

EMPIRICAL STUDIES

Individualised care in Flemish and Dutch hospitals: Comparing patients' and nurses' perceptions

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Abstract

Background: Patient-centred care has been recognised as vital for today's healthcare quality. This type of care puts patients at the centre, contributing to positive patient outcomes such as patient autonomy. Empirical research comparing nurses' and patients' perceptions of the support and provision of patient-centred care is limited and focuses solely on nurses and patients working and staying on surgical wards.

Aims and objectives: Comparing patients' and nurses' perceptions of patient-centred care on different types of hospital wards, and exploring if patient empowerment, health literacy, and certain sociodemographic and context-related variables are associated with these perceptions.

Design: Cross-sectional design.

Methods: Data were collected in ten Flemish (February–June 2016) and two Dutch (December 2014–May 2015) hospitals using the Individualised Care Scale (ICS). A linear mixed model was fitted. Data from 845 patients and 569 nurses were analysed. As the ICS was used to measure the concept of patient-centred care, it is described using the term 'individualised care.'

Results: Nurses perceived that they supported and provided individualised care more compared with patients as they scored significantly higher on the ICS compared with patients. Patients with higher empowerment scores, higher health literacy, a degree lower than bachelor, a longer hospital stay, and patients who were employed and who were admitted to Dutch hospitals scored significantly higher on some of the ICS subscales/subsections. Nurses who were older and more experienced and those working in Dutch hospitals, regional hospitals and maternity wards scored significantly higher on some of the ICS subscales/subsections.

Conclusion: Nurses perceived that they supported and provided individualised care more compared with patients.

Relevance to clinical practice: Creating a shared understanding towards the support and provision of individualised care should be a priority as this could generate more effective nursing care that takes into account the individuality of the patient.

KEYWORDS

cross-sectional, hospitals, individualised care, nurses, nursing, patient-centred care, patients, perception

INTRODUCTION

During the last decade, patient-centred care became a key attribute in healthcare services as it has been recognised as essential for today's healthcare quality [1]. Patient-centred care puts patients at the centre and is characterised by inclusivity and equity in the professional–patient relationship [2]. Nevertheless, even though patient-centred care is a core component of health care [3], challenges arise in daily practice. Literature seems to indicate that nurses and patients have different perceptions of patient-centred care and of the level at which it is delivered [4, 5]. However, empirical research that compares nurses' and patients' perceptions of the support and provision of patient-centred care is limited and focuses solely on nurses and patients working and staying on surgical wards. As the Individualised Care Scale (ICS) developed by Suhonen et al. [6] will be used to measure the concept of patient-centred care, we will refer to the concept of patient-centred care using the term 'individualised care'.

BACKGROUND

In 2001, the American Institute of Medicine described patient-centred care as care that is respectful of and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions [7]. Over the years, patient-centred care has been conceptualised differently but there is still not one clear definition of the concept and variation in terminology exists, including terms such as patient centredness, relationship-centred care, client-centred care, client-centred practice, consumer-centred care, user-centred care and individualised care [3, 8]. The latter term warrants further attention as in this study the ICS is used to measure the concept of patient-centred care [6]. According to a concept analysis based on a literature review, the ICS is one of the most commonly used scales that measures the broad holistic concept of patient-centred care [8]. Further, Suhonen et al. [9] indicate that both the concepts of individualised care and patient-centred care share the same theoretical basis, which rests on the principles of holism [9].

In the ICS, individualised nursing care is defined by Suhonen et al. [10] as care that takes into account personal characteristics of the patient in the clinical situation (the condition of the patient), the personal life situation and promoting patient participation and decision-making in the patient's care. Nurses have a key role in the support and provision of individualised care. By taking into account the patient's health problem, the reactions induced by hospital admission, and the situation in which patients have been admitted to the hospital, individualised care in hospitals is accomplished [10].

Studies have shown that providing individualised care can contribute to positive patient outcomes such as

self-management, patient satisfaction, patient autonomy, perceived quality of care and health-related quality of life [11–14] and reduces depression symptom levels [15]. Individualised care can also contribute to general job satisfaction and personal accomplishment among healthcare professionals [16].

Despite the physical and emotional benefits of individualised care for patients and nurses, literature indicates that inconsistencies between nurses' and patients' perceptions of individualised care exist. Specifically for the hospital context, the study of Suhonen et al., [5] analysing both patients' and nurses' perceptions of individualised care in five European countries, found that nurses assessed that they supported patient individuality more compared with patients.

