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ORIGINAL ARTICLE

Person-centred care competence and person-centred care climate described by nurses in older people's long-term care—A cross-sectional survey

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Abstract

Background: Person-centred care requires that nurses are competent in this approach to care. There may be an association between person-centred care competence and person-centred care climate, but it has not been demonstrated in the literature. This is the justification for the survey study to gain staff's perceptions of such a relationship.

Objectives: The aim of this study was to analyse the levels and associations between person-centred care competence and the person-centred care climate as assessed by professional nurses in long-term care settings for older people.

Methods: A descriptive cross-sectional survey design with cluster sampling was used to recruit professional nurses of different levels from six long-term care institutions for older people. Data were collected using the Patient-centred Care Competency scale (PCC) and the Person-centred Climate Questionnaire staff version (PCQ-S) in September 2021 and analysed with descriptive and inferential statistics.

Results: The mean score on the PCC was rated at a good level of 3.80 (SD 0.45), and the PCQ-S was rated at a good level of 3.87 (SD 0.53). The correlation between PCC and PCQ-S total scores ($r = .37$, $p < .001$) indicated that person-centred care competence and person-centred care climate were associated. No associations were detected between nurses' educational levels and PCC ($p = .19$) or PCQ-S ($p = .13$) or in terms of age or work experience.

Conclusions: The results provide insights into competence and climate levels of person-centred care and preliminary evidence of an association between nurses' assessed competence in person-centred care and the perceived person-centred care climate in long-term care. Nurses' individual characteristics did not appear to affect the level of person-centred care competence or climate. In the future professional nurses of different levels could benefit from effective continuing education in person-centred care. This study design serving for the future intervention study registered to the ClinicalTrials.goc NCT04833153

KEYWORDS
competence, long-term care, older people, person-centred care, survey

1 | INTRODUCTION

This study focused on person-centred care competence and the person-centred care climate self-assessed by nurse professionals in the context of long-term care (LTC) settings for older people. Person-centred care is often used as an indication of care quality and ethical value (NICE, 2015; WHO, 2015; Wynne, 2018) requiring nurse competence, that is, skills, knowledge, positive attitude and the ability to use person-centred care competence in practice (McCance & McCormack, 2017). Although person-centred care is a quality indicator of the care provided in LTC settings, the literature provides evidence of missed nursing care or even neglect within these care settings (Kalánková et al., 2021; Kangasniemi et al., 2021), which can indicate a lack of person-centred care competence.

Health-care systems differ between countries. Culturally, the definition of LTC varies widely, comprising all care settings in which people receive help with the activities of daily living, including home care, adult day care, assisted living and nursing home care (American Council of Aging, 2020). LTC has also been defined in terms of on-site 24 h/7 days delivery of care, health services and assistance with daily activities. These are commonly referred to as nursing homes and serve as homes for older people with multiple chronic conditions, most of whom are diagnosed with dementia (Estabrooks et al., 2013). In this study, LTC refers to 24/7 institutional care for older people.

1.1 | Person-centred care

The concepts of person-centred, resident-centred, client-centred and individualised care have sometimes been used as synonyms in the literature (Morgan & Yoder, 2012). At the core of each concept are humans, an understanding of individual autonomy, and respect for their dignity (Håkansson Eklund et al., 2019; Suhonen & Charalambous, 2018) and individuals' involvement in decision-making (McCance & McCormack, 2017). However, there are slight differences between the concepts based on the contexts in which they are used. In the hospital environment, the concept of patient-centred care is usually utilised, while person-centred care or resident-centred care is used in nursing homes (Morgan & Yoder, 2012). The concepts of person- and patient-centred care differ from each other in terms of their goals. The goal in patient-centred care is more on functional life, while person-centred care encompasses life and life situations, with meaningful life as a goal (Håkansson Eklund et al., 2019). Person-centred care provides a

Implications for Practice

What does this research add to existing knowledge in gerontology?

- The findings provide a benchmark level of nurses' person-centred care competence levels in older people's long-term care.
- New information is revealed on the relationship between nurses' person-centred care competence and their perceptions of the person-centred care climate.
- In the long-term care setting for older people, characteristics such as nurse's education, age and work experience are not significantly related to person-centred care competence.

What are the implications of this new knowledge for nursing care with older people?

