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The Voice of Academic Nursing

Domain 2: Person-Centered Care

Sub-competency	Progression Indicators (Observable Behaviors)	
	Developing	**Developed (Competence)**
2.1 Engage with the individual in establishing a caring relationship.		
2.1a Demonstrate qualities of empathy.	Listen to patients using verbal and nonverbal cues to understand their needs and concerns. Use simple, person-centered language when explaining procedures or plans of care. Use open-ended questions to elicit patient values and preferences, documenting them accurately in the medical record.	Anticipate patients' needs based on non-verbal cues and the clinical context, responding with appropriate emotional and clinical support. Leverage communication skills to elicit verbal and nonverbal information to inform the plan of care. Ensure patient preferences are consistently revisited and reflected in interdisciplinary team discussions.
2.1b Demonstrate compassionate care.	Demonstrate presence through eye contact, active listening, and appropriate verbal/nonverbal actions. Identify individual preferences to begin incorporating them into actions and conversations.	Remain fully present even in high-stakes or emotionally charged situations. Integrate individual patient preferences and emotional support into every interaction. Engage with healthcare team members to create a seamless, person-centered care experience, respecting holistic needs.
2.1c Establish mutual respect with the individual and family.	Use clear, patient-centered language and encourage patients to ask questions and clarify misunderstandings. Identify culture, values, beliefs, background, and developmental needs. Seek input and affirmation from the patient and significant others.	Adjust communication approaches in real-time as needed, ensuring concerns from the patient and their significant others are addressed. Integrate understanding of patients and significant others into actions and conversations. Engage family members or other key support individuals in conversations to ensure understanding and two-way communication.

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2.2 Communicate effectively with individuals.		
2.2a Demonstrate relationship-centered care.	Use therapeutic communication strategies and demonstrate empathy when interacting with patients, families, and caregivers, ensuring clear and respectful communication. Collaborate with patients and other healthcare team members to identify patient preferences, values, and cultural considerations without making assumptions. Contribute to team discussions by sharing insights from patient interactions to support a holistic care approach.	Integrate patients' cultural, emotional, and social needs into care plans. Facilitate patient autonomy by involving them in decision-making and providing relevant resources to support informed choices. Advocate for the patient's needs and preferences within the care team, ensuring they are reflected in care decisions.
2.2b Consider individual beliefs, values, and personalized information in communications.	Acknowledge patients' beliefs, values, and cultural practices during care. Incorporate patient preferences into communication.	Apply cultural humility and cultural competence in care discussions, fostering mutual understanding and respect. Resolve potential misunderstandings with cultural humility, mitigating implicit biases.
2.2c Use a variety of communication modes appropriate for the context.	Identify standard communication methods to share and receive information effectively with patients and team members. Adjust communication style based on the needs of patients. Demonstrate respect and professionalism when communicating with diverse individuals.	Apply appropriate communication methods to share clear and comprehensive information tailored to diverse healthcare settings. Customize communication approaches to align with the patient's needs to ensure understanding. Demonstrate skills in interdisciplinary communication, fostering effective teamwork and mutual understanding.

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2.2d Demonstrate the ability to conduct sensitive or difficult conversations.	Prepare for sensitive conversations by reviewing relevant patient information and considering cultural and emotional factors affecting the interaction. Use empathetic language and demonstrate active listening, ensuring patients or families feel heard and understood. Convey information clearly and respectfully, using simple language to discuss complex topics while ensuring comprehension.	Create an environment fostering trust, privacy, and emotional safety, ensuring patients and families feel comfortable expressing their thoughts and concerns. Handle conversations involving conflicting perspectives or heightened emotions with professionalism and composure, focusing on the patient's needs and goals. Utilize reflection, validation, and de-escalation techniques to navigate sensitive or emotionally charged topics effectively.
2.2e Use evidence-based patient teaching materials, considering health literacy, vision, hearing, and cultural sensitivity.	Identify and select evidence-based education materials aligning with the patient's health literacy levels and preferences. Demonstrate cultural humility by selecting materials that are respectful and relevant to the patient's cultural background and values. Ensure understanding by asking open-ended questions and encouraging patients to repeat key information in their own words.	Tailor evidence-based teaching materials to meet individual patients' or families' specific educational needs, cultural context, and preferences. Anticipate and address barriers to understanding using interpreters and/or culturally appropriate resources.
2.2f Demonstrate emotional intelligence in communications.	Identify and respond appropriately to verbal and non-verbal emotional expressions from patients, families, and team members. Identify appropriate strategies to deliver bad news.	Demonstrate self-awareness and self-regulation while communicating. Lead sensitive discussions confidently and tactfully, ensuring all parties feel respected and supported.

