Taking into account patient preferences in personalized care: Blending types of nursing knowledge in evidence-based practice

Abstract

Aims and objectives: To explore how excellent nurses in hospitals take into account patient preferences in nursing decision-making in the evidence-based practice towards personalized care.

Background: In evidence-based practice, nursing decision-making is based on scientific evidence, evidence of best practice, and individual patient preferences. Little is known about how nurses in hospitals take into account patient preferences in nursing decision-making.

Design: Qualitative grounded theory.

Methods: Data collection entailed 27 semi-structured interviews with nurses designated by their colleagues as excellent caregivers, followed by 57 hours of participant observation. Data-analysis was conducted using three level coding with constant comparison and theoretical sampling. The COREQ checklist for qualitative research was followed.

Results: A main finding was that participants used three implicit tools to discover patient preferences: establishing a connection, using antennae and asking empathic questions, thus instantly reassuring patients from the very first contact. Their starting point in care was the patient's perception of quality of life wherein they shifted towards their patient's perspective: “Teach me to provide the best care for you in this situation”. During the observations it was confirmed that the excellent nurses behaved as they had described before.

Conclusion: Excellent nurses actively turn towards patients’ expectations and experienced quality of life by carefully blending individual sensitive and situation specific patient preferences with scientific evidence and evidence of best practice. In doing so they are able to balancing more equally patient preferences in to the equation called evidence-based practice, thus leading to wise decision-making in personalized nursing care.

Relevance to clinical practice: Patient preferences become a fully-fledged part of nursing decision-making in EBP when in education and practice the implicit knowledge of excellent nurses about how to take into account patient preferences to provide personalized care is more valued and taught.

KEYWORDS

connectedness, evidence-based practice, grounded theory, nursing decision-making, patient preferences, personalized care, wise decision-making

1 | INTRODUCTION

Taking into account patient preferences in nursing decision-making is fundamental to provide high-quality personalized care in the Evidence-Based Practice (EBP). According to the literature in EBP, evidence about patient preferences is the third component of three sources of evidence. Besides scientific evidence and best practice information about what works are norms, values and preferences of an individual patient important to take into account (Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). Nurses in direct patient care have to balance these three sources of evidence in daily practice for nursing decision-making to provide personalized nursing care. A fundamental aspect of nursing care is a nurse-patient relationship with an open communication, wherein the patient feels acknowledged and, where possible, can actively participate in the caring process (Feo, Rasmussen, Wiechula, Conroy, & Kitson, 2017; Newell & Jordan, 2015; Sidani, Epstein, Bootzin, Moritz, & Miranda, 2009). However, in the last decades a strong emphasis originated in the literature and in nursing practice to use scientific evidence, partly due to external demands such as healthcare systems and quality improvement policies. This is to the detriment of attention for individual patient preferences in healthcare decision-making (Den Hertog, 2015; Egerod, 2006; Haggerty & Grace, 2008; Haynes, Devereaux, & Gyatt, 2002).

The concern for patient preferences is fundamental to the ethical demand that inspires nursing practice by caring for patients and contributing to their healing within a personal relationship (Bishop & Scudder, 1997; Gastmans, 2013; Kitson, 2002; Feo et al., 2017). Expecting a personal relationship seems at odds with the growing complexity of care situations and the increasing amount of prescribed evidence-based interventions, quality instruments to fill in, and technological and medical advances (Avis & Freshwater, 2006; Dierckx de Casterlé, Izumi, Godfrey, & Denhaerynck, 2008; Newell & Jordan, 2015; Sellman, 2011). Promoting the use of evidence of patient preferences as part of the decision-making process in EBP yields a better access to provide personalized nursing care (Den Hertog, 2015). While most of current nursing literature focuses on developing and

executing guidelines based on scientific evidence, little is known about how nurses in hospitals establish and involve patient preferences in nursing decision-making and professional action.

