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1 Abbreviations

ALS	Advanced Life Support
COVID-19	Coronavirus disease 2019
ED	Emergency Department
NCD	Non-communicable diseases
PCC	Person-Centered Care
PCN-Framework	Person-Centered Nursing Framework
PCP-Framework	Person-Centered Practice Framework
WHO	World Health Organization

2 Introduction

Investing into the health system of the future and responding to the dynamics of the healthcare sector is necessary, especially during times of crisis such as the ongoing COVID-19 pandemic. These adjustments are necessary to react to the healthcare needs and provide economic sustainability. Moreover, the ongoing shift from a disease-oriented health system to a person-centered approach will increasingly become relevant in the next years (Council of the European Union, 2013b).

The most pressing issues in Austria´s health care sector can be described by the so-called “megatrends”, which cause problems especially in the highly developed countries. According to (Deml et al., 2022) five megatrends were identified, namely: Socio-demographic shifts, Broadening meaning of “health”, Empowered patients and service users, Digitalization in healthcare and Emergence of new models of care. The major challenges of a healthcare system are the aging populations, the rise of chronic illness in our populations and increasing public expectations (Mohrman & Shani, 2012). To address those problems, new models of care should be implemented. Additionally, the way the population is thinking must also be changed, because most people expect active engagement. According to the Council of the European Union, those models should be concentrating on making health systems more patient-focused and less provider-centered (Council of the European Union, 2013a). The proposed changes should focus on the process of care which has been explained by care models, which will be explained in chapter 3.2.3.PCP-Framework. To implement this approach, policy makers need to take fundamental measures (Genteis et al., 2003).

One of these models is for instance the person-centered nursing framework by McCormack and McCance. It is a middle range theory, which could be used as a basis for the implementation of the process in the practice. After more than twenty years of development and research, the framework consists of four constructs, which were adopted by undertaking small changes (McCormack et al., 2021). To implement this change, research is fundamental for the future. So far, the model has been applied to the acute and long-term setting. It could be concluded that the other healthcare sectors could benefit from the use of this model, as patient autonomy is a key aspect of McCormack’s and McCance’s model and essential for a good nurse-patient relationship (McConnell, 2018).

By implementing this concept, the highlight is to include the whole life of patients into the care (McCormack, 2004). Cultures having this person-centered approach and working within these fundamental principles experience a higher level of satisfaction. This could be traced to the components of power sharing between all stakeholders. Both, patients, and health care professionals, use the perspective of person or personhood and create a positive environment by promoting well-being. Measuring these outcomes is linked with satisfaction levels of patient and nurses (Edvardsson et al., 2009). Person-centered care can be described as holistic and humanistic approach and is synonymously used to good quality of care (McCormack, 2004). But it is not only about the improving of the patient experience, it also includes being cared with kindness, compassion and respect (Goodrich & Cornwell J., 2008).

Despite, this current development towards a person-centered approach, recent activities have shown failings within the healthcare systems, which influence the quality of care (Berwick, 2013). The following reports have shown a culture that focuses more on the system rather than on the patient and highlight inadequate communication. Notably, many reports of inadequate care delivery are specifically from emergency departments (ED). This setting is often confronted with overcrowding, medical errors, lengthy waiting times, unsatisfactory pain treatment and general staff and patient dissatisfaction (Lindner & Woitok, 2021).

The aim of this master thesis is to explore the effects of the patient-centered approach in the emergency department setting. Additionally, it aims to support nurses in reflecting their own care activities and what does person-centered care means for them during their daily working routine. Therefore, this study is conducted to look specifically at the processes of a person-centered culture in the setting of an emergency department. The research project is also aiming at investigating the patient´s perspectives and experiences in this special environment. Overall, the findings should provide a basis for implementing the person-centered care framework in the emergency department. By looking at the processes, it should provide a first step by going in this future development of a person-centered approaches.

3 Background

The original concept of person-centered care is based on the “Notes of Nursing” published by Florence Nightingale in 1860. Two of her main principles were caring for patients with empathy and strengthening of their independence (Nightingale, 1992). Care for the whole person was first defined in the context of psychiatry, such as in the theory “on becoming a person” of Rogers´ in the late 1950´s and 60´s (Rogers, 1995). Psychoanalyst Michael Balint was the first doctor, who questioned the traditional illness-oriented model and tried to include the physical and psychosocial parts of the practitioner´s role (Balint, 1969). Engle (1977) also discussed the idea of caring for the whole person and integrating the social, psychological, and behavioral dimension into a model. Based on this “biopsychosocial model”, Engel (1977) pointed out that every individual reacts differently and also depends on environmental factors (Engel, 1977).

Nowadays, the World Health Organization (WHO) strengthens this approach by focusing on patient’s needs and trying to guarantee that everyone has equal access to high-quality health care services. The WHO is advocating the use of this approach to strengthen this development of people-centered principles. It must be mentioned that the integration of these concepts in health services can be described as main goal in the following years. These fundamentals are an important tool to be prepared and respond better to health emergency crises, which will arise in the future. The strategies are for instance to empower and engage people more in their own health services and decisions (World Health Organization, 2015a).

> *“The overall vision for people-centered health care is one in which individuals, families and communities are served by and can participate in trusted health systems that respond to their needs in humane and holistic ways. […] People-centered health care is rooted in universally held values and principles which are enshrined in international law, such as human rights and dignity, non-discrimination, participation and empowerment, access and equity, and a partnership of equals (WHO Western Pacific, 2007, p. 7).”*

This paradigm shift started already at the beginning of the 21st century and included a cultural change. Before, a systematic model was used under which basically doctors, and care providers worked together to treat illnesses and injuries with very little input

from patients or their families. But this changed in the last couple of years and health care professionals started to actively listen to the patient´s and family´s needs. This trend can be linked to the fact that patients are their own experts and know their demand and what is best for them. So, the new approach was all about patient- and family-centered care and to get them more involved in decisions. This was a shift from a clinic-led to a patient-led system, which started in the first decade of the 21st century (Abdulrahman Mohammed Al et al., 2018; Håkansson Eklund et al., 2019).

Patient-centered care can be achieved by "*treating the patient as an unique individual"* (Redman, 2004). By following these standards, patients are treated with respect and as individuals. Furthermore, it helps the patients to articulate their needs. The main objective of the approach is to understand the patient's will and their perspective. Thus, health care professionals should respect these decisions at any time and show empathy during the treatment (Lutz & Bowers, 2000).

However, this shift was only from one extreme to another, but how could the in-between look like? The beginning was an inclusion of all stakeholders, and the approach was a people-centered one. To illustrate this safer and more inclusive care approach, it includes the lived experience of the patients with the health care expertise. In this cycle of care, everyone is as important as anyone else throughout the care pathway, with no existing hierarchy. By involving everyone to the same degree, the patients should not be reduced by their diseases or illnesses. As treatment with individual people, their needs and preferences should be considered along their care process. Additionally, every individuum of care should receive an individual voice and have an individual part in the health setting (Håkansson Eklund et al., 2019; Tyreman, 2018).

Especially, nurses are the biggest group amongst healthcare professionals and spend most of their time with the patients in the hospital setting. Therefore, they are in a prime position and should be involved while defining the concept of person-centered care (Molina-Mula et al., 2017). However, definitions exist to express people's needs in an hospital setting (Nolan et al., 2002). The most important ones are strategies such as communication, partnership, and health promotion (Robinson et al., 2008). Hakansson et al. (2019) analyzed that the main goal of person-centeredness is maintaining a high-quality of life for the person(Håkansson Eklund et al., 2019).

3.1 Theoretical Part

In the theoretical part, besides some explanations of important terms, the implementation of the possible effects and evaluation of the centering on people will be described. This is followed by a definition of an emergency department, the current trends of care and the person-centered approaches in this setting. The following definitions are explained in more detail, as they are intended to provide a basis. Furthermore, they should help to provide a theoretical understanding to answer the research question in the best possible way. At the end of the theory section, the research objectives and questions are presented.

3.2 Person-Centeredness

The aim of this chapter is to identify the concept of person-centeredness, personhood, and the concept of caring to add clarity to discussions about these terms. The aims of a philosophical analysis of the person represents our humanness and the factors which can be linked as most challenging in our lives. Also, most concepts of persons are based on physical and psychological characteristics. Narrowing down such perspectives of person could potentially lead to not being treated on an individual level and be reduced to an object. According to philosophers, humans are different from other species, because they can engage in reflective evaluations. This kind of reflection makes human beings unique as they are capable of change and choosing the kind of life they want. But the aspect of moral responsibility identifies the person as human being which can be described as individual personhood (McCormack, 2004).

> "*The evidence would suggest that as nurses we need to recognize what the patient considers as caring and use this to influence changes in practice, where the prime goal is to promote person-centeredness* (McCance et al., 2009, p. 416)."

Additionally, the concepts of person and personhood are central to both, caring and person-centeredness. Additionally, this idea of a reflective person as mentioned before can be related to the aspects of caring. Also, the nursing theory as caring of Boyking and Schoenhofer (1993) can be associated to the concept of personhood. These concepts demonstrate the life of how people want to live (McCance et al., 2009, p. 416) and establish the individual behavioral attitudes. As well as the literature of person-

centered care imitates the impression of focusing on the aspects of person linked to caring interactions. Especially, through the relationship of patients and nurses, the actual person must be considered during this interaction process. Therefore, the importance focuses of getting to know the patient as a person, which can be characterized in the concept of caring. McCance et al. (2009) highlighted in their research article the synergy between this different aspect and that this understanding is relevant for the professional nursing practice (McCance et al., 2009).

The author of the literature review announced the clarity for both terms' "personhood" and "person-centeredness" must be focused to implement a person-centered approach. McCormack argued that there are four main domains within this context: being in relation, being in a social world, being in place and being with self. The translation of person-centered care into practice can often be identified as main challenge. Applying the term "personhood" and "person-centeredness" in the practical environment is difficult, because of the understanding. Both terms are nearly describing the same thing but are still different in some components. Therefore, it is essential to describe the basic level of this concepts to discuss the core elements in nursing practice (Tanya McCance et al., 2011).

3.2.1 Terminology of Person-Centeredness

"Person-centeredness" has become increasingly popular and familiar within the health and social care sector over the last decades (Paparella, 2016). This development brings changes for providers and recipients of care, because patients want more active involvement and make own decisions for their health (Gardiner, 2008). The movement reflects a way from the narrow biomedical view to putting the patient at the center of care delivery (Hughes et al., 2008, 2008). However, the content and meaning of person-centered demands can be described within the context of staff members, the care environment and the activities within the care processes themselves (Edvardsson et al., 2009).

Hughes et. al. (2008) described those different types of centeredness exist in various contexts. These differences are characteristic by the practical usage of each typus. The movement reflects in health and social care for generating a broader view. The involvement of social, psychological, cultural and ethical aspects are fundamental for the human being (Hughes et al., 2008).

But no standardized definition could be found when searching through the literature. It is also very complex and there is confusion due what person-centeredness imply and the consensus about its meaning (Docteur & Coulter, 2012; Morgan & Yoder, 2012). According to Govindarajan et al. (2010) all definitions include two fundamental principles: patient involvement and individualized care. As a result, this issue of no standardized definition could take the risk of misunderstanding of what person-centered care means in a practical usage in an acute setting (Clissett et al., 2013; Higgs & Gilleard, 2016).

3.2.2 Personhood

The discussion about who and what makes a person is decades old. The moral philosopher Immanuel Kant (1724-1804) found that everyone who exists has equal worth and value and has the right for equal respect. Based on the categorial imperative by Kant every human has basic moral duties for themselves and others (Johnson & Cureton, 2004). Personhood is a broad concept which has no definition. The historical stretching goes back into early civilization, but the approach is quite different (Young, 2019). There are culturally and religious variations within defining a person depending on their socio-economic background. But the consensus is that social beings are positioned in social, political, and cultural interactions (Craemer, 1983). According to Young the unanimity about personhood is described in various models as relational, developmental, and fundamental human rights (Young, 2017).

> *Personhood is "a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being* (Kitwood, 1997, p.8)."

Medically, the focus is often on the physical symptoms of the patient and how to treat this specific signs rather than focusing on the whole person. This reduction of medical problems can be described as reductionist model. The approaches of treating the entire individual provides a holistically view and integrates multiple dimension (Thomas et al., 2018). However, personhood is an experience which depends on attributor as much as on the receiver. Additionally, there may be salutatory effects in treating every patient as social equal (Blain-Moraes et al., 2018).

Personhood is a central concept of nursing because the focus in this discipline is about the engagement with persons. In the concept analysis of nursing literature, the

following related terms between personhood and person-centered-care were found dignity, individuality, and autonomy. It must be considered that in clinical situations, both nurses and patients recognize the significant role which could be linked to the relational approaches of personhood. As a consequence of enhancing one´s personhood, the patient empowerment can be actively considered. This contribution of identifying should be examined especially during critical moments in life such as adult disability, end of life or sudden onset of illness (Sofronas et al., 2018).

3.2.3 Concept of Caring

Historically, the concept of caring can be explained by the word care for others and a way of connecting. Especially in the context of nursing, it can be identified as a form of assistance, support, and alleviation for improving quality of life or whenever illness encounter. In the professional context of nurses, the basic principles of nursing can be characterized by the availability, reliability, emotional and physical support of patients (Drahošová & Jarošová, 2016). Sebrant and Jong (2020) discovered four main themes in their analysis: “To be”, “To want”, “To be able to” and “To do”, which can be found in the practical field under the aspect of caring. The focus should be on how the nurse perceives the meaning of caring, including being a person who practices caring by reflecting and developing. Healthcare institutions should provide a working environment where healthcare professionals can express all dimensions of caring (Sebrant & Jong, 2021).

Furthermore, the concept of caring and the theoretical perspectives can be combined with the fundamental principles within the nursing setting. The description of caring represents the humanistic nature of nursing. The term of nursing is also well-defined as a several caring activities that premise a range of skills. Overall, both nursing and caring have values and attitudes on one hand and activities on the other. Nursing also includes skills like problem solving and the provision of physical care, but the main importance is the helping relationship. Interactions between the patient and the nurse highlight the importance of crucial human elements. This combination of human science can lead back to the nursing philosophy which could be based on the human care aspects. (T. V. McCance et al., 1999) concluded in their review that caring can be recognized as central concept within the discipline of nursing. In this review, the conclusion was that the caring theories and applications in practice are fundamental if caring is considered as integral part of the nurse´s role.

3.3 Person-centered Care

As discussed earlier, the traditional healthcare model focus on the diseases and don´t acknowledge the person own abilities to be an expert in their own life based on individual experiences (Phelan et al., 2020). This is a globally trend which is continuously changing and being challenged. The main problem is the growing number of patients with complex and chronic diseases. This changes proposed different models of care, because the paternalist and biomedical model of healthcare dominated in the 20th century is no longer appropriate (Butler et al., 2016; Risberg et al., 2006). Nowadays, the healthcare policy endorse person-centered care, which focuses on the person as a patient (McCormack, 2003). The World Health Organization states that person-centered care responds to a person´s individual need including preventive and curative needs, rather than reducing on the disease (World Health Organization, 2007).

According to Ekman et al. (2015), person-centered care approaches identify the patient as a person with all their resources even with their illness. The basis are listening to the patient story and the interaction between patient and the healthcare professionals (Ekman et al., 2015). However, research has shown that person-centered care can be linked to shorter hospital stays, lower readmission rates, higher quality of care and satisfaction (Ekman et al., 2015; Tanya McCance et al., 2013). These advantages are providing an increased interest in adopting and implementing person-centered care. Nevertheless, it is regarded as an unclear concept, because of limited knowledge and understanding among healthcare professionals (Lodge et al., 2017; Moore et al., 2017). Awareness about this concept lead to a greater need to implement PCC (Lydahl, 2017). An integrative literature review described that no unique definition of person-centered care exists. Bynre et al. (2020) emphasized three fundamentals how person-centered care is understood and practices as people, practice and power (Byrne et al., 2020).

> "*Person-centered Care is an approach to practice established through the formation and fostering of therapeutic relationships between all care providers […] patients and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development (McCormack et al., 2010).*"

Rosengren et al. (2021) described in their literature review how the concept of person-centered care has been adopted in Europe in relation to the healthcare systems like Beveridge, Bismarck and out of pocket. To adopt this concept, a systematic approach at all levels of healthcare is necessary (Rosengren et al., 2021).

3.3.1 Frameworks

Over the last years, major conceptual and theoretical developments have been made to provide a PCC concept. A framework should explain how the PCC concept is intended to work by outlining the elements of principles of person-centered care and the acquisition needed to achieve the impacts. A very clear framework is important to guide monitoring and evaluation. A conceptual framework is a set of specific ideas that can be used within a larger theoretical framework. There are quite a few PCC-Frameworks for nursing approaches like the Senses, the Burford Model and McCormack and McCance´s Framework. These frameworks mention attributes such as methods of interactions, coordination of services and care, the care environment, and the outcome measures. The insights from these examples provide the connection from individual practice and healthcare services (Brooker & Latham, 2015; Johns, 1994; McCormack & McCance, 2006; Nolan et al., 2006).

Nurses are the healthcare professionals who spend most of the time with people (Molina-Mula et al., 2017). Moreover, nurses must see their patient as unique and create a meaningful relationship. Therefore, it is important to establish a balance of power between the provider and recipient of care (Byrne et al., 2020). Firstly, the health care providers must identify the patient's strength and empower them to self-managing and generate autonomy. As a result, the person becomes the chief of their own care journey (Ross et al., 2015). The literature review by Byrne et al. (2020) announced that a PCC concept is a method how nurses deliver care.

McCormack and McCance (2006) developed a framework that healthcare professionals can use for understanding person-centeredness and to implement this approach. An iterative process was used to develop this framework, meaning similar actions are repeated multiple times to achieve a goal. The combination of two existing models by systematic steps were obtained to develop the final PCP-framework. On the one hand, McCance´s Framework was used, which focuses on the experiences of patients and caregivers regarding caring in nursing. On the other hand, McCormack´s Framework concentrates on person-centered practice especially for the older population. Over the years, the framework has been used in a variety of settings, continually tested, and revised to integrate the latest results from the observed literature. The result is a model that consists of the following 5 constructs: the macro context, prerequisites, the care environment, person-centered processes, and person-centered outcomes. Experimental studies have validated the hypothesis about the connection between the different constructs that contextual resources need to be considered first, followed by person-centered conditions, next step by the care environment, and then the focus can be on person-centered processes for achieving person-centered outcomes

Internationally, the theoretical framework of “person-centered care” (PCC) was identified as providing guidelines for implementing person-centered practice (Slater et al., 2017). Over the past decade, the original PCC has evolved into the Person-Cantered-Practiced (PCP) Framework of McCormack and McCance. The focus was shifted on the relationship between patients and health care professionals. In addition, the fundamentals of providing such a relationship are respect of the persons´ needs, individual rights, mutual respect and understanding (McCormack et al., 2021).

3.3.2 PCP-Framework

According to the PCP-Framework four main domains should be consolidated: (1) prerequisites that focus on healthcare provider’s attributes; (2) the practice environment that focuses on care delivery context; (3) care processes that focus on care delivery activities; and (4) person-centered outcomes that focus effective person-centered practice results. Finally, there is a broader macro context which can be described as fifth domain, reflecting the strategic and political background that affects the development of person-centered culture (McCormack et al., 2021).

I. The “**prerequisites**” concentrate of staff and healthcare workers who can deliver an effective person-centered care. The required attitudes are “being professionally competent”, “development interpersonal skills”, “commitment to the job”, “clarity of beliefs and values” and “knowing self”. These should all be considered equally for managing the constantly changing context.

Professionally competent	The knowledge, skills, and attitudes of the person to negotiate care options, and effectively provide holistic care.
Developed interpersonal skills	The ability of the person to communicate at a variety of levels with others, using effective verbal and non-verbal interactions that show personal concern for their situation and a commitment to finding mutual solutions.
Knowing self	The way a person makes sense of his/her knowing, being and becoming through reflection, self-awareness, and engagement with others.
Clarity of belief and values	Awareness of the impact of beliefs and values on the healthcare experience and the commitment to reconciling beliefs and values in ways that facilitate person-centeredness.
Commitment to the job	Demonstrated commitment of persons though intentional engagement that focuses on achieving the best possible outcomes.

II. “**The practice environment**” presents the difficulties within the context in which healthcare is faced. The importance is to identify the key elements of the context and contain the people, processes and structure that influence the effectiveness of person-centered care. Therefore, seven characteristics are defined “appropriate skill mix”, “systems that facilitate shared decision making”, “the sharing of power”, “effective staff relationship”, “organizational systems that are supportive”, “potential for innovation and risk taking” and “physical environment”.