- Educational level, age or work experience do not limit the opportunity for nurses to develop their competence in person-centred care.
- Promoting nurses' person-centred care competence is important in long-term care settings for older people.
- The importance of person-centred care competence and a person-centred care climate is one of the factors related to the quality of the caring culture.

How could the findings be used to influence policy or practice or research or education?

- The identified association between nurses' competence and climate in person-centred care warrants the nurses, nursing managers, educators and policy makers to seek ways to develop person-centred care competence.
- Further research is needed to verify whether the association found between person-centred care competence and person-centred care climate is causal, and thereby can be used to promote person-centredness in care.
- Person-centred care competence and climate can be improved in long-term care; more effort is required by providers and managers to promote and enable staff to achieve these desirable outcomes.

more comprehensive and holistic view of persons and who they are, while patient-centred care refers to patient care in the context of patient–professional relations regarding a health problem or illness (Zhao et al., 2016).

The person-centred care concept has been used in this study for reasons that it includes whole-life orientation, while health problem orientation (Håkansson Eklund et al., 2019) may be the main reason for living in LTC. A person-centred care approach is key for long-term caring relationships, which requires that staff focus on enabling empathy, respect, engagement, relationship, communication, shared decision-making, holistic focus, individualised focus and coordinated care. It merits a strong position in LTC settings for older people, as it is associated with quality of life (Terada et al., 2013) and experiences of quality of care (Edvardsson et al., 2017).

1.2 | Person-centred care competence

Nurses' competence in general in the older people's care context has been studied, with only 65% of nurses indicating that they had adequate competence to work in LTC settings for older people. Thus, the competence development of nurses is needed, especially for older people's well-being. The characteristics predicting nurses' competence have been shown to be age, continuing education, length of work experience (Kiljunen et al., 2019), education level and work environment (Bing-Jonsson et al., 2016).

Competence has generally been defined in terms of knowledge, skills and attitudes (Cronenwett et al., 2007). Nursing practice requires not only the above but also the complex application of these to practice based on nursing values (Cowan et al., 2005). Person-centred care competence refers to this complex application of knowledge, skills, attitudes and values, including the content of person-centredness, respecting patients' perspective, promoting patient involvement in care processes, providing for patient comfort and advocating for patients (Håkansson Eklund et al., 2019; Hwang, 2015).

Nurses' competence in person-centred care has been studied in the hospital environment (Hwang et al., 2019) and was rated between moderate and good 3.61 (SD 0.46). Nurses' older age, higher education level and longer working experience have been linked to assessments of better person-centred care competence (Hwang, 2015). However, there is a lack of research evidence about person-centred care competence in LTC settings for older people.

1.3 | Person-centred care climate

Person-centred care climate has been described in terms of the physical environment, people's doing and being, and the organisation's philosophy of care (Edvardsson, 2008). Thus, person-centredness highlights the climate of safety, a climate of everydayness and a climate of community, to support full life and life-situation in the LTC settings of older people, and individuals living there.

The person-centred care climate has been studied in different settings, including hospitals (e.g. Al-Surimi et al., 2021), ambulance care services (Rantala et al., 2018) and nursing homes (e.g. Lood et al., 2019; Sjögren et al., 2015; Vassbø et al., 2020; Yang et al., 2019). The person-centred care climate has been assessed by nurses (e.g. Al-Surimi et al., 2021; Vassbø et al., 2019; Yang et al., 2019), patients (e.g. Rantala et al., 2018), residents (e.g. Yang et al., 2019) and relatives (e.g. Lood et al., 2019). The climate has been studied, for example, in association with quality of care (e.g. Lood et al., 2019), person-centredness (Rantala et al., 2018), the role of care providers (Al-Surimi et al., 2021), nursing home facilities and residents' characteristics (Bergland et al., 2015) and job satisfaction (Lehuluante et al., 2012; Vassbø et al., 2020). In one study, the mean score level of the person-centred climate assessed by nurses was 45.96 (SD 15.36), measured by the Person-centred Climate Questionnaire (PCQ-S) staff version (Edvardsson et al., 2015). In relation to increasing age and level of education, statistically significant results have also been obtained using the PCQ-S completed by nurses in a study by Al-Surimi et al. (2021), although the length of nurses' work experience was not statistically significant. However, research about person-centred care in relation to the person-centred care climate in LTC care settings for older people is scarce.

