to the chronic pain area in collaboration with patient representatives and included a decision-helper to guide patient-provider conversations and decision cards to enable patients to make treatment choices based on transparent, systematic information. Along the process, iterative workshops engaged the healthcare providers. Using the structured conversation tool in clinical patient encounters is the next step. The level of implementation will be monitored by the question from the National Danish Survey of Patient Experiences: "Were you involved in decisions about your examination/treatment?" Outcomes: The implementation process so far has been time-consuming, requiring re-examination of the substance of multidisciplinary collaboration and adjustments to workflows. The efforts are expected to lead to more appropriate treatment decisions aligned with patient preferences by involving the patients at every step of their treatment, thus reducing reliance on individual healthcare providers. Ultimately, we assume that using the structured conversation tool to achieve SDM and person-centered care will improve patient satisfaction.

# Evaluating the impact of personalised care at service and system levels: Learning from the Wessex Academy for Skills in Personalised Care programme [B078]

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The Comprehensive Model of Personalised Care promotes choice and control for people over the way their healthcare is planned and delivered. This brings benefits to people's health and wellbeing alongside improved health system efficiencies and savings. Despite having a core focus within UK health service policy, implementation of this multifaceted concept is complex and challenging. Whilst strides have been made towards personalised care becoming "business as usual", universal adoption has been slow. Since 2018, the Wessex Academy for Skills in Personalised Care (WASP) has developed, tested and refined a training programme which strives to facilitate the changes required to put personalised care into practice. This programme includes three core elements: a) system-wide evaluation of personalised care delivery from the perspectives of multiple stakeholders, b) training for healthcare professionals to develop the attitudes, knowledge and skills required, and c) quality improvement training and mentorship to translate learning into change. (Figure 1). This study aims to evaluate the implementation of the WASP Programme and describe a) if/how it has brought change within healthcare teams, and b) the impacts on personalised care delivery within local services and systems, and the resultant benefits for patients. This is a mixed methods study with two concurrent work packages (WP). WP1 involves separate workshops with healthcare teams (n=2) who participated in the WASP programme between 2020-24. WP2 involves healthcare teams undertaking the 2025 programme (n=3) with data collected via online surveys and semi-structured interviews at several timepoints

(Figure 2). To date, 25 clinicians have participated in data collection. Data analysis is framed through Normalisation Process Theory and the Consolidated Framework for Implementation Research. Early findings highlight many factors influencing personalised care and that delivery is impacted by cultural, operational and system barriers. Further refinement of the WASP programme will take these factors into consideration.

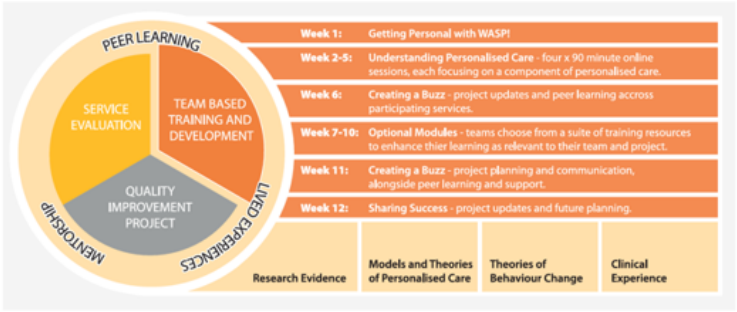


*Figure 1*

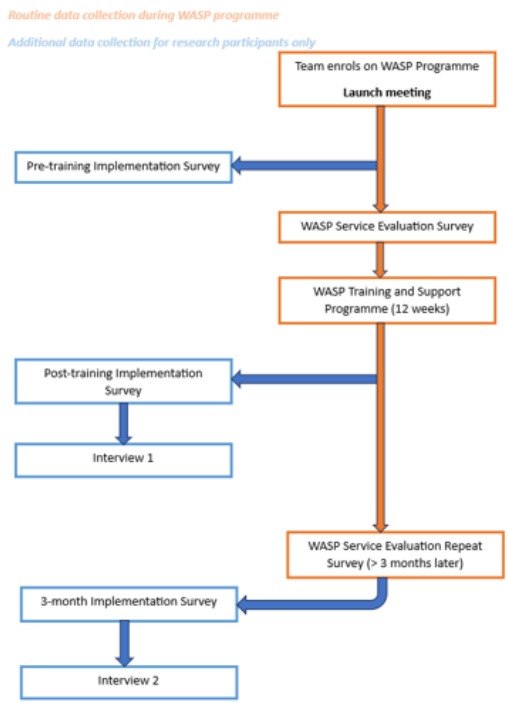


*Figure 2*

# Evidence-based and person-centred bladder care for patients in hip surgery – are fundamentals met in orthopaedic nursing? [B079]

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Introduction: While clinical practice guidelines often guide nurses and allied health professionals in how to maintain quality of care vis-à-vis physical needs, how to arrange for patients' participation is more seldom established. The OPTION-trial tested and evaluated an intervention facilitating the adoption of clinical practice guidelines for bladder-monitoring in hospitals. We also investigated whether this impacted on the patients' preferences for and experiences of being involved in their care in general, and bladder care in particular. Aim: To describe the impact on patient participation of an intervention facilitating implementation of evidence-based clinical practice nursing guidelines in orthopaedic care. Methods: This study represents a secondary analysis of the OPTION outcomes in 17 orthopaedic units in Sweden. Patients' preferences for and experiences of participation was measured with the 4Ps questionnaire, and interviews with nursing and rehabilitation staff in the intervention units were conducted. Both statistical and qualitative analyses were performed. Results: We found no clear effects on preference-based participation. The intervention may have had some impact on patients' opportunities to engage in such ways and to the extent they favoured: post intervention and at the 1 year follow up, patients were

more likely to having been listened to in accord with their preferences. Staff described that they had achieved more knowledge regarding bladder care and were more prone to adhere to the clinical practice guidelines as well as to engage patients in the bladder-care following the intervention. Still, no such effect was detected for the patients' preferences for learning about symptoms, and/or engaging in self-care. Conclusion: Implementation of clinical practice guidelines does not per se boost the conditions for preference-based patient participation. While it can have a positive impact on the staffs' willingness to engage patients, the findings indicate a further need to emphasise a recognition of patients' resources in nursing guidelines.