Appropriate skill mix	The number and range of staff with the requisite knowledge and skills needed to provide a quality service relevant to the context.
Shared decision-making systems	Organizational commitment to collaborative, inclusive and participative ways of engaging within and between teams.
Effective Staff relationships	Interpersonal connections that are productive in the achievement of holistic person-centered care.
Power sharing	Non-dominant, non-hierarchical relationships that do not exploit people, but instead are concerned with achieving the best mutually agreed outcomes through agreed values, goals, wishes and desires.
Physical environment	Healthcare environment that balance aesthetics with function by paying attention to design, dignity, privacy, sanctuary, choice/ control, safety, and universal access with the intention of improving patient, family and staff operational performance and outcomes.

Supportive organizational systems	Organizational systems that promote initiative, creativity, freedom, and safety of persons, underpinned by a governance framework that emphasizes culture, relationships, values, communication, professional autonomy, and accountability.
Potential for innovation and risk taking	The exercising of professional accountability in decision making that reflects a balance between the available evidence, professional judgment, local information, and patient/ family references.

III. The "**person-centered processes**" focus on providing care by applying multiple activities which are necessary for health care professionals to practice with a person-centered approach. These fundamental processes are defined in the following and are also described in detail:

Working with the person's beliefs and values	Having a clear picture of the person´s values about his/ her life and how he/she makes sense of what is happening from their individual perspective, psychosocial context, and social role
Sharing decision making	Engaging persons in decisions and making by considering values, experiences, concerns, and future aspirations.
Engaging authentically	The connectedness between people, determined by knowledge of the person, clarity of beliefs and values, knowledge of self and professional expertise.
Being sympathetically present"	An engagement that recognizes the uniqueness and value of the person, by appropriately responding to cues that maximize coping resources through recognition of important agendas in their life

Working holistically	Ways of connecting that pay attention to the whole person through the integration of physiological, psychological, sociocultural, development and spiritual dimensions of persons

- "**Working with the person's beliefs and values**" is necessary to learn about the patient´s values and making sense of what is happening from an individual perspective. The patient's unique value system should provide a basic guidance on how to interact with the patient due to their psychosocial context and social role.

- "**Engaging authentically**" means working with engagement which reflects how the relationship is between a health care provider and the person. Each interaction should be provided on an individual basis. This relies on the nurse´s skills to react to the care environment and benefit the patients.

- "**Sharing decision making**" focuses on the use the patient's beliefs and values to optimize the communication. Therefore, patients are facilitated with the principles of person-centeredness. Everyone should have the right to make decision about their treatment, care options and health. This ensures an interdependent and interconnected relationship between the caregiver and the care recipient.

- "**Being sympathetically present**" describes a way of being present with the patient and comprehending the other´s individual experiences and their needs. The following aspects are fundamental for a person-centered outcome in which the need to establish a therapeutic relationship is necessary. Therefore, health care professionals should deliver a sympatric appearance to understand the patient´s losses and their present limitations. To accept the person with every characteristic, it is essential to talk and spend time with the patient.

- "**Working holistically**" means integrating the whole person and their live into the treatment with the external environment. To achieve this aspect, it is fundamental to provide the process of care as a routine. Challenging is to pay

attention to the whole person with an overall therapeutic benefit (McCormack et al., 2021).

IV. The "**person-centered outcomes**" are important for creating a healthful culture and making the person-centered care effective. The development of a workplace that guarantees human flourishing while working under conditions that aims to creating a good outcome for the care givers and care receiver.

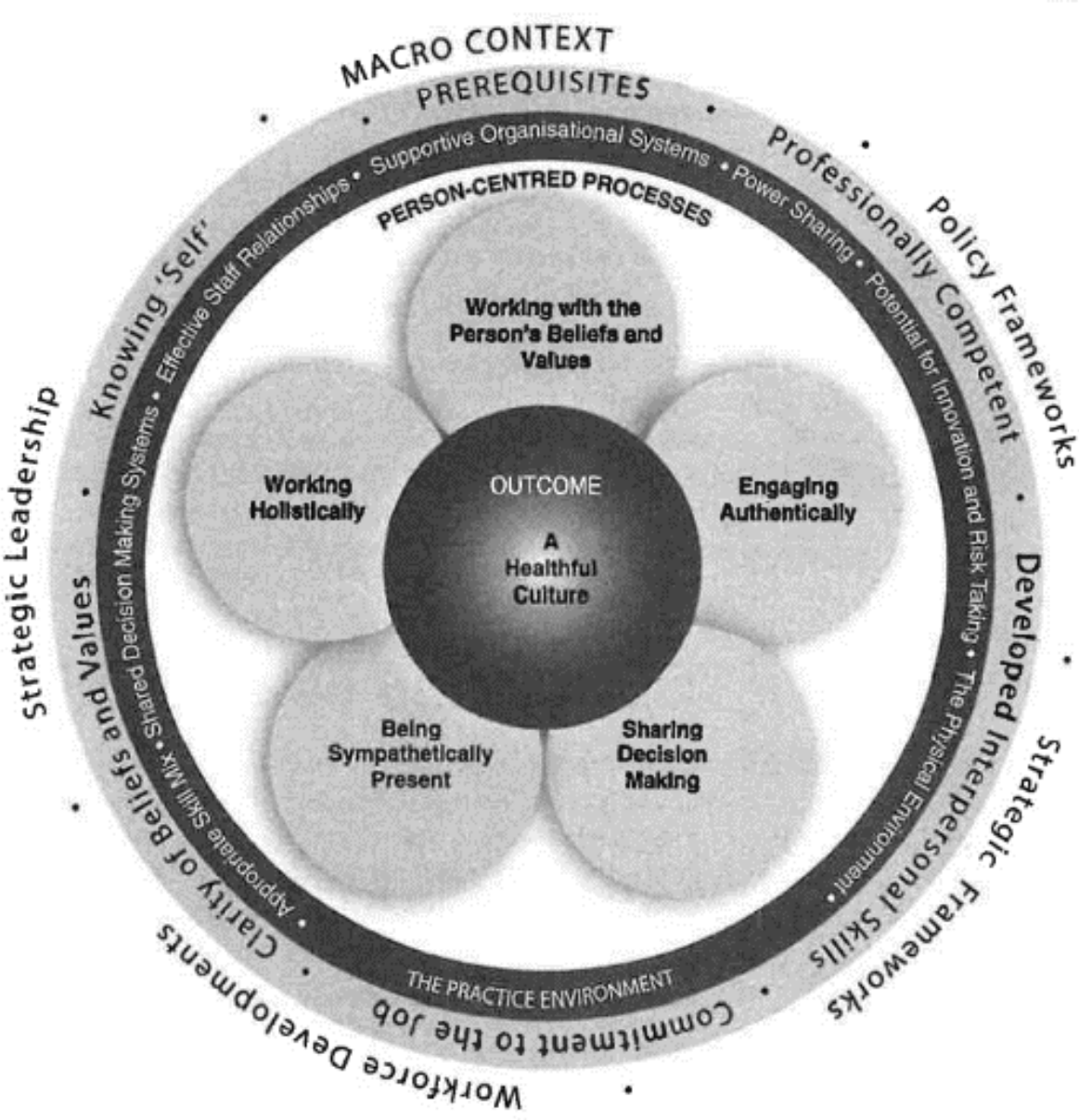


Figure 1: Person-centered Practice Framework (McCormack & McCance, 2021)

3.3.3 Implications of PCC for practice.

Worldwide, a person-centered approach is relevant because patients feel more confident and become independent by making their own health decisions. Originally, this concept was only limited to the discipline of nursing science and is now getting expanded to many other classifications. Different healthcare settings are included, which considers both practical and educational aspects. Primarily, the people-centered approaches are performed in the United Kingdom, the United States, Canada, Scandinavia and Australia (McCormack & McCance, 2021). The evaluation took place in different contexts, with a specific focus on older people in long-term care setting, because older people are considered as a vulnerable population (Edvardsson et al., 2009; Martínez et al., 2021). Overall, the positive aspects of this concept can be summarized as a positive impact on the general health condition, a reduction of physical complaints and a decrease of challenging behavior rates (Edvardsson et al., 2009; Martínez et al., 2021). Hudon et al. (2011) noted that health costs could be reduced by implementing a person-centered approach, because the satisfaction level and emotional status of caregivers and receiver will improve. Moreover, it is important to mention that patients are getting empowered in the care process, which downsizes symptoms such as distress. The health policy should be steered towards person-centered approaches (Hudon et al., 2011). The engagement and compliance from the patient's perspective will be increased by introducing this approach. In addition, an improvement of the patient´s health and quality of life standards will also be achieved (DeSilva et al., 2014).

Further, Han et al. (2016) identified person-centered care as one of the strongest factors that have an impact on patient satisfaction and care experience. According to this qualitative study, there are multiple effects which can be achieved through a person-centered culture. These include a better and faster diagnosis process, earlier intervention options as well as an improved and more effective medication management (Han & Radel, 2016). The above-described positive aspects are not only limited to patients, but also include health care professionals and family members. For example, family members of patients are more satisfied after experiencing person-centered care (McCormack et al., 2010). Additionally, health care professionals also experienced a higher level of work engagement and satisfaction. Employees who have not worked within this culture are at a higher risk for dropping out of their job,

experience of work-related stress and psychological burnout (DeSilva et al., 2014; Sjögren et al., 2013). The work environment in a health care setting can be improved by letting the employees engage in decisions. This goal of letting health care professionals take part in assessments can be achieved by increasing the overall awareness towards a human-centered approach (Tyreman, 2018).

The development of the human-centered nursing framework has now spanned nearly a decade, and during that time it has been used in a variety of ways and contexts. The framework is supported by empirical research, developed through a large-scale study, and further tested and refined through an ongoing program of applied research. As stated earlier, the PCP-Framework from McCormack and McCance is a mid-range theory and is developed for practical usage (McCormack & McCance, 2021). The theory holds that health care employee attributes are a prerequisite for managing the care environment and to provide effective care through person-centered care processes. This leads to the achievement of person-centered outcomes for patients and staff in a hospital setting (Slater et al., 2017).

Firstly, the PCP framework was developed for people with dementia and integrated into long-term care facilities (Clissett et al., 2013). This implementation process has been tested through several studies and evidence has indicated first successes. However, some research papers point towards the importance of implementing the PCP framework in acute settings. Yet, there are some challenges when it comes to reaching this target (Clissett et al., 2013; Santana et al., 2018). The ED is one specific context in acute hospitals where only a few aspects of person-centered care are known by now (McConnell, 2018).

3.4 Setting Emergency Department (ED)

For this thesis, the setting of an emergency department and its function need to be defined and established. People entering an ED usually have their first contact with healthcare services (Person et al., 2013). In the past, the definition of ED was unclear and different terminologies existed such as “Casualty” or “Accident and Emergency”. However, the most used term today is “Emergency Department”, which describes a department in the hospital where services for primary health care needs are offered. Following this definition, an ED is thus not limited to emergencies or serious accidents (Breen & McCann, 2013). According to the WHO, an ED is surrounded by a healthcare

institution to deliver efficient emergency care to members of the population who develop a suddenly occurring illness or are involved in a trauma. Within a health system, it is an essential part and everyone should get access to this kind of services for preventing morbidity and mortality (World Health Organization, 2019). EDs provide services 24-hours 7 days a week with full life saving facilities that include ambulance services, general practitioners, and self-referrers (Person et al., 2013). The usage of a triage classification system helps to treat the incoming patients according to their priority needs (Breen & McCann, 2013).

In the Austrian health context, every general hospital must operate an ED. Doctors with various specializations are working together to treat the patient according to the principle of best care (BMSGPK, 2020). EDs in Austria have a small ward nearby for patients who just need to stay for one night or are waiting for transferring. Beside general EDs, there are also different variations with specializations such as trauma centers. To avoid overcrowded EDs in Austria, primary care outpatient clinics and primary care units have been established over the last 20 years. These projects have improved the access to primary health care need for the Austrian population and are also being adapted to changing requirements (BMSGPK, 2022).

3.4.1 Current Trends of care in ED

Nowadays, several factors have contributed to an increased demand of ED services in high-income countries. A minimization of hospital capacities and a discontinuation of individual services due to personal shortages can be observed on an international level (Melon et al., 2013). Additionally, the need for modernization and state-of-the-art technologies in acute health care services will increase. As a result, a reduction in the number of general hospitals and the replacement of some smaller units in urban areas could be seen as a major future issue. Related factors that have been observed include overcrowding, an ageing population, increasing multimorbidity and chronical diseases (Rocovich & Patel, 2012). The widening cultural diversity and higher levels of alcohol misuse and abuse which arise in big cities must be considered as well because these factors contribute to an increased complexity of interventions. Moreover, patients who do not require emergency care have to be guided to the right institutions. Kennedy (2017) sees issues such as the winter bed crisis and delayed discharges as additional daily challenges in the working environment of an ED.

According to the worldwide demographic trend, people will get older due to changes in lifestyle, health, and medical advances. In industrialized countries, declining fertility rates and increasing longevity will soon present a challenge (Anderson & Hussey, 2000). As a result, the healthcare system must adapt and deal with the consequences. Especially in the setting of an ED, geriatric patients have specific needs and want more medical attention (Wilber et al., 2006). The ED could be seen as a unique environment in the hospital setting with highly specialized care requirements. The overall priority and goal of an ED is quick patient evaluation and turnover. In the triage system, decisions and diagnoses must also be made quickly by health care professionals because of time pressure (Person et al., 2013). The literature synthesis by Handel et al. (2010) found out that the challenges of an ED are overcrowding, poorer quality in the outcome and reduced profit (Handel et al., 2010). The issues described above have an impact on the working conditions for the staff. The pressure to perform and maintain work life balance influences how employees in an ED work (Person et al., 2013).

Nurses who have been interviewed as part of the study by O´Mahony (2011) would describe the ED environment as intense and stressful. This is caused by the high level of emotional exhaustion and frustration. Yet, despite the disadvantages, most of the nurses found positive aspects of working within a team in ED setting (O'Mahony, 2011). However, current findings from the literature identified that ED staff must have to handle external pressure such as waiting times and shift work (Crilly et al., 2014; Short et al., 2015). Despite this, the staff in an ED was aware of the problematic issues in their workplace which created a concomitant risk for patients (Johnston et al., 2016). (Person et al., 2013) suggest that the processes and environment should be improved to provide a safe and efficient patient care.

3.4.2 PCC in the ED

McConnell et al. (2016) explored the concept of person-centeredness in the context of an ED in a literature review. According to the analysis, no papers were identified that discuss the themes of person-centeredness in the context of an ED (McConnell et al., 2016). Combining the aspects of the framework defined by McCormack and McCance (2021), the themes could be matched with the following aspects (McCormack & McCance, 2021).

Prerequisites as described in the PCP-Framework focus on the attributes of staff members and include being professionally competent; having developed interpersonal skills; commitment to the job; being able to demonstrate clarity of beliefs and values; and knowing oneself (McCormack & McCance, 2021). McConnell et al. (2016) identified the focus of medical-technical interventions in the ED. However, this evidence suggests that ED staff need to reevaluate the concept's value and the fundamental of care (McConnell et al., 2016).

The care environment as described by McCormack and McCance (2021) focuses on the context in which care is delivered and includes: appropriate skill mix; systems that facilitate shared decision making; effective staff relationships; supportive organizational systems; power sharing; and the potential for innovation and risk taking (McCormack & McCance, 2021). Factors such as responsibilities and pressures on the ED staff occurred in most literatures. Therefore, especially the inadequacies in the care environment must be addressed (McConnell et al., 2016).

A literature review found that the ED care environment influences staff engagement through person-centered processes. Person-centered processes as described by McCormack and McCance (2021) focus on delivering care through a range of activities and include working with patient's beliefs and values; engagement; having sympathetic presence; sharing decision making; and providing for physical needs (McCormack & McCance, 2021). To exemplify, the focus of ED staff lies on tasks and intervention which means that they were not able to fully engage with the patients. To achieve person-centeredness, there must be a shift towards attitudes and behaviors which focus on this approach (McConnell et al., 2016).

4 Problem Statement

In the field of health care, patients should get empowered and take responsibility for their own health. Non-communicable diseases (NCDs), also known as chronic diseases, are long-lasting and the outcome of a combination of genetic, functional, environmental, and social issues. Especially for NCD, 41 million people die worldwide every year, because they are the leading deaths. Additionally, about every third adult suffers from multiple combinations of these diseases. People living with NCDs´ must make great effort to access all the care they need (World Health Organization, 2022). These patients find themselves disempowered, disengaged and unable to manage their own health needs. This could also be linked to current approaches in care, which focus on curative and hospital-based services. To help nurses shift the focus away from curative and toward the patient, Integrated Care is helpful. Therefore, attention should be put to health promotion, prevention, and integrated care (Godwin et al., 2021). This future development is increasingly shaped by an ageing population and the globalization of unhealthy lifestyles. Integrated Care can be identified as a valuable approach to transform healthcare systems and to deliver patient-oriented care. Four main aims could be identified in this context:

I. Improving overall population health, which manages to prevent costly chronical diseases and multi-morbidities.

II. Enhancing the patient experience, which includes empowering and engaging patients to play an active role in their care.

III. Reducing the costs of care.

IV. Improving the well-being of healthcare professionals, which could be related to positive experiences (Bodenheimer & Sinsky, 2014).

"*The patient´s perspective is at the heart of any discussion about integrated care. Achieving integrated care requires those involved with planning and providing services to impose the patient´s perspectives as the organizing principle of service delivery* (Lloyd & Wait, 2005, p. 7)."

The transformation of the health care system is necessary because the goal is to achieve person centeredness (Wolfe, 2001). The person-centered and integrated-care concept are often used to describe a holistic view of the person in need of care, respecting subjective experiences, values, needs and preferences (Brooker & Latham, 2015; Edvardsson et al., 2008; McCormack & McCance, 2006). Particularly in hospitals, the importance of involving the public in direct health interventions has increased over the past decade (Groene et al., 2009; Ree et al., 2019). In 2016, the WHO announced a global strategy for human resources of health promoting strategies to adopt the relevance of individuals in the healthcare system that are organized based on the needs of people (WHO, 2015, 2016). This international approach could represent a paradigm shift in the healthcare setting. The patients should become more powerful and actively participate during their treatment which also leads to shared-decision-making (Fridberg et al., 2021; WHO, 2016; World Health Organization, 2015b).

Person-centeredness could be identified as a key concept of this paradigm shift and means delivering high quality care to patients following ethical principles (Nolte et al., 2020; Ree et al., 2019). According to this concept, a patient should be treated as a person with individual needs and experiences (Britten et al., 2020; McCormack & McCance, 2016). Implementing PCC into practice is complicated because there is no general definition (Harding et al., 2015; Olsson et al., 2013). Harding et al. (2015) emphasize the need to provide evidence of the benefits of person-centered care and to develop a standardized approach. This illustrates the recognition of the need to create a theoretical person-centered framework to achieve this step (Harding et al., 2015).

However, Slater et al. 2017 consider the Person-Centered-Practice-Framework (PCP-Framework) to be an internationally suitable guideline for practice and research in the healthcare setting (Slater et al., 2017). The PCP-Framework developed by McCormack and McCance, explains the dimensions of person-centeredness and how it can be transferred into practice. The fundamental aspects are the relationship between the health care professional and the patient (McCormack & McCance, 2006). The challenges for developing such a concept and the implementation of it are dependent on contextual factors like the organizational culture, the learning environment, and the care environment. Another issue is the integration of person-centeredness into

everyday practice (McCormack et al., 2011). The aim of this framework was to investigate the intervention stage of a project by evaluating the effect of the implementation of person-centered nursing in a tertiary hospital setting (McCormack & McCance, 2006). Developing a person-centered concept and implementing this framework requires a whole team in a department. In Ireland and Austria, researchers integrated this framework in long term care facilities and made adoptions where necessary (Dewing et al., 2021; Mayer et al., 2020; McCormack et al., 2010). As Mayer et al. (2020) described, it is necessary to develop basic principles for care as a bridge to practice. These should represent the knowledge and understanding of what person-centered care means in a specific setting such as a long-term care facility (Mayer et al., 2020).

The promotion of a person-centered concept has the potential to make a difference for the care experiences of patients and health care professionals (Binnie & Titchen, 1999; Pope, 2012). McCance et al. (2012) researched how the context of an acute hospital setting influences the engagement of health care professionals in a practice development program. The findings indicate that the implementation of the PCP concept is complicated by the tough working environment staff members experience in ED settings (Tanya McCance et al., 2012). The correlation between the different constructs of the framework should be operationalized in different practice settings to provide insight on potential areas for improvement (Slater et al., 2015).

One of the key components of the PCP-Framework are the care processes which are focusing on delivering care. Weis et al. (2020) used among other things the care processes for translating and adapting the PCP-Framework from English to German (Weis et al., 2020). McCormack et al. (2010) highlighted that the results from the care processes show the importance of high-quality relationships between nurses and patients. The authors described this relationship as a meaningful engagement, because it enables patients to make decisions on their own and to ask healthcare workers for help whenever needed (McCormack et al., 2010). The focus of health care professionals is on tasks and procedures and there is an absence of working with the patient's beliefs and values (McCormack et al., 2010; Wiman & Wikblad, 2004).

