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Résumé

Les perceptions des patients concernant les soins individualisés : une évaluation des propriétés et des résultats psychométriques de l'échelle de soins individualisés

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Les organisations de services de santé désirent offrir des soins centrés sur le patient. Toutefois, il reste difficile de mesurer cet aspect de la qualité des soins. Cette étude transversale a examiné la fiabilité et la validité de l'échelle bipartite de mesure des soins individualisés (ESI-A, ESI-B) *(bipartite Individualized Care Scale [ICS-A, ICS-B])* dans une population canadienne ayant subi une arthroplastie genou-hanche. La cohérence interne des ESI-A et ESI-B était élevée; cependant, la validité factorielle n'était pas entièrement étayée. Vingt-cinq pour cent des participantes et des participants ont fourni des commentaires additionnels ouverts afin de décrire leurs perceptions, leurs besoins et leurs suggestions, et noté que l'échelle de Likert les obligeait à regrouper leurs commentaires et ne leur permettait pas de communiquer leur perception de chaque membre du personnel infirmier. Les conclusions de l'étude indiquent que lorsqu'ils évaluent les soins infirmiers, les patientes et les patients trouvent important de pouvoir partager leur histoire personnelle. Les études qualitatives qui seront effectuées dans l'avenir devraient examiner ce que pense le personnel infirmier des soins centrés sur le patient, ainsi que comporter une investigation sur les systèmes et les aspects liés au processus qui favorisent ou gênent la prestation de soins plus individualisés.

Mots clés : soins centrés sur le patient

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Patients' Perceptions of Individualized Care: Evaluating Psychometric Properties and Results of the Individualized Care Scale

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Health-care organizations aim to provide patient-centred care, yet measurement of this aspect of care quality remains a challenge. This cross-sectional study investigated the reliability and validity of the bipartite Individualized Care Scale (ICS-A, ICS-B) in a Canadian hip and knee arthroplasty population. Internal consistency of the ICS-A and ICS-B was high; however, factorial validity was not fully supported. Twenty-five percent of participants provided additional open-ended comments to describe individual perceptions, needs, and suggestions, noting that the Likert-scale approach required them to aggregate their feedback about rather than share their perceptions of individual nurses. The findings indicate that it is important to patients to be able to share their individual stories when evaluating nursing care. Future qualitative studies should examine the nurse perspective on the provision of patient-centred care, including investigation of systems and process-related features that foster or hinder more individualized care.

Keywords: patient-centred care, patient-focused care, client-centred care, nursing-care quality, patient satisfaction, care maps

Patient-care delivery in clinical specialty areas is driven by two objectives: the provision of efficient, standardized care; and the delivery of patient-centred care. The increasing use of care maps has led to more consistency in care, improved quality, better health outcomes, reduced risks, decreased length of stay, and increased patient education (De Bleser et al., 2006; Woolf, Grol, Hutchinson, Eccles, & Grimshaw, 1999). However, following such care pathways may result in lower care flexibility and decreased thinking by staff (Atwal & Caldwell, 2002; Ilott, Rick, Patterson, Turgoose, & Lacey, 2006) and might not sufficiently meet individual patient expectations (Dozier, Kitzman, Ingersoll, Holmberg, & Schultz, 2001). Patient-centred care is a phenomenon that has been defined as a "way of providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patients' values guide all clinical decisions" (Institute of Medicine, 2001, p. 3). A recent dimensional analysis of patient-centred care by Hobbs (2009) established that the concept includes a "complex series of nurse-patient interactions that go beyond the collection of information about patient preferences"

(p. 59). According to the author, the goal of patient-centred care is "the alleviation of vulnerabilities as experienced by the patient" (p. 55), which consist of compromised physiological states and threats to individual identity such as feeling alienated or lacking control.

Looking at definitions of patient-centred care, it is clear that the provision of more individualized care is a central element of patient-centredness that appears frequently in the nursing literature. Radwin and Alster (2002) generate the following empirical definition of individualized care: "Individualized care results when the nurse knows the patient as a unique individual, and tailors nursing care to a patient's experiences, behaviors, feelings, and perceptions" (p. 62). The importance of individualized care is well established and has been found to be highly valued by nurses, patients, families, and health-care administrators (Davis, Byers, & Walsh, 2008; Radwin & Alster, 2002). It is correlated with high levels of patient satisfaction (Dana & Wambach, 2003) and health-related quality of life (Suhonen, Valimaki, Katajisto, & Leino-Kilpi, 2007).