1.4 | Aim of this study

The evidence of the levels of nurses' person-centred care competence and person-centred care climate is very limited in LTC, and the association between person-centred care competence and person-centred care climate has not been demonstrated in the literature. Therefore, the aim of this study was to analyse the levels and associations of self-assessed person-centred care competence and the perceived person-centred care climate of professional nurses in LTC settings for older people. This evidence may be needed to promote a culture of caring for vulnerable older people in LTC settings and to support ethically high-level and value-based decision-making by policy makers, managers of LTC institutions and nurse educators.

2 | MATERIALS AND METHODS

2.1 | Design, setting and sampling

The study used a cross-sectional survey design serving for the future intervention study, registration number NCT04833153 in ClinicalTrials.gov. Reporting followed the STROBE statement for cross-sectional studies (von Elm et al., 2007). Cluster sampling was used, and sample size was calculated by rule of thumb (a total of 31 variables × minimum of 5 nurses per variable = 155) (Wilson van Voorhis & Morgan, 2007). The study survey was distributed in six LTC institutions within two middle-sized cities in the western part of Finland. The cluster sampling was used for intervention study, and two cities and their six institutions were retrieved by random selection. These

institutions had similar organisational structures, working conditions, nurses' educational levels and the same nurse–patient ratio. None of these institutions had had any continuing educations about person-centred care earlier.

Data were collected via paper–pencil questionnaires in September 2021. Professional nurses with all levels of education—registered nurses (RN), elderly care professionals (ECP), licensed practical nurses (LPN) and nursing assistants (NA)—were recruited by the researchers with the help of nurse managers, who distributed information letters about the study and allowed those willing to participate to complete the questionnaires during working hours. Most of the professional nurses in LTC settings for older people are LPNs in Finland. The inclusion criteria for nurses were that they worked permanently or as long-term locums (at least 6 months) in the units. During the data collection period, there were 268 nurse professionals working in the study units who met the inclusion criteria; all were eligible, invited and included in the study.

2.2 | Instruments

The data were collected using two validated instruments: the Finnish version (Suhonen et al., 2021) of the Patient-centred Care Competency (PCC) scale (Hwang, 2015) and the Person-centred Climate Questionnaire (PCQ-S) staff version (Edvardsson et al., 2015). The PCC scale measures competence and consists of 17 items using a 5-point Likert-type scale (1 = minimum score – 5 = maximum score; the higher the score, the higher the person-centred care competence). The Cronbach's alpha (α) of the internal consistency reliability of the PCC scale used was 0.92. It is divided into four subscales: respecting patients' perspectives (α = .85), promoting patient involvement in care processes (α = .81), providing for patient comfort (α = .84) and advocating for patients (α = .80) (Hwang, 2015).

The PCQ-S comprises 14 items using a 6-point Likert scale (0 = minimum score – 5 = maximum score; the higher the score, the higher the person-centred care climate). The Cronbach's alpha of the internal consistency reliability of the PCQ-S used was 0.88. It is divided into three subscales: a climate of safety (α = .82), a climate of everydayness (α = .82) and a climate of community (α = .82) (Edvardsson et al., 2015). The PCQ-S was translated into Finnish according to standard forward-back translation procedures (Sousa & Rojjanasrirat, 2011), following the process of the previously adapted patient version (Stolt et al., 2021).

Nurses' background variables were age, education, working experience in social and health care, and working experience in the current unit.

2.3 | Data analysis

The data were analysed statistically using R statistical software version 4.0.2 (R Core Team, 2020). Participants' background characteristics and PCC and PCQ-S scores were summarised using descriptive statistics (frequency, %, mean, SD, min, max and range). The internal consistency of the instruments was examined using Omega (Ω) (Dunn et al., 2014), with bootstrapped 95% confidence intervals for total scales and subscales. Sum variables for both the entire PCC and its four subscales and the entire PCQ-S and its three subscales were formed according to the theoretical framework provided by the original references and authors, summed together and divided by the number of items. The correlation between the PCC, the PCQ-S and characteristics with numerical scale, including age and work experience, was tested using Spearman's correlation coefficient. Educational characteristics were analysed as categorical variables using the Mann–Whitney U-test. The statistical significance level was set at $p < .05$.