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2.3 Integrate assessment skills in practice.		
2.3a Create an environment during assessment that promotes a dynamic interactive experience.	Initiate assessments using professional communication to build trust and encourage open dialogue. Utilize open-ended questions to actively engage patients in sharing health history, concerns, and goals.	Tailor communication to create a caring and respectful environment based on patient needs. Identify and address communication barriers by using innovative strategies and tools.
2.3 b Obtain a complete and accurate history in a systematic manner.	Employ focused questioning techniques to gather essential information about the patient's chief complaint, medical history, and lifestyle factors.	Synthesize comprehensive histories incorporating social, behavioral, physical, and cultural influences. Use open-ended questions to encourage patients to describe their health experiences in their own words.
2.3c Perform a clinically relevant, holistic health assessment.	Identify and prioritize assessments addressing the patient's immediate needs and presenting symptoms. Collect subjective and objective data to support clinical decision-making.	Apply clinical judgment to determine assessment sequencing and urgency. Adjust assessment priorities in real-time based on clinical judgment and patient feedback. Prioritize assessments based on the patient's immediate needs and presenting symptoms.
2.3d Perform point of care screening/diagnostic testing (e.g., blood glucose, PO2, EKG).	Follow policies and procedures when utilizing equipment and conducting point-of-care testing. Determine the necessity of point-of-care testing based on clinical indications.	Identify and manage errors in point-of-care testing. Collect and handle specimens according to established policies and procedures.

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2.3e Distinguish between normal and abnormal health findings.	Recognize and analyze normal and abnormal health findings. Consult clinical guidelines and evidence-based resources to verify deviations from normal findings. Differentiate between findings requiring urgent versus routine follow-up and communicate appropriately with healthcare team members.	Identify patterns in abnormal findings and correlate them with potential underlying conditions. Use abnormal findings to prioritize interventions and refine care plans. Synthesize normal and abnormal findings in relation to the patient's disease process.
2.3f Apply nursing knowledge to gain a holistic perspective of the person, family, community, and population.	Incorporate family dynamics and support systems into the assessment process. Identify community-level factors affecting holistic patient care.	Analyze data trends to assess their influence on patient well-being. Integrate clinical findings with environmental and societal data to develop comprehensive, person-centered care plans.
2.3g Communicate findings of a comprehensive assessment.	Document accurate assessment findings in the patient's health record. Provide patients with clear and comprehensible explanations of assessment findings to ensure their active involvement in care decisions.	Communicate key findings to the healthcare team during handoffs and case discussions. Collaborate with healthcare team members to discuss and interpret findings, contributing to informed clinical decision-making.
2.4 Diagnose actual or potential health problems and needs.		
2.4a Synthesize assessment data in the context of the individual's current preferences, situation, and experience.	Obtain relevant physical assessment data from patients and other sources.	Make evidence-informed decisions based on an understanding of the individual needs of the patient. Refine data continuously by integrating feedback from diverse sources and adjusting for the evolving patient status.

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2.4b Create a list of problems/health concerns.	Identify key health concerns to generate a problem list based on assessment data from the patient and other sources. Share the problem list with the healthcare team to facilitate collaborative planning.	Incorporate input from interdisciplinary team members to prioritize the problem list and integrate it into the care plan. Update the problem list as new information becomes available, ensuring its accuracy and relevance.
2.4c Prioritize problems/health concerns.	Organize health concerns based on immediacy and potential impact on the patient's well-being. Consider patient preferences when prioritizing identified health problems.	Analyze the interplay of multiple health concerns to anticipate and mitigate potential complications. Facilitate team discussions to ensure alignment on prioritization and care strategies.
2.4d Understand and apply the results of social screening, psychological testing, laboratory data, imaging studies, and other diagnostic tests in actions and plans of care.	Interpret basic diagnostic results, distinguishing normal from abnormal findings. Interpret abnormal diagnostic findings in the context of individual health status and conditions. Integrate diagnostic data into the initial plan of care, ensuring alignment with the patient's clinical needs.	Recognize the interactions between multiple diagnostic findings and their cumulative impact on patient health. Engage in interdisciplinary discussions on diagnostic findings to inform and guide care decisions.
2.4e Contribute as a team member to the formation and improvement of diagnoses.	Identify the etiology and underlying factors of various conditions. Communicate key findings from assessments clearly to team members.	Anticipate relevant assessment and diagnostic tests for different health conditions. Provide informed recommendations regarding diagnoses to the healthcare team.