## Exploring needs and preferences for shared decision-making among patients with bladder cancer, their close caregivers and healthcare professionals [B080]

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Introduction & Objectives: Patients with muscle-invasive bladder cancer (MIBC) face complex treatment decisions related to curative-intent therapies, such as radical cystectomy or concurrent chemoradiotherapy. These choices significantly affect patients' quality of life and future health. Shared decision-making (SDM) is considered the gold standard for good clinical practice, aiming to align evidence-based treatment options with patients' values and preferences. Yet, in the context of bladder cancer, SDM remains under-implemented and under-researched. This study explores experiences with decision-making and identifies needs and barriers to SDM, with emphasis on person-centred care. Materials & Methods: This study is

the first phase of CHOICE-BC, a PhD project aiming to strengthen SDM and person-centred practice in bladder cancer care and is conducted at Copenhagen University Hospital. The study includes semi-structured interviews with 15–20 patients who have recently undergone curative treatment decision-making. Where relevant, joint interviews with caregivers will be conducted. Two focus group interviews with healthcare professionals (HCP) from urology and oncology will complement the data. Analysis will follow Braun and Clarke's reflexive thematic approach. Study Status: Recruitment is scheduled for autumn 2025, with analysis completed in early 2026. The study is designed to ensure that findings will be available for presentation at Global Conference on Person-Centred Care 2026. By contributing detailed insights into how SDM is experienced in this setting, this protocol aims to support further development of person-centred strategies in cancer care. Expected Outcomes: The study will generate knowledge on communicative, emotional and organizational dimensions of SDM in bladder cancer care. Insights will inform the co-design of a digital SDM tool tailored to patients' and HCPs needs, grounded in pedagogical and person-centred principles. Ultimately, this research aims to enhance patient involvement, support more meaningful clinical conversations and contribute to the advancement of person-centred practice in oncology and other complex care contexts.

## Building a Person-Centred Culture in Municipal Care: A Follow-Up Study of a City-Wide Educational Initiative [B081]

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[6] University of Skövde, Sweden

Background: Person-centred care (PCC) is gaining momentum in many health systems as a shift from provider-centric to patient-centric services, emphasizing meaningful lives over purely functional outcomes. In Sweden, PCC is a key priority in national healthcare policy and law and is being explored as a response to demographic and financial challenges. However, most research on PCC focuses on hospital settings and chronic illness, while knowledge about its implementation in municipal care remains limited. Study Context: In 2024, the city of Helsingborg launched a municipality-wide training initiative in PCC, targeting all staff across elder care and disability support services. The initiative includes a web-based course, followed by individual and group reflections aimed at fostering shared understanding and practical transformation. The training was developed in collaboration with patient representatives, grounded in the European standard for patient involvement in healthcare. Study Aim: This research aims to explore how PCC is implemented through this initiative. The study will examine changes in care practices, staff perspectives, and experiences of patients and service users. Methods: Using a mixed-methods design, the study includes surveys (mP-CAT and PERCCI-S), focus groups, and administrative data. Data will be collected before and after the intervention from staff, patients, and service users across a range of municipal care contexts. The study employs a participatory follow-up research approach, observing changes without influencing the intervention process. Expected Contribution: This study will generate critical knowledge about the implementation of PCC outside hospital settings, including the feasibility of adapted measurement tools, perceived changes in care quality, and organizational impact. Results will be able to be presented at the time of the conference.

## Oncologists' experiences of decision-making in later lines of metastatic breast cancer treatment: Balancing between autonomy and authority [B082]

*Karolina Larsson[1], Vastergaard Elisabeth[1], Linda Svensson[1], Elisabet Ohrn[2], Fredrik Wärnberg[1], Anna Ofverholm[1], Maria Ekholm[3] & Matilda Liljedahl[1]*

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[3] University of Linkoping

With the rapid development of new treatments for metastatic breast cancer, selecting the most appropriate treatment strategy has become increasingly complex. In daily practice, oncologists often encounter clinical situations that are not well represented in clinical trials and where guidelines offer limited direction. The challenge of adequately integrating patients' preferences adds another layer of complexity. In this study, we aimed to explore oncologists' experiences of making treatment decisions in later lines of treatment in metastatic breast cancer. This qualitative study was conducted with a constructivist approach and utilized individual interviews with twelve oncologists in Sweden. The study participants had 5-40 years of experience in breast cancer care, working in publicly funded healthcare. Inductive reflexive thematic analysis was applied to identify themes, focusing on both the manifest and latent messages within the data. Results We identified three themes describing the strategies used by oncologists during consultations: Allowing the patient to make the final decision (autonomy), Relying on professional knowledge and experience to decide (authority), and Inviting the patient to a dialogue to decide (alliance). A fourth theme was identified: Turning to colleagues for advice and support (accountability), an action that took place outside the consultation. Participants described how they navigated between these approaches depending on the patients' and their own needs. Making treatment decisions in metastatic breast cancer is a complex and challenging task. This study showed that in situations where clinical guidelines do not offer clear advice, oncologists took on different approaches to decision-making -shaped but how they viewed their role in relation to the patient. We believe that enhanced awareness can support oncologists by easing the burden, fostering more sensitive and insightful interactions with patients, and ultimately improving the quality of decision-making.

# Embodied Scholarship: A Reflective, Person-Centred Practice for the Practitioner-Scholar [B083]

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[2] Adelaide University

[3] HammondCare, Australia

This presentation explores embodied scholarship as a dynamic, person-centred process of scholarly inquiry grounded in lived experience. Drawing on reflective practice and autoethnographic methodology, the presentation examines the journey of a practitioner-scholar navigating personal, relational, and cultural terrains through reflexive engagement. Autoethnography privileges the scholar's own narrative as a site for meaning-making and cultural insight. Here, embodied scholarship becomes a 'river of inquiry,' welling up from an ontological source, in this case, theological personalism, supported by storytelling as an epistemological approach, flowing through crisis and epiphany toward new knowledge, insight and growth, before moving on to subsequent cycles of embodied scholarship. The presentation aligns with the Person-Centred Practice Framework (McCormack & McCance 2021), emphasising knowing self, authentic relationships and transformational learning. Reflexivity, transparency, and creative expression are central, enabling the practitioner-scholar to engage with their own limitations, biases, and evolving identity. Key issues to be explored include: Embodied scholarship as a practice-based, person-centred orientation integrating the personal, professional, relational, and cultural dimensions of practice and scholarship. Writing as a method of inquiry, using expressive, creative, and evocative storytelling to bring forth meaning, evoke empathy, and foster connection between the personal and scholarly. Reflective practice as a bridge linking lived experience with scholarly insight through reflexivity, transparency, and critical self-awareness. The presentation will draw on the presenter's method and work as author of An Everyone Story: Finding our way back to compassion, hope and humanity, a commercially published, award-winning autoethnographic account of the transformation of an

Australian healthcare service for older people with complex needs. The narrative traces the journey from toxic, dysfunctional culture to one that is person-centred, humanised, and compassionate. The presentation will interest practitioners seeking to engage in meaningful scholarship emerging from lived experiences within clinical practice and care.