Another more recent study by Papastavrou et al. [4] on decisional control over care found that nurses rated their abilities in helping patients to decide how to be involved in healthcare decisions higher than their patients did. Studies within other fields of nursing practice also found that nurses are not always aware of the patients' perspective and tend to have different views of the care provided. For example, the results in the study of Zhao et al. [17] confirmed that nurses had higher perceptions of the quality of nursing care than patients.

Notwithstanding that the studies of Papastavrou et al. [4] and Suhonen et al. [5] have contributed to the development of individualised care in clinical practice, these studies focus solely on the assessment of individualised care in surgical wards. There is a need to further explore how patients and nurses perceive individualised care in other various types of hospital wards. This will help to identify discrepancies in nurses' and patients' perceptions of individualised care and related factors, which can be used to improve individualised care.

METHODS

Aims

The aim of this study was two-folded: (1) to compare Dutch-speaking patients' and nurses' perceptions of individualised care, taking into account the perceptions of nurses and patients of different types of hospital wards and (2) exploring if patient empowerment, health literacy, and certain sociodemographic and context-related variables are associated with these perceptions.

Design and participants

A secondary analysis of baseline data that were collected on wards participating in two different quality improvement projects to enhance a patient-centred approach in hospitals

was performed (i.e. a study on the implementation of Bedside shift reporting and a study on the implementation of the Tell-us card; a communication tool that patients can use to report what is important for them during their hospital admission and before discharge) [18–21]. Nurses who worked on the participating wards were invited to participate if they had direct patient contact and work experience of at least 6 months on the hospital ward [21]. Criteria for selecting the patients were: being aged 18 years or over, able to speak and read Dutch, having an expected hospital stay of minimum 1 day and being mentally competent as assessed by the assigned nurse [21]. In total, 845 patients on 34 wards and 569 nurses on 29 wards were included in the analysis [21].

Data collection

The data were collected in Flanders (10 hospitals), the Dutch-speaking part of Belgium and the Netherlands (two hospitals) [21]. In both Dutch-speaking countries, data were collected as baseline measurement on wards which participated in the two aforementioned improvement projects to enhance a patient-centred approach in hospitals [21]. In Flanders, data were collected between February and June 2016, and in the Netherlands between December 2014 and May 2015 [21].

Flanders

Quality coordinators, chief nursing officers and chief medical officers from all Flemish regional hospitals ($n = 68$) and university hospitals ($n = 3$) received an invitation from the Federal Public Service for Health for participation in the two aforementioned improvement projects [21]. Information sessions on the implementation projects were organised [21]. Wards for surgery, geriatric care, internal medicine, medical rehabilitation and maternal care were included [21]. Psychiatric wards, paediatric wards, psychogeriatric ward, palliative wards, emergency or intensive care wards, day hospitals, burns units and outpatient clinics were excluded because the specific characteristics of these wards require a specific approach towards individualised care [21].

The researchers received a list (from the head nurses) indicating which hospitalised patients on the included wards met the inclusion criteria. The ICS for patients was distributed on the included wards by a member of the research team and recollected after 2 h [21]. If patients did not have the possibility to complete the questionnaire in time, a collection box was available on the ward [21]. If patients were not able to fill in the questionnaire due to motoric difficulties, a member of the research team (Tell-us card project) or a study nurse with no affiliation to the research team (Bedside shift reporting project) assisted the patients [21]. The ICS for the

nurses was disseminated in a sealed envelope. Researchers visited the wards weekly to remind the nurses of completing the questionnaire.

The Netherlands

Two surgical wards and one cardiology ward of the same university hospital and one cardiology ward of a regional hospital were invited to participate in the study on the implementation of the Tell-us card [21]. Preliminary meetings took place with ward managers to discuss the eligibility for the study.

Patients meeting the inclusion criteria received a questionnaire from the nurses working on the wards with a pre-paid return envelope to be filled in at home after discharge. The questionnaire for the nurses was distributed in a sealed envelope [21]. Nurses received two reminders by email to complete the questionnaire.