Increasingly, health-care organizations are attempting to assess patient perspectives and to evaluate performance and quality of care (Jenkinson, Coulter, Reeves, Bruster, & Richards, 2003). However, there is limited research on the types of patient needs that remain unmet during hospitalization and an evident lack of sufficient attention to specific patient needs and expectations (Muntlin, Gunningberg, & Carlsson, 2006). In North America the NRC Picker Survey is commonly used to assess patient satisfaction with care. A clear picture of patient perceptions of individualized care, an important element of patient-centred care, cannot be obtained using standard patient satisfaction surveys alone (Davis et al., 2008).

Little is known about patients' perceptions of individualized nursing care (Land & Suhonen, 2009) and patients' views regarding the importance of specific individualized nursing interventions. Studies designed to incorporate patient perspectives can help to clarify dimensions of patient-centred care (Hobbs, 2009). The search for an instrument to measure the quality of individualized and patient-centred aspects of care has turned up a significant body of research in relation to an instrument called the Individualized Care Scale (ICS) developed by Suhonen, Valimaki, and Katajisto (2000). This instrument was developed through a process of deductive reasoning based on an extensive review of the literature on individualized care (Suhonen et al., 2000; Suhonen, Valimaki, & Leino-Kilpi, 2002). Content analysis was used to explore the definitions and to conceptualize relevant dimensions of the construct (Suhonen, Leino-Kilpi, & Valimaki, 2005). Individualized care was conceptualized as a phenomenon that recognizes that individual patients experience and perceive the same care in a variety of ways according to their different values

(Suhonen et al., 2005). Dimensions include consideration of patients' views on how individuality is supported through nursing interventions and, for example, how their personal situation is being considered, how their individual feelings and reactions are taken into account, and how their decisional control over care is realized. Instrument questions and subscale foci match some of the dimensions of patient-centred care as described recently by Hobbs (2009). In Hobbs's work, dimension components include the patient's perceptions of events, abilities, resources, and choices and describe the patient as an individual with needs, preferences, values, and beliefs that must be integrated into the care experience. The questions examine nurse-patient interactions as perceived by patients and include areas such as patients' vulnerabilities related to the clinical situation, patients' personal life situation, and patients' decisional control over care. Suhonen et al. (Sukonen, Valimaki, Leino-Kilpi, & Katajisto, 2004; Sukonen et al., 2005) conceptualize individualized care in two ways: in terms of the patient's perspective on the degree to which nursing interventions have been tailored to his or her individual needs, situation, characteristics, and preferences; and in terms of how well the patient's individuality has been taken into account in his or her care.

The ICS has demonstrated good psychometric properties in European studies and was used in a recent international comparative survey with an orthopedic patient population (Suhonen et al., 2008). Available results have demonstrated that there are differences between countries in the way that patients' perceive the nursing care they receive (Suhonen et al., 2008). After consulting with the ICS developer, we designed this study to test the instrument in a Canadian health-care setting, recognizing the multiculturalism and diversity of Canadian residents.

Aim of the Study

The purpose of this study was primarily to explore the psychometric properties of the ICS in a Canadian Centre of Excellence for Hip and Knee Replacement and secondarily to examine whether participants perceived their care to be individualized. The specific research questions were as follows: 1. *To what extent is there evidence to support the factorial validity of ICS scores when applied to patients receiving hip or knee replacement?* 2. *To what extent is there evidence to support the internal consistency of ICS scores when applied to patients receiving hip or knee replacement?* 3. *To what extent is there evidence to support the convergent construct validity of the ICS when applied to patients receiving hip or knee replacement?* 4. *Is there a difference in either ICS-A or ICS-B total scores based on (1) age (≥ 65 vs. < 65 years), (2) discharge unit (acute vs. short-term), and (3) gender?* 5. *To what extent is there* *an association between (1) total Schmidt scores and ICS-A and ICS-B total scores, and (2) length of stay and ICS-A and ICS-B total scores? 6. What are patients' views on individualized nursing interventions and individualized care received?*

Methods

Design

Consistent with the original methodology used by Suhonen et al. (2005), a cross-sectional design was applied to explore the psychometric properties of the ICS at point of discharge with patients undergoing total hip replacement (THR) or total knee replacement (TKR). Owing to the subscales and multi-item nature of the ICS, internal consistency and factorial validity were examined. A convergent construct validation approach was used to examine the validity of the ICS by comparing its scores to those of the Schmidt Perception of Nursing Care Survey (SPNCS), a measure to assess similar information (Schmidt, 2003, 2004).