## Mapping the involvement of persons with aphasia in shared decision-making following cerebrovascular accident(s) [B084]

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[1] Stellenbosch University

Background: Shared decision-making is a collaborative process, built on the notion of co-construction and person-centred care, that involves both client and clinicians in making health-related decisions through the incorporation of research evidence, clinician expertise, and preferences of the persons with aphasia. Aphasia may affect the ability of persons with aphasia to participate in shared decision-making. Rationale: Despite growing developments, research pertaining to the involvement of those with communication impairments, such as aphasia, in shared decision-making processes remains scattered across the knowledge base. As such, the need for a synthesis of how persons with aphasia are involved in shared decision-making is crucial. This thesis, as such, aims to obtain, synthesise, and socially validate current research pertaining to the involvement of persons with aphasia in shared decision-making. Methods: The review followed the Arksey and O'Malley framework and the PRISMA-ScR reporting guidelines. Five electronic databases (PubMed, EBSCOhost, Web of Science, SCOPUS, and Taylor and Francis) were searched for studies published between 2000 and 2025. Finally, consultation with persons with aphasia themselves, as well as SLTs, was conducted to socially validate the findings. Findings: A total of 15 sources of evidence were included. The findings reveal that persons with aphasia can make informed decisions and participate in shared decision-making if provided with appropriate strategies and supports. However, the

predominance of clinician-led decision-making and the exclusion of persons with aphasia from involvement in shared decision-making processes is still evident. This exclusion is evident across all clinical contexts in which persons with aphasia interact and is particularly exacerbated in acute and subacute healthcare settings. Conclusion: Persons with aphasia are notably excluded from shared decision-making. As such, the use of communication supports and a person-centred approach is imperative in allowing persons with aphasia to be involved in processes pertaining to their healthcare, such as shared decision-making.

## The Contribution of Person-centred Cultures to the Aetiology and Management of Depression Among Older Adults in Nursing Homes: A Realist Review [B085]

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Background: As high as half of older adults in nursing homes (NHs) live with depression globally. This is associated with suicide, poor quality of life, increased use of acute care services, among other negative impacts. While depression can be attributable to many causes, cultures in NHs are viewed as contributing to the cause of depression. Objective: This review aimed to understand how, why and in what contexts person-centred cultures, the expected cultures of care in NHs, contribute or not to the amelioration of depression among older adults using realist review. Methods: Realist review is a theory-driven review that explains whether or not an intervention works, how, why and in what contexts in the form of theories. The theories are in the form of contexts (factors that enable or constrain the intervention), mechanism (the resource provided by the intervention and the reasoning/ response of stakeholders), and outcome (expected or unexpected change)-CMOs. This review was informed by four initial programme theories (IPTs). Evidence was gathered in the form of CMOs from eight data bases to refine the IPTs in collaboration with expert and local reference panels. Results:

Forty CMOs derived from thirty rich and relevant papers informed the refinement/development of 6 programme theories (PTs), explanations of how person-centred cultures can contribute to the amelioration of depression. The PTs explain the importance of leadership and staff skills development, care processes that promote autonomy, environmental (physical and social) and organisational enablers and social connections in ameliorating depression among older adults in NHs. Conclusion: By explaining how specific resources, reasoning and responses of staff and older adults interact with specific contexts in NHs to contribute to the amelioration of depression among older adults, this review offers practical insight to stakeholders in NHs sector on how to bridge the gap between practice, policy, and organisation.

## Following A Standardized Pathway- Patient Perspectives on Colorectal Cancer Care: A Qualitative Study [B086]

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Background: Patients with Colorectal cancer is following standardized care pathways, based on clinical guidelines. The focus is primarily on surgical procedures and outcomes. However, the clinical interventions represent a limited aspect of the patient's overall experience. Both patients and healthcare professionals report a high degree of fragmentation and an environment where cancer care is perceived as a form of production. This system leaves minimal room for healthcare professionals to interact with patients and the national ambition of achieving person-centred care becomes difficult to realize. Aim: To describe patient experiences within standardized care pathways for colorectal cancer. Method: A qualitative descriptive design was used. Convenience sampling included sixteen patients. Data were collected using semi-structured interviews and analysed using qualitative conventional content analysis. Results: The analysis emerged three themes: Travelling along the colorectal cancer care pathway, bearing the mark of the

disease, and telling one's story. Patients' narratives revealed a distinct asymmetry in the relationships in the care, some patients described experiences of inclusion and a sense of partnership, while others perceived the healthcare professionals as distant and disengaged. Feelings such as loneliness and the need for inclusion played a significant role to achieve participation. Integrate person-centred care within standardized frameworks requires healthcare professionals to move beyond procedural adherence and instead tailor their approach to meet each patient's unique and evolving needs. In this context, continuous contact with a specialist or contact nurse emerged as a crucial factor in fostering a trusting relationship, as well as encouraging the patient's active participation in their care. Conclusion: There is a discrepancy between the intended goals of standardized care pathways and the actual experience. The findings highlight the essential role of specialist nurses in bridging the gap between clinical routines and patient expectations, thereby advancing the implementation of person-centred care within standardized systems.

## Everything new? – Adaption of nursing processes at a Swiss geriatric ward by using practice development in combination with Lean management [B087]

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The Quality of care for older adults in in patient geriatric settings relies heavily on well – structured workflows and a lived person-centred approach. This project describes the adaptation of nursing processes on a geriatric ward in a Swiss hospital for acute Geriatric medicine, using the methodology of Practice Development (PD) according to Brendan McCormack and Tanja McCance. The aim was to implement sustainable improvements in daily nursing routines through participatory process and the integration of Lean principles. As part of a continuous improvement process (CIP), a small working group which consist of nurses with different grades was established. Based on a joint analysis of the current situation, key areas for action were

defined. Central to the project was the optimization of workflows in early and late shifts. Lean management tools such as a "regular flow" at defined times and structured daily huddles for communication and reflection were introduced. Furthermore the 7 P (Person, Plan, Priority, Personal hygiene, Pain, Position, Presence) and the 5 P (Priority, Personal hygiene, Pain, Position, Presence) methods were applied to address both organizational and cultural dimensions. The implementation led to greater role clarity, improved transparency, better communication, and a noticeable reduction in stress among team members. Staff reported increased job satisfaction and improved collaboration. The combination from values-based Practice Development with structured process optimization proved particularly effective for achieving sustainable change in everyday nursing practice. This project exemplifies how the integration of Practice Development, Lean thinking, and participatory teamwork can enhance the quality of care in geriatrics while simultaneously improving working conditions for nurses within a short time.