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2.5 Develop a plan of care.		
2.5a Engage the individual and the team in plan development.	Gather perspectives from both the patient and team members. Respectfully acknowledge the contributions of all team members to the planning process. Encourage patient participation in plan development to foster ownership and autonomy.	Collaborate with the healthcare team to make informed healthcare decisions. Advocate for the patient in healthcare team planning.
2.5b Organize care based on mutual health goals.	Collaborate with patients and stakeholders to set achievable goals reflecting their priorities and capabilities. Organize activities logically to address prioritized goals efficiently.	Implement care activities to monitor progress toward health goals, adjusting as needed. Incorporate patient feedback to refine care organization and enhance goal achievement.
2.5c Prioritize care based on best evidence.	Refer to the best available evidence to prioritize interventions with the most significant impact on patient outcomes. Explain the rationale for prioritized interventions. Identify necessary resources to meet goals.	Synthesize short- and long-term care priorities based on patient feedback, evidence, and goals. Revise priorities as new evidence, conditions, or team input emerge. Synthesize evidence to support prioritization and decision-making. Advocate for evidence-based priorities aligning with stakeholders' needs.

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2.5d Incorporate evidence-based intervention to improve outcomes and safety.	Identify interventions supported by clinical or policy guidelines. Ensure chosen interventions prioritize safety. Assess patient responses to interventions and adjust as needed to ensure safety and effectiveness.	Implement evidence-based interventions to address complex healthcare delivery issues. Evaluate interventions for effectiveness and safety, contributing to continuous quality improvement. Apply emerging evidence and innovations to enhance patient care outcomes.
2.5e Anticipate outcomes of care (expected, unexpected, and potentially adverse).	Identify potential outcomes of planned interventions. Monitor for signs of adverse or unintended outcomes and take prompt action when needed.	Develop plans to prevent and mitigate potential adverse outcomes. Utilize clinical reasoning to anticipate complex or unexpected outcomes of care.
2.5f Demonstrate rationale for plan.	Identify relevant evidence to support decision-making. Align plan of care rationales with patient preferences and values.	Reflect on the plan of care rationales to ensure alignment with best practices and goals of care.
2.5g Address individuals' experiences and perspectives in designing plans of care.	Explore the patient's lived experiences and perspectives. Consider cultural, social, and emotional factors when designing care plans.	Maintain an ongoing dialogue with the patient to adapt the care plan as their needs evolve. Seek opportunities to understand experiences different from one's own to ensure comprehensive care.
2.6 Demonstrate accountability for care delivery.		
2.6a Implement individualized plan of care using established protocols.	Follow established protocols and guidelines to implement the plan of care accurately and efficiently, ensuring it is tailored to the patient's needs. Coordinate with team members to ensure seamless implementation of the care plan.	Implement protocol-driven care based on the patient's specific context. Anticipate and address barriers to care implementation, evaluating continuity, patient outcomes, and effectiveness.

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2.6b Communicate care delivery through multiple modalities.	Provide concise, clear verbal updates to team members during shift handoffs and interdisciplinary meetings. Document and communicate care delivery using electronic health records (EHRs) and other digital tools. Explain care activities to the patient to ensure understanding and engagement while soliciting feedback.	Use appropriate communication tools and strategies to effectively share patient care updates, ensuring clarity and collaboration across healthcare teams. Facilitate real-time communication among team members across multiple modalities to enhance care delivery. Deliver patient education to empower individuals to participate actively in their care.
2.6c Delegate appropriately to team members.	Identify tasks suitable for delegation based on the scope of practice and team members' competencies to ensure patient safety. Provide clear instructions when delegating tasks to team members. Verify team members' understanding of delegated tasks. Monitor delegated tasks and provide feedback as needed.	Delegate tasks according to expertise and roles within the team. Foster a collaborative environment where delegation is structured and well-coordinated. Address and resolve delegation-related issues promptly and constructively.
2.6d Monitor the implementation of the plan of care.	Observe patient responses to care interventions and compare them to expected outcomes. Identify and address deviations from the plan promptly to maintain continuity of care. Communicate observations to the care team to support coordinated monitoring efforts.	Monitor data and implement interventions to mitigate potential complications. Incorporate feedback from patients and team members to refine the care plan.