2 | BACKGROUND

The third central component of EBP, patient preferences, is described by Sackett et al. (2000) as the unique preferences, considerations and expectations that a patient brings to the clinical encounter. Patient preferences are a result of cognition, experience and reflection and express themselves in the respect of values (Casper & Brennan, 1993; Sackett et al., 2000). In practice, the nurse-patient relationship is part of a complex network of relationships between professionals, family and other caregivers. Therefore individually tailored nursing care can only be achieved if patient experiences, values and preferences have a place in healthcare decision-making (Feo et al., 2017; Sidani et al., 2009). Trust, feelings of security, and connectedness in the caring relationship are important starting points to be able to make decisions regarding the most positive outcomes (Abma, Oeseburg, Widdershoven, & Verkerk, 2009). Personal control over the disease process is increased when patients have control over obtaining information and are allowed to participate in decision-making (Auerbach, 2001; Feo et al., 2017). Kiesler & Auerbach (2006) conclude that the weight of these two aspects is partly determined by the quality of interpersonal communication and the behaviour of the professional. Participation in decision-making requires an equal relationship and only gives joint responsibility if the patient has the right information and the opportunity to consider various options (Larsson, Sahlsten, Sjöström, Lindencrona, & Plos, 2007). Due to their condition, some patients will need the support of a nurse (Sahlsten, Larsson, Lindencrona, & Plos, 2005). Researchers agree that there is no "formula" for the relative weight that nurses in their decision-making should give to the three separate components in EBP (Melnyk & Fineout-Overholt, 2006).

The way patient preferences should be established and incorporated in decision-making in nursing is barely described in recent professional literature nor in the literature on nursing education. In an extensive literature study by Den Hertog (2015) towards the operationalization of the concept

of patient preferences in the context of nursing decision-making in EBP, it appeared that patient preferences can be accounted for in a quantitative and qualitative manner. In quantitative research patient preferences can be operationalized as either paternalistic, shared or informed, following the model of shared treatment decision-making. Where in the paternalistic style the nurse takes decisions, in the informed style patients make their decisions based on the information provided. Further, in the shared style decisions are made in nurse-patient consultation (Charles, Gafni, & Whelan, 1999; Florin, Ehrenberg, & Ehnfors, 2006; Smoliner, Hantikainen, Mayer, Ponocny-Seliger, & Them, 2009). Within the qualitative scientific research tradition patient preferences, as in social and cognitive aspects of an individual patient and his or her family, are part and parcel of joint decision-making. Therefore within this tradition denominating patient preferences as either paternalistic, shared or informed does injustice to and is too limited to understand the patient's more fine-grained values and preferences as part of shared decision-making in daily nursing practice. Preferences in the qualitative stream of thought can and should be identified only through communication, even though the interactions between nurses and patients in a hospital setting are limited in time (Kiesler & Auerbach, 2006; Newell & Jordan, 2015; Risjord, 2010; Sellman, 2011).

Having different ideas about the operationalization of the concept of patient preferences hinders a better understanding of what is meant in literature when referencing to balancing the preferences and other sources of evidence in deliberate decision-making processes in EBP (Sackett et al., 2000). Nurses feature scientific or theoretical and ward cultural knowledge to provide technically good care. These types of knowledge are supplemented with knowledge of best practice such as procedural and personal practice knowledge. Reflexive knowledge of nurses reflects the critical and integrative knowledge (Mantzoukas & Jasper, 2008). Having said this, it remains unclear how nurses in the midst of hectic of everyday practice should assess individual patient preferences and involve them in nursing decision-making. Benner (1984) called nurses who were able to integrate genuine personal attention in to optimal care as ‘excellent’. The aim of this study was to understand how excellent nurses include patient preferences in their decision-making in EBP-context. To meet the

aim of this study, the central research question was: How do excellent nurses in hospitals establish patient preferences and take them into account in daily nursing decision-making in EBP to provide personalized care?

3 | METHOD

Design

A qualitative grounded theory study, aimed at theorizing processes, was considered the best method to determine individual opinions, values and believes of the nurses to take into account patient preferences in nursing decision-making (Corbin & Strauss, 2008). Ethical approval for this research was obtained through the ethical committee of the Free University of Amsterdam, the Netherlands. The 'COnsolidated criteria for REporting Qualitative research' (COREQ) checklist, was followed.

Participants

The management of five medium-sized hospitals in the Netherlands gave permission to execute this research. Employing purposeful sampling, contact persons in the involved hospitals were asked to send an email of the researcher to the nursing teams on the wards with the question "Which colleague of you is the most suitable person to provide nursing care for yourself or for your beloved ones?" because of a strong technical knowledge and of a warm personal bond in the care provision. Nurses who would nominate themselves were excluded from the study to prevent for potential biases. After the intended candidate's consent, the nurses could send the candidate's name via email to the researcher. In a population of over 700 nurses ($N > 700$), 29 nurses known for their excellent performance were nominated. These nominated nurses were approached by email for an interview appointment and received information about the research. They were free to decide whether to participate or to refuse. Finally, two nurses withdrew participation because they were too busy on the ward.