## Person-centred practice in a nursing home: a continuous culture change process [B088]

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This contribution presents the implementation of person-centred practice at a long-term care facility in Switzerland. Guided by the Person-centred Practice Framework (McCormack & McCance) the project aims to foster a culture of personhood, relational care and staff empowerment. The cultural and attitudinal change is supported by reflective practice, leadership engagement, and ongoing dialogue across all staff levels. Organizational conditions are adapted to support the person-centred agenda. The implementation strategy is built on different pillars: fostering the nursing prerequisites regarding person-centred attitude, improving the care environment and reflecting the person-centred processes. Therefore we use different methods: in-house training, interactive workshops regarding

attitude and understanding of care, reframing the role of the team coaches, systematically reflecting leadership and empowerment processes, systematic participation of the nursing teams in change projects, case reviews and practice mentoring by advanced practice nurses. Particularly two main change processes accompany implementation: (1) strengthening of the nursing process due to the introduction of an adapted primary nursing model with focus on the involvement of the residents and their families in the individual care plans and (2) the change of the shift schedules (duration of the shifts, constellation of the shifts and planning strategies). We aim on the following outcomes which we monitor regularly: employee satisfaction, satisfaction of the residents and their families, restraint use, use of antipsychotic drugs, staff turnover, number and quality of individual care plans, absenteeism and hospitalization rate. In the presentation we report on our experiences in the continuous change process. We present obstacles and the strategies which worked for us to overcome them as well as success factors for the specific field of nursing homes.

## Translating Frameworks into Care: Staff Perspectives on Person-Centred and Relationship-Based Approaches in Aged Care [B089]

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[2] Macquarie University

Person-centred care (PCC) and relationship-based care (RBC) approaches are increasingly being viewed as the gold standard of aged care in Australia. However, their applications can often be interpreted differently across residential care settings and industries. To understand how these models are applied in real life settings by aged care workers, we interviewed residential care staff to explore how staff understand and implement these approaches in their practice. The aim was to capture on the ground perspectives of the principles of PCC and RBC, how they are translated into daily practice, and

how they align with established aged care frameworks in the Australian context. Eighty staff across a range of aged care roles were recruited to participate in semi-structured interviews. Participants were asked to define PCC and RBC in their own terms, describe how they incorporate these approaches into their work, and provide examples of moments they shared with residents that reflected the principles of the model. Their answers were analysed for both conceptual and practical insights, while also exploring the link between staff experiences and the theoretical frameworks that shape these models. Preliminary findings suggest that perspectives from aged care staff offer valuable insight into how these models are implemented in residential aged care environments. Through centring staff experiences, the study gives us an insight into how staff practice key components of the models in the context of aged care models and the gaps in their ability to deliver the model. Results of the study will help inform sector-wide discussions on how models are implemented from policy to practice and improve the responsiveness of care delivery. Findings will inform recommendations for strengthening practice and care alignment within Australian and International frameworks in aged care.

## What aspects to consider when aiming for sustainability of a family-based intervention in Integrated Person-centered Care [B090]

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Background: The ongoing national transition in Swedish healthcare towards Integrated Person-centered Care (IPC) [Nära vård] can lead to continuous, seamless, and personalized support for individuals with severe illness, aligning with the core principles of palliative care. Respecting the ill person's unique circumstances, needs, and preferences also involves addressing the family member's needs. Facing life-threatening illnesses affects families emotionally and psychosocially, but there are limited psychosocial interventions available. The Family Talk Intervention (FTI), based on psychoeducation, narrative, and dialogical methods, shows promising results. Assessing FTI's implementation sustainability helps ensure families' access to psychosocial and thus address important gaps within an IPC [Nära vård] approach. Aim: This study explores how healthcare professionals (HCPs) perceive contextual factors influencing the sustainability of FTI after implementation, particularly when a parent with children or youths faces a life-threatening illness. Method: Fifteen HCPs (13 hospital social workers and two registered nurses) working in specialized palliative homecare services or advanced cancer care were trained in FTI before offering it to families. After a medium of 18 months, focus groups or individual interviews were conducted. Data was analyzed using conventional qualitative content analysis. Results: HCPs identified various factors affecting the sustainability of FTI. First, trying to prioritize FTI and coordinate families was complex due to resource constraints, such as a lack of time. Secondly, working without FTI-educated colleagues hampered sustainability as the HCPs using FTI felt isolated, especially when managers and team members showed little support. Thirdly, the satisfaction of seeing families become stronger contributed to a receptiveness for change, provided fulfillment and motivation to continue using FTI, despite contextual challenges. Significance of the Results: This study shows that organizational support, resources, and individual factors such as receptiveness for change are crucial for intervention sustainability, as the positive impact motivates continuous use of an intervention despite challenges.

# Learning & Education

## When theory meets reality – A learning journey about anchoring and developing person-centered care in everyday clinical practice [B091]

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Person-centered care (PCC) is based on the understanding that the patient can make informed decisions, with care tailored to their personal goals and needs. Translating this model from theory into practice has proven to be complex and requires a supportive care culture, committed leadership, and targeted education (1–2). In 2024, a development initiative was initiated with the aim of developing PCC in clinical practice. An education program with defined learning objectives was designed for a pilot unit. To assess the care environment, meetings with managers, clinical observations, and quality measurements were conducted. Healthcare staff completed surveys on PCC before and after the education, and patient records were analyzed with a focus on PCC aspects. The outcome measures for the education included feasibility, staff perceptions of PCC, and nursing documentation. Following the pilot, the project was expanded to the entire clinic. A revised version of the survey was distributed to all staff physicians, nurses, and assistant nurses. Results were analyzed and presented in a report aimed at encouraging reflection and supporting continued development. Based on survey responses, a practical tool a "pocket guide" for PCC was developed for use in daily practice, for example in care situations, ward rounds, ethical discussions, and daily reflections. A digital educational module was also created and made available via our clinic's e-learning portal to further reinforce knowledge toward PCC. Implementing PCC into practice requires more than theoretical understanding. It requires continuous training, motivation, and the courage to challenge established ways of working. In addition, it calls for self-reflection, mutual respect, teamwork, and a shared sense of common goals. As part of this development initiative, we have

gathered knowledge, experiences, and concrete examples from everyday clinical practice. These insights serve to inspire and disseminate best practices to develop PCC within the reality of healthcare.