Sample and Setting

Patients were recruited at a Canadian tertiary-care facility specializing in joint-replacement surgery. Consecutive patients undergoing primary THR or TKR from April to December 2009 were approached prior to discharge from either of two acute-care units or the short-term rehabilitation (STR) unit. Our projected sample size was 400, based on the requirements for the factor analysis of five to ten respondents per variable (Streiner, 1994). Inclusion criteria were as follows: (1) able to read and understand the questionnaire, (2) primary replacement procedure, (3) discharge home from acute-care or STR unit, and (4) able to complete the questionnaire independently. Approval was granted by the institution's research ethics board and informed written consent was provided by all participating patients.

Measures

The ICS is a 38-item self-administered questionnaire divided into two parts. Developed in Finnish, the ICS has been translated into English, Greek, and Swedish. An adapted English version reduced to 34 items, with 17 items in each part, has been used in the United Kingdom as part of an international comparative study (Suhonen et al., 2008). Part A asks about how nurses provided care, with items such as (2a) *nurses talked with me about my needs that require care and attention* (ICS-A, 19 items). Part B asks about the degree to which the patient experienced individualized care, with items such as (2b) *my needs that require care and attention have been taken into account in my care* (ICS-B, 19 items) (Suhonen et al., 2000, 2004, 2005). The instrument is intended for use in acute-care hospitals at the point when patients are being discharged home. Both the ICS-A and the ICS-B consist of three subscales: clinical situation, personal life situation, and decisional control over care. A scale from 1 *(fully disagree)* to 5 *(fully agree)* is used for patients to rate their level of agreement with each statement. Scores are then added up for all subscales and for the total score each of Part A and Part B.

Several expert analyses have established the content validity of the ICS (Suhonen et al., 2000). In terms of internal consistency, Suhonen et al. (2005) report Cronbach's alpha as 0.94 for the ICS-A and 0.93 for the ICS-B. Principal component analysis supports factorial validity by generating a three-factor solution, which accounts for 65% of the variance in the ICS-A and 61% in the ICS-B (Suhonen et al., 2005). Structural equation modelling has also provided support for the hypothesized dimensions and domains in the ICS (Suhonen et al., 2008). Evidence for the convergent validity of the tool was observed in a study examining the ICS with components of the SPNCS and the Oncology Patients' Perceptions of the Quality of Nursing Care Scale (Suhonen, Schmidt, & Radwin, 2007).

For the purposes of establishing the convergent construct validity of the ICS, the SPNCS was administered together with the ICS. The SPNCS is an empirically constructed scale based on a grounded theory study of patients' experiences of nursing care received during their hospital stay (Schmidt, 2003). The measure consists of four subscales: seeing the individual patient, explaining, responding, and watching over. Each subscale includes three to five items, a total of 15 items to be rated on a Likert scale from 1 to 5. The total scale had a Cronbach's alpha reliability of 0.96 in a 2004 study sample (Schmidt, 2004). Evidence of its validity has been demonstrated in several studies (Schmidt, 2004; Suhonen, Schmidt, et al., 2007).

Data Collection

In order to meet ethics board regulations concerning patient privacy, a physiotherapist or occupational therapist who were part of the patient's circle of care approached the patients for verbal consent to have a research assistant (RA) visit them on the day prior to discharge or the day of discharge. For those patients who agreed, the RA provided written and oral information about the nature and purpose of the study, and later, after written consent had been obtained, distributed the ICS and SPNCS questionnaires. Information on the following variables was obtained from the patients' charts: age, gender, type of surgery, length of stay, hospitalization (acute care only or acute care plus STR), and discharge destination. In terms of hospitalization, most patients in the facility are discharged from the acute-care unit after 4 to 5 days; the STR unit is used for those who require up to 7 additional days of care due to their home-support situation, their preoperative function, or the presence of co-morbidities.

It is important to mention that the RA reported that many patients expressed disappointment when they realized that their participation in the study would not consist of providing individual feedback in the form of an interview. It became apparent that many patients wanted to give additional feedback and suggestions related to nursing care and that they wished to share their personal experiences. Given that the questionnaires did not include open-ended questions, patients were encouraged to write any additional comments on the back of their questionnaires.