2.4 | Ethical considerations

The study was conducted following good scientific principles, standards and guidelines (Finnish Advisory Board on Research Integrity, 2012; World Medical Association, 2013). Ethical approval was obtained from the University Ethics Committee on 7 June 2021. Permissions for instrument use were granted by email by the developers Jee-In Hwang (email), Elsevier (reprint of the items) and David Edvardsson (email). Permissions to conduct the study were obtained from both participating cities according to their standard procedures. The respondents were informed about the purpose of the study, anonymity, issues related to research ethics, reporting of the findings and the possibility of withdrawing from the study at any point. The participants signed an informed consent form.

3 | RESULTS

3.1 | Respondents

The respondents (n = 200, response rate 74.6%) comprised different levels of professional RN, ECP and LPN who worked in the sampled LTC settings. Educational levels were categorised into vocational (LPN) and polytechnic (RN and ECP) levels. Polytechnic-level qualifications were combined due to the small number of ECPs. There were no NAs. Educational level was mainly vocational (84%, n = 169) and polytechnic (16%, n = 31). The mean age of the respondents was 46 years (SD 10.81, range 20.00–63.00), and they had a mean of 17 years (SD 9.92, range 1.33–40.5) of working experience in social and health care and 6 years (SD 6.38, range 0.00–35.0) in the current LTC unit.

3.2 | Nurses' self-assessed person-centred care competence

The total score on the PCC was rated between moderate and good at 3.80 (SD 0.45, range 2.65–5). Among subscales of the

TABLE 1 Nurses' (n = 200) self-assessed level of person-centred care competence (numbers do not always add up to 200 because of missing values).

	n	Sum (SD)	Range	Mean (SD)	Range	Ω[a] [95% CI][b]
PCC total[c]	184	64.60 (7.57)	45–85	3.80 (0.45)	2.65–5	0.93 [0.92, 0.94]
Respecting patients' perspectives	198	23.43 (2.60)	17–30	3.91 (0.43)	2.83–5	0.84 [0.80, 0.87]
1. Value seeing health-care situations through patients' eyes	200			3.95 (0.56)	2.00–5	
2. Elicit patient values, preferences and needs as part of clinical interview, implementation of care plan, and evaluation of care	200			3.85 (0.61)	2.00–5	
3. Integrate understanding of multiple dimensions of patient-centred care such as patient and family preferences	200			3.82 (0.57)	2.00–5	
4. Communicate patient values, preferences and needs to other health-care team members	198			3.97 (0.66)	2.00–5	
5. Provide patient-centred care with sensitivity and respect for the diversity of human experience	200			4.07 (0.53)	3.00–5	
6. Support patient-centred care for individuals and groups whose values differ from own	199			3.80 (0.60)	2.00–5	
Promoting patient involvement in care processes	187	17.98 (2.72)	10–25	3.60 (0.54)	2.00–5	0.84 [0.80, 0.88]
7. Examine barriers to active involvement of patients in their care processes	199			3.73 (0.66)	2.00–5	
8. Assess level of patient's decisional conflict and provide access to resources	197			3.47 (0.68)	1.00–5	
9. Describe strategies to empower patients or families in all aspects of the care process	192			3.24 (0.72)	1.00–5	
10. Engage patients or designated surrogates in active partnerships that promote health, safety and well-being, and self-care management	199			3.55 (0.78)	2.00–5	
11. Respect patient preferences for degree of active engagement in care process	198			3.96 (0.64)	2.00–5	
Providing for patient comfort	198	12.11 (1.71)	9–15	4.04 (0.57)	3.00–5	0.88 [0.84, 0.90]
12. Assess presence and extent of pain and suffering	199			4.15 (0.61)	3.00–5	
13. Assess levels of physical and emotional comfort	199			3.99 (0.62)	3.00–5	
14. Elicit expectations of patient and family for relief of pain, discomfort or suffering	198			3.97 (0.68)	2.00–5	

(Continues)

TABLE 1 (Continued)

	n	Sum (SD)	Range	Mean (SD)	Range	Ω[a] [95% CI][b]
Advocating for patients	198	10.97 (1.85)	4–15	3.66 (0.62)	1.33–5	0.80 [0.74, 0.85]
15. Facilitate informed patient consent for care	198			3.59 (0.70)	2.00–5	
16. Communicate care provided and needed at each transition in care	199			3.68 (0.76)	1.00–5	
17. Participate in building consensus or resolving conflict in the context of patient care	200			3.69 (0.72)	1.00–5	

[a]Ω = OMEGA measure of reliability. Omega as a point estimate overcomes some of the fundamental problems intrinsic to the calculation of internal consistency evident with Cronbach's alpha coefficient (Dunn et al., 2014).