## Pull through together or be detached? A qualitative study of experiential learning in nurse education during interaction in age suit simulation [B092]

*Björn Bouwmeester Stjernetun[1, 2], Jenny Hallgren[1], Elzana Odzakovic[2] & Catharina Gillsjö[1, 3]*

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Background: Nurses are expected to a greater extent provide person-centred care to older persons in their home, which is line with god och nära vård. However, nursing students may lack the necessary motivation, skills, or knowledge. To bridge the gap between theory and practice, innovative didactic strategies are crucial. Age suit simulation is a didactic strategy that involves a shift of perspective, allowing the student to "walk in the shoes of an older person". An embodied understanding of the impact of long-term health problems can expand students' knowledge of how to provide person-centred care. Aim: To illuminate nursing students' interactions during age suit simulation from the perspective of being a blind older person and being an attendant guiding the blind person. Methodology: This study had a qualitative inductive design using reflexive thematic analysis and involved video footage and reflection notes among 68 students who simulated in a realistic apartment assigned the persona of either being blind or an attendant to the blind person. Findings: The findings demonstrate two distinct approaches: Students worked well together, adapted to each other's health problems, and developed their verbal and non-verbal communication. The health problems became a significant barrier for the students causing them to become increasingly separate from each other. Conclusion: The findings can be used to raise awareness of visual impairment and being dependent on

another person in daily life, as well as being an attendant with one's own health problems. The simulations are opportunities for students develop skills in how to guide a blind person in the context of a home environment and provide useful insights into being blind. The findings can also be used to support students´ understanding of informal caregivers as well as understanding of long-term health problems as a shared experience.

## Putting Healthcare Centre Stage: A Theatrical Arts Study of Partnership in Healthcare Encounters [B093]

*Victoria Brattström*[1]

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In this study two worlds are being engaged – healthcare and the theatrical arts – to investigate how partner-creating processes are established in encounters between patients and professionals in healthcare settings aiming for a more person-centred care. Controlled studies have shown that person-centred care can contribute to measurable changes and positive effects. Such a profound change of approach has, however, proven itself to be 'easier said than done', and there is a need for methods and approaches that can contribute to how a partnership between healthcare professionals and patients can be established and maintained. In the study two methodological concepts are brought in from the theatre through the Stanislavskian concepts of the Magic If and Given Circumstances which actors and directors use during rehearsals to analyse a playscript. To examine the asymmetry in human interaction in healthcare contexts and what means can be effective in creating partnerships in such situations, three care encounters are selected and transformed into theatre manuscripts. These scripts are explored with the help of actors who have taken the roles of healthcare professionals and patients in staged readings, and finally these actors are also interviewed alternately in the first and third person. Theatre expertise is employed to develop a research methodology for examining human interaction in the

healthcare setting. Inspired by the philosophical anthropology and critical hermeneutics of Paul Ricoeur an interpretative model is developed in the study, meaning the work of interpreting a role in a theatrical context, is ”read” through the theoretical lens of Ricoeur's theory of interpretation. Using Bengt Kristensson Uggla's concept laboratory of interpretation, the theatre's rehearsal process and the healthcare encounter dialogues are regarded as interpretation labs, illuminating how the patient-role is being co-created and re-interpreted (thus both discovered and invented) in the collaboration between patients and healthcare professionals during the healthcare encounter.

## Nursing Students' Experiences with Person-Centred Practice in Home Nursing [B094]

*Veronica Eidesgaard[1], Elise Johansen[1], Siri Brynhildsen[1], Camilla Anker-Hansen[1] & Liv Berit Olsen[1]*

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Background: Person-Centred Practice (PCP) represents a global priority in healthcare, focusing on maintaining respect for individual's life, integrity, and dignity, with strong emphasis on self-determination. It is expected that PCP will be integrated into the nursing students throughout their education, yet evidence suggests that focusing on the individual and facilitating holistic care and integrating person-centred attributes may be challenging. Aim: To explore undergraduate nursing students' experiences with PCP during home nursing placements, aiming to inform future educational strategies and support improved student competence in PCP. Method: Qualitative individual in-depth interviews were conducted with six nursing students during home nursing placements in south-east Norway in 2024/2025, using a semi-structured interview guide. The interviews were analysed using Braun and Clark's thematic analysis framework. Results: The nursing students experience the importance of having a holistic perspective practicing PCP. Being met with PCP as a student is significant for the development of competence in PCP. Four main themes emerged: Learning PCP, PCP

between staff and students, The organization of the service impacts opportunities and challenges for PCP and Staff's knowledge of various health services available is highly significant for PCP. Conclusion: Nursing students learn PCP in home nursing. The nurses meet the students in a person-centred manner. The organization of health services influences healthcare personnel's ability for PCP. Leaders and healthcare personnel should emphasize the organizational-, working- and supervision methods that facilitates PCP.

References: McCance, T. & McCormack, B. (2025). The Person-centred Nursing Framework: a mid-range theory for nursing practice. Journal of Research in Nursing, 30(1), 47–60. https://doi.org/10.1177/17449871241281428 Kulla, G & Slettebø, Å. (2021). Nursing students' learning about person-centred dementia care in a nursing home: A qualitative study. (n.d.). Nordic Journal of Nursing Research. https://doi.org/10.1177/20571585221083520

## Supervisors' person-centred approach in Extended supervision in special suitability assessments of professional students – a qualitative study [B095]

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[1] Østfold University College, Norway

Supervisors' person-centred approach in Extended supervision in special suitability assessments of professional students – a qualitative study Introduction: Suitability assessments are intended to ensure that students in professional study programs do not pose a potential risk to individuals they encounter in their professional practice. Norwegian regulations stipulate that if there are doubts regarding a student's professional suitability, a special suitability assessment must be initiated, and the student must be offered extended supervision. The literature highlights the importance of focusing on the student being guided within the various guidance offerings a student receives in higher education. Specifically, some literature emphasizes person-centred supervision. Purpose: The purpose of this study is to explore how faculty members in professional study programs experience guiding students

through extended supervision during special suitability assessments. Methods: The study is based on a qualitative exploratory design and individual in-depth interviews. Data analysis is conducted using Braun and Clarke's six-step thematic analysis approach. Results: The results show that informants describe the aim of extended supervision as a process focused on the student's challenges in meeting the requirements of being suited for the profession, they are training for. In this process they were concerned with the student as a person in the supervision and emphasised the student's needs and perspectives. The informants consider the relationship and collaboration with students as crucial. Discussions about third parties, such as patients, pupils, and children, were nevertheless significantly emphasised. To succeed in this, they utilised various guidance skills, such as open-ended questions, active listening, mirroring, perspectivation, and reflection exercises.