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2.7 Evaluate outcomes of care.		
2.7a Reassess the individual to evaluate health outcomes/goals.	Conduct routine reassessments to evaluate progress toward health goals. Compare current findings with baseline data to identify changes in the individual's condition. Share reassessment results with the healthcare team to facilitate coordinated evaluation and decision-making.	Integrate physical, emotional, social, and cultural factors into reassessments to comprehensively evaluate health outcomes. Synthesize patterns and trends in reassessment data, linking them to the effectiveness of interventions.
2.7b Modify plan of care as needed.	Identify necessary adjustments to the plan of care based on feedback from the patient and team members. Propose changes based on clinical guidelines and emerging patient needs. Engage the individual in discussions about plan of care adjustments to align with their preferences and values.	Collaborate with the interdisciplinary team to ensure care plan modifications are holistic and evidence-based. Provide a clear, evidence-supported rationale when modifying the care plan in discussions with the team or patient.
2.7c Recognize the need for modifications to standard practice.	Identify specific patient factors that may necessitate deviations from standard practice. Suggest potential adjustments to care practices to better suit the individual's context and goals in collaboration with the team.	Propose evidence-based alternatives based on the evaluation of current standard practices, meeting the individual's needs. Consider ethical implications when deviating from standard practices, ensuring ethical and patient-centered decision-making.

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2.8 Promote self-care management.		
2.8a Assist the individual to engage in self-care management.	Provide step-by-step instructions and demonstrations for specific self-care activities. Communicate ways individuals can take small, achievable steps toward self-care independence using positive reinforcement. Assess the patient's ability to perform self-care tasks, offering assistance and support as needed.	Design personalized self-care management plans aligned with the individual's health goals and lifestyle, adjusting the plan as needed. Support individuals in making informed decisions and encourage ownership of their self-care practices. Help individuals identify and overcome barriers to effective self-care. Collaborate with families or caregivers to support the individual's self-care efforts in a coordinated and sustainable manner.
2.8b Employ individualized educational strategies based on learning theories, methodologies, and health literacy.	Identify the individual's preferred learning style, literacy level, and learning readiness. Use plain language and visual aids to convey complex health information effectively. Employ standard educational materials and strategies to enhance understanding.	Develop individualized educational plans informed by learning theories and methodologies. Adapt materials and approaches to align with the individual's developmental stage, cultural background, and values. Assess the effectiveness of educational strategies and adjust them as needed to support self-care.
2.8c Educate individuals and families regarding self-care for health promotion, illness prevention, and illness management.	Provide clear, step-by-step instructions for health promotion and illness prevention practices. Distribute valid and reliable educational materials to support understanding of self-care practices.	Develop comprehensive education plans addressing health promotion, prevention, and disease management. Incorporate the latest research, guidelines, and cultural considerations into educational content for individuals and families.

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2.8d Respect individuals and families' self-determination in their healthcare decisions.	Honor the individual's right to make healthcare decisions, even when they differ from professional recommendations. Use empathetic and nonjudgmental language when discussing healthcare choices. Ensure individuals and families have all the necessary information to make informed decisions.	Advocate for the individual's and family's right to self-determination. Reflect on personal biases to ensure respect for diverse perspectives in healthcare decisions.
2.8e Identify personal, system, and community resources available to support self-care management.	Guide individuals and families to access healthcare resources. Identify when additional resources or referrals are needed to support self-care management.	Create personalized resource plans integrating personal, system, and community assets. Advocate for expanded access to resources to address gaps in care and support.
2.9 Provide care coordination.		
2.9a Facilitate continuity of care based on assessment of assets and needs.	Identify the individual's care needs, available resources, and potential barriers to continuity during transitions. Participate in follow-up care to support seamless transitions and ensure all stakeholders are informed.	Develop continuity supportive plans of care addressing immediate needs and long-term goals, integrating input from the individual and their family. Collaborate with the care team to align continuity efforts and ensure a smooth handoff.
2.9b Communicate with relevant stakeholders across health systems.	Identify appropriate communication tools and techniques to support continuity of care.	Communicate effectively with stakeholders through multiple modalities to ensure seamless care transitions.
2.9c Promote collaboration by clarifying responsibilities among individual, family, and team members.	Identify the roles and responsibilities of each care team member to the patient and family.	Communicate each care team member's roles and responsibilities to facilitate care coordination. Monitor the effectiveness of team collaboration and refine actions as needed to clarify roles.
2.9d Recognize when additional expertise and knowledge is needed to manage the patient.	Acknowledge when additional expertise is required and seek assistance as needed.	Utilize available resources and services to access the necessary expertise.

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2.9e Provide coordination of care of individuals and families in collaboration with care team.	Facilitate communication and coordination among team members to ensure consistency in care delivery. Identify and organize resources needed to support individuals and families during care transitions.	Track the effectiveness of care coordination efforts and make necessary adjustments to improve outcomes. Maintain clear and updated documentation of care coordination efforts in the patient's health record.