Semi-structured interviews

The researcher (RdH) conducted semi structured interviews with the excellent nurses (n=27) on the wards in their hospitals, asking about recent cases and using a topic list with important theoretical themes based on the literature study about the operationalization of patient preferences in EBP (Den Hertog, 2015). Theoretical saturation occurred at 25 interviews. Subsequent two interviews yielded some small nuances. The interviews lasted 45-60 minutes, were audiotaped and transcribed. Repeat interviews were not carried out because of the completeness of the stories. Simultaneously, data collection and data analysis occurred underpinned by Strauss and Corbin's framework of open, axial, and selective coding to develop a theoretical understanding of psychosocial phenomena (Corbin & Strauss, 2008). By using the constant comparative method, data collection and analysis took place simultaneously and as a result, preliminary subcategories emerged. In the end, three coherent themes could be constructed. The process of data analysis was supported by the program Atlas.ti 6.2 (Friese, 2014).

Observation

Additional participant observation was conducted of seven nurses during their shift (a total of 57 hours) aimed to see if something could be recognized in practice of the acquired theoretical concepts of the interviews. This was used as a method of data triangulation to enhance the validity in the empirical research (Denzin, 1989). Four of the 27 nurses insisted with subsequent observation, most of them were too shy because of the compliments of their colleagues for being an excellent nurse. After conducting the interviews, three other nurses were recommended for an interview, but then gave permission to observe their nurse-patient contacts during one shift. An observation list was used with characteristics of personal communication (e.g. Argyle & Trower, 1979) and features of personal contact as described by the participants in the interviews. The researcher was unobtrusive in the situation, because as a registered nurse she provided a helping hand to the observed nurse. All concerned patients gave orally their consent to the observer to be present in the care situation in which the nurse's way of communicating would be observed. The observer made field notes out of patients' field of vision (Spradley, 1980).

Reliability and validity

Corbin and Strauss (2008) mention four important criteria to establish reliability and validity in a grounded theory study: fit, applicability, conceptualization, and contextualization. The fit, the recognizability of the results for the intended audience, was achieved by applying member checking the participants' recognition of their answers to the identified tools. Therefore, memos and field notes were visibly incorporated into the results and discussed with the participants. The applicability of the presented insights was discussed in the research team and with experts in professional practice and education. Where practice experts fully recognized the insights, experts in education remained hesitant at first about the conceptualization of the findings. Dialogues between both groups resulted in agreement to the findings as a valuable addition to the body of knowledge of nurses. Thus highlighting the importance of the study the researcher provided contextualization by joining the logical flow of ideas that the participants presented and by noting the recording of methodological decisions in memos. In order to avoid biases in the knowledge construction, especially to the effect of the researcher, reflexivity in the research was guaranteed by regular consultations with the supervisors of this research (Corbin & Strauss, 2008; Malterud, 2001).

4 | RESULTS

To answer the question of how excellent nurses in hospitals establish patient preferences and take them into account in daily nursing decision-making in EBP 27 participants were interviewed. Corresponding to the normal distribution in the profession, most of them were female and two were male. The age range was 20-59 years. In addition, a total of seven participants was observed. Information about all participants is presented is Table 1. In the interviews participants were asked how they took into account patient preferences in daily nursing practice and in decision-making illustrated by telling about their experiences in practice. The ongoing interview process was deepened by asking additional questions, as a source of theoretical sampling, with a growing understanding of the phenomenon studied.

Table 1 Demographic features of the participants

NURSES *N* = 30	AGE	MALE / FEMALE	WARD	EXPERIENCE IN YEARS	OBSERVATION
1.	20 - 24	F	Oncology	1	Observed
2.		F	Oncology	1	
3.		F	Oncology	1	
4.		F	Internal	1	
5.		M	Geriatrics	1	
6.		M	Intensive care	3	
7.		F	Internal	4	
8.	25 - 29	F	Intensive care	5	
9.		F	Short stay	5	
10.		F	Orthopedics	6	
11.		F	Surgery	4	Observed
12.	30 - 34	F	Neurology	7	
13.		F	Surgery	7	Observed*
14.		F	Oncology	12	Observed*
15.		F	Geriatrics	13	
16.		F	Maternity	13	
17.	35 - 39	F	Children	17	
18.		F	CCU	17	
19.	40 - 44	F	Surgery	10	
20.		F	Oncology	20	Observed*
21.		F	Oncology	24	Observed*
22.	45 - 49	F	Maternity	30	
23.		F	Oncology	30	Observed
24.		F	Orthopedics	33	
25.	50 - 54	F	Surgery	13	
26.		F	Oncology	16	
27.		F	Surgery	32	
28.		F	Surgery	33	
29.		F	Surgery	34	
30.	55 – 59	F	Surgery	39	

*Also participant in the interview.