## Primary Care Physicians' Understanding of Patient-centred Communication: Implications for Training and Practice [B096]

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Background: Medical students frequently experience a "reality shock" when the patient-centred communication (PCC) skills they are taught at university fail to align with what they see in clinical practice. Primary care physicians therefore play a key role in modelling and teaching PCC in authentic clinical settings. Understanding how they conceptualize PCC is therefore essential, as it influences both their clinical practice and their approach to teaching. Methods: We conducted individual interviews with 18 primary care physicians (GPs and GP trainees) from healthcare centres in the Stockholm region. We used a semi-structured interview guide addressing their understanding of PCC and analysed data using a phenomengraphic approach. Results: The analysis identified four qualitatively different ways of

understanding PCC: a pedagogical structure, empathetic listening, a whole person-perspective, and a professional responsibility for patients and society. These categories are hierarchically related, with each higher category encompassing and extending the awareness represented in the less complex ones. Conclusion: The ways of understanding PCC ranged from focusing on information transfer to holistic, ethically grounded professional responsibility. Progression toward the higher categories was reflected in patient–physician relationships characterised by trust, combined with an awareness of how to balance patients' preferences with long-term patient benefit and the pursuit of sustainable healthcare. Implications: These findings suggest that medical schools may prioritise opportunities for continuity in patient encounters and training on ethical and emotional challenges, as these conditions could help support deeper PCC competencies. They may also help policymakers and clinical leaders understand the value of relational continuity in primary care and the need to support physicians in providing sustainable care.

## A qualitative study of health care workers' experiences of ad hoc ethical reflection during the workday [B097]

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Introduction/Background: Ethical reflection might contribute to better understanding of the person and the situation, because the health care workers take into consideration significant values and what is at stake in the specific situation for the individual. The individual, along with what matters most to them and what contributes most to their quality of life—becomes the focal point of care. Person-centeredness can uphold the dignity of the person by valuing their experiences and perspectives. Aim: The aim of this study was to explore experiences related to ad hoc ethical reflection and how ethical

reflection might be structured by healthcare workers in municipal care in Norway. Method: The study has an explorative design with a qualitative approach. We conducted four group interviews with health care workers who had received brief training in ethical reflection. Data was analyzed with systematic text condensation. The study is conducted in compliance with research ethics principles. Result: Analysis of data yielded two code groups (cg) and seven subgroups (sg): Please insert attached table. Conclusion: with implication for practice (educational and/or clinical) When health care workers experience ethical uncertainty and ethical issues, the study indicates that they take the initiative to reflect together. The study also indicates that when health care workers articulate the ethical problem, they include different perspectives and values at stake in their reflection. Consequently, ad hoc ethical reflection seems to promote person-centred practice.

## From procedure to person: Co-creating virtual patients to enhance learning and preparedness [B098]

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The learning environment during clinical practice for students in the health professions is becoming increasingly complex. To ensure both effective learning and patent-safe clinical practice, educational programs must prepare students with procedural skills as well as person-centered care. Previous research shows that virtual patients (VP) enhance clinical reasoning and support safe transitions to practice, while person-centred care promotes trust, collaboration, satisfaction and potentially reduces healthcare costs. Using VP to support learning in procedural skills and a person-centered approach remains underexplored. To design, develop, test, and evaluate person-centered virtual patients (PVP) as a learning activity for health professional students prior to simulation-based learning in a clinical skills centre. The ADDIE model (Analyze, Design, Develop, Implement and Evaluate) was used to develop ten person-centered virtual patients. The PVP were co-created with students, educators and patients. Ten PVP focusing on clinical procedures such as peripheral venous catheterization and injections were designed and developed. The PVP were created within the "Virtual Case System" (owned by Stockholm University) in collaboration with students as content developers, educators as experts in procedural skills and patients as experts in person-centered care. Preliminary results indicate that students appreciated the PVP as a valuable learning tool that enhanced their competence. Specifically, students reported improved ability to inform patients about procedures, respond to common patient questions about the procedure, and to reflect on ethical and societal aspects of care. Through collaboration between students, educators, and patients, ten PVP were designed. The PVP may serve as an effective learning activity to enhance students' preparedness in procedural skills and their ability to apply a person-centered approach during clinical practice.

## Integrating a student-centred teaching and learning culture in nursing education: an interpretative phenomenological study [B099]

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[1] Kristianstad University, Faculty of Health Sciences

[2] Kingston University

This interpretative phenomenological study explores the development and implementation of a student-centred approach in nursing education, emphasizing its alignment with person-centred care principles. The study involved 20 nursing educators during 2017–2018 academic year at a Swedish university, participating in five reflective seminars guided by European Standards and Guidelines for quality assurance in higher education. The aim was to explore how nursing academics developed and implemented a student-centred approach in their teaching practice, while addressing enablers and challenges encountered in practice. The findings highlight five key themes: (1) Student-centred alignment between theory and practice, (2) Fostering relational approaches and partnerships, (3) Embracing norm-critical teaching, (4) Emancipating old patterns and habits (5) Finding new roles in student-centred teaching. Educators adopted innovative methods, such as simulation, reflective practices, and inclusive curriculum design, to bridge the gap between theoretical knowledge and clinical application. Reflection and mutuality emerged as core elements in building lecturer-student relationships, encouraging active learning, and fostering professional development. Norm-critical pedagogy emerged as a pivotal approach in addressing biases and promoting inclusivity within the learning environment. Challenges included navigating power dynamics, balancing student autonomy with guidance, and addressing systemic barriers such as limited resources and entrenched teaching norms. Lecturers recognized the need for institutional support and continuous self-reflection to sustain a student-centred culture. Addressing power dynamics and institutional constraints, the study highlights the need for professional development that prepares lecturers for evolving roles as facilitators and mentors. Additionally, findings emphasize the importance of relational pedagogy, and norm-critical approaches, creating inclusive and empowering learning environments. The findings contribute to the ongoing discourse on pedagogical innovation in higher education, offering strategies to foster sustainable and equitable learning experiences.