[b]Bootstrapped 95% confidence intervals for OMEGA.

[c]PCC = Patient-Centred Care Competence scale (Hwang, 2015).

PCC, 'providing for patient comfort' was evaluated the highest at a good level of 4.04 (SD 0.57, range 3.00–5). The second highest subscale was 'respecting patients' perspectives', rated between a moderate and good level of 3.91 (SD 0.43, range 2.83–5), and the third was 'advocating for patients', rated between a moderate and good level at 3.66 (SD 0.62, range 1.33–5). The lowest subscale was 'promoting patient involvement in the care process', rated between a moderate and good level of 3.60 (SD 0.54, range 2.00–5). On the item level, the two highest items were 'assess presence and extent of pain and suffering', rated at a good level of 4.15 (SD 0.61, range 3.00–5), and 'provide patient-centred care with sensitivity and respect for the diversity of human experience', assessed at a good level of 4.07 (SD 0.53, range 3.00–5). The two lowest items were 'describe strategies to empower patients of families in all aspects of the care process', assessed at a moderate level of 3.24 (SD 0.72, range 1.00–5), and 'assess level of patient's decisional conflict and provide access to resources', rated between a moderate and good level of 3.47 (SD 0.68, range 1.00–5) (Table 1).

3.3 | Nurses' self-assessed person-centred climate

The total score of the PCQ-S was between moderate and good at 3.87 (SD 0.53, range 2.07–5). Among its subscales, 'a climate of safety' was evaluated the highest at a good level of 4.08 (SD 0.56, range 2.17–5), while the second highest was 'a climate of community', rated at a good level of 4.03 (SD 0.69, range 1.50–5). The lowest subscale was 'a climate of everydayness', rated at a moderate level 3.41 (SD 0.71, range 1.00–5). On the item level, the two highest items were 'a place where the residents are in safe hands', assessed at a good level of 4.30 (SD 0.69, range 1.00–5), and 'a place where staff use a language that residents can understand', assessed at a good level of 4.27 (0.64, range 2.00–5). The two lowest scores were 'a place where it is peaceful' assessed at level moderate 3.28 (SD 0.95, range 0–5) and 'a place where it is possible to get unpleasant thoughts out of your head' assessed at a moderate level of 3.25 (SD 0.93, range 0–5) (Table 2).

3.4 | Associations between person-centred care competence, person-centred care climate and nurse-related variables

There was a significant correlation between the total score of PCC and PCQ-S ($r = .37$, $p < .001$) (Table 3). The subscale correlation coefficients ranged from $r = .15$ to .45. The strongest correlation was between subscale 'respecting patients' perspectives' and subscale 'a climate of community' ($r = .45$, $p < .001$) and the lowest between subscales 'promoting patient involvement in care processes' and 'a climate of everydayness' ($r = .15$, $p = .044$). Educational level was not statistically significantly associated with PCC ($p = .19$) or PCQ-S ($p = .13$). The other background variables were not statistically significantly associated with total PCC: age ($r = -.13$, $p = .08$), working experience ($r = -.04$, $p = .55$), working experience in the current unit ($r = -.08$, $p = .30$), or with total PCQ-S: age ($r = -.07$, $p = .34$), working experience ($r = -.01$, $p = .94$) and working experience in the current unit ($r = -.11$, $p = .14$).

4 | DISCUSSION

The aim of this study was to analyse the levels and associations between person-centred care competence and the person-centred care climate as assessed by professional nurses in LTC settings for older people. Contrary to earlier studies (e.g. Al-Surimi et al., 2021; Hwang, 2015), nurses' age, educational level and work experience were not statistically significant in PCC or PCQ-S, which suggests that nurses' backgrounds do not limit their opportunities to develop their person-centred care competence. This result is relevant for the collective development of nursing practice in LTC-setting units for older people.