In total 2809 codes were allocated in the transcriptions of the interviews, which were distributed over 36 subcategories. Further analysis learnt that 7 core concepts remained. Firstly, these concepts pointed to the manner of comforting patients. Secondly, participants talked about 'hardly tot describe or implicit and intuitive' use of communication tools. Lastly, the core of their care provision is formed by the experienced quality of life of the patient him- or herself. These findings are presented in Figure 1.

Observation of communication and behaviour to discover patient preferences	Clicking/connection	Antennae	Empathic questions
Use of voice	Soft, friendly, convincing when patient indicated fear at admission, sometimes a little louder when using humour to comfort the patient…	Anxiously because patient did not breathe properly after operation, firm when action was needed …	Inquire friendly about the fear of dying of the patient – low voice; convincingly when she inquired about pain, …
Expression on face	Open, relaxed, frowning when patient talked about illness, smiling reassuringly most of the time, …	Perceptive, mindful. Questioning look when patient does not remark nurses' worries, …	Interested when talking about family issues, future of the patient…
Attitude	Personally involved, interested in the patient…	Worried, insisting questions, …	Interested in patient and family, in patient's experienced quality of life…
Physical behaviour	Calm behaviour, touching hand or knee when talking, Sitting next to patient, physical proximity, …	Check of patient's physical condition and medical equipment, consulting colleagues, …	Take time, listening attitude, let the patient speak, …
Gestures	Quit calm, …	Restless, …	A little more expressive, …
Use of space	Familiar and close, also to family, …	Familiar and close, also to family, …	Familiar and close, also to family, …

Figure 1 Example of a partially completed observation schedule

Firstly, from the first moment they meet, nurses comfort patients as to instantly instantiate optimum patient participation in the care process. Further they use three implicit and intuitive communication tools to find out patient preferences. Thirdly, nurses tune in to patient's experienced quality of life to attune to norms and values that are important to this patient in general and transcend the current situation.

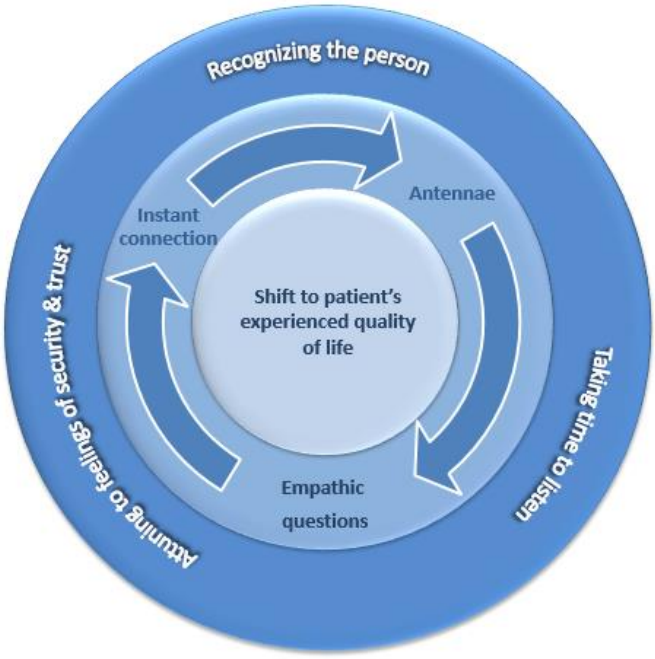

FIGURE 2 Model of excellent nurses' knowledge how to take into account patient preferences in nursing decision-making

4.1 | Recognizing the person with feelings of security and trust

Some nurses talked about an own rhythm of patients in being ill and that they tried to discover how to connect with. In a very short time participants learned to know the person who the patient was and patients learned to trust 'their' professional. P13 stated that "This sign of mutual trust is a prerequisite for the patient and the nurse to discuss feelings of fear or pain in a very early stage". To evoke feelings of security and trust, to break the tension, or to ease patients when they are upset, the participants usually used humour – only after they have estimated whether this was possible. "For your family I'll bring coffee, but especially for you I have a little cocktail. Than they laugh and relax a little." (P20). If confidence was lacking and patients were angry or irritated, the nurses tried to give words to the tension and provided room for reactions. Usually it was possible to restore patient's confidence in this way. Occasionally another nurse would be asked to take over the care thus dampening or changing a non-helping dynamic.