Especially in the ED, the literature highlights that the working environment mainly focuses on medical and technical interventions (Kihlgren et al., 2004; Muntlin et al., 2010; Skar et al., 2015). This was confirmed by several studies where ED nurses declared that they are concentrating on developing technical and medical skills as opposed to improving their caring competence (Nyström et al., 2003; Wiman & Wikblad, 2004). Interactions with patients were limited to carrying out medical tasks and following doctor's orders (Morphet et al., 2015; Wiman & Wikblad, 2004). This mindset norms of ED staff helped them cope with the unpredictable and stressful environment (Person et al., 2013). Internationally, a stressful environment can be discovered through the organizational factors and patient care within the working conditions (Johansen, 2014; Sawatzky & Enns, 2012). The level of engagement and interactions of nurses with patients influences their overall relationship. The behavior of the staff has been reported as being authoritative, being judgmental and confrontational (Lau et al., 2012). Nurses' work at the ED is centered around saving lives and treating ill patients (Elmqvist et al., 2012).

McCormack and McCance (2010) highlighted the importance of care management with a focus on care process to provide effective and person-centered care (McCormack & McCance, 2010). The literature review shows the demand of person-centered care in ED work impacted nurses to deliver person-centered processes (McConnell, 2018). However, McCormack and McCance (2010) argued that this could be achieved by nurses changing their caring attitudes and behavior (McCormack & McCance, 2010). Due to the increasing interest in person-centeredness in care as an optimizing strategy for quality of care in gerontological care, its application principles must also be evaluated in other settings (Martinez et al., 2016). In a review by De Silva (2014), it is emphasized that most studies have looked at the clinical setting, but increasingly studies concerning the long-term care setting are now being published. McConnell (2018) states that there are certain benefits in exploring and implementing the person-centered approach in the ED context (McConnell, 2018).

In our current healthcare system, the focus is on the medical paradigm and disease orientation, but there is a change that has already started in recent years. In the future, the focus will be more on preventive strategies, health promotion programs and integrated care concepts. This is related to the key elements of the person-centered approach. In addition, these principles include a holistic view and empowering people to take responsibility for their own health.

The described paradigm shift, inquiry must also take place in specific settings such as an ED. Therefore, this master's thesis will focus on the ED, as it is a very fast-living place in the hospital. Usually, patients stay here for a short period of time and should be treated quickly. After that, patients are discharged or admitted to the appropriate department of the hospital. Because of this short length of stay, it is important to address what a person-centered culture can look like.

Additionally, the ED faces many challenges, which have been described in chapter 3.4. "*Setting Emergency Department (ED)*". The population is aging, and the associated work pressures are increasing. Thus, a person-centered approach should be considered to address these issues. Originally, the PCP-Framework from McCormack and McCance was developed for long-term care facilities. However, this framework is a medium-range theory and therefore can be used for practice development in other areas of the hospital.

5 Research aim & question

Following a literature review of the person-centered approach in the ED, fundamental principles should be developed for this unique setting of the hospital. The basis should rely on the PCP-Framework by McCormack and McCance (2021), with focus on the processes. Since the evidence-based literature is limited concerning person-cantered approaches in acute settings, the aim of this research is to examine the relevance of this topic in the ED. The translation process is thus intended to bridge the gap between theory and practice. Therefore, the first step is to explore principles of person centredness for this special setting. Following research question will lead the thesis:

Which principles can guide person centered care in the emergency department?

The main goal is to find out how person-centeredness can be lived in this specific setting of an ED. As a first step, the transitions of the processes into an ED are described by development of principles, which should provide a first bridge to a practical implementation. Moreover, an attempt is made to present patients' experiences and perspectives based on the existing literature. This perspective is crucial as patients should be more involved in the development processes. In addition, it will be shown which steps are necessary for practice development in an ED. This work is intended to provide an initial foundation and should be used for further research. The importance of this concept and working according to person-centered principles will become more and more important in the future.

6 Method

This research is an exploratory study, which aims to provide an overview of the person-centered care process in the setting of the emergency department. Thus, a qualitative research approach was chosen to answer the research question and achieve the goals of this study. The target of qualitative research is to explore a phenomenon from those affected by it and to find out what it means to be a part of the target group. The study intends to contribute to the body of research through analyzing subjective experiences (Mayer, 2019b). To ensure a robust and comprehensive coverage of the concept of person-centered care, De Silva (2014) recommends a combination of approaches and the inclusion of multiple perspectives. In addition to surveys, for example, interviews, observations, or focus groups allow to deepen and analyze certain aspects in more detail (De Silva, 2014). However, such an all-encompassing survey proves to be very time-consuming and would go beyond the scope of this master thesis. As a result, three different data sets were collected through the following methods:

I. One focus group with five nurses, who are currently working at an emergency department in Vienna.

II. Two expert interviews, who are specialized on the transfer of theory into practice in the context of person-centered care.

III. One systematic literature review was conducted to represent the patient perspective.

These three components of data were used in conjunction and were analyzed as described the steps below.

6.1 Descriptive qualitative research

In qualitative research, an attempt is made to represent the result of the reality of meanings and contexts, which happens during social interactions. This observation is done with the representations of subjective truths or realities (Mayer, 2019b). These aspects were addressed in the focus group conducted. The aim of the focus group was to describe the nurses' experiences in an emergency department and to present the perspective of caregivers. In addition, the aim was to find out which person-centered

measures are already existing in this setting. Further steps were carried out for transferring the processes of an already existing framework into a new setting.

The goal of qualitative research is also to present a phenomenon from the perspective of those affected and to find out what it means for them (Mayer, 2019b). It was also crucial in this work to show what it means to live person-centered principles in the setting of an emergency department and how the outcome of the persons treated in this setting could be optimized. To present as truest a picture as possible of the object of research, the fact being researched must always be considered. Objectivity is hard to obtain compared to qualitative research because subjective views are presented. That is why it is necessary to develop concepts from the collected data and to exemplify from the individual experience (Mayer, 2019b). The datasets in this study should conduct an overview of the person-centered care processes in the special setting of an emergency department.

This method of inference from particular to general approaches is based on the logic of qualitative research and is mostly inductive. As a result, the process of data collection and analysis in qualitative research is usually quite open and can be designed flexibly. The central principle in qualitative research is openness throughout the research process. This puts the character of explorative thinking in the foreground. In doing so, one tries to disregard any previous experience and to open our eyes to the research object. In addition, this requires a certain flexibility in the approach and in the evaluation process (Mayer, 2019b). It was attempted to adhere to these principles as much as possible throughout the research process. Especially in the process of the data evaluation a high degree of flexibility was demanded. In addition, the data was discussed with a research team and study colleagues again and again, to incorporate new perspectives on the data. During the research process, an attempt was made to maintain the exchange of discussions. This is also what characterizes the elements of qualitative research, namely that communication is maintained. Qualitative research can thus be understood as a process of mutual negotiation of reality.

In addition, the basic principles of Holloway and Wheeler (1997) can be mentioned, who have also highlighted other aspects.

I. The emic perspective mentions that one want to present the views from the insiders. This means that one wants to investigate and interpret the meaning of certain experiences for the researched. In this way, the subjective explanation of the affected persons for their actions is explained. To adopt this perspective, an empathic relationship between researcher and researched must prevail. The analysis of the data is interpreted within this context (Mayer, 2019b). This perspective could be taken by the researcher because she herself once worked in this field. This enabled her to empathize with the caregivers and to deal with them empathetically, since there was an understanding of the different situations.

II. The primacy of data means that data had absolute priority. This means that the researcher´s work is an analytical summary of reality. An important prerequisite is the impartiality of the researcher towards the subject (Mayer, 2019b). This could be ensured because the researcher has not worked directly in the emergency department setting for over a year. Thus, although there is a certain proximity to the subject matter, there is also already enough distance to treat the data analytically.

III. In terms of access to the research field, it is crucial to gain access, to get to know this culture as well, so that this environment can also be interpreted accordingly. In order to develop a certain understanding, the researcher must also explore this field in detail and be familiar with this setting (Mayer, 2019b). This is because the researcher herself has already gained work experience in this setting of an ED. This means that she is familiar with the environment and has a good understanding of what the culture is like there. In addition, she can also assess, recognize, and weigh the importance of certain situations. For example, an understanding of what it means to work in emergency situations and why the person is at risk of not being noticed in these situations.

IV. Regarding the relationship within the research project, it is important to establish a balanced position. This implies that a trusting relationship must be established for participation (Mayer, 2019b). Although the researcher had personally known all the focus group participants, an attempt was still made to establish a professional relationship in the context.

V. The interaction of data collection and evaluation requires a high degree of flexibility. An interpretation of the data can start relatively early, but a constant adaptation and redevelopment must take place (Mayer, 2019b). This was done by the researcher exactly in these flexible steps. Initially, an evaluation of the focus group took place. Then the data from the literature reviews were added and finally the results from the expert interviews. This process was in constant change and had to be adapted again and again.

VI. A dense description can be found from the available data or from the context. In the process, the environment, and the people in it are described. The research process must be comprehensible and understandable so that an empathic understanding is gained (Mayer, 2019b). This comprehensible description of the entire research process is comprehensively presented and described within the scope of this master thesis.

Within qualitative research, different directions have developed, which are oriented either towards methodological or philosophical issues. Sometimes a study cannot be classified in one of these certain directions, for example, if it is oriented towards the general basic principles of qualitative research. Therefore, in this context of the master thesis, qualitative research is discussed (Mayer, 2019b).

The aim is to describe a phenomenon or an actual state about which little is known and to present and analyze it subsequently. The choice of this design is made to collect certain characteristics of an institution or situation in connection with a certain phenomenon (Mayer, 2019b). The purpose of this master's thesis is to examine the principle of person-centeredness in the setting of an ED. Since this principle is still largely unexplored in the specific setting and there is hardly any data for this, this methodology was chosen. On the one hand, the actual state should be determined whether nurses are familiar with the principles of person-centeredness in this setting

and apply this. On the other hand, information should be gained about what it means to work person-centered in the setting of an emergency department from a patient perspective and from the perspective of caregivers. In addition, the experiences of experts were included to depict the phenomenon even more clearly and with other perspectives.

6.1.1 Rigor in the qualitative research

Providing academic results, some criteria must be fulfilled for keeping a high quality. In some cases, the development of these criteria is highly controversial in qualitative research. However, the position of developing one's own criteria to describe and measure the quality of qualitative research is the most accepted in social research. The qualitative criteria outlined by Philipp Mayering (2016) can be used, which are frequently applied, especially in German speaking countries (Mayer, 2019b). Strategies which are relevant to the qualitative approach of this study are mentioned below.

I. Process documentation: The comprehensibility for the following master thesis is given due to detailed documentation and exact citation. Consequently, the program MAXQDA was used to get a better overview of the individual steps. The procedure was always precisely documented and agreed with the supervisor. Individual stages of this academic paper were disclosed for providing a high standard.

II. Argumentative interpretation validation: Qualitative research is characterized of interpretation by using form of categories from the data material to get results. This procedure is not standardized in comparison to quantitative research and as a result cannot be proven with statistic methods. Therefore, the procedure and process of the research must be sufficiently comprehensible (Mayer, 2019). For this academic paper, key terms and categories were developed from the content of the focus group, the expert interviews, and the systematic literature review. A combination of these three data sets was used to answer the research questions, enriched with quotes from these three sources.

III. Rule-guidance: Qualitative research did not stand out for standardization processes and the gathered information must be processed systematically and not arbitrarily (Mayer, 2019b). By usage of the evaluation scheme of the grounded theory methodology, the data in this thesis were processed in a systematic sequence and rule guided. Additionally, all the other data resources were also systematically evaluated and compared by following the guidelines of the content analysis.

IV. Proximity to the object: Generating a pure point of view to a phenomenon within a study is of relevance in qualitative research. The researcher itself had one and a half years of working experience in the field of an emergency department. However, the researcher currently is not working in this field and considered the statements and the interpretation of the results from a clear distance. Through the conversations with the focus group participants, it was possible to gain further insights into the person-centered approaches in the context of an emergency department. In addition, through the discussions within the expert interviews, some new perspectives could be elaborated. In addition, the systematic literature review tried to cover the patient perspective in an emergency department.

V. Communicative validation: The research findings extracted from the data can be presented to and discussed with the interview participants in order to check their validity (Mayer, 2019). This did not take place for the present work due to lack of time resources and the willingness of the nurses, because the participants did not want to discuss the work further. In addition, the results of the focus group were discussed with the experts and their opinion and experience was included. However, the data and elaborated results were regularly discussed, debated, and reviewed with the supervisor, a research team as well as with fellow students in the same research field during the evaluation phase validation (Mayer, 2019).

VI. Triangulation: An increase in the quality of qualitative research work can be achieved with the help of triangulation. This involves the combination of diverse analytical steps and methods of the survey. The presentation of results can be shown to be sharper and less biased by taking different perspectives on the phenomenon (Mayer, 2019). Therefore, three different data sources were used in this work, which were obtained with both qualitative and quantitative methods. The focus group and the expert interviews took place with a pre-defined guideline, which contains a theoretical basis. This base provided the theoretical framework of person-centered care. The patients' perspective was obtained by means of a systematic literature review. The linkage was then carried out with a coding scheme based on a content analysis.

6.2 Data Collection

This chapter explains the integration of the PCP-Framework and the method of data collection which was conducted in two phases during the study. Other aspects are the recruitment process of participants for the focus group and for the expert interviews. In the attached graph the procedure of the entire research process is presented in more detail.

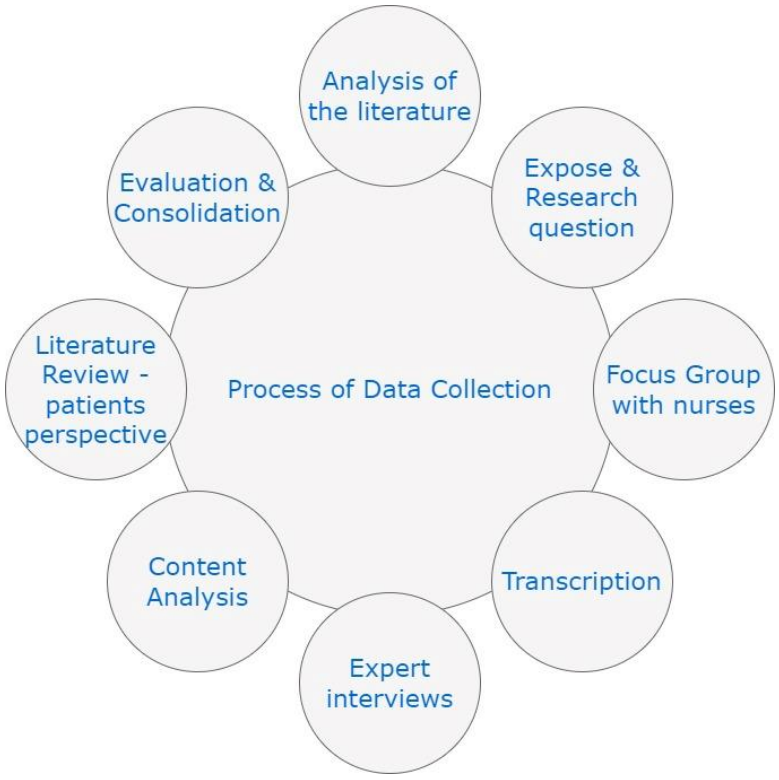


Figure 2: Overview of the research process

6.2.1 Participants

Qualitative research demands that participants are suitable and helpful to achieve the aim of the study. Therefore, the recruitment process and selection process were planned to produce the desired results. Additionally, the participants were chosen for a specific purpose, which means the selection was based on certain criteria such as working in the same department or experienced a similar event. A fundamental principle for qualitative research is data saturation which means that the data collection process is finished when no new information can be obtained (Mayer, 2019). Since this is a research paper within a master´s thesis and time and resources were limited, these criteria could not be fully considered. It was only possible to include one focus group, as possible candidates were hard to convince and not easily motivated to contribute.

I. Focus group: When using focus group interviews, the aim is to present a common perception of reality. The focus should also be on the interaction of the participants to obtain and understand data. Krueger and Casey (2009) described fundamental principles, which can be applied to this particular type of interview. The principles focus on the interaction of people, who have something in common and discuss a specific topic to derive qualitative data and to obtain a more in-depth information (Mayer, 2019).

   Therefore, nurses who are experienced in working in the emergency department participated in the focus group and were included. After the recruitment process six nurses in Vienna agreed to participate and wanted to be part of the study. Only registered nurses with a special diploma or degree were included for be a part of this study. Participants didn't need special knowledge in the field of person-centeredness. The online focus group was carried out on 03 February 2022. One person did not show up for the scheduled interview appointment, thus only five people participated.

   Recruitment process: This process started after the positive feedback of the exposé. Through the researcher's work experience in the emergency department, participants were recruited in this immediate area. The approach was still very passive, although hardly any participants could be found. Therefore, the researcher tried to advertise via Instagram and Facebook to find participants in this focus group. However, the recruitment process via social

media platforms didn't lead to meaningful responses. Therefore, ultimately all participants were selected within the social and professional context of the researcher. An attempt was made to generate a great diversity among the participants, who work in different hospitals. However, this was unfortunately not possible within the scope of this work and due to reduced resources. Nevertheless, all participants worked in an emergency department for providing the principle of homogeneity.

Regarding the date, a Doodle poll was sent to the participants in mid-December 2021 to find a suitable date early. From the moment the date was fixed, and the participants were determined, a separate email was sent out. This contained an agenda about the process, an information sheet about the framework, the consent form, and a short questionnaire about the demographic data, which are included in "*Appendix 11.2-11.5*". Before the interview took place, all participants returned the written signed consent form and questionnaire.

Creation of the guideline: In conducting the group interview, attention was paid to establish a phased process. An attempt was made to organize the focus group, like a person-centeredness workshop. Additionally, a study colleague was asked to assist in taking notes so that the researcher could focus on the discussion. At the beginning, a round of introductions took place to facilitate the interview. Afterwards, the researcher briefly introduced the framework and mentioned that the focus would be on the processes. In the first part of the focus group, an emergency department, its work processes, and daily structure were discussed together with the participants. After that, a change of perspective took place, in which the nurses should put themselves in the shoes of patients who come to an emergency department. Finally, the individual processes of the framework were elaborated and their importance in the setting, i.e. the emergency department, was described.

Integration of Person-centered Practice Framework: The theoretical framework which strengthened this study was the Person-Centered Practice Framework, which was described in the chapter 3.3.2. This framework was used for many phases of periods for data collection and analysis during the following study.

For the first stage, which was the focus group, the guideline was conducted based on the PCP-Framework with the focus on the care processes.

II. Expert interview: Expert interviews can be used as a method to explore and reconstruct complex bodies of knowledge. In this process, people who have a very specific knowledge about a social issue are included in the research. Therefore, two experts with experiences in transformation theory into practical usage in the context of person-centered care were chosen. Both are also familiar with the PCP-Framework and have gained several skills in this context.

Recruitment process: The supervisor of this master's thesis facilitated introductions to three different experts. These would come into closer consideration given their experiences. Therefore, all three persons were contacted by mail in mid-February 2022. In this email the research project, the research question and the request for an interview were included. All three responded within a few days, but only two agreed to participate in the study. The reason given for the cancellation was that this person is not as familiar with the procedures in an emergency department.

Selection process: However, two experts agreed to participate and therefore the dates were planned for the beginning and end of April 2022. It was decided to plan a period between the two interviews to ask constructive questions and to obtain different results. Both interviews were conducted online via Microsoft Teams and have been recorded. The interviews were recorded with voice recorder of the researcher´s mobile phone and then transcribed. In the complex transcription process, a high-quality audio recording is a prerequisite and what is said is recorded aloud. Furthermore, the pauses, as well as the exact length of the pauses and the inhalation and exhalation are marked. The expert interviews were subsequently analyzed qualitatively.

Creation of the guideline: Before the interviews took place, a guideline for the researcher was prepared. However, situational adaptations always took place, depending on the expert and the development of the interview. The questions were mostly open-ended to allow the experts to speak freely about their personal experiences. The first part of the interviews was shorter, with a brief

introduction. This was necessary to address the area of activity and the experience of the people in this area and it confirmed to the selection of the experts. Afterwards, general questions about the development of practice were asked to find segue to the topic. More specific aspects and special features of an emergency department were mentioned. Finally, the already obtained results of the focus group were discussed and the experts' opinions on the results were obtained. All interviews were scheduled for a maximum of one hour and lasted between 40-60 minutes.

Expert interviews:

Expert 1 for practice development and person-centered care:

This expert was selected because she specifically focuses on person-centeredness in the context of diversity. She was also able to bring aspects to this work through her expertise as a nursing expert in a university hospital in Switzerland. Furthermore, at the very beginning of the PCP-Framework, she also started to incorporate it into her work at the hospital. She was instrumental in steering the nursing development and conducted some observations in the process. This online interview was conducted on April 5th, 2022.