Data Analysis

All quantitative analyses were conducted using SPSS version 16.0 statistical software. The factorial structure of the ICS-A and ICS-B scales was explored by performing principal component analysis followed by an oblique Promax rotation. An oblique Promax rotation was applied because we believed a correlation would exist between factors. Following interpretation of the results from the factor analyses, we calculated Cronbach's alpha for each subscale. We also examined the distributions of ICS-A and ICS-B scores and, based on the findings, calculated summary statistics for the total scores. *T* tests for independent sample means were applied to test for differences between (1) persons aged ≥ 65 and those aged < 65, (2) acute-care and STR units, and (3) males and females. We applied Spearman's correlation coefficient to examine the associations between (1) total Schmidt, ICS-A, and ICS-B scores; and (2) length of stay and ICS-A and ICS-B total scores. Spearman's coefficient was chosen based on a scatterplot of the data, which suggested a curvilinear relationship between the Schmidt, ICS-A, and ICS-B scores.

Our research design did not include a qualitative component. However, many patients provided open-ended responses on the back of the questionnaires. Our team made the decision to conduct a secondary data analysis (Van Den Berg, 2005) of the handwritten notes, which were transcribed verbatim, excluding any confidential information such as name, unit designation, or date. Using standard descriptive qualitative methodology (Sandelowski, 1995), two researchers, one an expert in qualitative research methodology, independently coded the transcripts. Theory was peripheral rather than central to this work (Sandelowski, 1993) and was based on our understanding and application of some aspects of narrative theory — that is, the assumption that patients' voices can and should prevail over the theoretical voice of the researchers.

Therefore, we looked for repetitive patterns in the open-ended questions and organized these into themes.

Results

The response rate of eligible patients approached by the RA was 89.8% for completion of both questionnaires administered; 10.2% declined participation mainly for the reason of "not having the time" or "being tired when approached"; in a few cases the reason was "not being interested." Overall, 10.2% of those approached by the RA did not meet the inclusion criteria; the most common reason was "language barrier" or "not being able to read or understand the questions." The characteristics of the 412 participants are summarized in Table 1.

Table 1 *Characteristics of Sample (*N *= 412)*

Variable	**Characteristics**
Gender	Female *n* = 266 (65%)
Age: *mean (SD)*	64.8 years (11.06) (*range* = 35–89)
Surgery type	TKR *n* = 259 (63%); THR *n* = 153 (37%)
Unit of discharge	Acute care *n* = 291 (71%) STR *n* = 121
Length of stay: *mean (SD)*	Acute care: 5.1 days (*range* = 3–15) STR: 8.8 days (*range* = 5–19)

Table 2 summarizes the mean scores by item in the ICS-A and ICS-B. Missing data are also captured by item, the lowest being 0.7% and the highest 5.3%. Several ICS-B items describing patients' care experiences ranked higher than the related ICS-A items, which describe specific nursing interventions; for example in item 13a, *nurses asked me what I want to know about my condition,* 60.3% of respondents agreed or strongly agreed, versus 86.2% in item 13b, *I have received sufficient information about my condition.* Items with the highest percentage of respondents disagreeing or strongly disagreeing included mainly ICS-A items and only a few ICS-B items.

Table 3 displays the pattern matrix factor loadings for the ICS-A. The unrotated variance components were 53.5, 8.8, 6.7 for the three factors, compared to 23.6, 22.6, 23.0 for the rotated factors. With the exception of two items, the loading patterns support the three-factor structure proposed by the measure's developer. Table 3 also reports the pattern matrix

Table 2 ***Item* Means, SDs, *Missing Data, Strongly Agree/Agree With Statement***

ICS-A Abbreviated Items	***n***	***Mean (SD)***	**Missing Data %**	**Agree %**
The nurses:				
1a talked with me about feelings I have	408	3.93 (1.23)	1.2	70.8
2a talked with me about my care needs	410	4.35 (1.03)	0.7	83.7
3a gave me the chance to assume responsibility for my care	407	4.51 (0.90)	1.5	88.7
4a identified changes in how I have felt	403	3.99 (1.09)	2.4	72.0
5a talked with me about fears and anxieties	395	3.57 (1.34)	4.4	59.3
6a made an effort to find out how the condition has affected me	401	3.57 (1.28)	2.9	60.6
7a talked with me about what my condition means to me	397	3.36 (1.33)	3.9	49.8
8a asked me what kind of things I do in my everyday life	404	3.30 (1.44)	2.2	48.8
9a asked me about my previous experiences of hospitalization	405	2.93 (1.44)	1.9	36.5
10a asked me about my everyday habits	404	2.89 (1.45)	2.2	35.2
11a asked me whether I want my family to take part in my care	409	3.31 (1.53)	1.0	51.8
12a made sure I understood instructions received	406	4.25 (1.07)	1.7	82.3
13a asked me what I want to know about my condition	403	3.67 (1.30)	2.4	60.3
14a listened to my personal wishes with regard to my care	405	4.01 (1.13)	1.9	70.7
15a helped me take part in decisions concerning my care	403	3.95 (1.21)	2.4	68.3
16a helped me express my views on my care	401	3.69 (1.23)	2.9	58.4
17a asked me what time I would prefer to wash	406	3.51 (1.47)	1.7	57.9