The participants overall emphasized the importance of creating and maintaining social connectedness in the caring relationship as a key prerequisite in obtaining and using information

about patient preferences in nursing decision-making. Nurses expressed the importance of picking up signals, both with words and non-verbal. Several nurses explained: “I instantly recognize, in one or two minutes, what kind of person the patient is and how to provide optimal support and nursing care based on the response of the person.” Some nurses asked a lot of personal questions to put the patient at ease while others just asked the information needed to provide their nursing care. One nurse explained this as: “I recognize the other as a unique person. I don't need to know everything, but I do need to know the things that are needed to connect with my care.” (P27). More participants called themselves a people’s person, always looking for the natural connection with the patients and other care providers. P6 stated “Kindness, protecting their dignity, uh, showing that they are important to you, that you listen to them, empathy, that they feel safe with you.”

All participants discussed “deliberately taking time to listen to listen to the individual patient, even when it is very busy on the ward.” P7 explained: “A lot of patients struggle with questions about the purport of their illness and by storytelling they try to give meaning. For them it is important that somebody listens. As a nurse, you see often more of the inner questions than a patient realizes, I pose my questions so, that he will pose his question utter aloud.” In the observations it became clear that these conversations just took a couple of minutes. The nurse thereby sought physical proximity and often grabbed a chair or stool to let them know non-verbally that he or she was listening. P13 described:

> Last week I was in a double room with a patient who needed a lot of physical care and one who is schizophrenic in the anamnesis, self-reliant, but okay, she needed guidance. And that lady that eh, yes, you always pass by that easily, hey, I was just busy and all sorts of other things that you really should do. So yes, at some point I grabbed a stool and sat down. Because I really wanted to spend those few minutes, because you could see that she felt lost. You see that. [You see?] Well, so I see ... and it was just before the visiting hour and her partner, who came in and who ... I don't even know what it was about, but I listened to their

> story and I wrote down their questions for the doctor's visit next morning. And that partner looked at me and took my arm, and was crying, that partner, and said: no one has done this in the eight days she has been here! (P13)

4.2 | Implicit and intuitive communication tools

According to the participants, "good nursing care in ethical perspective can only be provided if there is an interactive and instant social connection." For this interaction to happen, the nurses referred to three tools that they use.

The tool of making an instant connection, or 'click' as participants referred to it, is described as actively establishing connectedness with a patient, "of course when the situation is suitable for this." Virtually, all participants succeeded in making this connection with the patient within two minutes after the first meeting. "I am a person who is more naturally prone to making a connection", P19 stated. The participants explained that they "need connection for effective communication, and as a result, patients can participate more easily in their healing process." P10 explained that it has to do with feelings of being acknowledged: "It is important that he [the patient] can surrender a little, then he can indicate how he really feels and then I can do more for him. He gets permission to be himself." Within the observation the tool of instant connection was seen through the confidential level of communication in which it appeared that nurse and patient knew each other for several years. In their conversations participants also made often physical contact putting a hand on the arm or leg as a sign of attention and closeness. "Because there is a connection, patient's deeper feelings of concern and fear can be discussed." (P1).

Without exception, the participants talked about a second tool, a sort of "antennae, to tune in to patient's feelings of security and trust, and to monitor the quality of your care." P13 described it as "Eh, that extra feeler you have, I do not know… You have a sharp eye on the patient, I don't really get it, I have thought about it, but how can I explain? It's like possessing a sensor." According to P10 the development of antennae can be described as "practicing and expanding your sensitivity towards

patients' situations in nursing practice." P28 described an antenna as "Like being an antenna of your radio tuned to the right wavelength of the patient." Other participants emphasized that "the use of antennae makes it possible to do your work in peace and rest, because you can monitor that way". If antennae alarm, they immediately go to the patient and checked if anything is wrong. How this alarm work is hard to explain: "It's something that itches on my skin, I don't know what it is, you see it, you notice it, and you feel it. I don't know how ..." (P12). In questions afterwards the observation it became clear that nurses react on e.g. timely avoiding eye contact, little differences with the last contact, another position of the patient in bed, or changed body language. Some participants called it working with intuition or gut feelings. But P25 was sure when it comes to the use of antennae:

> It is an expression of connectedness, knowing the characteristics of this person's observation. Your antenna warns, it is about knowledge, absolutely knowledge! I always try to teach nurse students this, they have to tell me what they see, what they hear ... what are the characteristics of this person? (P25)

According to P25 working with antennae really has to do with implicit knowledge. She explained that students have to learn the medical issues, but also psychological and behavioural knowledge in education. This knowledge becomes meaningful when students apply it in practice. "In the beginning the nurse consciously has to observe the patient and give meaning to what she sees, but after more work experience she gathers the information more automatically. Only in cases where there is something wrong, she is aware of the observation and will find out why her antennae were alarmed."