This study identified a good level of self-assessed person-centred care competence in Finnish LTC care settings. The subscale review showed that 'providing for patient comfort' was the highest scored subscale, while 'promoting patient involvement in the care process' was scored the lowest. This result is comparable to previous studies (Hwang et al., 2019; Suhonen et al., 2021). The highest scored

TABLE 2 Nurses' (n = 200) self-assessed level of person-centred care climate (numbers do not always add up to 200 because of missing values).

	n	Sum (SD)	Range	Mean (SD)	Range	Ω[a] [95% CI][b]
PCQ-S total[c]	196	54.22 (7.42)	29–70	3.87 (0.53)	2.07–5	0.88 [0.85,0.90]
A climate of safety	197	24.50 (3.38)	13–30	4.08 (0.56)	2.17–5	0.79 [0.75,0.83]
1. A place where you feel welcome	199			4.18 (0.83)	0–5	
2. A place where you feel acknowledged as a person	200			3.92 (0.91)	0–5	
3. A place where you can be yourself	200			4.07 (0.88)	1–5	
4. A place where the residents are in safe hands	200			4.30 (0.69)	1–5	
5. A place where staff use a language that residents can understand	198			4.27 (0.64)	2–5	
6. A place that feels homely for the residents even though it is an institution	200			3.77 (0.91)	0–5	
A climate of everydayness	199	13.64 (2.83)	4–20	3.41 (0.71)	1.00–5	0.75 [0.68,0.81]
7. A place where there is something nice to look at	200			3.45 (0.91)	0–5	
8. A place where it is peaceful	200			3.28 (0.95)	0–5	
9. A place where it is possible to get unpleasant thoughts out of your head	199			3.25 (0.93)	0–5	
10. A place which is neat and clean	200			3.68 (0.96)	0–5	
A climate of community	199	16.11 (2.75)	6–20	4.03 (0.69)	1.50–5	0.80 [0.74,0.85]
11. A place where it is easy for residents to keep in contact with their loved ones	199			3.86 (0.92)	1–5	
12. A place where it is easy for residents to receive visitors	200			4.04 (0.84)	2–5	
13. A place where it is easy for residents to talk to the staff	200			4.20 (0.78)	1–5	
14. A place where residents have someone to talk to if they so wish	200			4.04 (0.90)	1–5	

[a]Ω = OMEGA measure of reliability. Omega as a point estimate overcomes some of the fundamental problems intrinsic to the calculation of internal consistency evident with Cronbach's alpha coefficient (Dunn et al., 2014).

[b]Bootstrapped 95% confidence intervals for OMEGA.

[c]PCQ-S = Person-centred Climate Questionnaire Staff version (Edvardsson et al., 2015)

subscale included items on the assessment of pain and suffering. This score differs from previous evidence, which shows that health-care providers in the LTC context often have limited knowledge of pain assessment. Having a relationship with the resident and knowing how they express pain can be a way to improve pain assessment and, therefore, quality of care, especially in residents with cognitive impairment (Knopp-Sihota et al., 2019). We did not have background information on the extent to which the participating nurses in this study have participated in continuing education, specifically on pain care, which may have an impact on this finding of the highest subscale.

Nurses' self-assessed competence in promoting older people's involvement in the care process was between moderate and good. Notably, today's almost worldwide challenges, such as unusually high workloads, social distancing, staff shortages (Jones et al., 2022) and the COVID-19 pandemic, may affect the nurse's assessment of

TABLE 3 Associations between person-centred care competence and person-centred care climate (numbers do not always add up to 200 because of missing values).

	PCQ-S total			A climate of safety			A climate of everydayness			A climate of community		
	n	*r*[a]	*p*[b]	*n*	*r*	*p*	*n*	*r*	*p*	*n*	*r*	*p*
PCC total	182	.37	<.001*	183	.34	<.001*	183	.24	.001*	184	.41	<.001*
Respecting patients' perspectives	195	.36	<.001*	196	.30	<.001*	196	.23	.001*	198	.45	<.001*
Promoting patient involvement in care processes	185	.23	.002*	186	.22	.002*	186	.15	.044*	187	.30	<.001*
Providing for patient comfort	195	.39	<.001*	196	.36	<.001*	196	.26	<.000*	198	.37	<.001*
Advocating for patients	195	.38	<.001*	196	.37	<.001*	196	.24	.001*	198	.38	<.001*

Abbreviation: PCC, Person-Centred Care Scale; PCQ-S, Person-centred Climate Questionnaire staff version.

[a]Spearman's rank correlation coefficient.

[b]*p*-Value

*Statistically significant level <.05.

residents' involvement in the caring process. During the data collection, there were also isolation situations in those units, which may have affected the results. Nurses may have felt that they were unable to engage in activities of daily living, which are part of the caring process in LTC settings. Another interpretation based on Hwang et al. (2019) is that nurses may have limited awareness of the importance of involving residents in the caring process. This may indicate that in the caring process, nurses still need more awareness about person-centred care practice, especially about the process of person-centred care.