# Diabetes Intervention involving person-centred Nutritional Education (DINE-trial) [B100]

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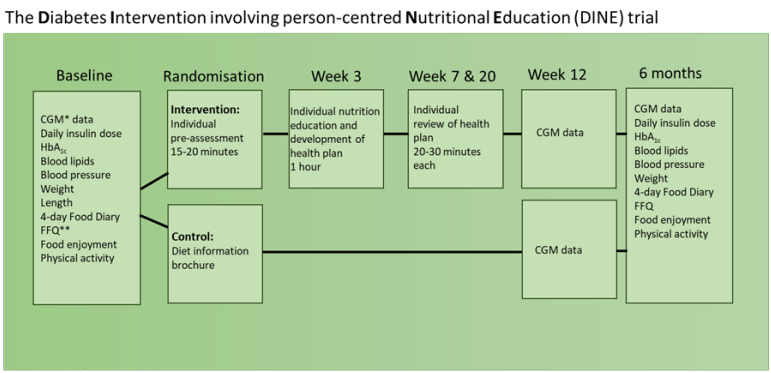
Background and objectives: Adopting a plant-based diet with limited animal-source foods can reduce non-communicable diseases and food sector emissions. Managing Type 1 diabetes (T1D) adds complexity to following dietary advice. A person-centred approach, focusing on the individual rather than the disease and partnership as a core component of care, is beneficial but challenging for healthcare professionals to implement consistently. The Diabetes Intervention involving person-centred Nutritional Education (DINE trial) aims to evaluate the efficacy of a pre-assessed nutritional education compared to standard care and short dietary information for adults with T1D. The study will examine the intervention's impact on glucose levels, diet, lipids, and blood pressure. Methods: The DINE trial is a non-blinded, randomised study in Sweden. The primary hypothesis is that a person-centred nutritional education has an impact on glucose time in range for adults with T1D. Fifty-four adults, ≥18 years, with T1D >12 months and an HbA1c level >57 mmol/mol will be enrolled. Data collection includes food diary, food frequency questionnaire, glucose measured by continuous glucose monitoring (CGM), Hba1c, lipids, blood pressure, food enjoyment, height and weight, measured at baseline and at six months (See Figure). The intervention group will receive an individual pre-assessment focused on partnership in care, followed by a nutritional education programme and co-creation of health plans with a dietitian. Results: Recruitment started in May 2025, and the intervention will run during 2025/2026. Differences in CGM metrics, HbA1c, lipids, blood pressure, dietary patterns and food enjoyment, from baseline to study endpoint at six months will be investigated between intervention and control group. Conclusions: Adults with T1D will gain

essential knowledge about healthy, and environmentally friendly eating and achieve better blood glucose management through person-centred approaches. Furthermore, they may improve their understanding of the lifestyle choices that can prevent future diabetes-related complications.




## Translating Theory into Practice: an implementation of Family-Focused Care [B101]

*Pernille Friis Rønne[1, 2], Malene Barfod O´Connell[3], Stine Maria Rosenstrøm[2, 4], Michella Runge Kjøbeløv Bjerregaard[5, 6], Camilla Ejlertsen[6], Julie Jacoby Petersen[3], Karen Frydenrejn Funderskov[7, 8], Anne Brødsgaard[2, 6, 9] & Karin Piil[8, 10, 11]*

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Background and aim: When health challenges disrupt everyday life, patients and their families need highly qualified care from specialists, along with care that acknowledges their lived experiences, values, and preferences. Despite the growing recognition of person- and family-centered care, healthcare professionals are still primarily trained to identify and solve problems for patients, rather than with them. This traditional approach positions the clinician as the expert and the patient as a passive recipient of care. To truly meet the complex and evolving needs of patients and families living with health challenges, a fundamental shift in mindset is required - one that embraces partnership, shared knowledge and decision-making, and an equal relationship. This study assesses the impact of a family-focused care course on healthcare professionals' attitudes and practices and examines the barriers and facilitators to its implementation. To support a shift toward partnership in care, a collaboration between Amager-Hvidovre Hospital and University Hospital of Copenhagen, Rigshospitalet (FRAG; Family-focused Research and Applied Science Group) developed one- and three-day courses for multidisciplinary healthcare professionals. These courses promote family-focused practice across diverse clinical settings. Methods: This longitudinal mixed-methods study invites healthcare professionals, e.g., nurses, physicians, social workers, and psychologists (n = 80-100 per year) to attend one- or three-day courses. Combining quantitative and qualitative data, the study tracks changes in clinical practice at baseline and at one-, three-, and twelve-month post-course follow-ups. Results and perspectives: This presentation outlines the structure and evaluation of FRAG's courses, designed to promote family-focused care since 2024. The evaluation identifies individual and organizational barriers to implementation, offering

insights into the gap between knowledge, education, and practice. Findings may inform strategies to close the gap and support broader adoption of family-focused care - ultimately benefiting patients and their families.

## A Qualitative Impact Evaluation of Patient and Community Engagement in Research (PaCER) [B102]

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Background: Training and education can play a significant role in empowering patient partners and strengthening their meaningful engagement in health research projects. The Patient and Community Engagement Research (PaCER) program is a three-course certificate program delivered by the University of Calgary Continuing Education, with support and oversight from the Alberta SPOR SUPPORT Unit Patient Engagement Team. The 12-month program aims to train patients and community members to conduct a patient-oriented and participatory health research project- to bring patient-informed health research evidence into health care planning, practice and policy. Since 2012, the PaCER program has supported over 45 health research projects. Purpose: Since 2019, our team (Alberta Strategy for Patient Oriented Research (AbSPORU) Patient Engagement Team) has been providing academic guidance to the PaCER program. Researchers sponsor a group of learners to take the course and complete a project. The purpose of our study is to understand the impacts of the PaCER program. This includes PaCER's impact on the project sponsor's program of research and past students' academic careers and work in health research and health systems. Methods/Process: The Kirkpatrick model for evaluating training programs guided the development of this evaluation. We conducted 18 interviews with past sponsors and alumni, using purposive sampling. Each participant took part in a one-on-one, semi-structured interview. Sponsors and alumni shared their experiences,

perceived professional and personal impacts following the PaCER program, and areas of improvement for the program. Data was analyzed iteratively using inductive thematic analysis. Key Findings: Alumni described the significant personal impact and empowerment, academic contributions, and increased and more valuable patient partner opportunities. Both alumni and sponsors spoke about finding meaningful patient engagement opportunities as motivation of taking PaCER. Sponsors described subsequent projects informed by PaCER, personal impacts of sponsoring a cohort, and potential impacts on health policy and implementation.