The third tool in the second circle of Figure 1 is the tool of asking empathic questions towards the patient and his or her family. During the day, nurses have to react professionally on sometimes quick changing feelings of patients, feelings that depends on e.g. being nervous, feeling excited or anxious. P5 talked about an example of a female patient in end of life care. She forced

herself to walk with her husband during visiting hours. He thought she had to practice walking for coming home. For more than a week, she wanted to please him and went on walking. But when he had left, she always asked the nurses to give medicine that she would never wake up again because she was so tired. P5 asked her for what reason she didn't tell him the truth and why she avoided to be honest with him? Were they both afraid to face the truth? The next visiting hour, the nurse carefully asked both of them critical questions and gently guided her and her husband to talk about the upcoming end. "Why would he push her to practice to walk and preparing for coming home? She wouldn't make it. It was good care to direct them gently in this way."

In the observation, it became clear that nurses really work on nurse-patient relationship through an open manner of communicating, being friendly and patient. They asked a lot of empathic questions to inquire about patient satisfaction and to discuss expectations and disappointments in nursing care. Working with this open attitude, and adhering to emotional changes of the patient quickly, they generally experience open contacts with patients. In one of the observation shifts P22 and the observer went to an older lady, suffering from bad phantom pains in her amputated left leg. Every time she knew that the nurses came to help her out of bed, she loudly screamed and cursed to the nurses during for over half an hour. It only stopped when she lay in her bed again. This lady told enthusiastically that this for her special nurse succeeded in reassuring her by first listening to her complains, then asking what she herself wanted and how she wanted to achieve her rehabilitation goals. Smiling, she admitted that she had something to overcome. Outside the room P22 explained:

> Some nurses decided to neglect her screaming, because they assumed it was just her fear for falling. But I thought it was because the dignity of this woman that we had to do something different. We started with a moment of rest, expressing that we were not in a hurry. We were clear in our goal to mobilize her, but asked her before starting how she was doing today and how her pain level was. Than we asked her how she thought we could manage it in the

> best way. It takes time to explore and fit in the patient's ideas, and negotiating, because you can't just leave everything to a patient. (P22)

4.3 | Shift to patient's experienced quality of life

Both, in the interviews and the observations, the participants constantly emphasized that when determining the required nursing care they follow guidelines and protocols, but in addition, they also tune in to the patient's experienced quality of life. "Some patients do not want further treatment, but are afraid to talk about it. Others would prefer more or different treatment, but hesitate to ask their doctors. And more often, patients feel depressed about the situation and lack hope." (P13). Several participants mentioned that, to attend to these feelings, they ask patients "Teach me how to take care of you in this situation". The nurses thus actively and deliberately turn towards their patients' feelings and expectations to, where possible, improve experienced quality of life. P20 remembered a remarkable moment that she reached the emotional level of an admitted woman who was difficult to deal with in their nursing care:

> This patient, a pastoral employee, received palliative care due to colon cancer. Although she was used to talk with suffering and ill people, she was unable to talk about her own disease process. I was in the room when she asked for lukewarm milk during a coffee round, but the nurse-student reacted that she didn't have it, just hot and cold milk. I joked that she had to mix it, like all good and evil things in life. We all laughed heartily at the clumsiness of the nurse-student. Although I immediately doubted about the inappropriateness of my comment in her perspective, I remarked to her that it was the first time I saw her smile. Thereafter, we talked about her desperation in the situation for over half an hour. Of course she was not forced to talk, but I'm just very interested, say curious. The humorous remark, not intentionally staged, became a bridge to discuss her concerns and her approaching end. And yes, despite our very busy ward in the hospital, I take time for that! (P20)

In addition to the information they receive from the patient, they also consult with the family, with colleagues and other disciplines to get a complete picture of the situation. They are actively building a frame of reference, which they consider to be part of their professionalism. They balance all the gathered personal information with evidence from science that is reflected in the guidelines and their own professional knowledge. In constant consultation with in the nursing team they try achieve the intended personalized care by attuning to the experienced quality of life of the patient.
In the observations was confirmed that these excellent nurses really take time to listen to the worries of patients. It was seen that P20 in a very busy shift made an appreciative comment about a number of photos of a new-born baby on the wall in a patient's room. The patient started to cry and told, hindered by word finding problems due to brain metastases, that it was her first grandson. The nurse closed the door, grabbed a chair, and put a hand on her knee. She listened carefully, gave her the time to finish her sentences, and denied the not correctly used words. The patient admitted that she of course was pleased with the arrival of her grandson, but she also knew that she would not see him grow up. Her family did not want to talk about her end of life, so she felt distressed about the future. The nurse invited her to celebrate the baby's birth every new day of her life as long as she is there and for a moment let it go of the future. Just a few minutes later the nurse went on to run on the busy ward again. Afterwards she commented: "I could give her another perspective, just by listening. Why wouldn't I do that?"