Expert 2 for practice development:

This expert was selected because he has led several projects for acute care hospitals in practice development in Switzerland. These hospitals also have two emergency departments integrated, which is why he has also some expertise in this context. Additionally, he is one of seven directors for the “international community of practice.” He is in close contact with the developers of the person-centered care framework. Therefore, he is responsible for the further development of this in the German-speaking area. The expert´s experience with the framework meant that it had to be incorporated into the following work. This made it possible to specifically work out which further steps would also have to be considered in a concrete implementation in the future. This online interview was conducted on April 25th, 2022.

6.2.2 Systematic Literature Review

The basis for the application of research results is a systematic literature review. The aim is to explore the current state of research on a certain topic, which allows further steps to be planned in practice (Mayer,2019). Therefore, this method was used as a first step at the beginning and again during the research process. The aim was to present the patients' perspective on an emergency department and how this setting is experienced by them. This Review can be split into three different groups, which were carried out between March and May. 2022.

Phase 1 Determination of the object of investigation:

As a first step a rough literature research was conducted to get an overview about the topic. After that, an attempt was made to narrow down the topic more, using the PICO scheme as a guide.

P = population, these were patients at an emergency department

I = intervention, experience of person-centered care treatment

Since this was the aim of the question, the components C for comparison and O for outcome could be omitted. These components were not considered relevant for getting the patients perspective.

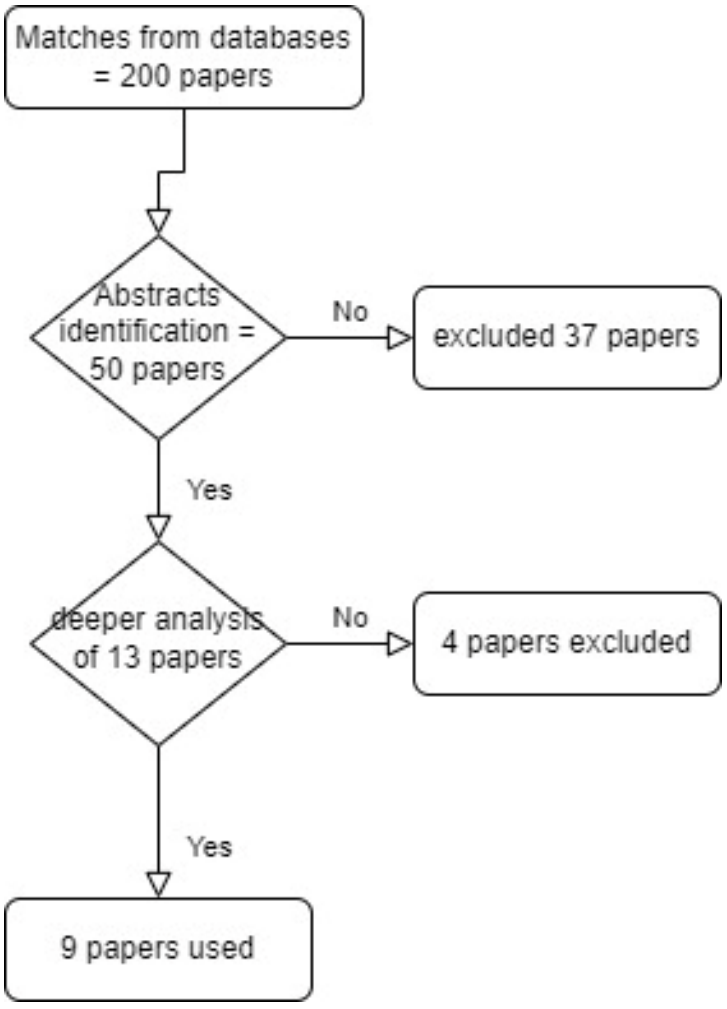
Phase 2 Research:

In this phase, the focus was on actual research, using the appropriate search tools in the specific databases to try to find suitable literature. The following databases were used “Google Scholar”, “University of Vienna”, “SpringerLink”, “Wiley Online Library”, and “Science Direct”. Only literature that was peer reviewed and available online was sought for, with an additional filter on qualitative research, because the individual experiences should be described. The next step was the selection of the search criteria by using inclusion and exclusion criteria. The period was limited to the last ten years up to and including 2012. Regarding language, both English and German language literature were included. The following search criteria were used in different combinations: patient, person, experiences, perspective, emergency department and emergency room.

Phase 3 Evaluation, reading and criticism

In this phase, the literature was evaluated. Certain formal and content-related criteria were used to check the quality of the studies. For this work, the evaluation criteria of studies by the authors Brandenburg, Panfil, and Mayer (2007) were used as a basis (Mayer, 2019). According to Brandenburg, Panfil and Mayer, the process of searching can be described cyclically. In the beginning, a rough search took place in the previously mentioned databases with the most diverse combinations of search terms, where 200 papers were identified. Afterwards, 50 papers were examined in more detail and the abstract identification took place. While reading the abstract, the focus was on whether patients were interviewed in an ED and their experiences were presented. Then thirteen studies were shortlisted and described in more detail in an Excel list. But after, the analysis of the data in more detail, only nine papers were included into this master thesis.

Figure 3: Flowchart of the systematic literature review of the patients´ perspective in the emergency department



6.2.3 Method of data collection

In summary, the different methods of data collections are mentioned below for giving a quick overview. As a first step, the recruitment of the focus group started, and a date was fixed. The focus group was held with five nurses from emergency department in Vienna which was at the beginning of February 2022. After fixing a date, which was suitable for most of the participants, the data was communicated to everyone. By special request from the participants and the COVID-19 restrictions an online meeting via JITSI was planned and the link was sent to everyone. Participants received a questionnaire to provide their demographic data via email one week before the start. In this email, all participants also received the written informed consent, an agenda, and a handout about the PCP-Framework, which is listed in the appendix. In the meantime, the researcher prepared a guideline and whiteboards which were used for structuring the focus group discussion. This guideline matched with the PCP-Framework in some parts, especially the care processes. During the focus group, one study college of the researcher also took part to provide notes on the whiteboard which made the results more visible. The recorded focus group had a total length about one and a half hour. The recording was direct via JITSI and saved to the researcher's Dropbox account.

Afterwards, the recruitment of the expert interviews started and two of the three were willing to participate. Two time slots were fixed in April 2022 and these interviews were also held online via MS Teams, because the experts are currently not living in Austria. Additionally, the guideline compiled based on the findings of the focus group. Before the appointment the experts, received information regarding the study and a written consent form. The duration of the two expert interviews were between 40 and 55 minutes. The recording was conducted via mobile phone recorder and saved to the researcher´s Dropbox account.

As a last step a systematic literature review was performed for getting the patients´ perspective in the emergency department. The procedure was described in detail in chapter 6.2.1. "*Participants*." After all, nine studies were used and included due to their matching criteria. This analysis was a process between March and May 2022 and was repeatedly compared with the existing results. Therefore, new adjustments in the research took place again and again until a satisfactory result was available.

6.3 Data analysis

The evaluation of the qualitative data can be described as a creative process. There are no fixed standards, so there is constant adaptation to the data. Although there is a certain degree of freedom in the analysis, it must still be described carefully and comprehensively so that it is consistently comprehensible. For the following work, an interpretative reductive method was used. Thereby an open meaning of the data is in the foreground and summarizes this in the further steps to categories (Mayer, 2019). The researcher oriented herself to the content analysis according to Mayring (Mayring, 2015).

6.3.1 Deductive Content Analysis according to Mayring

Qualitative content analysis is an evaluation method that is used for social science research projects in which texts are processed. The communication that is the focus of the research project must be recorded, so that the object of the analysis is the "fixed communication". However, not only texts are suitable for the method, also images or symbolic material can be used for this purpose. Here, the analysis of the content of the communication and the formal characteristics are important. The aim of this method is to proceed systematically and to follow explicit rules during the analysis. So that others can also understand and, if necessary, reproduce the category (Mayring & Fenzl, 2019).

This ensures the methodological standard of intersubjectivity. The work is not only rule-guided, but also theory-guided. This means that the material is analyzed under a question and results are interpreted in the context of the experiences of others with the same subject. Therefore, the goal of a qualitative content analysis according to Mayring is also to draw conclusions about the material to be analyzed. to draw conclusions about certain aspects of the communication", so that the statements of the statements of the "sender" and his intentions or the effects on the "receiver" can be worked out (Mayring, 2015, p. 13).

In qualitative content analysis according to Mayring it is important to interpret texts within their context, in which the material is investigated for its origin. However, the procedure is not a standard instrument that always looks the same, but it must be adapted to the concrete material and constructed to address specific research

questions. In summary, this procedure differs from "free interpretations" in that each step of the analysis and all decisions in the evaluation process must be traceable to justified and tested rules (Mayring, 2015, p. 51, 2020, p. 498). The rules of text analysis can be flow models, units of analysis (or) content-analytic rules. These rules are continuously revised in a circular process in so-called feedback loops. feedback loops are revised. However, they ultimately remain constant for the entire material passage. As soon as a saturation of data has been reached, the process of is switched over to conceptualization (Mayring, 2015).

6.3.2 Data preparation

As a first step, the gathered data must be prepared and written down. For this purpose, a verbatim transcription took place since this represents the basis for a detailed interpretative evaluation. The transcription of the focus group and the expert interviews was carried out by the researcher herself to give her the opportunity to familiarize herself with the data. Since the various interviews were conducted in German, the transcription was also conducted in German. Here, the basic form was applied to, that a transcription into a normal written German took place. This includes that any dialect was cleaned up. It also simplifies the reading and editing afterwards. This method was chosen because this work is about a pure content analysis and therefore the linguistic aspects can be neglected. The rules by Kallmeyer and Schütze (1976) were considered to the extent that good readability is nevertheless ensured (Mayer, 2019). The following characters were used in the prepared transcripts only:

(,) = abbreviation of a statement
… = middle break
(Pause) = long pause

In addition, all participants were anonymized during transcription. In addition, so-called filler words, such as “Ähm” or “yes”, were largely omitted, as they had no meaning in terms of content. The transcriptions were written in German and embedded in MAXQDA. This software program was used during the complete analysis part. Also, this part of the evaluation still took place in German, as it was easier for the researcher to discuss the results that way. The transcripts were already in German, so only the interviews had to be translated during the coding process. To ensure a more precise overview, three different data sets were initially used.

I. Transcript of the focus group
II. Transcripts of the two expert interviews
III. Results from the systematic literature review, included nine studies

It started with the focus group, followed by the studies from the literature, and concluded with the expert interviews. However, this phase was a continuous process that cannot be precisely timed. However, the period of analysis took place from March to June 2022 took place.

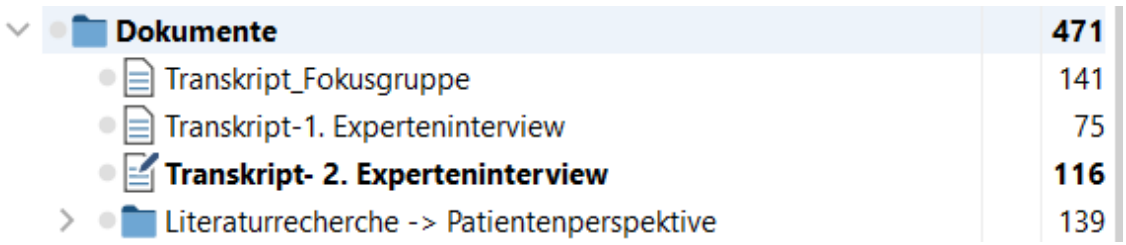
6.3.3 Method of data evaluation

In the following, the procedure is described in more detail, based on an interpretative-reductive method. This has been additionally developed in accordance using the Mayring's content analysis. Over the next four steps, the exact procedure is described to make it transparent for the reader.

I. Step 1: Familiarizing with the material, recognizing important content issues

After reading the transcripts and the studies several times, one can recognize the most important information. This step was perceived as crucial to get familiar with the different materials and to identify the research direction. Relevant content blocks were subsequently highlighted in PDF format. For further processing, the embedding of these PDFs into the MAXQDA software then took place. Additionally, the highlighted sequences were also coded.

Attached is an abstract impression about the different documents used for analyzing. Overall, there were 471 codes derived, 141 codes for the focus group, 75 codes for the first expert interview, 116 codes for the second expert interview and 139 codes for the systematic literature review.



Graph 5: Overview of the documents used in MAXQDA

II. Step 2: Coding and formation of categories

As a first step, an attempt was made to open code all the data. However, the three different data sets were treated separately from each other and initially no mixing between the data took place. Paraphrases to the excerpts were found for the first time and these were then generalized. In addition, verbatim quotations were often taken over one-to-one, because this was decisive for the qualitative meaning of the content.

Graph 6: Overview of the code system with the three different perspectives

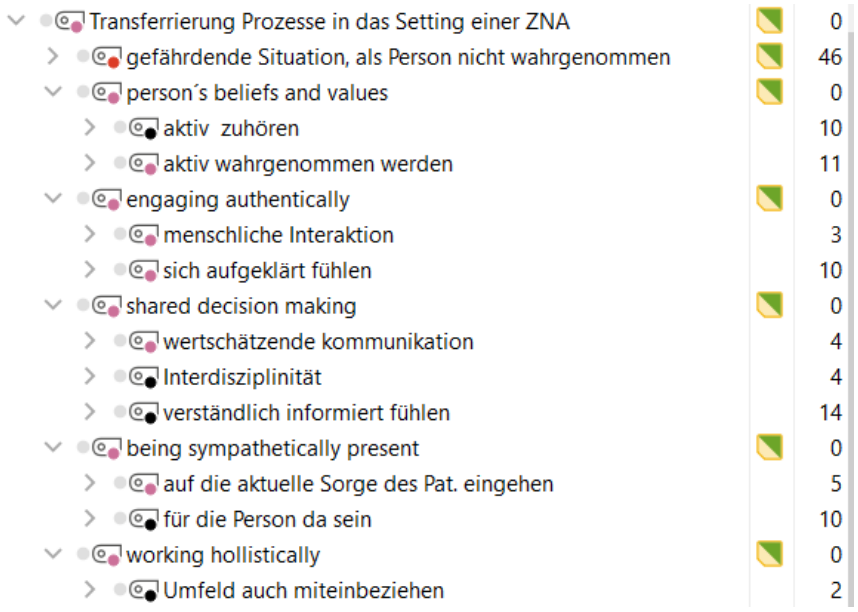
In the next step, the individual codes were summarized, and an attempt was made to find subcategories and super categories. In this process, a partial alignment with the other data sets already took place. In addition, primary categories were found and attempted to be merged. Similar super categories were already found, which was decisive for the next step.

III. Step 3: Synthesis of all interviews with a category scheme

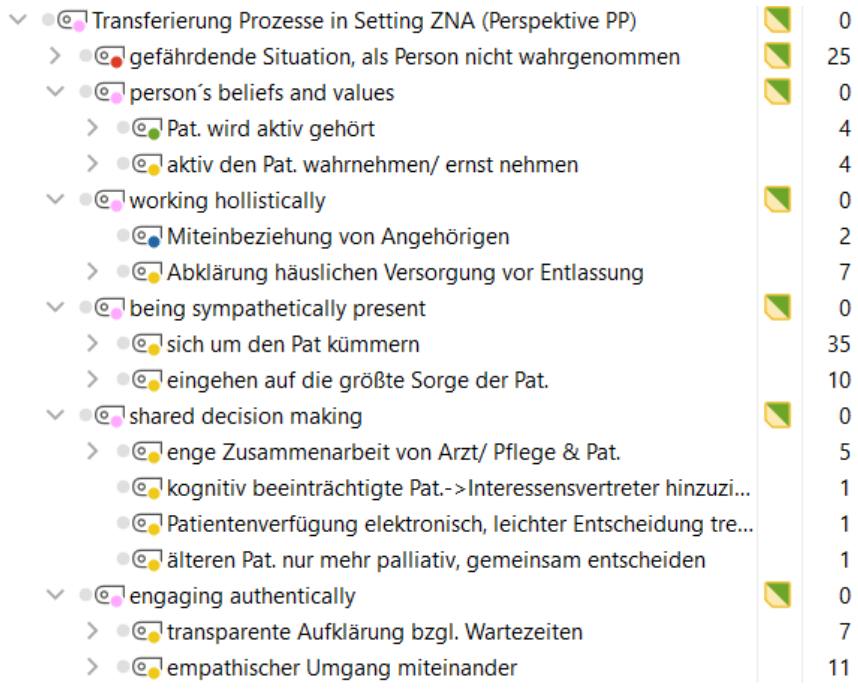
After the individual data sets have been coded separately, they were superimposed in next step. For the patient´s and the nurse's perspective a main category was used, named "transfer of the process in the setting of an emergency department", which was essential to answer the research question. In this step the researcher went back to the original theoretical framework and focused on the processes. Here, the already formed subcategories were again assigned to the individual processes. The definitions of the five person-centered processes from the PCP-Framework were used to combine the subcodes.

As mentioned below, an extra category was found which was "vulnerable moments where a person is not perceived as whole." There were 46 codes identified, which fit into this category from the literature review and 25 codes from the focus group were suitable for this category. For the different processes,

there were various numbers of codes identified since various numbers of codes were identified because there was no even distribution. To sum up, for the “person´s beliefs and values” 29 codes were identified, for “engaging authentically” 31 codes, for “shared decision making” 30 codes, for “being sympathetically present” 60 codes and for “working holistically” 11 codes.



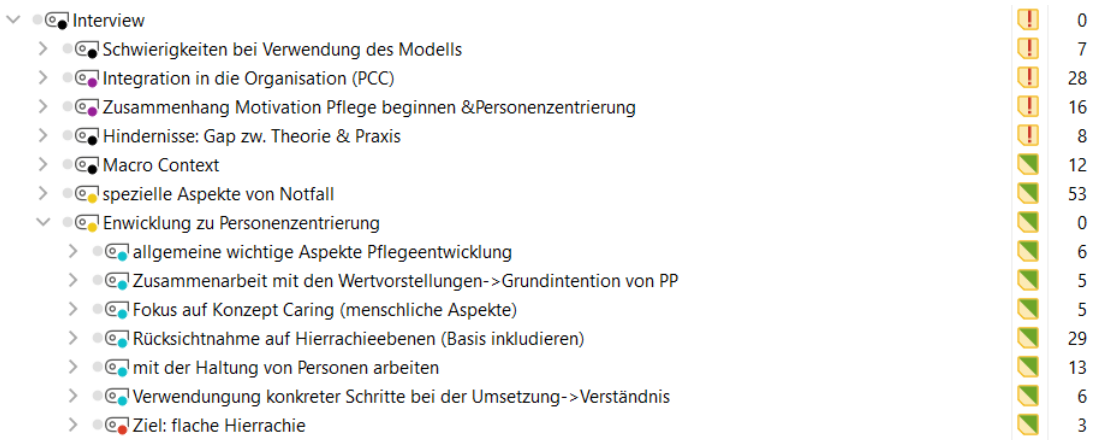
Graph 7: Overview of the transferred process from the patient’s perspective



Graph 8: Overview of the transferred processes from the nurse’s perspective

Moreover, for the focus group and the literature review, the researcher tried to find other codes which fit into other aspects of the PCP-Framework. For the “prerequisites” there 25 codes identified together and for the “practice environment” 12 codes were fitting. Regarding the analysis of the expert interviews, the code structure was different, because the focus was not on the processes. Nevertheless, categories could be formed, which coincided with the results of the processes. A total of 33 codes were found, which included how a person is perceived, being actively there for a person, and knowing the person's greatest concern. These areas were deemed important because things can happen quickly, especially in this fast-paced setting like an emergency department. In addition, it was possible to find out some hindering factors which could possibly make it difficult to work according to these principles of person-centeredness in this setting. A total of 12 codes were found, which were based on the premises, structures, and liveliness of an emergency room. Additionally, there were also 12 codes rendered, which fit into the macro context of the theoretical Framework.

In addition, a new category was found during the expert interviews, which could be related to the ongoing development of a person-centered culture in an acute or emergency department setting. A total of 67 codes were found, which were appropriate. The importance of the hierarchy levels in this context was particularly outstanding, which is why almost 30 codes were found in this context. In addition, it is crucial to work with the value concepts of the persons, because this was also seen as a basic intention, whereby 20 codes could be assigned here.



Graph 9: Overview over the Code system of the expert interviews

IV. Step 4: Establishing connections

In the last step, the correlations between the individual categories were established, which represents a reductive data evaluation process. To obtain a better overview over the data, the results were written down. During this process, the translation into English took place. Moreover, a graph was developed for answering the central research question. All three data sets were compared, evaluated, and merged. Findings that did not primarily serve to answer the research question were nevertheless introduced into the results.

6.4 Ethical aspects

In this chapter ethical aspects that are relevant for this work are explained in more detail. These are usually considered a starting point for research projects and have a high priority in scientific work. Attention is being put on basic principles of privacy protection (Mayer, 2019a).