ICS-B Abbreviated Items				
1b Feelings about condition taken into account	389	3.85 (1.17)	3.6	66.3
2b Care needs taken into account	402	4.18 (1.06)	2.7	79.6
3b I assumed responsibility for my care	406	4.58 (0.73)	1.7	94.1
4b Changes in how I felt taken into account	398	4.12 (0.98)	3.6	75.5
5b Fears and anxieties taken into account	399	3.93 (1.14)	3.4	56.4
6b Effects of condition taken into account	404	3.98 (1.10)	2.2	70.3
7b Meaning of condition taken into account	401	3.86 (1.16)	2.9	65.4
8b Activities in everyday life taken into account	402	3.58 (1.31)	2.7	52.8
9b Previous hospital experiences taken into account	391	3.58 (1.35)	5.3	44.7
10b Everyday habits taken into account	403	3.58 (1.32)	2.4	56.4
11b Family involved in care	403	4.20 (1.12)	2.4	77.4
12b I followed instructions I have received	400	4.68 (0.74)	3.1	94.5
13b I have received sufficient information about my condition	406	4.36 (1.03)	1.7	86.2
14b My hopes/wishes have been taken into account in my care	403	4.02 (1.09)	2.4	70.3
15b I have taken part in decision-making concerning my care	404	4.23 (0.99)	2.2	80.4
16b Opinions I expressed have been taken into account in my care	400	4.18 (0.99)	3.1	77.3
17b I made my own decision on when to wash	407	4.14 (1.25)	1.5	77.9

Table 3 ***Pattern Matrix Factor Loadings for the ICS***

	Component		
ICS-A	**1**	**2**	**3**
ICS10a	.877		
ICS9a	.877		
ICS8a	.740		
ICS11a	.572		
ICS17a	.563		
ICS14a		.816	
ICS15a		.807	
ICS3a	–.406	.738	
ICS16a		.638	
ICS12a		.609	
ICS13a		.489	
ICS1a			.813
ICS5a			.753
ICS4a			.716
ICS6a			.687
ICS7a	.491		.604
ICS2a		.495	.546

Subscales as conceived by developer:
Clinical Situation: ICS1a, ICS2a, ICS3a, ICS4a, ICS5a, ICS6a, ICS7a
Personal Life Situation: ICS8a, ICS9a, ICS10a, ICS11a
Decisional Control Over Care: ICS12a, ICS13a, ICS14a, ICS15a, ICS16a, ICS17a

	Component	
ICS-B	**1**	**2**
ICS8b	.972	
ICS7b	.919	
ICS9b	.912	
ICS10b	.881	
ICS6b	.811	
ICS5b	.755	
ICS1b	.638	
ICS14b	.580	
ICS4b	.562	
ICS2b	.520	
ICS12b		1.0
ICS3b		.902
ICS15b		.619
ICS16b		.557
ICS13b		.531
ICS11b		.512
ICS17b		.339

Subscales as conceived by developer:
Clinical Situation: ICS1b, ICS2b, ICS3b, ICS4b, ICS5b, ICS6b, ICS7b
Personal Life Situation: ICS8b, ICS9b, ICS10b, ICS11b
Decisional Control Over Care: ICS12b, ICS13b, ICS14b, ICS15b, ICS16b, ICS17b
Note: See Table 2 for details of specific items.

factor loadings for the ICS-B. A two-factor structure rather than the three-factor structure proposed by the measure's developer was supported. The unrotated variance components were 54.0, 9.6 for the two factors, compared to 35.6, 28.0 for the rotated factors. Examination of the initial component matrices for the ICS-A and ICS-B revealed that all items loaded > 0.54 for ICS-A and > 0.49 for ICS-B. Cronbach's alpha was 0.94 for both scales. Given the magnitude of these factor loadings and internal consistency coefficients, all ICS-A items were summed to form a single score and all ICS-B items were summed to form a second single score. The distributions of the ICS-A and ICS-B scores were not consistent with a normal distribution. Accordingly, median and percentile values are reported as measures of central tendency and dispersion in Table 4. Spearman's rank order correlations between the Schmidt total and the ICS-A and ICS-B totals were 0.76 (95% CI: 0.72, 0.80) and 0.80 (95% CI: 0.77, 0.83), respectively.