Measurement

The ICS was used to assess patients' and nurses' perceptions of individualised care. The ICS, originally developed in Finland, is a bi-partite scale that contains 34 items. The scale allows to measure both nurses' and patients' perceptions of individualised nursing care by means of two separate ICS subsections: The Individualised Care Scale – Patient (ICS-Patient) [6] and The Individualised Care Scale – Nurse (ICS-Nurse) [22]. Both subsections contain 17 items and have the same two-part (ICSA and ICSB) structure. ICSA measures patients' and nurses' views of how individuality was supported through nursing activities [23]. ICSB measures how patients perceive their care as individual to them and how nurses perceive the maintenance of individuality in care provision [23]. Three subscales are involved in both subsections: (1) the clinical situation of the patient (ClinA and B, seven items), (2) the personal life situation of the patient (PersA and B, four items) and (3) decisional control over the care of the patient (DecA and B, six items) [6, 22]. The first subscale examines how nursing interventions have supported individuality in the clinical situation and how nurses and patients perceive individuality in the clinical situation (items relating to the patients, their feelings, needs, abilities, health condition and meaning of illness) [24]. The second subscale examines how nursing interventions have supported the personal life situation of the patient and how nurses and patients perceive individuality in the personal life situation of the patient (items relating to previous experiences of hospitalisation, habits and family) [24]. The third subscale examines how nursing interventions have supported decisional control over care and how nurses and patients perceive individuality in decisional control over care

(items relating to the power of patients to participate in their care; knowledge preferences, patients' wishes, and opportunities for decision-making and expressing opinions) [24]. The answering categories per item are 5-point Likert scales ranging from fully disagree to fully agree. Both subsections have a separate total score. The higher the ICSA subsection scores, the better the patient individuality is supported through nursing activities [5]. A high score on the ICSB subsection indicates a higher perception of individuality in patients' care [5]. The ICS was previously psychometrically validated for the Dutch healthcare context [21]. The Dutch version of the ICS showed acceptable psychometric performance, supporting its use for the Dutch and Flemish healthcare context [21]. Internal consistency using Omega ranged from 0.83 to 0.96 for the ICS-Nurse and from 0.88 to 0.96 for the ICS-Patient [21]. The model fit suggested sufficient evidence to sustain the construct validity of the Dutch ICS [21].

For patients, the following sociodemographic and context-related variables were included: age, gender, level of education, living situation, employment status, days of admission, wards categorised in accordance with their specialty (surgery, internal medicine, medical rehabilitation or maternity), region/region (Flanders or the Netherlands) and type of hospital (regional or university).

Patients' health literacy was measured using three questions developed by Chew, Bradley and Boyko [20, 25]: (1) 'How confident are you filling out medical forms by yourself?', (2) 'How often do you have problems learning about your medical condition because of difficulty understanding written information?', and (3) 'How often do you have someone help you when you read hospital materials?' [20, 25]. The answering categories per question are 5-point Likert scales ranging from never to always. Higher scores (range: 0–15) reflect greater problems with reading and understanding information.

Patient empowerment was measured by the short form of the Patient Activation Measure (PAM-13) [20, 26]. The answering categories per item are four-point Likert scales from 1 (totally disagree) to 4 (totally agree) and non-applicable. Higher total PAM-13 scores (range 0–100) reflect higher levels of patient activation [20, 27].

The following sociodemographic and context-related variables for nurses were included: gender, age, years of work experience in nursing, work percentage, level of education, type of hospital (regional or university), wards categorised in accordance with their specialty (surgery, internal medicine, maternity, medical rehabilitation or geriatric) and region/region (Flanders or the Netherlands).

Ethical considerations

This study was approved by the Ethical Committee of Ghent University (B670201526903) and Radboud University

(2014–1350), and the ethic committees of the participating hospitals in Flanders and the Netherlands. All nurses and patients participating in this study gave a written informed consent after they received detailed information on the purpose of the study.

Data analysis

All analyses were conducted using SPSS 25.0 [28]. The categorical variables were described using frequencies (percentages), and the continuous variables were described using means, medians and standard deviations (SD). To analyse the differences between nurses' and patients' perceptions of individualised care, a linear mixed model was used. A random intercept for the patients nested within wards was specified to take into account the multilevel structure of the data [29].

To explore possible variables associated with nurses' and patients' perceptions of individualised care, all variables with $p < 0.010$ were included in a multilevel, multivariable model. Backward selection ($p < 0.05$) was used to determine which variables best explain the data. For the variables employment status, empowerment and health literacy, only data for the Flemish patients were available. Therefore, additional analyses were conducted for the Flemish patients including the aforementioned variables. To identify multicollinearity between the variables in the model, the tolerance and variance inflation were calculated. The tolerance value needs to be above 0.4, and the variance inflation factor (VIF) needs to be below 4 [30].