Comprehensive information and voluntary participation

It should be noted that all potential participants must be capable of giving consent that the consent is given voluntarily and that this is recorded in an Informed Consent (Mayer, 2019a). Since all participants were adults and not cognitively impaired, the question of ability to give consent did not arise. Nevertheless, every participant received a written wide-ranging information to ensure their ability to make decisions and understand the research topic and aim. Therefore, all participants received an informed consent and an informational paper about the PCP-Framework. One participant of the focus group asked for some more detailed information ahead of the focus group, which was provided in a call. The copy of the information letter and the of the Informed Consent can be found in the appendix of this thesis.

Guarantee of data protection and anonymity

It must always be ensured that the identity of the participants remains undisclosed, and that the data is not passed on to third parties (Mayer, 2019a). It is also important to ensure that the data is only used within the research project and is kept in a safe place. As part of the evaluation, the personal data of the participants of the focus groups will

be anonymized by assigning pseudonym. The contact details are kept in a locked digital place and are only accessible to researcher within the research project.

Protection of the individual

Generally, protection means no harm should be done, there should be rather a benefit for individuals or society (Mayer, 2019a). Since this is not an intervention study, physical harm or physical burden is refrained. The participants of the focus groups are informed that their participation is voluntary, and they could drop out at any time, before processing the data. They should not be exposed to any additional risks during these focus group interventions.

Another aspect that must be considered for privacy protection is the principle of truthfulness. This means that during the study, especially in the phase of data collection, data evaluation and publication, there must be no manipulation. For this principle there is no other control authority than the researcher, therefore the truthfulness and academic integrity of the researcher are important (Mayer, 2019a). By the fact that this work is done by a person supervising, there is at least some sort of control.

For this research, no submission to the ethics committee was necessary because patients were not directly involved in the survey and nurses and experts were not designated as vulnerable groups.

7 Results

At the beginning a description of the three independent sources that contributed to the data analysis will be described. Firstly, an outline of how person-centered actions could look like in an ED are presented. Here, however, the focus on the special moments that can occur in the emergency department setting is mentioned. Secondly, the patients´ needs will be mentioned and followed by the nursing principles. Finally, a presentation of what are the crucial aspects for the developing a person-centered culture follows.

7.1 Sample

7.1.1 Focus Group Participants

The five participants of the focus group were between 25 and 53 years old. Three were female and two were male. The participants all have Austrian citizenship and declared "German" as their native language. Everyone announced that English was their foreign language. As professional qualifications, all are employed as nurses in the higher service for health care and nursing. The working experiences are from one to over 15 years as professional nurses. The extent of their employment ranges from part-time "30 hours per week" to full-time "40 hours per week". The additional training of the applicants includes "emergency management", "Advanced Life Support (ALS)-Provider", “Psychiatric care for children and adolescents” and "Practice Supervisor". In addition, one person volunteered as emergency paramedic and has some specific skills in this area. The participants are currently employed in emergency departments in Vienna, Austria.

Participant	Sex	Further Training	Age (in years)	Work Experience (in years)	Employment Scale
#1	Female	Emergency Management Practice Supervisor Psychiatric care for children and adolescents	53	Over 15	Full time

#2	Female	Emergency Management	30	5 to 10	Full time
#3	Male	ALS- Provider	32	5 to 10	Part-Time
#4	Female	Emergency Management	25	1 to 4	Full-Time
#5	Male	Emergency Paramedic	26	1 to 4	Part-Time

Figure 4: Overview of focus group participants

7.1.2 Experts

Both healthcare experts have extensive experience within the context of the person-centered culture. They are both located in Switzerland and have made decisive contributions to implementing the person-centered approach in the German-speaking countries. Also, both have finished a PhD program and have contributed many scientific publications. One of the experts, also worked closely together in the theoretical development of the PCP framework. They also have direct experience of how to successfully translate theory into practice. One of them is still actively implementing an advanced nursing practice role in the hospital he is responsible for. To sum up, these two experts have gained extensive experience throughout their professional careers. Therefore, they were able to provide interesting insights that were relevant for answering the research question and further development.

7.1.3 Literature Sources

Finally, nine studies were included in this study because they met all selection criteria. In addition, all of these provided results that represented the patient perspective in the emergency department setting. Seven of these studies used a qualitative design, one used a quantitative design, and one study conducted a systematic literature review. Below is a graphic that aims to show the author, study type, study objective, methodology, and results. This overview is intended to provide a rough summary of the studies used.

Graph 10: Overview of the systematic literature review

Author (Year)	Study Type	Study Aims	Methods	Results
(Schouten et al., 2022)	Qualitative patient journey study	The aim of the study was to achieve patient-centered care at the ED for older patients.	As a method, the used a qualitative patient journey, because the inclusion of the perspective and experience was necessary. For the study, 13 patients over the age of 70 years were interviewed. The focus was on their experiences through their ED journey including return visits. The researchers developed a conceptual framework with codes.	The average age of the participants was 80 years and 62 % of them were male. By using the framework five themes were identified: health status, social system, contact with the general practitioner, aftercare, discharge, and expectations. In total, 34 subthemes could be recognized, but only two were prominent ones: waiting time and discharge communication.

(Swallmeh et al., 2018)	Qualitative focus group study	The aim was to understand patient experiences as participants progressed through a major Irish teaching hospital ED.	Seven focus groups were conducted to understand the patient experience throughout the ED journey. 42 participants were willing to be part in this project, shared their perceptions and outlined key factors affecting their journey. To identify improvement themes, a playing exercise was used. Data were analyzed using thematic analysis and data analysis software (NVivo 10).	Capturing ED patient experience increases our understanding and process impact on the patient journey. Factors identified included information, access, assurance, responsiveness and empathy, reliability, and tangibles such as surroundings, food, and seating.

(Freitas et al., 2021)	Qualitative case study	This study aimed at identifying value and waste in an emergency department (ED) patient flow process from a patient and clinician perspective.	Observations and informal conversational interviews were conducted with health care professionals and patients. The researchers explored the patient flow, value, and waste activities in the context of an ED. By creating a framework with the resulting aspects, a thematic analysis was used to represent the ED patient flow process.	Resulting aspects directed to straight development in the patient's health or the exchange of information in the care process. Wasteful aspects were those with no patient activity, no direct ED clinician involvement, or an inappropriate use of ED resources. However, there was an inequality in responses between clinicians and patients with clinicians identifying more features in the process.

(Phiri et al., 2020)	A phenomenography approach	The aim of this study was to explore and understand the patient´s experiences through a triage process in an ED.	10 semi-structured individual interviews were conducted with participants. These were triaged as yellow and green in an ED in a public hospital in Botswana. Collaborative creative hermeneutic data analysis by 11 nurses working in the same context identified categories of description.	Three categories appeared from patient experiences: triage environment, triage nurse and waiting times. Following data analysis, the nurses reflected that they were not aware of the consequences in the way triage was currently conducted. Consensus was reached that they should move away from focusing on a biomedical model towards person-centered triage, which then underpinned the outcome space for triage in the emergency department.

(Hermann et al., 2019)	Qualitative descriptive design	This study aimed at understanding patients' experiences in interactions with health care professionals in the context of an ED.	An assessment from the healthcare providers survey was used to formulate a semi-structured interview guide. 30 patients were included, who were in the ED and experienced fast track via communication. Data were analyzed using content analysis methodology.	Foundational themes include behaviors that convey courtesy and respect and are required for participants to view their interactions with nurses and providers as positive. Interactive themes describe humanistic ways in which nurses and providers conveyed courtesy and respect, reassurance through careful listening, attentiveness, and explaining things in an understandable way.

(Sonis et al., 2018)	Systematic literature review	The objective of this study was to perform a systematic review of existing literature to identify specific factors most identified as influencing ED patient experience.	A literature search was performed, and articles were included if published in peer-reviewed journals, primarily focused on ED patient experience, employed observational or interventional methodology, and were available in English. After a structured screening process, 107 publications were included for data extraction.	Of the 107 included publications, 51 were published before 2011, 57 % were conducted by American investigators, and 12 % were published in nursing journals. The most identified themes included staff-patient communication, ED wait times, and staff empathy and compassion.

(Blackburn et al., 2019)	Action research with qualitative interviews	This study aimed to develop a holistic understanding of the informational and communicational requirements of patients and staff in the ED.	Action research involving patient qualitative interviews and a staff focus group were used. Both parts were transcribed and qualitative analyzed with a framework by charting and sorting material into key issues and themes. The data analysis also included coding and interpretation processes throughout the study.	15 patient and family interviews identified four main themes associated with information and communication in the ED. Six ED staff members participated in the focus group, which identified three emergent themes echoing some findings from the patient qualitative interviews. These categories were the staff-patient relationship, the explanation of treatment, and communication.

(Yarney & Atinga, 2017)	Cross sectional design	The purpose of this study is to examining factors salient to gauging quality of emergency care and priority areas for care improvement.	Cross-sectional data were collected from patients admitted in the ED in two different regions. A structured questionnaire designed with inputs from emergency medicine physicians and patients was used to collect data from 381 patients. Principal component analysis (PCA) and logistic regression models were computed to respectively determine salient measures.	By the application of the PCA method, four factors could be identified: social and relational care, attentive prehospitalization care, ward quality and privacy and medical supplies. All those identified factors had statistically significant association with patient overall perception of quality.

(Péculo-Carrasco et al., 2020)	Exploratory qualitative study	To determine the feelings of safety among patients taken to hospital after requesting urgent care, based on their experiences and those of their careers and prehospital emergency care professionals.	The participants were patients that requested care through the emergency telephone service. The structured sampling design was based on an intentional, nonprobability selection following pragmatic criteria. Seven groups of patients and two groups of professionals were formed (65 participants). The recordings were fully transcribed before their validation and codes were assigned to ensure anonymity. The ATLAS.ti software was used for the analysis.	Neither group provided a clear definition of the meaning of feeling safe. It appeared easier to give examples that had a positive or negative influence on their perception of feeling safe. During the analysis of the discourse, six categories were detected after grouping the related codes.

7.2 ED as a Unique Environment

The ED is a unique environment where various health care professionals are working closely together to get the best outcome for the patients (Sonis et al., 2018). Due to this interdisciplinarity, there are many special elements, which must be considered. There is also a high patient-flow, and many individuals must work together, which sometimes creates a stressful environment. Though it is a hectic place, the improvement of this issues might contribute to enhance the patient´s experience and thereby focus on the patient-centered care aspects (Schouten et al., 2022). By improving the patient flow through the ED, the process could be optimized.

For example, (Schouten et al., 2022) recommended to provide a clear communication style to improve the efficiency of care. In the focus group of (Swallmeh et al., 2018) patients discussed the improvement of the patient´s ED pathway so that the patients could be treated more quickly with reduced waiting hours. In addition, they pointed out that the quality of an ED can be related to the quality and availability of supplies (Yarney & Atinga, 2017). Despite enough modern equipment, highly qualified staff, also seemed to be essential for the patient's satisfaction (Swallmeh et al., 2018). The experiences of the patient of how they go through their own ED journey and their pathway should be created on an individual basis.

> "[...] *person-centeredness in an emergency department are actually very simple skills that we implement all the time anyway, but we're just not always aware of it* (Cite focus group, line 201)."

Therefore, doctors and nurses must work together closely and bring in different ideas of what the best outcome looks like. However, conflicts can arise when these two professional groups work together. Among other things, these are certainly of historical origin, which is due to the hierarchical structures. Doctors considered it is most important to work with the most up-to-date protocols, while "*the nurses placed greater value on emotional support, physical presence, a composed manner, and interventions to reduce anxiety* (Péculo-Carrasco et al., 2020, p.4726)." This shows that the work attitudes of these two groups are very different. In addition, priorities are set differently, which is probably also due to the distinctive types of training.

> "*It can be Caring, it can be Moments of Trues, it can be a person-centered culture, that's just the reason I go into this care in the first place* (Cite expert interview 2, line 28)."

Individuals who are beginning to work in nursing want to work closely with persons in need. Every nurse has, as their basic intention, working in a person-centered way and these are also the original reasons why they have chosen this profession (Cite expert interview 1, line 17, 32). Especially in our world and in the new generation, there is this motivator to help people and to be present for those who need care (Cite expert interview 2, line 40). When asking nurses, why they started as a caregiver, the following answer arise frequently:

- Having time for the people
- Working with people
- Do something meaningful
- Job security (Cite expert interview 2, line 40).

These described aspects can be correlated to the person-centered approach and the fundamental principles. Nevertheless, looking at the person-centered care aspects and culture the question arises, how this could look like in a setting of an emergency department (Cite expert interview 2, line 16), because in an ED setting, patients come and go, resulting in a constant flow. Patients should never stay in the emergency department too long and should either be discharged again or admitted to the appropriate department.

> "*This liveliness and the demand to permanently get involved in new situations is a great challenge at an emergency department* (Cite expert interview, line 13)."

7.2.1 Surrounding Factors in the ED Context

For most people, a visit to an emergency department is a unique and special experience. That is why environmental factors should be designed to make people feel comfortable. In addition, people are already in a state of exception, so that their stay should be made as pleasant as possible. Research indicates that people were already stressed due to the geographical location and accessibility of the ED (Péculo-Carrasco et al., 2020; Schouten et al., 2022). For a reduction of this stress factor, efforts should

be made to provide good labelling and signage so that the emergency room can be easily found. Therefore, getting to the emergency room should be made as easy as possible, especially if people are not coming via an ambulance.

When they finally reach the ED, some factors should be considered, so that people feel comfortable and are in a safe environment. To ensure the patient´s comfort, some physical factors should be thought of included seating, food, beverage, Wi-Fi, plug points for phone charging and heating. These rather simple aspects can already help the patient to feel more relaxed, which is important for a positive health care outcome. Waiting times are usually rather long and a major problem, which will be discussed in more detail later. For this reason, special efforts should be made to meet the needs of the patients. Notably, many patients mentioned that they would prefer options to buy healthy food while waiting. They also mentioned that the waiting room should be clean, warm and with enough comfortable seating options (Swallmeh et al., 2018). Therefore, enough gurneys should be available and being offered to patients, because they provide physical comfort (Freitas et al., 2021).

As a final point, it is essential for the patients that they can trust the people working in the ED. Therefore, some elements should be fulfilled to meet these expectations. In the ED setting a wide range of disciplines must be covered and caregivers must be trained and highly qualified (Cite focus group, line 40). A good team is composed of young and senior, experienced personnel, because their different perspectives and competence levels could be integrated into the care process (Cite focus group, line 39, 171). Specifically, during triage, caregivers need to have skills, experience, and patience. In addition, nurses must have a good instinct and be stress-resistant because the environment requires it (Cite focus group, line 58-63). When caregivers meet these expectations and skills, it can help to provide person-centered care.

7.2.2 Vulnerable Moments for a Patient in the ED

The biggest challenge in the setting of an ED is that there is a certain liveliness and the need to constantly adapt to upcoming situations (Cite expert interview 1, line 13, 19; (Yarney & Atinga, 2017). The quality of care depends on patient volume, which is lower in the morning than in the afternoon (Cite focus group, line 34, 67; Cite expert interview 1, line 13). “P*eople come in and out of here like on an assembly line* (Cite

expert interview 1, line19).” Due to the short stay at the ED, the patients must remain in the flow and so the procedures must be quick (Cite expert interview 2, line 16). This setting of an ED is new for people and most of them only enter when they are extremely worried about their own health condition. Going into unfamiliar environment is often linked with fearfulness and feeling vulnerable in this situation. This includes that many patients feel that they lose their autonomy and independence (Swallmeh et al., 2018). Loss of autonomy and loss of independence lead to uncertainty and anxiety because patients do not know what is going on with them and little is communicated with them (Blackburn et al., 2019; Péculo-Carrasco et al., 2020). Patient inclusion can reduce anxiety and uncertainty when making decisions. Involving patients in decisions about their health conditions is dependent on the will of the whole team and seeing the patient as an individual person (Cite focus group, line 151).

I. Triage process

On arrival to the ED, as a first step, nurses have to identify if the patients are at the right place by finding out the main problem (Freitas et al., 2021). According to Phiri et al. (2020), during the triage process, patients experienced that they had not received enough information. The participants also expressed concerns about a lack of privacy moments and about the nurses´ attitude. But, when privacy and confidentiality are negatively affected, patients find it difficult sharing vital information with healthcare professionals (Phiri et al., 2020). Moreover, negative experiences regarding the communication style were identified, because nurses did not listening or asked additional questions (Schouten et al., 2022). Providing information with basic investigations such as an ECG, urine tests and measuring vital signs was identified as valuable and efficient (Freitas et al., 2021).

II. Treatment

All patients said that the provided information by the ED staff was crucial and a valuable part of their experience (Swallmeh et al., 2018). Additionally, the explanations about the treatment were inadequate and patients preferred understanding their condition and their therapy (Blackburn et al., 2019). Patients also experienced distress, because of a slow response due to appropriate pain relief and they were unaware why (Swallmeh et al., 2018).

Patients with dementia, bedridden patients or patients with cognitive impairments are vulnerable. They can no longer express themselves adequately and are therefore easily overlooked (Cite focus group, line 95, 149). Vulnerable patients are at higher risk of being seen only as a problem and not as a person who is fully integrated into the treatment pathway than other patients (Cite focus group, line 22). Due to communication barriers and higher patient volumes, the participants from the focus group, described it as difficult to establish honesty and transparency (Cite focus group, line 85, 149). Additional patients who come to the ED and are not an emergency, receive less care and are less likely to be forgotten (Expert interview 2, line 22). Leaving patients all to themselves, they need more attention and are perceived as annoying (Cite focus group, line 180).

> "*Some patients only come because of a trifle, and no one really feels responsible* (Cite focus group, line 139)."

During an emergency, life-saving interventions are in the focus and the aspect of changing care could be a risk factor for seeing the whole person, because medical interventions are dominant (Cite expert interview 1, line 27; Cite focus group, line 44). Patients appreciate such a behavior in the situation because they probably want first and foremost a competent medical treatment (Cite expert interview 2, line 16, 22). Due to emergencies, the other patients get too little attention and consideration.

> "*They just don't get as much attention as the others* (Cite focus group, line 141)."

III. Waiting Time

> "*I waited seven hours in an empty corridor, wondering where the other patients were. So, as a patient, I thought to myself, no one is working there, because I waited seven hours, but saw no one. I didn't get any information and it really made me feel screwed* (Cite focus group, line 103)."

In the study by Swallmeh et al. (2018) all participants reported that the waiting time had an impact on their ED experience (Swallmeh et al., 2018). According to Schouten et al. (2022), waiting time was cited as a major problem in all interviews, and many patients had negative experiences (Schouten et al., 2022). Not only patients, but also health care professionals identified waiting time as a wasteful period, where nothing is happening (Freitas et al., 2021). Long waiting times were perceived as annoying and patients expressed frustration and felt emotionally distressed (Phiri et al., 2020;

Schouten et al., 2022; Swallmeh et al., 2018). In addition, patients wanted to leave the ED because they had not been informed how long they would have to wait (Blackburn et al., 2019; Schouten et al., 2022; Swallmeh et al., 2018). Three focus group participants expressed the feeling of being forgotten in the waiting room and that no one is responsible for you, and you get the feeling of being lost (Cite focus group, line 90- 91).

> *"Participants in five focus groups emphasized how the ED was constantly busy so that staff were unable to find enough time to communicate with them appropriately* (Swallmeh et al., 2018, p. 8)."

IV. Discharge

Healthcare professionals in the ED must be responsible for ensuring that patients are discharged, and that follow-up care is provided. Patients feel they have been discharged too soon. In addition, instructions are sometimes inadequate, so patients soon return to the ED (Schouten et al., 2022). Follow-up care should be provided to avoid these return visits. The nurses in the focus group also experienced that physicians did not take responsibility during this process. Therefore, nurses have full responsibility for this part and feel that they must take care of vulnerable people.

7.2.3 Leading the ED team

The management style in the ED is very strict and direct, which means that one person is responsible for the leading position and tells the others what to do. The person, who has this task, must stand up and guide the way forward. It can be compared to an ongoing crisis, such as the COVID-19 pandemic, in which this model is necessary from the start. This situation could be compared to emergency circumstances, in which one person´s life depends on it. Since emergencies occur all the time in the ED, one person must take the lead and give proper instructions to the team (Cite expert interview 2, pp 25). To exemplify, a person arrives at an ED and is life-threateningly ill, an action must be taken immediately. This also implies that in this situation, someone must clearly provide leadership and distribute the exact tasks and procedure steps so that no necessary process steps are overlooked.

> "*I am a beekeeper myself and the way the swarms are organized, it is not the queen who says what happens. But there is a decisive swarm, which is also a swarm intelligence that determines where the swarm goes. That is, if a colony divides and a new colony is formed, then it is the intelligence of the entire swarm that tells them where they will go and which building, they will move into, and that is not the queen. So, the queen plays an important role, but not in that she directly leads the group of bees. But the bees decide together where they want to go and what they want* (Cite expert interview 2, pp 24)."