Table 4 ***Summary Statistics and Internal Consistency***

Measure	**Median (25th, 75th percentiles)**	**Cronbach's α**
ICS-A (17 items)	64 (52, 76)	0.94
ICS-B (17 items)	70 (60, 81)	0.94
Schmidt (15 items)	65 (56, 73)	0.96

The total scores of neither the ICS-A ($\bar{d} = 0.60$, $t_{346} = -0.35$, $p = 0.73$) nor the ICS-B ($\bar{d} = 1.05$, $t_{347} = 0.73$, $p = 0.47$) differed between patients aged ≥ 65 and patients aged < 65. The SPNCS scale did detect differences in these age groups ($\bar{d} = 3.04$, $t_{377} = 2.60$, $p = 0.010$). Length of stay was not associated with the ICS-A ($r = -0.06$, $p = 0.25$) or the ICS-B ($r = -.03$, $p = 0.55$). Also, discharge unit (acute-care vs. STR) was not associated with the ICS-A ($\bar{d} = 0.13$, $t_{347} = 0.07$, $p = 0.95$) or the ICS-B ($\bar{d} = 0.92$, $t_{348} = 0.57$, $p = 0.57$).

For almost all items, males' agreement with the statements of both scales was slightly higher than females'. However, there was a non-significant difference between females and males for the total score means of the ICS-A ($\bar{d} = 2.95$, $t_{347} = 1.67$, $p = 0.10$) and the ICSB ($\bar{d} = 2.58$, $t_{348} = 1.70$, $p = 0.09$).

Qualitative Feedback

The themes we identified related to positive experiences of nursing care, negative experiences of nursing care, nurses as overworked, and a sense that patients encounter many nurses during a hospital stay and therefore cannot respond to questions about "nursing care" that merge this multiplicity of experiences into one category. Finally, some patients indicated that they did not want nurses to ask about their feelings, which suggests that this item on a questionnaire should be contextualized, perhaps by asking patients if such care is desired before asking if it was provided.

For the most part, the nurses were described positively, with adjectives such as "professional," "caring," and "excellent" used frequently to describe their work. Following are some of the comments written: "everyone on staff is so pleasant to interact with," "this has been a very positive experience," "the nursing care has been excellent," "my preferences and concerns have been recognized," "my progress has been carefully monitored and assessed."

However, respondents also indicated that questions about nurses' interventions were difficult to answer, as the survey asks about nurses as a single, homogeneous group. One participant wrote: "nursing staff is not a single entity — they are individuals: on a scale of 1 to 10, I had several 10s, several 5s and at least one -1." When patients described a negative encounter they often stressed that it was not representative of the overall care they had received and that this confounded their ability to rate their nursing care overall. One patient wrote: "I found nurse x hostile, sarcastic and somewhat uninterested — I would not have mentioned it, but it was so much in contrast to what was provided by all the remaining staff."

Of those respondents who reported problems with their nursing care, most attributed this to the nurses being "overworked" and "rushed." Several people believed that poor nursing was related to lack of funding and low staff-to-patient ratios. One patient commented, "Lack of funds is the number one reason why the nursing staff are unable to be more one on one, or attentive with me as a patient." Many commented that the nurses' workload was too large, preventing them from spending more time with patients individually.

Specific instances of poor nursing care were cited. These included the following: family members being asked to leave the bedside for the night, patients being left in a wet bed due to leaking ice bags for over 2 hours, patients being left on the bedpan for over an hour, patients not being properly hooked up to the call button, and patients not having their beds properly anchored. However, in general, participants indicated that such poor nursing care was an exception. One respondent summed up her opinion this way: "I wish this questionnaire had dealt with isolated incidences; 99% of the staff was very good but I had one really bad experience."

Finally, participants commented on the overall survey design. Some felt that the focus on "feelings" was not appropriate or useful. One respondent wrote: "I was not asked all the 'touchy feely' questions noted in this survey; I felt the questions were cliché-riddled and not relevant."

Discussion

In this Canadian sample of patients hospitalized for THR and TKR, the factorial validity of the adapted English version of the 34-item ICS was not fully supported. The three subscales in ICS-A — the patient's clinical situation, personal life situation, and decisional control over care — were supported with the exception of two items: 3a *(gave me the chance to assume responsibility for my care)* and 17a *(having a choice when to wash).* The subscales in ICS-B were not supported, with the items making up personal life situation not loading as a separate factor. It is possible that these findings are related to the sample. In prior research, general orthopedic and trauma patients were studied. Also, the mean age of the sample was 8 years older in this Canadian study than in Suhonen, Valimaki, et al.'s (2009) international comparative study. Between-country differences have also been reported and may have influenced the findings (Suhonen, Berg, et al., 2009). As described by Suhonen et al., it is not known whether these differences result from differences between cultures, nursing-care practices, health-professional roles, or patient-related factors (Suhonen, Berg, et al., 2009). It should be noted, however, that the sample is considered representative of the Canadian THR and TKR population, as the gender distribution and age of the sample are reflective of current trends reported in the 2008–09 annual report of the Canadian Joint Replacement Registry (Canadian Institute for Health Information, 2009).