The nursing profession and its core values, which are based on strong ethical values such as respect for human dignity, require an excellent level of person-centred care competence. Nevertheless, the subscale 'respecting patients' perspectives' was rated at a good level, which is comparable with earlier studies (Hwang et al., 2019; Suhonen et al., 2021). Based on the core of the concept of person-centred care, this result may indicate that there is still a need for clarification of values such as autonomy and dignity in nursing, especially in the care of vulnerable older people. Providers and managers of these kind of care setting need more effort to promote and enable nurses to take part of continuing education to promote value-based and person-centred nursing care.

The person-centred care climate level was assessed as being relatively high as well, corresponding well with the results in Swedish (Edvardsson et al., 2015) and Chinese (Yang et al., 2019) LTC settings for older people. There may be a shortage of resources that has hampered LTC settings for older people for a long time. Thus, there might have been situations in institutions that required isolation because of COVID-19, which may have had an impact on the conversation between residents and nurses. Social contact with visitors has also been restricted. In any case, getting rid of unpleasant thoughts requires, for example, social contact with others, activities or possibilities to see something nice around you. It seems to be at a low level in all LTC settings. In highly constrained environments with high acuity of resident needs, there may be limited scope or even awareness to work with environmental interventions providing positive distractions to unpleasant thoughts.

The results of this study showed that person-centred care competence and a person-centred care climate are related. The correlation was fairly low but still statistically significant. The results provide support for the hypothesis that developing the person-centred care competence of nurses of all ages and levels can influence the person-centred care climate and, thus, the culture of nursing care. Further research is needed to explore whether there is causality between person-centred care competence and climate.

4.1 | Limitations and strengths

The results of this study need to be interpreted in light of some limitations. First, the data were collected from two cities in one

region, which limits the generalisability of the results. Second, the instruments may overlap in some items. Third, the instruments used are self-assessments; hence, the results may be affected by psychological mechanisms and social desirability bias (Karpen, 2018). Fourth, the PCQ-S was translated into Finnish according to the recommended translation process but without pilot testing on a corresponding sample; instead, pilot testing of the previous validation of the patient version of the PCQ was relied on. However, the response rate was relatively high (76%), and the sample was sufficiently large. The number of missing values was low, indicating that both measurements were clear and easy to use. Measurements of internal consistency were high (Omega = .93 for PCC and .88 for PCQ-S).

5 | CONCLUSION

This study revealed that the characteristics of individual nurses did not affect the level of person-centred care competence or climate. The findings suggest that person-centred care competence and person-centred care climate are connected, although evidence indicating causality is still lacking. Further experimental research could be beneficial in investigating the possibilities of promoting nurses' person-centred competence and may indicate its potential causality in the person-centred climate. If there is causality, promoting nurses' person-centred care competence could have an impact on the person-centred care climate, which older people and their next of kin can also notice. Only then can it influence the quality-of-caring culture.

6 | Implications for Practice

Findings from this study indicate that nurses' person-centred care competence and their perceptions of the person-centred care climate can be associated and nurses' background details as education level, work experience and age is not significant on this relation. Nurses, nursing managers, educators and policy makers can use these findings in their development plans to promote nurses' person-centred care competence and organisations' person-centred care climate in order to improve the quality-of-care culture in long-term care for older people.

AUTHOR CONTRIBUTIONS

All authors have read and approved the final manuscript. MP, MS and RS involved in the conception and design of the study. MP, MS, DE, MP and RS involved in drafting the article. MP, MS, DE, MP and RS involved in revising it critically for important intellectual content.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICS STATEMENT

The Ethics Committee for Human Sciences at the University of Turku, Health Care Division. Approval number 19/2021. When considering the researcher's request, information about the research obtained from the delivered documents, and the national guidelines for the ethical principles of research with human participants and ethical review in human sciences, the Ethics Committee gives assent to the research. According to the Ethics Committee, the planned research project under the preliminary ethical review can be ethically approved on 7 June 2021. Permissions for instrument use were granted by email by the developers Jee-In Hwang (12/2020), Elsevier (reprint of the items, License number 5497490356775) and David Edvardsson (12/2020).

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