This example of the swarm of bees shows that working together as a team is always important. To do so, the hurdles of hierarchical thinking must be overcome, and everyone must have their say. In an emergency room, it is probably highly dependent on the individual situation in which the person finds themself. But of course, the output would improve by integrating the team into decisions and asking them for their opinion. Especially, when the first acute phase of an emergency has been overcome, all those team members involved should be included. This should also lead to a joint reflection and evaluation of the steps that were taken, as well as the next steps. Healthcare workers should be involved, and their proposed solutions included (Cite expert interview 2, pp 24), because a cooperation is necessary for improving the patient´s outcome.

7.3 Patients´ Needs

In the following chapter, the needs of the person while being at the ED are explored. These elements must be included for accepting the patient as a person and involving them into the care process. By recognizing these individual requirements of a person in the ED, they can be seen and treated as individuum.

7.3.1 Being Perceived as a Person

In the setting of an ED, the **patient wants to be perceived actively** during the care process. Patients need to feel safe, and this could be achieved "*if the responsible nurse perceives the patient and really looks at the patient* (Cite focus group, line 146)." Really looking at the person also expresses respect. In addition, patients feel protected when treatment is humane, such as when they are treated kindly, considerately, and compassionately (Péculo-Carrasco et al., 2020; Cite expert interview 2, line 22). "*The*

patient feels most holistically cared for when each professional group present communicates with the patient at eye level (Cite Focus group, line 189)." Moreover, maintaining eye contact as well as health care professionals being on the same physical level, was perceived as important nonverbal behavior by the patients (Hermann et al., 2019). Caregivers also benefit from eye contact and equal eye level, as this allows them to build a relationship with patients.

> "[…] *so, it's just this fast throughput. It is also important that the caregivers are satisfied, that it is not only functional, but that they also get a feeling of wholeness* (Cite expert interview 2, line 16)."

During the care process, nurses should provide communication rules, which are common in our society. Such simple elements help make people feel like they are being perceived. Being perceived as a person is supported by the person-centered approach and is important for the treatment process.

7.3.2 Being Listened to

As part of a respectful communication style, health care professionals should attend dynamically to the whole story of the patients. "*In the beginning, just let the patient tell the story of why they are coming* (Cite focus group, line 190)." Perceiving active dealing with the patient could be due to being **listened actively** to the patient´s concerns (Hermann et al., 2019); Cite Focus group, line 93, 190). Nurses from the emergency department said that "*they listened to them. I am really trying, to understand them* (Cite focus group, 131)." This could mean "*asking follow-up questions and checking for understanding by reiterating what was said* (Hermann et al., 2019, p.527)," so, a basic rule includes maintaining full focus on the person while listening (Hermann et al., 2019).

Persons, even in the ED, should get the feeling that their treatment is individually adapted to the needs. Blackburn et al. (2019) identified this kind of feeling by interviewing patients. They get the feeling, "*they were being 'listened to' when staff asked questions about their ED journey, enabling them to feel they were receiving individualized care* (Blackburn et al., 2019, p.32)." Meanwhile, "*allowing patients to explain without interruption and also taking notes, while the patient is talking (Hermann et al., 2019, p. 6)."* Such simple and basic communication rules are essential to treat patients respectful.

7.3.3 Having the Chance to Make my own Decisions

Treating the patients with respect, nurses want to *“let patients decide what they want and what is best for them* (Cite focus group, line 124).” Patients want to take this responsibility and “*expected to be treated as individuals* (Swallmeh et al., 2018, p.709),” which is an “*essential prerequisite to create awareness that the patient is a person* (Cite expert interview 1, line 21).” It could also improve the patient-career relationship, if “*the professionals were concerned about the patient as a person, and not just the symptoms* (Péculo-Carrasco et al., 2020, p.4725).” Therefore, caregivers should speak to the patient as a real person and address them by name rather than only with a number or a case (Hermann et al., 2019; Cite focus group, line 143, Cite expert interview 1, line 27).

> “[…] *treated me like a real person, like I belonged there (Hermann et al., 2019, p.527).”*

7.3.4 Being Informed

Patients want to **feel comprehensibly informed** about their care pathway in the ED (Yarney & Atinga, 2017). Providing them with accurate information and explaining treatments to them in detail can improve the patient experience (Schouten et al., 2022). In order to get patients to actively engage, they need information for example about how to take prescribed medications and their potential side effects (Blackburn et al., 2019; Hermann et al., 2019; Swallmeh et al., 2018). Furthermore, these explanations are useful to reduce patients’ anxiety (Blackburn et al., 2019). The usage of communication styles and tools, such as applying pictures, are methods to ensure the explanation was understood (Hermann et al., 2019, Cite focus group, line 163).

Communication also plays an important role during the treatment, as patients prefer clear statements and a responsible caregiver who is there for them (Cite focus group, line 88, 184, 197). Patients are calmer and satisfied, when they receive all relevant information, which increase their confidence (Blackburn et al., 2019; Cite focus group, line 88, 95 & 2). When patients get all relevant information, they receive a **feeling of being enlightened**. They can also more easily understand and accept therapy decisions and long waiting times (Blackburn et al., 2019; Hermann et al., 2019; Swallmeh et al., 2018). This is also beneficial for nurses, since the patient will have

fewer requests (Cite focus group, line 82, 94). Messages need to be delivered in a clear and honest way, so, that the patient knows what they are getting into and can be prepared for a longer wait, for example (Cite focus group, line 91, 117; (Blackburn et al., 2019; Schouten et al., 2022). "*This indicates that clear communication regarding waiting times is important and to make sure that patients do not feel like they are forgotten and excluded* (Schouten et al., 2022, p. 2)*."*

The use of "*simple language to explain aspects of the ED visit are noticed by patients, whether it is regarding medications or diagnosis* (Hermann et al., 2019, p.528)." Patients simply want to know what is going on with their condition as well as their treatment (Blackburn et al., 2019; Hermann et al., 2019). They also want to feel safe, so a realistic assessment of the situation should be a key factor (Péculo-Carrasco et al., 2020).

7.3.5 Involving my Next to Kin

Patients expect health professionals to take their social and family background into consideration (Péculo-Carrasco et al., 2020). The **involvement of the entire social environment** is relevant to the patients (Schouten et al., 2022; Cite expert interview 1, line 34), however, a patient should be free to decide whether or not the accompanying person is present during a medical examination (Cite focus group, line 124, 195).

> "*When I know someone is going to be discharged, I want to make sure they are well taken care of at home* (Cite focus group, line 195)."

As a nurse, one tries to make sure that the patient is well taken care of, because only then can they be discharged (Cite focus group, line 50- 51). Especially with elderly and intoxicated patients, it is particularly important to pay attention the discharge process (Cite focus group, line 50, 65). Another option is to involve discharge management to ensure that the patient is well cared for and does not come back soon (Cite focus group, line 194).

7.4 Nursing principles

In the following chapter, the prerequisites for caregivers for providing a person-centered approach within the ED are considered. The following characteristics were considered: transparent communication, being present as caregiver, building a relationship with the patients, recognizing the patient´s biggest concern, providing a sense of security and close collaboration with other disciplines.

7.4.1 Transparent Communication

Ensuring that patients are seen and heard, can be achieved through honest and providing clarity about their health condition (Schouten et al., 2022). Regardless of the different patient needs, increased communication and information enhance the experience of an ED visit (Blackburn et al., 2019). "*This often had an impact on the patient´s mental health and wellbeing* (Blackburn et al., 2019, p. 5)." Patients also want to actively participate in decisions throughout the treatment process (Swallmeh et al., 2018). "*The patients are cognitively impaired; however, it would make sense to involve a stakeholder* (Cite focus group, line 164)." Moreover, supported decision-making increases the patient´s ability to tolerate longer waiting times, because they valued the information exchange (Freitas et al., 2021).

> "[…] *an elderly person does not want intensive care and it is jointly decided that only a palliative setting will be used* (Cite focus group, line 152)."

7.4.2 Being Present as a Caregiver

Patients expect the ED staff to react to their different and specific needs (Hermann et al., 2019; Swallmeh et al., 2018). In order to receive a positive outcome relating to treatment for the patients, they had to feel comfortable (Cite focus group, line 23). Providing the patient, a feeling of meaningfully company through the entire pathway in an ED is crucial (Expert interview 2, line 16). Moreover, nurses need **to be present** for the patient and spend enough time with them. Care providers should not act rushed and even simple gestures such as shaking the patients´ hand (Hermann et al., 2019) are humane, caring, and accessible (Cite expert interview 1, line 34). Additionally, exercising small talk with patients is necessary and phrases such as "*have a nice day*" provide the patient the feeling that someone cares about them (Hermann et al., 2019).

> "[…] *he was treated well; he feels empowered to take care of himself and seek health care* (Hermann et al., 2019, p.527)."

If the nursing staff really care about the patient, longer waiting times are usually accepted (Cite focus group, line 88). Usually, there is less activity in the mornings so that there is more time for each patient (Cite focus group, line 68). Generally, it is time saving, if the patients are well-informed, because then they will have fewer requests (Cite focus group, line 94). Nurses want to actively be available for their patients and take responsibility by enabling one-to-one care (Cite focus group, line 146, Cite expert interview 1, line 34). To exemplify, if the waiting time is longer, nurses try to be there for the patients by maintaining eye contact or asking actively, if patients needed something (Cite focus group, line 182, 146, 84).

> "[…] *when I'm waiting there, that if I'm sitting there and someone walks by. And the person then says to me, we haven't forgotten them, do you need anything in the meantime? Has something changed? So that would be the optimal I think, where I would feel well taken care of* (Cite focus group, line 93)."

The protection of one's privacy is another necessary aspect relating to the feeling of safety. It must be noted that this is something spatially difficult, however nurses still try to ensure privacy during treatment procedures (Cite focus group, 128). Often, many people are around, and the environment can be very hectic at times. Nevertheless, even then it is necessary to provide a safe atmosphere. A viable solution would be attaching a "no entry" door sign, when a patient is exposed or written an EKG (Cite focus group, line 130). Nurses should also try to adjust to the patients' needs, as presented in the example below (Cite focus group, line 166, 169, 180, 190, Cite expert interview 1, line 27):

> "I*f someone wants their mom to come along, I try to understand, accept, and make it possible* (Cite focus group, line 131)."

To sum up, nurses should aim to act in the most professional way while maintaining a trustful relationship and providing a safety net is (Cite focus group, line 137, 139, 144).

7.4.3 Building a Relationship to the Patient

Transparency and honesty form the basis for a **respectful and humanly interaction** between nurse and patient (Cite focus group, line 85, 88, 122). During such a process, building trust and communication are essential components. Nurses from the focus groups, emphasized that it is important to introduce oneself by name and profession to build rapport with the patient (Cite focus group, line 135, 142-144). To improve the connection with the patient, eye contact should be made (Cite focus group, line 179), which constitutes an important feature for patients at the ED who have high concerns about their health (Cite expert interview 1, line 27).

Nurses should aim to treat patients the way they would want to be treated themselves, when coming into an ED. Therefore, they mentioned that it was important to change the perspective from time to time and empathize with the patient. Facing the patient with respect and tolerance, this will also be returned to the nurse (Cite focus group, line 197- 199). Patients expect responding promptly to concerns from the nurses, but it is also the other way around (Phiri et al., 2020). "*If patients are respectful to us, then I think nurses return that back to the patient* (Cite focus group, line 122)." Moreover, if patients *"go to the hospital and get treated nicely, it makes one feel good to take care of one's health (Hermann et al., 2019, p. 5)."* Additionally, the emotional components should be considered during the care process and patients appreciate such a behavior from nurses.

> "*This suggests that although patients expected to wait to receive treatment, their care experience could be improved through regular communications and interactions with staff (Blackburn et al., 2019, p. 4)."*

Needs of the person and the caregiver are essential elements of communication. "*Most participants expressed the expectation that healthcare staff should have the necessary medical knowledge to treat them safely and to answer their questions in a friendly way* (Swallmeh et al., 2018, p. 7)." Regardless of the professional appearance, patients expressed how simple interactions, such as smiling, positively affected their care journey. Politeness and courtesy influence the patients' experiences through their ED visit and can improve their satisfaction level, too. To exemplify, nurses who introduce themselves as part of the health care team changed the patients´ ED expierence (Hermann et al., 2019). Patients also wanted nurses to be more open, spontaneous,

friendly, and human-centered, while establishing connections (Hermann et al., 2019; Schouten et al., 2022).

7.4.4 Recognizing the Patients´ greatest Concern

> "[…] *the person without seeing the problem is difficult in the emergency room. Since the patient with their problem should be as a part of what is happening* (Cite focus group, line 23)."

According to the interviews, patients want their **biggest concerns addressed** during their care pathway at the ED (Cite expert interview 1, line 19). As a first step in the triage process, the patient's main problem must be evaluated immediately and the right department must be found (Cite focus group, line 61). The focus should always lie on the person and nurses should actively perceive them. Even nurses from the focus group explained that they would have felt uncomfortable and not taken serious, if health care staff only looked at their computers (Cite focus group, line 93). This also includes explanations about the further proceeding (Cite focus group, line 84). Attention must be placed on the patient´s current situation, regardless of any other distractions during the process of respectful interaction (Hermann et al., 2019; Yarney & Atinga, 2017), Cite expert interview 1, line 34). The quality of care is not only connected to the professional skill mix, but also to the ability for dignified interaction (Yarney & Atinga, 2017). This also means that not the illness should be at the center, but rather the whole patient (Cite focus group, line 22, 189), as expressed in the quote below:

> "[…] *Then I would also feel personally holistically cared for as a patient. So, these sufferings include both the disease, physical and psychological, and for example, if it is only about the care of the cat at home. This can also be stressful. So, if you can pick up the all-round carefree package in the emergency room, then this would be the optimum from a holistic point of view* (Cite focus group, line 189)."

7.4.5 Providing a Sense of Security

When healthcare professionals started listening and giving patients as much information as they needed, they would automatically feel safe (Péculo-Carrasco et al., 2020; Swallmeh et al., 2018). Patients needed the feeling of safety while waiting in the waiting room and they also wanted to make the most out of this period (Freitas et al.,

2021; Swallmeh et al., 2018). Being aware of the worries besides the medical emergency can build trust and is fundamental for building a respectful relationship (Cite focus group, line 147). "*The value was in providing care that may be considered beyond the scope of emergency care* (Freitas et al., 2021, p. 4)." Nurses must reassure and respond to the emotional needs of patients by recognizing their fear and anxiety in this new environment (Hermann et al., 2019), Cite expert interview 1, line 19).

> "*Especially in emergencies, I always ask them if they wanted to talk to someone on the phone, if they wanted to let someone know* (Cite focus group, line 147)."

7.4.6 Collaboration with other Disciplines

Patients are usually aware of the relationship, teamwork, discourse, and gestures between members of the emergency team (Péculo-Carrasco et al., 2020). This **interdisciplinary** working environment is often challenging for patients because they are unsure who is responsible for them and therefore feel unconfident about their treatment (Blackburn et al., 2019). Improvements in patient experience could be achieved through effective collaboration between physicians and nurses (Sonis et al., 2018). Establishing a triangle with the patients, nurses and physicians must be willing to make decisions together (Cite focus group, line 149). Such a collaboration between all healthcare disciplines is essential to involve patients in decision-making to work according to the person-centered principles (Cite focus groups, line 152, 174). Nurses act as translator to mediate between doctors and patients (Cite focus group, line 182). In particular, "*the patient is usually there (at the decisions), when asked* (Cite focus group, line 151)."

"*It depends on this triangle, and if the two corners harmonize well, the third corner is also somehow taken. That is my experiences, but unfortunately it doesn't happen that often. When that happens, the job can even be kind of fun* (Cite focus group, line 147)."

7.5 Crucial Aspects for Developing a Person-Centered Culture at the ED

The implementation of a PCP-Framework and achieving successful care development involves strategic, professional, and political stakeholders (Cite expert interview 2, line 12). The direction of development of nursing should be towards professional, modern, and evidence-based nursing and implemented in the future (Cite expert interview 2, line 10). Nursing professionals need to create an awareness of what it takes to be

person-centered (Cite expert interview 2, line 21). At the beginning of this paragraph, some general aspects will be described for the implementation process of a person-centered approach. However, it must be mentioned that it is important to look in an ED and take the vulnerable moments into consideration. The reason for this is that the person is at a risk of being forgotten as a whole person due to the fast-moving environment of an ED.

I. Working together with the Base

To establish a foundation, it is necessary to work with caregivers on what is important to them in providing care (Cite expert interview 1, line 17, 21). While defining the professional context of nurses, it is strongly connected with the concept of caring where human aspects are at the center (Cite expert interview 2, line 10, 38). Therefore, an environment must be developed where both caregivers and receivers are satisfied (Cite expert interview 2, line 16, 22). Moreover, having the attitude of person-centered approaches mineralized in a fast environment improves the experiences of the patient (Cite expert interview 2, line 22). If the basic attitude of caregivers is identified, a person-centered way could be achieved (Cite expert interview 2, line 10). The identification the intention, that people want to work in a person-centered way is one of the important matters for practical implementation (Cite expert interview 1, line 32). Professional caregivers want to work in a person-centered culture, as it is the reason why many started this profession (Cite expert interview 2, line 10; Cite expert interview 1, line 25).

> "*The secret is, of course, that even if you come down from above, you have to try, and I think I only succeeded to a certain extent, actually it would be ideal, that you then have to work very firmly with the basis* (Cite expert interview 2, pp 36)."

II. Consideration for Hierarchy Levels

In our current hospital settings, hierarchic structures are predominant and conflicts between doctors and nurses are often based on hierarchies. As an example of such a situation was presented in the focus group where the nursing staff was enthusiastic about an issue while the medical profession was rather reluctant (Cite expert interview 2, line 26). The experience of the experts has shown that everyone must work together in an interdisciplinary team to ensure successful implementation of person-centeredness (Cite expert interview 2, pp 29, 36). The very essential aspect is working together with the leading position and have their commitment (Cite expert interview 1, line 17). A caregiver from the focus group also mentioned that "*leadership needs to implement to make a difference at the grassroots level* (Cite focus group, line 200)." Having the support of the management level is necessary to have enough personal resources, the next step is working together with the front-line workers (Cite expert interview 2, line 10, 28).

> "[…] *only when the management team is clear about what it is and what they want, what they can do, what they are able to implement in an environment, then they will succeed in going there* (Cite expert interview 1, pp. 17)."

One of the main goals of person-centeredness is to flatten the hierarchic structures, while implementing the person-centered concept. "*Because in the person-centered culture, you want to involve the person, you want to include them in decisions, you want to ask them, you want to give feedback, you want to be allowed to question each other. This automatically leads to a different form of hierarchy, to a flat hierarchy* (Cite expert interview 2, pp 26)."

III. Integration into the Organization

By adopting the style of the organization into a flattening hierarchy, a person-centered approach becomes more possible. It is like changing things that way, for example solving the problem with mix-up of drugs so that medicines can no longer be directed in any other way (Cite expert interview 2, line 28). This mechanism of control allows mistakes to stop happening or to be avoided. It is crucial to create an organization in which nursing development is regarded as the primary goal (Cite expert interview 2, line 12). By creating structures, in which employees feel comfortable, the attitude of

the health care staff must also be like a person-centered approach (Cite expert interview 2, line 38). The communication of such values can only be implemented if the mission statement of the entire organization stands behind it. In conclusion, the organization needs to incorporate this as a structural part in order to achieve its success (Cite expert interview 2, line 30-35).

> "*What you then manage to have present as a vision among the nurses. If this is not a value that the hospital or institution wants, then the nurses will not implement it either, because they may then orient themselves to the values that one would like to implement in the institutions or in nursing care* (Cite expert interview 2, line 28)."

7.6 Transfer into the Care Processes

In the following paragraph, the results will be classified into the already existing PCP-Framework, which focuses on the care processes. In practice, the areas cannot be clearly separated, and several aspects simply assign themselves to more than one care process.

I. Working with the Person´s Beliefs and Values

The patient's beliefs and values can be described as central elements, as they are crucial for PCC. Therefore, the goal is to find out what is important to the person and what they value. This can be achieved through a type of assessment that maps the patient's lifeworld. In the ED, nurses must maintain a respectful and people-friendly approach, because only then will people trust the nurses. By recognizing the person's greatest concerns, which is essential in this unique setting, the patient can receive the best possible care. Based on the outcomes of the focus group, the person must be actively noticed and listened to on their care journey. In addition, people are given the feeling that they can make their own decisions about their health conditions. In particular, the patient's social environment should also be involved, as it supports them during their illness. People are social beings and need familiar people to help them make decisions and be there for them.