5 | DISCUSSION

The current study investigated how so called 'excellent nurses', designated by their colleagues, on the hospital wards take into account patient preferences in their daily nursing decision-making in EBP towards personalized care. All participants were nominated by their colleagues according to the set criteria of working on a hospital nursing ward and being a nurse who provides good technical and also personalized care. The substantive theory composed in this grounded theory study shows that

these nurses feature specific knowledge on how to find out individual patient preferences and how to take into account these preferences in daily nursing decision-making. The participants were unknown to the researcher and could talk openly about their experiences on the wards because of the arranged anonymity in the signed informed consent.

Parts of the presented model in Figure 1 appeared in some studies, but were not previously related to taking into account patient preferences in nursing decision-making. The findings in this study are assembled as parts of a model of knowledge of excellent nurses on attuning to patient preferences in EBP context. The knowing-how in the outer circle of the composed model, about comforting the patient by recognizing him or her and creating feelings of security and trust, and taking time for adequate listening, is often memorized in the literature about providing qualitative good nursing care and often compared with (skilled) companionship (e.g., Dierckx de Casterlé, 2015; Feo et al., 2017; Gastmans, 2013; Kinsella, 2009). The second circle presents the set of three implicit and intuitive communication tools of nurses, by which they gain access to and monitor individual patient's feelings and well-being (Den Hertog, 2015; Den Hertog & Niessen, 2019). The first tool in this set, actively making an instant connection, is previous described – also in nursing practice - by Brafman and Brafman (2015) who explain this way of making an instant connection between persons as 'click-making'. More common in the literature, this tool is often recognized in the concept of (social) connectedness with the patient (Atlas, Grant, & Ferris, 2009; Miner, 2007; Scheel, Pedersen, & Rosenkrands, 2008). Argyle and Trower (1979) describe the level of connectedness as communication on a high level of shared emotions, where feelings can be exchanged quickly. With the second tool, using 'antennae', the nurses monitor this connection by tuning in to feelings of wellbeing of the patient (e.g., Benner, Hooper-Kyriakidis, & Stannard, 2011). Argyle and Trower (1979) emphasized that the antennae only can be used effectively if there is a good quality of communication. This quality requirement of communication is also reflected in the third tool, where asking empathic questions leads to answers of how patients really feel. In the inner circle in the presented model, the excellent nurse shifts to the patient's experienced quality of life and asks what

expectations he or she has, transcending emotions of the moment towards further expectations of life.

Other authors too recognized the know-how of nurses in using the communication tools and making a shift to the patient's perspective (Gastmans, 2013; LaSala, 2009). They refer to the internal goods in moral practices as described by MacIntyre (1981). Using the implicit and intuitive communication tools, and applying the perspective shift in a personal caring relationship provides access to the individual patient preferences in a way that blends types of knowledge and balances different kinds of evidence in EBP into an amalgam that is characterized as wise decision-making (Kinsella, 2012; Mantzoukas & Jasper, 2008; Risjord, 2010; Sellman, 2011, 2012).

We are able to compare the substantive theory found in this grounded theory study with the studies of Patricia Benner in becoming an expert nurse. She describes the process of becoming an expert nurse in a linear five-step model, where nurses will have gained internalized knowledge and skills proceeding from intuition in the final step. These competences are acquired through repetition and recognition in nursing practice. Benner's research team used the theory of reflection-on-action of Donald Schön to research this kind of knowledge (Benner, 1984; Benner, Hughes, & Sutphen, 2008; Benner, Hooper-Kyriakidis, & Stannard, 2011; Schön, 1983). Nursing professionals learn stepwise through experience which elements must be included in a patient situation and which can be omitted. This learning moves from analytical to intuitive thinking and from interpreting situations as separate parts to understanding the context as a coherent whole. Because views and expectations about patient care are disputed, refined or refuted by the outcomes in the care, professionals naturally grow to the next level of development. This learning cannot be viewed separately from the use of scientific knowledge, clinical perception and the development of skilled know-how (Benner, 1984; Benner et al., 2011).