## Bridging the knowledge gap: improving personalized emergency care for people living with sickle cell disease [B103]

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Sickle cell disease (SCD) is a hematologic disease associated with decreased life expectancy. SCD comes with vaso-occlusion in the blood vessels, causing extremely painful vaso-occlusive crises (VOCs) which are the main reason for emergency room visits among persons with SCD. Earlier care-seeking and timely treatment are associated with better outcomes. Still, this patient group receive treatment later than patients with other pain conditions due to poor understanding among healthcare professionals (HCPs) regarding SCD and the contrast between chronic and acute pain. In combination with these barriers, there are also preconceptions and stigma when HCPs prescribe opioids. It is important to have patient grounded clinical guidelines and effective interventions to manage e.g. VOCs as well as for better personal treatment. The aim of this study was to explore what has been done to improve ED experiences for people with SCD, and to find knowledge gaps for further research. To meet the aim a review of the scientific literature was conducted. The extension for scoping reviews (PRISMA-ScR) from the Preferred Reporting Items for Systematic Reviews and Meta-Analyses was used as a checklist for the study. To capture the different components from

the articles, and to include the frequency of the phenomena, a manifest qualitative content analysis was used. By examining the barriers and interventions related to personalized care, as well as strategies to enhance knowledge, this study contributes to a deeper understanding of how people with SCD can receive more equitable and respectful treatment in EDs. It emphasizes the importance of educating healthcare professionals to foster greater insight into the everyday lives of people with SCD, thereby mitigating negative attitudes and improving personal treatment.

## Enhancing Mental Health by Meanings on Person-centred Care Through Drama in Healthcare Education: A Systematic Review and A Focus Group Study [B104]

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Background: Nursing students and professionals have mental health problems during clinical practice. Meanings on person-centred care could improve their mental health. Drama in education could enhance meanings and mental health. Therefore, clinical scenarios could be simulated with drama techniques, to provide process-oriented and reflective experiences on person-centred care in the group setting. however, these impacts on nursing students and professionals are unknown. Method: A systematic review and a focus group study were developed to explore whether drama in nursing education could enhance meanings on person-centred care mental health. The systematic review included peer-reviewed articles about drama in nursing education between 2013-2023 (PROSPERO: CRD42024504082). The focus group study recruited Year-3 nursing students without experiences of drama in nursing education (OSF Pre-registration: https://osf.io/yrnj2/). Results: Both studies identified two meanings on person-centred care: centring persons and becoming professional. However, findings of these two studies were divergent: only positive meanings on person-centred care were identified and synthesized in the systematic review, while nursing students

discussed both positive and negative perceptions on drama in nursing education. This systematic review found participants felt therapeutic, and constructed two positive aspects of meanings on person-centred care, including positively perceived selves and relationships, as well as becoming more professional in clinical practice and future directions. 22 nursing students participated in the focus group discussion. They could know themselves in drama. However, in the group, they would feel awkward and vulnerable. To reduce these uncomfortable feelings, they proposed three solutions for psychological safety: peer support, non-judgement, and positive affirmation from the facilitator. They perceived that interactions in drama were artificial and hoped actual patient involvements; and they felt scepticism about its impact due to insufficient clinical knowledge. Implications for Person-centred Care Education: Findings from these two studies reflected nurse characteristics of person-centred care: professional competence, interpersonal skills, and self-awareness.

## Exploring Person-Centred Competencies in Undergraduate Nursing Students through the Lens of Person-Centred Moments: A Reflective Account [B105]

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Background: As part of the Erasmus+ project PerCen NursEdu, we aim to anchor person-centredness as a key competence in undergraduate nursing

education in German-speaking countries. To this end, a competency model is to be developed. The first step was to collect data on meaningful experiences of students and teachers through the lens of "Person-Centered Moments" by McCormack and colleagues. So far, they are primarily used as a tool to support person-centered cultural development in practice. Focus: This reflective account discusses the methodological and conceptual potential of "Person-Centred Moments" for exploring person-centred competencies in undergraduate nursing students. The reflection raises critical questions about how person-centred competencies in nursing students can be identified and supported in education. Key Considerations: Based on the idea that meaningful care experiences reflect the underlying competencies of practitioners, the "Person-Centred Moments" method, on the one hand, invited nursing students to share self-selected narratives of person-centred care. On the other hand, it served as a tool for data production for scientific interest. It thus fulfilled a hybrid form between narration and reflection, extending the previous purpose of the method. These collected moments offered access to competence as enacted in real situations, rather than merely described or theoretically hypothesized. The reflection highlighted how students shaped effective care through relational, ethical, and contextual responsiveness, revealing what they did, how they acted, and what knowledge and skills they drew on. By surfacing often implicit dimensions of competence, the method aligns with theoretical perspectives that view competence not as static knowledge, but as a dynamic, context-sensitive capacity to act in complex care environments. Conclusions: By focusing on real care experiences, "Person-Centred Moments" support a more dynamic view of person-centred competence and demonstrate how combining narrative and reflective methods can help capture the ways in which competences are manifested in specific situations.

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8. AXEL WOLF & JOAKIM ÖHLÉN (Eds). *The Second Global Conference on Person-Centred Care: Bridging Practice, Organisation and Governance. Abstract book*. Göteborg, 2026.

This is the abstract book for the second Global Conference on Person-Centred Care (GCPCC) with the theme *Bridging Practice, Organisation and Governance*. The conference will take place in Gothenburg, Sweden, from 4th to 7th May, 2026 and has been organised by the University of Gothenburg Centre for Person-Centred Care (GPCC) – a strategic government-funded area in healthcare research since 2010.

The GCPCC provides a recurring international arena and platform for diverse individuals interested in furthering person-centred care in the broadest sense, i.e. care and social care from practice and organisation to governance and inter-interrelationships thereof. The theme reflects the current maturity of our field, spanning from practice at the point of care, integrated pathways and organisations to governance and macro-level perspectives.

This book presents all abstract contributions presented by the invited expert keynote speakers, pre-conference workshops, and workshops, panels/symposia, as well as oral and poster presentations selected on the basis of expert reviews of submitted abstracts. In total, the book presents over 300 abstracts.