- Being listened to
- Having the Chance to make my own Decisions
- Recognizing the Patients´ biggest concerns

- Involving my Next to Kin
- Building a relationship to the Patient
- Being Perceived as a Person

II. Engaging authentically

This area can be achieved if the caregiver accepts that each person must be treated individually. In addition, each situation is unique, which is strongly influenced by values and beliefs. In this regard, individuals must be perceived and known. If these conditions are respected, a trusting environment can be created even in a complex setting. The ED, as mentioned earlier, can be described as a unique environment, so it is important to provide the patient with a sense of security. In addition, transparent communication should be ensured during this process by actively addressing the person's needs. By focusing attention on the person, he or she is given the feeling of being enlightened as a person, which empowers him or her to make his or her own decisions. In summary, decisions must be made at the individual level and interdisciplinary working conditions must be included.

- Providing a sense of security
- Transparent Communication
- Being listened to
- Having the chance to make my own decisions
- Collaboration with other disciplines

III. Shared Decision Making

The decision-making process should incorporate the experience and knowledge of all those involved, which are important for decision-making. The basis for a professional relationship is acceptance of people's values and beliefs. The goal is to be able to empathize with the individual and understand the meaning of the interactions. To achieve this goal, respectful and humane interactions must be ensured so that people are empowered to make their own decisions. People can only make their own decisions if they are given all the information, they need to make decisions about their health status. Both expertise, that of the caregiver and that of the recipient, should be

linked through transparent communication. Patients are their own experts and have the most experience and knowledge about their own bodies. But health care professionals also have some expertise and knowledge. Furthermore, these different professions should always work closely together by combining this interdisciplinary context.

- Building a Relationship to the Patient
- Having the Chance to Make my own decision
- Being informed
- Transparent Communication
- Collaboration with other Disciplines

IV. Being Sympathetically Present

This process describes a particular way of being present. Here, the goal is to ensure that people respond appropriately and adequately to a variety of situations. In addition, the characteristic of being emphatically present becomes visible through verbal or nonverbal activities in normal everyday situations. In the hectic environment of an emergency room, caregivers should be truly present and there for the person. In addition, the person gets the feeling of being actively perceived as a human being. To ensure this, healthcare professionals should listen to the person and update them regularly, otherwise they would get the feeling of being left alone, which is contrary to a person-centered approach. Patients should feel educated throughout the care process and visit.

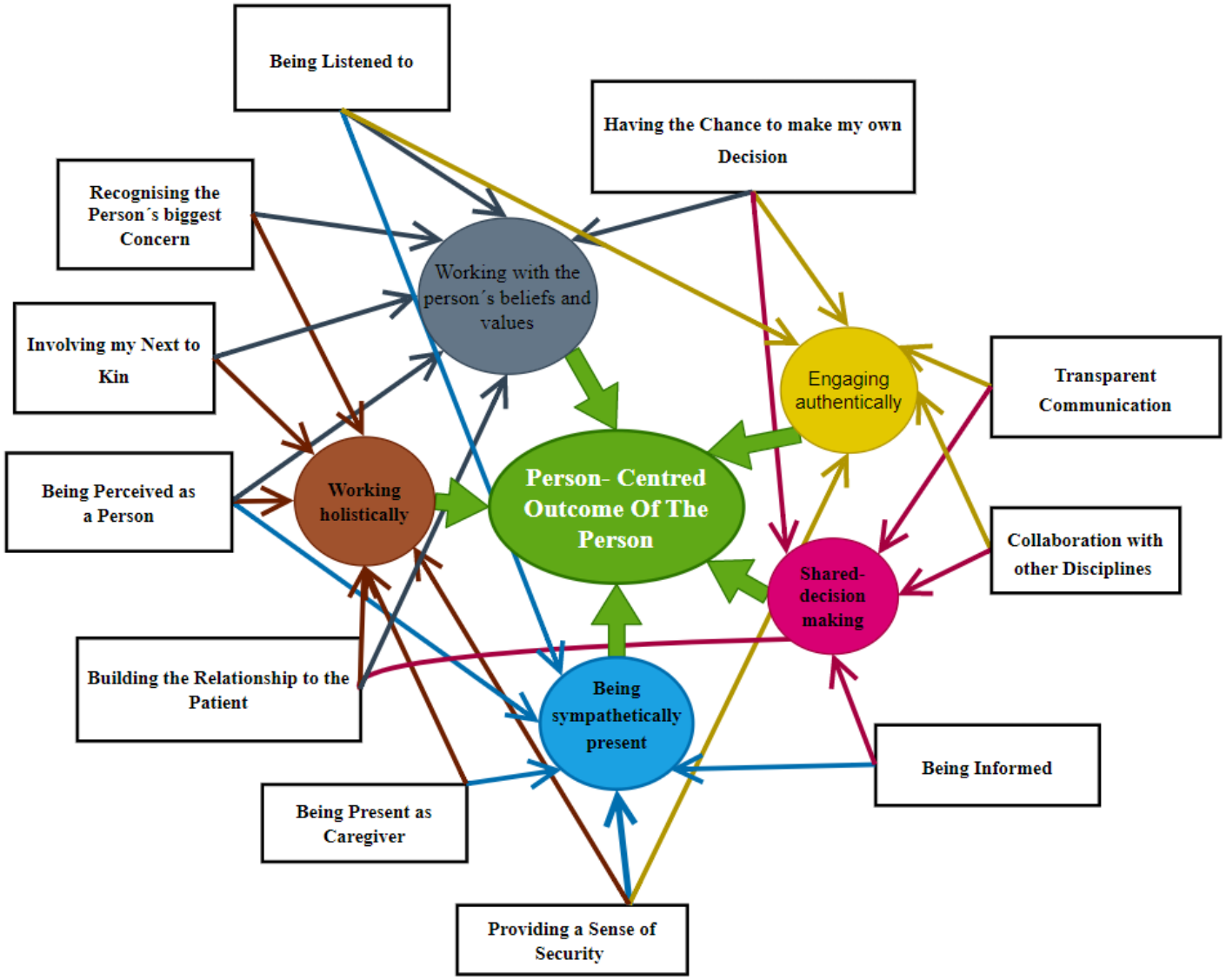
- Being Present as a Caregiver
- Being Perceived as a person
- Listened to
- Being informed
- Providing a Sense of Security

V. Working Holistically

In addition to the physical aspects, the various aspects of personality must also be considered. In this context, the: cultural, developmental, spiritual, and psychological. To achieve this, the person's social environment must be included in the care pathway. As a nurse, part of the responsibility is to make sure patients have someone they trust. To ensure this, healthcare professionals need to be there for the person, which also provides a sense of security. In addition to this safety net, caregivers and recipients should ensure respectful interactions and treat each other equally. In addition, assessing the greatest concern must be a top priority, because when this is ensured, patients can be actively perceived as a person and taken seriously.

- Recognizing the Patients´ biggest concerns
- Being perceived as a person
- Being Present as a Caregiver
- Providing a Sense of Security
- Involving my Next to Kin
- Building a Relationship to the Patient

Figure 5: Overview of the processes of the PCP framework in the setting of an emergency department.



8 Discussion

The purpose of this study was to analyze how to apply a person-centered approach in the ED. Such a development process provides the first bridge to implementation.

8.1 Specifics of the ED in terms of the PCP-Framework

As a first step of the **implication from the PCP-Framework will be combined with the results from this thesis**. McCormack and McCance developed the PCP-Framework specifically for nurses to understand and implement a person-centered approach into the practical field (McCormack & McCance, 2006). The authors Slater et al. (2017) identified this framework to provide useful guidelines for developing a person-centered care culture in the health-care setting (Slater et al., 2017). The evaluation and integration were considered in long-term care facilities, as vulnerable old people need a special observation for outcomes (Edvardsson et al., 2009; Martínez et al., 2021; McCormack & McCance, 2006). Vulnerable patients also attend the ED and are at higher risk to be only seen as a problem rather than people in need (Cite focus group, line 22, 95, 149). All patients want to be seen as real human beings and therefore, they should get addressed with their real name and treated as an individual person with needs and experiences (Hermann et al., 2019); Cite focus group, line 143, Cite expert interview 1, line 27).

Building a meaningful relationship is considered one of the fundamental principles of a person-centered culture throughout the treatment process in the ED (McCormack & McCance, 2021, Cite focus group, line 190). During this process, all persons involved should be treated with respect. Thus, simple and basic communication rules must be provided, such as actively listening and a respectful interaction (Hermann et al., 2019). By applying a person-centered approach and empowering people to actively work with these principles, the distress level could be decreased (Hudon et al., 2011). According to Swallmeh et al. (2018), patients not receiving adequate pain relief during treatment in the ED perceived this as a burden(Swallmeh et al., 2018). Therefore, an effective medication management should be provided to increase the patient's satisfaction level. These above-described events have been experienced and could be minimized by implementing a person-centered culture (Han & Radel, 2016).

Adopting such a culture could satisfy not only patients, but also family members and health professionals (Cite focus group & expert interviews; (McCormack & McCance, 2021). Through this approach, the basic idea of nursing could be experienced in a new way, which would also be incentive for the next generation of nurses entering this field (Cite expert interview 1, line 17,32; Cite expert interview 2, line 40). Improving health care can be achieved by actively involving employees in decision-making (Tyreman, 2018). When the goal of this culture is not met, the rate of career dropouts and stress-related burnouts increases. (DeSilva et al., 2014; Sjögren et al., 2013).

Furthermore, an ED requires an extreme level of interdisciplinary and highly skilled healthcare personnel (Johnson & Cureton, 2004; Person et al., 2013; Sonis et al., 2018). During the triage process, a quick screening must be conducted to determine the person´s main problem (Freitas et al., 2021; Person et al., 2013). Phiri et al. (2020) experienced that patients were concerned during the triage process if they did not receive sufficient information (Phiri et al., 2020). However, efficient measures were the provision of enough information by combining basic exanimations such as ECG, urine test and measuring vital signs (Freitas et al., 2021).

Several studies have recognized the phenomena of overcrowding and high patient flow that underlines this stressful environment (Schouten et al., 2022). The results could affect the quality of care for the patient and lower profit (Handel et al., 2010). However, current evidence from the literature and from this study indicates that ED staff need to develop specific skills to deal with external pressures related to wait times and the deleterious effects of shift work. These include, for example, good intuition in emergency situations, and stress resilience (Crilly et al., 2014; Short et al., 2015).

McConnell et al. (2016) recognized that the principles for ED nurses were related to a focus on medical-technical interventions and the presence of a culture of appreciation (McConnell et al., 2016). Person-centered processes, as described by McCormack and McCance (2021), focus on providing care through a range of activities and include: “*working with patient's beliefs and values*”; “*engagement*”; “*having sympathetic presence*”; “*sharing decision making*”; and “*providing for physical needs*” (McCormack & McCance, 2021). For example, ED staff concentrated on tasks and interventions were not able to fully engage with patients (McConnell et al., 2016). During an emergency, life-saving intervention are in the focus and the aspect of alternating care

could be a risk factor for seeing the whole person. This includes that medical interventions dominate and have the highest priority in this situation (Cite expert interview 1, line 27; Cite focus group, line 44). Patients appreciate it when receiving competent medical treatment (Cite expert interview 2, line 16, 22).

However, these findings suggest that ED staff need to reevaluate their values and the core principles of care (McConnell et al., 2016). To achieve this goal, respectful and people-friendly interaction must be provided so that people feel empowered to make their own decisions (Fridberg et al., 2021; WHO, 2016; Cite focus group & expert interviews). The importance of including patients into the hospital setting depends on the willingness of the entire team (Groene et al., 2009; Ree et al., 2019; Cite focus group, line 151). Challenges for further implementation and development may depend on contextual factors involving strategic, professional, and policy stakeholders. In the future, the integration of person-centeredness into everyday practice must be professional, modern, and evidence-based (McCormack et al., 2011; Cite expert interview 2, line 12, 10).

8.2 Conclusion

The results have shown that the ED must be considered a unique environment. Reasons are, for example, a high patient flow, a stressful atmosphere, conflict situations in the interdisciplinary team, and hierarchic structures. The implementation of a person-centered method in this field could minimized these problems. The fundamental of this approach is to flatten hierarchical structures and put the person´s needs in the center of interest.

The connection between the caregivers and receivers could be combined by the needs of the person in the ED and the prerequisites of the nurse. Overall, twelve different categories were identified by using nurses, patients, and expert perspectives. Afterwards, they could be assigned to more than one of the five care processes from the PCP-Framework by McCormack and McCance. These parts are named: “be actively listened to as a person”, “making your own decisions as a person”, “ensuring transparent communication”, “combining interdisciplinary”, “getting the feeling of enlightened as a person”, “respectful and human friendly interaction”, “person would like to feel informed”, “providing a sense of security”, “being present as a caregiver”, “actively perceive as a person”,” sharing social environment of people” and

“recognizing the person´s biggest concern”. The combination of the identified categories and the processes was a first step in identifying that a person-centered approach is possible in the ED. The satisfaction level would be improved for health care providers and receivers. However, a person-centered culture must be developed in the ED for practical usage.

The implementation of practical development can be successful by following strategic plans and creating awareness to the fundamental principles of person-centered care. All different levels, such as the managers and front-line workers, in the hospital setting must be on board and work together as a team. In the expert interviews, they essentials parts for successful implementation were mentioned: “working with the base”, “consideration of the hierarchy levels” and “the integration into the organization”. Besides that, some specific elements were mentioned, which were specific in the ED. Most importantly, the vulnerable moments of the patients should get distinct attention because the risk of not being perceived as a person is critical. Following elements were mentioned frequently and describe the patients´ journey through the ED visit: “during the triage process”, “general treatment phase” and “waiting time and discharge”. Nurses must constantly adapt to new arising situations in this liveliness environment. Therefore, communication in the team and with the patients is fundamental. Although, the development of a person-centered culture in the emergency department is necessary, special consideration should be drawn to these critical moments.

8.3 Recommendations for nursing practice

The following results of this master´s thesis is intended to provide approaches for possible further developments in an ED. The previously described characteristics are intended to inform how nurses ideally want to work. The person-centered approach is an attempt to create conditions that are equally inclusive of all participants. The nature of this approach is why people choose to enter the nursing profession. It is imperative to focus more on this basic intent of nurses, as this is the beautiful side of the profession, and the reason people chose it.

However, when this approach and these expectations are not met, people leave the nursing profession. It is understandable that these are the reasons for leaving when certain basic needs are not met. Therefore, it is especially important to take their needs into account and actively ask them for their opinion. As mentioned earlier, the grassroots must also be involved in these processes to enable successful implementation. In a focus group that addressed this issue, the waiting room was mentioned as a crucial area for improvement. Here, the recommendation was made that a permanent person should be responsible for this area. In addition, information sharing should be improved. Since information sharing has an impact on patient outcomes, it should be done without disruptive issues.

This way of working will become increasingly important in the future, as evidenced by the COVID-19 pandemic. Frontline staff should be more involved because they come from the immediate environment and know what matters. By including their needs more in development aspects, they are likely to feel better understood in the future. These aspects will be crucial in integrating a new culture into a hospital, which will be of great importance in our future. Especially with younger generations in mind, who associate a good work-life balance with well-being. It's not primarily about having a career, but rather about what kind of culture the hospital has, whether certain values can be upheld that are important to you. Otherwise, leaving might be a legitimate option.

8.4 Implications for research

Various suggestions for future research can be derived from the findings obtained in this master's thesis. In particular, the relevant topics focusing on nursing processes should be used as a basis. As a next step, further data could be collected, and the nursing perspective needs to be explored in more detail with additional focus groups. In this setting, the development of person-centered basic principles could be achieved. This work could be used as an attempt to look more closely at person-centered aspects under specific conditions. Moreover, it could be found that these are not so far from the actual lived reality. Certain aspects just need to be made more aware and focused to be implemented properly.

From a scientific perspective, it is also important to minimize the gap between theory and practice. It is important to consider all components and keep the hierarchy levels as flat as possible. Nevertheless, implementing these aspects in the hospital and in the ED is difficult, but it must be tried. Therefore, it is of great importance to always work closely with the practice and develop concepts that lead to successful practice development. For example, when applying the framework concept, it must be presented and elaborated in a simplified way so that it can be directly applied in practice. This simplified outline needs to be implemented to achieve a common understanding, as it is usually presented in too abstract manner.

Soon, the scientific community should work with this model and develop guidelines. On the one hand, these results serve to explore the ED within a person-centered approach. Certain guidelines have been shown to be important in implementing such a culture. In this context, it was possible to identify particularly dangerous moments when there is a high risk that a person is not fully integrated into the care processes. These moments should be further identified and discussed, as some of these aspects are already present in the literature. However, specific recommendations for action need to be developed to avoid these errors and ensure that they no longer occur in an ED. Soon, the person-centered culture approach will come to the forefront in hospitals as the entire healthcare system seems to be moving in this direction. This shift was described earlier when the disease-centered approach shifted to an integrated care approach.

8.5 Limitations

In the following thesis, limitations must be considered, which are mentioned in the following chapter. Due to the resources and scope of a master's thesis, it was not possible to analyze the entire PCP-Framework in the context of an ED. Therefore, the limited time can be considered a strong limitation, as the researcher must complete her studies within a certain period. Nonetheless, the results of this work offer a first step in gaining insight into what a person-centered culture might look like in the context of an emergency department. The differences with international studies and the relevance of research application to nursing practice warrant this study and further research in this area.

In particular, the impact of the COVID-19 pandemic is a limitation of this work in many ways. For example, the focus group and expert interviews were conducted online, which made constructive exchanges much more difficult. However, the recruitment process for the focus group proved more difficult than initially anticipated. In the end, only five participants were willing to participate, which can also be considered a limitation. For a constructive discussion, at least six participants should take part in a focus group. Unfortunately, however, this could not be fulfilled, as one person dropped out without an excuse. Also, due to time constraints, it was not possible to conduct another focus group. In addition, all attempts possible by the researcher to recruit participants were made during the recruitment process, which lasted for two months. Thus, the originally set goal of the number of participants for the focus group was not met. Furthermore, participants were only found through personal contacts in the province of Vienna, Austria.

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11 Appendix

I. Abstract

II. Information letter

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VII. Results from focus group with whiteboards

11.1 Abstract (English)

Background: Person-centeredness is a trend that has taken hold in the healthcare sector over the past decade. McCormack and McCance's PCP-Framework has proven to be an effective guide for implementation in nursing practice.

Objective: The main objective was to investigate person-centeredness in the setting of an ED and how and if it is lived according to these principles.

Method: Three different types of data sets were used in this qualitative exploratory study: a focus group with ED nurses, two expert interviews, and a systematic literature review to capture patient perspectives. The focus group and expert interviews were transcribed. All data sets were coded using MAXQDA software, followed by a Mayring content analysis.

Results: The fundamentals of this person-centered approach are the flattening of hierarchical structures, the equality of all participants in decision-making, and the focus on the needs of the individual. By linking the categories to the processes, a person-centered approach is possible, as the satisfaction of all involved would improve. However, a culture needs to be developed so that these specific steps can be put into practice. Special attention should be paid to weak moments, as the risk of not being perceived as a person in these areas was considered critical.

Discussion: Challenges for further implementation and development may depend on contextual factors involving strategic, professional, and policy actors. In the future, the integration of person-centeredness into everyday practice must be professional, modern, and evidence-based.

Keywords: person-centered care, emergency department, practice development, nursing

11.2 Abstract (German)

Hintergrund: Personenzentrierung ist ein Trend, der sich in den letzten zehn Jahren im Gesundheitssektor durchgesetzt hat. Das PCP-Framework von McCormack und McCance hat sich als wirksamer Leitfaden für die Umsetzung in die Praxis gezeigt.

Ziel: Das Hauptziel bestand darin, die Personenzentrierung im Umfeld einer Notaufnahme zu untersuchen und festzustellen, ob und wie sie nach diesen Grundsätzen gelebt wird.

Methode: In dieser qualitativen explorativen Studie wurden drei verschiedene Arten von Datensätzen verwendet: eine Fokusgruppe mit Krankenpflegepersonen der Notaufnahme, zwei Experteninterviews und eine systematische Literaturrecherche zur Erfassung der Patientenperspektive. Die Fokusgruppe und die Experteninterviews wurden transkribiert. Alle Datensätze wurden mit der Software MAXQDA kodiert, gefolgt von einer Inhaltsanalyse nach Mayring.

Ergebnisse: Die Grundlagen dieses personenzentrierten Ansatzes sind die Verflachung hierarchischer Strukturen, die Gleichberechtigung aller Beteiligten bei der Entscheidungsfindung und die Konzentration auf die Bedürfnisse der Einzelnen. Durch die Verknüpfung der Kategorien mit den Prozessen ist ein personenzentrierter Ansatz möglich, da sich die Zufriedenheit aller Beteiligten verbessern würde. Die Entwicklung einer personenzentrierten Kultur ist für die Umsetzung der spezifischen Schritte in die Praxis auf einer Notaufnahme notwendig. Die vulnerablen Momente sollten im Fokus stehen, da die Gefahr, dass in einer Notaufnahme die Patienten nicht als Person wahrgenommen werden.