The insights of Benner thus made room for learning by experience and the understanding of how to deal with patients as (groups of) people with their own concerns (Risjord, 2010). It is striking that in the present study not only experienced nurses were rated as excellent, but also newly starting

nurses. It is noted here that the participants were not selected on their amount of knowledge on how to take care of categories of patients and 'learning to know them' as Benner et al. (2011) the concept 'excellent' described. In this research 'excellent nurses' were designated by their colleagues as technically talented professionals and as persons who really recognize the individual patient within two minutes after meeting regardless of his or her reason for admission or illness. These findings reflect an on-going iterative process of experiential learning that never stops, and will start again in every new nurse-patient relationship. Taking into account individual norms, values and preferences of patients is described in the literature as moral quality in nursing care (Benner & Wrubel, 1989; Gastmans, 2013). Benner described that many reports reveal how nurses treat vulnerable people, how they offer safety and comfort and how attention and encouragement are a source of support (Benner et al., 2008; Benner et al., 2011). That is why she emphasized that the nurses in training must learn the skill of *phronesis*, translated as practical wisdom, to be sensitive to the moral side of care provision. Hereby she referred to the work of Aristotle, in which phronesis is part of the moral imprint of people in good practice. In contrast to Benner, phronesis is according to Luntley (2011) not about applying what is known, but "initiates learning". From an attitude of attentive receptivity, the professional can not only know to act, but also act to know - or at least hope to learn (Dunne, 2011). This practical wisdom falls back on the ability to reason from the perspective of this one patient and weighing it up in a context where standardized protocols no longer make a contribution (Kemmis & Smith, 2008; Kinsella & Pitmann, 2012; Sellman, 2012). Sellman (2012) established a modern paradox in this regard: nursing professionals learn technical rationality in a situation in which they are stimulated to provide individual tailored nursing care. The attention to practical wisdom has disappeared, while in current days it is precisely the search for excellence that enables professionals to get to know the specific preferences of the patient from their own perspective.

In the current research the focus was on how nurses find out and take into account patient preferences in nursing decision-making in EBP to provide personalized care from nursing perspective.

Firstly, it is recommended to continue this research of how to take into account patient preferences in nursing decision-making, especially the aspect of balancing different sources of evidence. Further, it is recommended to research how patients themselves feel recognized and acknowledged, especially how they experience the way how excellent nurses involve them and their family in nursing decision-making in EBP to personalize care. From literature it is known that patients experience different approaches in nursing practice, but it would be interesting to learn more about how patients experience wise decision-making in nursing care and how in nursing education students can made more sensitive to gain this implicit knowledge.

6 | CONCLUSION

Excellent nurses in hospitals take into account patient preferences in nursing decision-making in evidence-based practice and succeed in personalize nursing care by three qualities of their more or less implicit knowledge. These nurses recognize the patient as a person in the very first moment of contact. They try to evoke feelings of security and trust by adequately listening to the patient. With their implicit and intuitive communication tools, they find out patient preferences and preferences of family members, and deal with these preferences in their nursing decision-making in daily practice. The core of daily nursing decision-making is to connect to the patient's experienced quality of life, which they balance with professional nursing guidelines and experiences in nursing practice to provide their care. The knowledge qualities of establishing patient preferences and taking them into account is summarized in a highly coherent model of implicit knowledge of excellent nurses in nursing decision-making. These nurses have the courage to take time for communication on their very busy wards and work more efficient and effectively in their decision-making with the information obtained about the individual patient preferences.

Our interest was epistemological in nature. The implicit and intuitive communication tools we found by theoretical sampling, seem to contribute to adherence of patient preferences and therefore to a wise decision-making in nursing practice, where scientific evidence, evidence from professional

experience and evidence about patient's norms, values and preferences carefully are balanced by the excellent nurses with their different types of knowledge. This wise decision-making is denoted as the Aristotelian concept of phronesis. Additional research is recommended to discover how patients themselves experience this implicit and intuitive knowledge of nurses in their nursing decision-making and how it contributes to the patient's experienced quality of life. Up to now and according to the literature, it is also recommended to use of scientific evidence in EBP, but give more attention to wise decision-making as an important part of experiential professional knowledge.

7 | RELEVANCE TO CLINICAL PRACTICE

Patient preferences become a fully-fledged part of nursing decision-making in EBP when in education and practice the implicit knowledge of nurses about how to take into account patient preferences to provide personalized care is more valued and taught. This can be achieved by an ongoing attention for moral sensitivity in nursing practice and by reflecting on what knowledge has been gained in experiential learning.

What does this paper contribute to the wider global clinical community?

- A model is presented of how excellent nurses in hospitals find out and take into account patient preferences to weigh them in wise nursing decision-making in EBP.
- The input of patient preferences in nursing decision-making in EBP is, in addition to scientific evidence and evidence of professional experiences, of crucial importance to provide personalized care.
- The described knowledge of the excellent nurses in this research is, based on literature, linked to Aristotelian concept of *phronesis*, the wise decision-making in good practices.

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