Due to the results of the factor analyses, reliability and other descriptive estimates were not reported for the subscales. The Cronbach's alpha estimates of 0.94 for the ICS-A and ICS-B in this sample compare favourably with estimates in the literature. Consistent with prior findings, there was also evidence of convergent construct validity in that the sum of the ICS-A and the ICS-B displayed good correlation with the sum of the SPNCS (Suhonen et al., 2005). Interestingly, neither the ICS-A nor the ICS-B discriminated between patients under and over 65, whereas the SPNCS scale did discriminate between the two age groups. In the study by Suhonen, Valimaki, Katejisto, and Leino-Kilpi (2006), age was found to be predictive of positive perceptions of individual care. The findings of that study were similar to ours in terms of length of stay and gender.

Comparing this study's item means with the item means in the Suhonen et al. (2005) study, patient perceptions in the European sample were comparable to those in the Canadian sample. For example, lower means were obtained for more personal questions related to everyday life activities and habits. The present study confirmed previous findings (Land & Suhonen, 2009; Suhonen et al., 2008) that not all nurses ask patients about their personal habits, everyday life activities, and previous experiences with hospitalization, but added the insight that not all patients desire this type of exchange. Our results do not provide a clear picture of the importance to patients of nurses getting to know them as a person. One patient commented that she had already provided information about her personal life on the preoperative questionnaire and that this would give nurses what they required in order to care for her. At this hospital, all patients provide comprehensive information about their personal life situation preoperatively and the information is accessible to all health-care providers, which might have influenced the way respondents answered this survey question. Another patient stated that nurses have many responsibilities and that the inclusion in care of more personal aspects is not needed. These statements could be consistent with the view of many patients. Interestingly, Lynn and McMillen (1999) found that when patients were asked to rank elements of nursing care, they did not value the need for nurses to *know who they are as a person.* Of 90 items, this item ranked 83rd. In the same study, nurses also ranked this item low (72nd). This large study conducted in the southeastern United States comprised 448 patients and 350 nurses from seven hospitals and a total of more than 40 medical/surgical units. In a similar study by Larrabee and Bolten (2001), in the category "caring about me" the item *getting to know you* was important to only 34% of the 199 medical/surgical patients surveyed prior to discharge. More qualitative studies should be conducted to investigate how nurses experience patients' wishes with respect to sharing more personal aspects of their lives. Studies could also further explore how important it is for nurses to "get to know" their patients. In addition, in order to conceptualize close-ended questions, patients should first be asked if questions on specific nursing interventions are desired. This means that researchers should explore what is really important to patients in specific health-care settings before asking if an intervention has been completed by staff, as it may not even be of concern to the patients.

In this Canadian sample, the patients apparently experienced greater family involvement than those in the European sample (Suhonen et al., 2008) (ICS-A, 3.31 vs. 2.67; ICS-B, 4.20 vs. 3.58). This finding cannot be generalized to other Canadian hospitals but might confirm this joint replacement centre's particular focus on family involvement. Family members at the hospital are encouraged to become "coaches" and to accompany the patient through the whole experience, from pre-admission to post-discharge.

Many patients commented that this survey was difficult to answer because it aggregated all nurses who provided care for the patient together and it was hard to think in terms of an average. It seems likely that some respondents who had one or few negative experiences amongst many positive ones chose to give a neutral response (neither *agree* nor *disagree*) whereas others selected *disagree to some extent* or *disagree.* In addition, patients expressed clearly that they wanted to comment on their individual stories and that the design of the study did not include the option of exploring their individual perceptions of interactions with specific nurses. It now seems somewhat paradoxical to use a standardized survey approach to assess patient perceptions of individuality in the care they received. It is interesting that no publications on the results of the ICS include a discussion of such conflict experienced by respondents. There are no reports that respondents in the European studies chose to provide handwritten comments to supplement their perceptions. Future qualitative studies might enhance our understanding of this phenomenon from a patient perspective.