Schlussfolgerung: Die Herausforderungen für die weitere Umsetzung und Entwicklung können von kontextuellen Faktoren abhängen, an denen strategische, professionelle und politische Akteure beteiligt sind. Die Integration der Personenzentrierung in den Praxisalltag muss in Zukunft professionell, modern und evidenzbasiert erfolgen.

Schlüsselwörter: Personenzentrierte Versorgung, Notaufnahme, Praxisentwicklung, Pflege

11.3 Information letter

Information zum geplanten Projekt

„Person-centered care at the emergency department “

Sehr geehrte Damen und Herren!

Ich, Marianne Brantl, bin Studierende des Masterstudiums „Pflegewissenschaft“ an der Universität Wien und plane im Rahmen meiner Masterarbeit ein Projekt zum Thema der Personenzentrierung auf einer Notaufnahme durchzuführen.

Die Verantwortliche für die Datenerhebung und die Auswertung bin ich.

Der theoretische Rahmen liegt auf dem Framework „Person-Centered- Care“ von Brendan McCormack. Die Ergebnisse sollen dazu beitragen, die Personenzentrierung in einem speziellen Setting, wie einer Notaufnahme näher zu untersuchen und zu beschreiben.

Hierbei ist Ihre Expertise bezüglich Theorie-Praxis-Transfer relevant, um die Umsetzung von neuen personenzentrierten Grundprinzipien auf einer Notaufnahme zu erarbeiten. Zur Datenerhebung werden Sie an einem online Interview teilnehmen, wobei Sie eine Einladung via MS Teams bereits erhalten haben. Die voraussichtliche Dauer beträgt eine Stunde.

Vor der Teilnahme an dem Interview bitte Ich Sie um eine schriftliche Einverständniserklärung. Ihre Teilnahme an diesem Projekt ist freiwillig. Ihr Name und Ihre Kontaktdaten werden in der Masterarbeit nicht aufscheinen.

Das Interview wird digital erfasst, dies bedeutet der Ton und das Video werden mit Hilfe eines Programmes aufgezeichnet. Ihre Daten, die im Zuge des Interviews erhoben werden, werden bis zum Abschluss der Masterarbeit unzugänglich aufbewahrt und vor dem Zugriff Dritter geschützt und nach Abschluss der Arbeit gelöscht.

Es werden keine Daten aus dem Interview, unter Wahrung der Anonymität, also durch das Nicht-Nennen von Namen, weitergeben. Diese Daten werden ausschließlich zu wissenschaftlichen Zwecken verwendet.

Die Ergebnisse werden ausschließlich ohne Ihren Namen und Kontaktdaten verarbeitet. Dies bedeutet, dass „Niemand“ aus den Ergebnissen erkennen kann, von welchen Personen die Angaben gemacht wurden.

Eine Kopie der Einwilligungserklärung wird Ihnen ausgehändigt und ein Widerruf der Zustimmung kann Ihrerseits jederzeit ohne Angaben von Gründen erfolgen. Ein Teilnahmeausstieg führt zu keinerlei Nachteilen für Sie.

Vielen Dank, dass Sie an dem Projekt teilnehmen möchten.

Marianne Brantl

Korrespondenzadresse bitte per e-mail: a01540887@unet.univie.ac.at

11.4 Consent Form

Einverständniserklärung zur Teilnahme an einer Studie
„Person-centered care at the emergency department “

Name Teilnehmer*in (Druckbuchstaben):

Ich wurde von der verantwortlichen Person dieser Studie (Marianne Brantl) vollständig über Wesen, Bedeutung und Tragweite der Studie aufgeklärt. Ich hatte die Möglichkeit Fragen zu stellen, habe die Antworten verstanden und habe zurzeit keine weiteren Fragen. Mir sind möglichen Nutzen und Risiken dieser Studie bekannt.

Ich hatte ausreichend Zeit, mich zur Teilnahme an dieser Studie zu entscheiden und weiß, dass die Teilnahme daran freiwillig ist. Ich weiß, dass ich jederzeit und ohne Angabe von Gründen diese Zustimmung widerrufen kann, ohne dass sich dieser Entschluss nachteilig auf mich auswirken wird.

Ich bin damit einverstanden, dass in dieser Studie Daten von mir aufgezeichnet werden. Mir ist bekannt, dass meine Daten anonym gespeichert und ausschließlich für wissenschaftliche Zwecke verwendet werden.

Ich habe eine Kopie der Einwilligungserklärung erhalten und erkläre hiermit meine freiwillige Teilnahme an der Studie.

Datum

Unterschrift Teilnehmer*in

11.5 Brief questionnaire

Kurzfragebogen zu den demographischen Daten:

- Welchem Geschlecht fühlen Sie sich zugehörig?
    - Männlich
    - Weiblich
    - Divers
- Wie alt sind Sie? (Angabe bitte in Jahren) _____
- Welche Staatsangehörigkeit haben Sie?
    - Österreich
    - Deutschland
    - Sonstige, bitte genauer ausführen: _____
- Welche Muttersprache haben Sie?
    - Deutsch
    - Englisch
    - Sonstige, bitte genauer ausführen: _____
- Welche weiteren Sprachen sprechen Sie?

_____

- Welche Ausbildung zur Gesundheits- und Krankenpflege haben Sie abgeschlossen?
    - Diplomlehrgang
    - Hochschulabschluss
    - Sonstige, bitte näher beschreiben:

      _____
- In welchem Ausmaß sind Sie derzeit erwerbstätig?
    - Vollzeit (40h)
    - Teilzeit (30h)
    - Sonstige, bitte genaue Stundenzahl angeben: _____
- Wie lange üben Sie Ihre Tätigkeit als Gesundheits- und Krankenpflegeperson schon aus?
    - 1-5 Jahre
    - 5-10 Jahre
    - 10-15 Jahre
    - Über 15 Jahre
- Wie lange arbeiten Sie bereits in einer notfallmedizinischen Ambulanz?
    - 1-5 Jahre
    - 5-10 Jahre
    - 10-15 Jahre
    - Über 15 Jahre
- Haben Sie Zusatzausbildungen absolviert?
    - Ja, bitte genauer ausführen: _____
    - Nein

11.6 Guideline for focus group

5-10 min	Einstieg	Vorstellungsrunde	Kennenlernen & Warm- Up
20 min	PCP-Framework nochmal kurz wiederholen	2 Statements vorstellen und darüber diskutieren: a. Personenzentriertes Arbeiten bedeutet, eine Person nicht losgelöst von ihrem Umfeld und als Problem zu sehen, sondern sie zu integrieren. b. Die Person-zentrierte Pflege kann den Prozess eines Patienten*innen im Akut- und Langzeitbereich positiv beeinflussen.	Schluss grobe Zusammenfassung liefern
		Hilfsfragen: Welche Gedanken und Erfahrungen habt ihr zu den genannten Statements? Wo stimmt Ihr überein? Wo seid Ihr anderer Meinung? Was fällt euch hierzu ein?	Ziel: Konzept verstehen, um damit weiterzuarbeiten
20 min	Definition einer Notaufnahme	Im nächsten Schritt möchte ich, dass Ihr euch die unterschiedlichen Bereiche überlegt, welche Personen werden hierfür gebraucht/ eingesetzt? Welche konkreten Aufgaben haben diese Personen/ müssen diese erfüllen? Jetzt wollen wir versuchen einen Tagesablauf oder eine Struktur zu erstellen, wie ein typischer Tagesablauf auf einer Notaufnahme derzeit bei euch ausschaut? Sozusagen berichtet mir einfach von dem Ist- Status und bringt eure Erfahrungen gerne mit ein.	Generierung eins allgemeineren Verständnisses, wie der allgemeine Ablauf auf einer Notaufnahme funktioniert, Kennenlernen der Strukturen und Ressourcen, Struktur Tagesablauf, Rollenverteilung
5 min		Optionale Pause/ Puffer einplanen	
55 min		Diskussion Teil: Part A: Patienten*innen-Perspektive (20“)	

		Part B: Erarbeitung Grundprinzipien (30“)	
20 min	Part A: Generierung eines Perspektivenwechsels: Patienten*Innen-Perspektive	Einleitung: Wir stellen uns nun vor, als Patient*In die Notaufnahme zu betreten. Wie wollt Ihr als Person wahrgenommen werden? Dabei sollt Ihr alle Eure Erfahrungen miteinfließen lassen, die Ihr in dem Umfeld von einer Notaufnahme schon gesammelt habt. Wie müsste diese Notaufnahme aussehen, dass Ihr als Person hinausgeht und sagt hier wurde ich als Person wahrgenommen, hier ist Personenzentrierung zum Einsatz gekommen. Zwischenfragen: Wie muss Ihnen die Pflegepersonen in diesem Kontext entgegenkommen? Was wäre Ihnen da /in diesem Kontext am allerwichtigsten? Was muss da genau passieren? Was wäre Ihnen besonders wichtig? Was würdet Ihr gerne erleben? Lässt auch das Feedback von den Patienten*Innen miteinfließen (sowohl negativ als auch positiv)	Ziel: Patienten*innen Perspektive auf einer Notaufnahme
35 min	Part 2: Erarbeitung der Grundprinzipien einer Pflegeperson auf einer Notaufnahme	Bedeutung ganzheitlichen Pflege auf einer Notaufnahme a. Mit den Werten und Überzeugungen der Person arbeiten: Individualität (Wie kann das auf einer Notaufnahme erreicht werden? Was braucht die Pflegeperson?) b. authentisch bezüglich seiner Profession sein: Beziehungsaufbau ermöglichen (Obwohl der Patient*in nur kurz da ist, wie kann trotzdem Vertrauen und	Ziel: Erarbeitung der Grundprinzipien einer Pflegeperson für die Notaufnahme

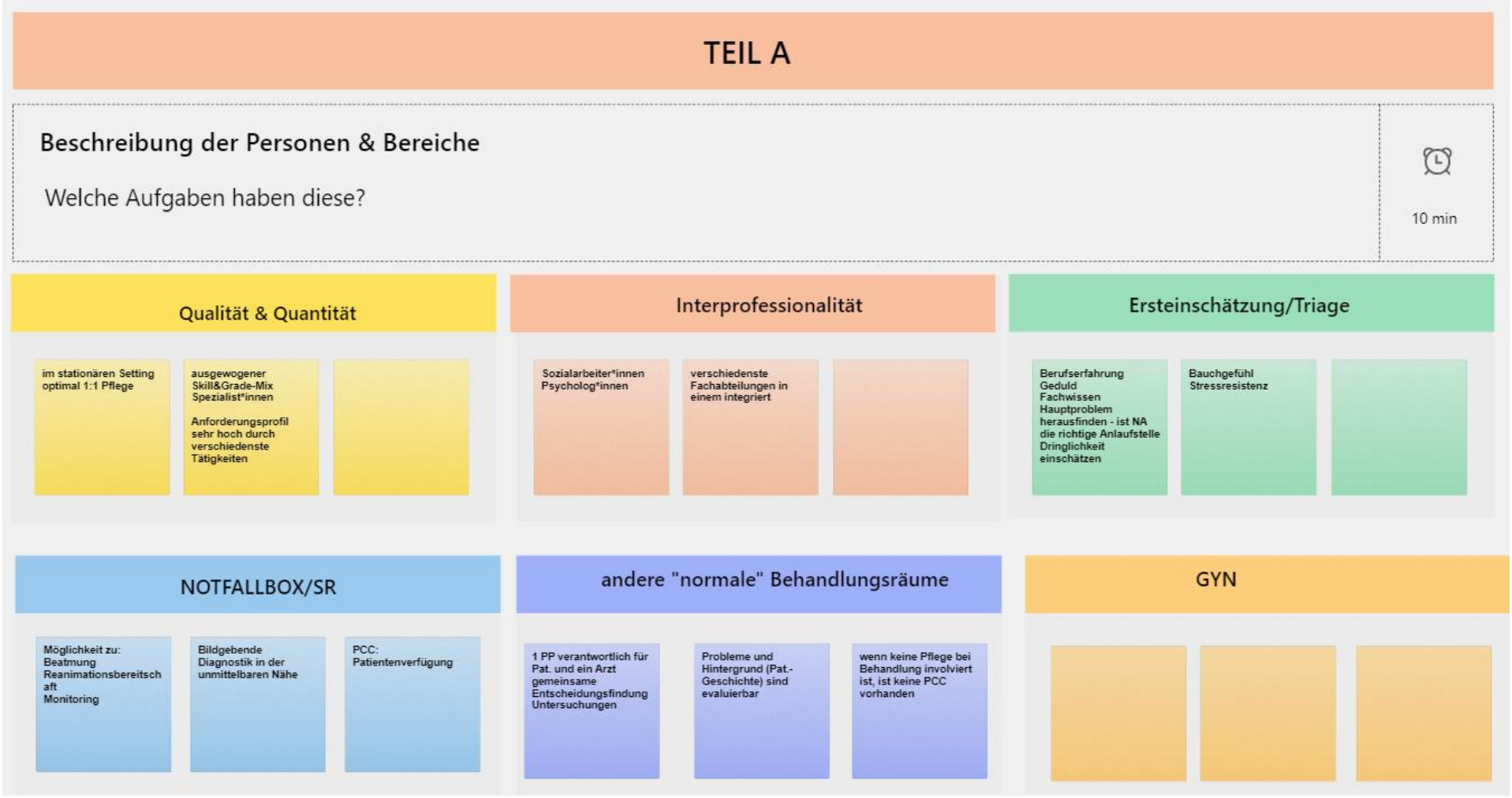
		eine Beziehung aufgebaut werden) c. Gemeinsame Entscheidungen treffen: Kommunikation (Wie kann eine Kommunikation stattfinden? Was sollte ermöglicht werden, um gemeinsame Entscheidungen treffen zu können? d. „Da sein“: Präsent sein (Was kann ich als Pflegeperson tun, damit sich der Patient*in wahrgenommen fühlt?) e. Ganzheitliches Arbeiten: Umfeld (Was muss ich erreichen, damit ich die Patienten*innen ganzheitlich betrachte, mit seinem kompletten Umfeld betrachte?) Hilfsfragen: Was bedeutet das? Was kann es bedeuten nach diesem Grundsatz zu arbeiten? Was heißt das für mich als Pflegeperson? Wie kann ich …?	
5 min	Abschluss/ Outcome	Jeder soll noch 1 abschließende Sätze sagen, was er heute gelernt hat bzw. was er in seinem Arbeitsumfeld integrieren möchte. kurze Zusammenfassung durch Moderatorin (Bedanken für die Teilnahme)	

11.7 Guideline expert interviews

Einstieg	Bzgl. des Ablaufes würde ich gerne zu Beginn bitten Ihren Tätigkeitsbereich zu erklären und sich kurz vorstellen und ich werde ergänzende Fragen stellen
Ergänzende Fragen: Angaben zur Person/ Tätigkeitsbereich:	Wie lange sind Sie schon in dem Bereich der Praxisentwicklung tätig? Welche Erfahrungen haben Sie bereits dabei sammeln können? Bei welchen Projekten haben Sie bereits mitgewirkt? Wo sehen Sie derzeit die größten Herausforderungen in der Praxisentwicklung in der Pflege?
Hauptteil: Fokus auf die allgemeine Praxisentwicklung im Akutsetting beziehungsweise einer Notaufnahme lenken.	Wie könnten allgemeine Umsetzungsschritte in die Praxis in einem Akutsetting aussehen? (Was darf hierbei nicht vergessen werden?) Was denken Sie was das Spezielle an einer Notaufnahme ist? Was muss in diesem Setting bei der Umsetzung von Theorien in die Praxis besonders beachtet werden bzw. welche Voraussetzungen braucht es?
Ergänzende Fragen	Was sollte vermieden werden, damit eine Umsetzung erfolgreich gelingt? Welche Faktoren sind bei einer Umsetzung besonders wichtig?
Fokus auf die Notaufnahme	Was denken Sie wie eine Person in einem Setting wie einer Notaufnahme wahrgenommen werden? Beziehungsweise welche Gefahren oder Momente gibt es? Was braucht es das in so einem Setting personenzentriert gearbeitet werden kann? Was ist Ihre Meinung beziehungsweise welche Erfahrungen haben Sie schon gemacht, wie mit Grundprinzipien weitergearbeitet werden könnte? Welche Grundsätze müssen vorherrschen, um sogenannte Prozesse in ein Setting einer Notaufnahme zu transferieren? Wie kann Personenzentrierung in einem Setting der Notaufnahme mit Pflegepersonen entwickelt werden? (Was wäre die nächsten Schritte, um diese in Arbeitsprozesse von Pflegepersonen einzugliedern?) Welche Umgebungsfaktoren bräuchte es in einer Notaufnahme, um die Praxisentwicklung zu unterstützen?
Abschluss/ Rückblick/ Ausblick	Würden Sie aus Ihrer Sicht noch weitere Ergänzungen bzgl. der Umsetzung vornehmen? kurze Zusammenfassung des Gesagten Danksagung bzgl. Zeit nehmen und der Teilnahme Information über Auswertung der Ergebnisse Verabschiedung

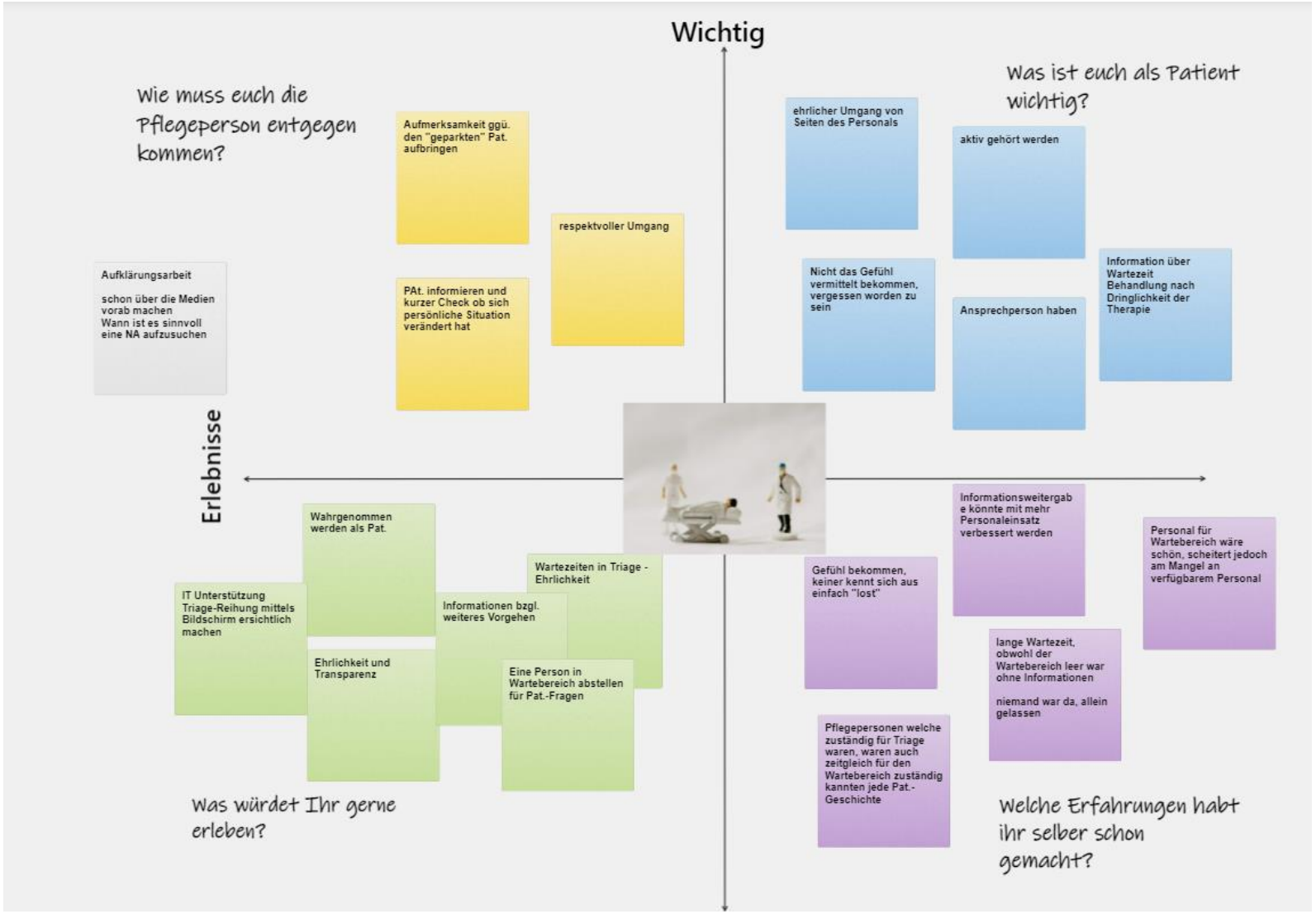
11.8 Results from focus group with whiteboards

11.8.1 Definition of the emergency department



11.8.2 Day structure

11.8.3 Patient-perspective



11.8.4 Transferred Processes