Some patients perceived nurses as busy, overworked, and rushed, with little time to listen, talk, and provide more individualized care. The increase in patient admission rates and the significant decrease in length of hospital stay associated with Ontario's strategy to decrease THR and TKR wait lists has indeed affected this hospital's nursing units and might have influenced patient perceptions of nurses' workload. Although health-care delivery models and resources available to support care are under constant scrutiny and budgetary evaluation, little seems to be done to educate patients on current realities in health-care delivery, such as nurse-to-patient ratios. Recent work by Suhonen et al. (Suhonen, Gustafsson, Katajisto, Valimaki, & Leino-Kilpi, 2010a, 2010b; Suhonen, Valimaki, & Leino-Kilpi, 2009) describes driving and restraining forces for the provision of individualized nursing care, including staffing, organization of work, and nurses' personal characteristics. The qualitative findings of our study indicate that nurses' personal characteristics might play an important role in how patients perceive the care they receive. While all nurses at this centre have a comparable workload, apparently some are able to respond to individual patient needs better than others. Personal characteristics might include a nurse's individual values, work organization, approach, and attitude. It is not uncommon to observe nurses telling patients how busy they are, that they do not have time, and that they have to care for a number of other patients. Such remarks contribute to patients' perceptions that nurses are overworked or that the facility is understaffed. Nurse leaders should provide education and support by discussing the impact of nurses' comments on patients' perceptions.

The generally higher ratings for the ICS-B might be a result of these items being perceived as not specific to nursing care but as relating to the care provided by the interprofessional team. For example, patients might have received information about their condition from professionals in a variety of health-care disciplines, which then resulted in a higher rating for item 13 in the ICS-B compared to the ICS-A. However, it can only be speculated that the higher means are a result of patients evaluating the care experience in general and not nursing care in particular. Respondents also reported that they could not answer some of the questions as they found them to be irrelevant to their particular situation. For example, both the ICS-A and the ICS-B include an item about previous experiences with hospitalization. It is not clear if those respondents who had never been hospitalized before chose not to answer, selected the neutral response, or disagreed with the statement. Some respondents also suggested that some questions were ambiguous. However, the number of missing item responses was not high (Table 2) and in fact was lower than that reported by Suhonen et al. (2005).

Our study had several strengths, including the representativeness of the sample of the Canadian arthroplasty population and the rigour with which data were collected. Ongoing communication with the RA allowed for early identification of respondents' wish to provide additional information and hence the suggestion that they write their comments on the back of the questionnaire. These additional data deepened our understanding of the patient perspective on not only the care received but also the survey instrument. A limitation of the study was the exclusion from the questionnaire of two statements used in the recent European international ICS study: *It is important that nurses care for me as an individual* and *During hospitalization the nurses cared for me as an individual.* In that study, the majority of patients in Finland (89%), Sweden (97%), and the United Kingdom (80%) agreed strongly or to some extent that it was important for them to be cared for as an individual, whereas in Greece only 71% considered this important (Suhonen et al., 2008). The agreement was somewhat lower when patients were asked if nurses cared for them as an individual, with only 55% of the UK sample strongly agreeing (Land & Suhonen, 2009). However, our study's additional qualitative data provide insight into what seems to be important to the Canadian patient population. A strong message emerged from the many pages of handwritten notes: that it is most important that all basic care needs be met, such as toileting, and that patients not have to endure any "unpleasant" encounter with a nurse.

Implications and Future Directions

Further research is needed to determine the best methods for evaluating dimensions of patient-centred care. As expressed by one quarter of the participants, many patients might prefer to share their individual stories by commenting on the care provided by specific nurses than to complete a survey that tends to aggregate all nurses into one category. Patient experiences also need to be contextualized in order to provide a better understanding of how their evaluation of particular aspects of care aligns with their preferences, such as being asked about their personal feelings. The findings also highlight the importance of continuous evaluation of the quality of nursing care and the need for future research to examine organizational culture and the characteristics of nursing care delivery as well as unit structures and processes. The findings demonstrate the need for ongoing nursing management investigation of isolated incidences of poor nursing care, as reported by some patients. Unit leaders are responsible for obtaining ongoing individual patient feedback and following up on any concerns identified.

Finally, nurse leaders must assume responsibility for implementing strategies that improve care dimensions such as emotional support, an area that commonly does not score well. Nurses need to be adequately prepared to incorporate patient-centred approaches into their routine practice. Targeted interventions could include the use by all staff of standard open-ended questions (such as What is on your mind today?) that promote communication between patients and health-care providers. Aside from asking such specific questions, nurses must be encouraged to become more attentive and comfortable with whatever information their patients choose to share with them.

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