RESULTS

Characteristics of the participants

Part of the data were previously published in the psychometric validation study of the Dutch ICS by Theys et al. [21]

Patients were on average 57 (SD =19.3) years old and 57% of the patients were female [21]. Most patients (71.1%) lived together with a partner, friend or family, had an education lower than bachelor's degree (66%) and were retired (46%) [21]. The median hospital admission was 5 days. An overview of all patients' and nurses' characteristics can be found in Tables 1 and 2 [21].

The mean age of nurses was 40 years (SD =12.5). Most nurses (90%) were female [21]. Fifty-one per cent of the nurses had a bachelor degree, 42% had a vocational degree, and almost 3% had a university degree [21]. Around 4% of the participants were nursing assistants [21]. Most nurses had 1–5 years of work experience (24%) or 20 or more years of work experience (31%) and were fully employed (43%) [21].

TABLE 1 Characteristics for patients

	Patients (<i>n</i> = 845) ^a
Age mean (SD)	56.5 (19.3)
Gender <i>n</i> (%)	
Male	363 (43.1)
Female	479 (56.9)
Health literacy mean (SD)	2.5 (0.85)
Empowerment mean (SD)	57.72 (12.7)
Days of hospital admission median	5
Level of education of patients <i>n</i> (%)	
<Bachelor	551 (65.8)
Bachelor	203 (24.3)
Master	83 (9.9)
Living condition <i>n</i> (%)	
Alone	185 (26.0)
With a partner, family or friend	506 (71.1)
In a service flat, assisted living or a nursing home	21 (2.9)
Employment status	
Employed	277 (39.0)
Unemployed	24 (3.4)
Student	16 (2.3)
Disabled	65 (9.0)
Retirement	329 (46.3)
Type of hospital	
University	325 (38.5)
Regional	520 (61.5)
Type of ward	
Internal medicine	178 (21.1)
Maternity	146 (17.3)
Geriatric	N/A
Surgical	300 (35.5)
Medical rehabilitation	192 (22.7)
Mixed surgical/internal	29 (3.4)

Part of the data were previously published in the psychometric validation study of the Dutch ICS by Theys et al. [21]

Abbreviation: N/A, Not available.

^aNumbers for the demographic characteristics of participants may not total 845 due to missing data

TABLE 2 Characteristics for nurses

	Nurses (<i>n</i> = 569) ^a
Age mean (SD)	39.7 (12.5)
Gender <i>n</i> (%)	
Male	58 (10.2)
Female	511 (89.8)
Level of education nurses <i>n</i> (%)	
Nurse assistant ^b	22 (3.9)
Vocational nurse ^c	237 (42.1)
Bachelor educated ^d	288 (51.2)
Master educated ^e	16 (2.8)
Years of nurses' work experience <i>n</i> (%)	
<1 year	28 (4.9)
1–5 years	139 (24.4)
6–10 years	107 (18.9)
11–15 years	71 (12.5)
16–20 years	48 (8.4)
>20 years	176 (30.9)
Work percentage	
<50%	87 (16.0)
50%–99%	222 (40.9)
100%	234 (43.1)
Type of hospital	
University	186 (32.7)
Regional	383 (67.3)
Type of ward	
Internal medicine	125 (22.0)
Maternity	76 (13.4)
Geriatric	80 (14.0)
Surgical	160 (28.1)
Medical rehabilitation	103 (18.1)
Mixed surgical/internal	25 (4.4)

Part of the data were previously published in the psychometric validation study of the Dutch ICS by Theys et al. [21]

^aNumbers for the demographic characteristics of participants may not total 569 due to missing data.

^bOne year of education at level 3 of the European Qualifications Framework (EQF).

^cThree years of education at level 5 of the EQF to obtain a diploma in Nursing.

^dThree years of education at level 6 of the EQF to obtain the degree of Bachelor in Nursing.

^eFive years of education at level 7 of the EQF to obtain the degree of Master in Nursing.

Comparison between nurses' and patients' perceptions of individualised care

Statistical results showed significant differences between nurses' and patients' perceptions on all subsections and subscales of the ICS, except for the DecB subscale. Table 3 provides an overview of the multilevel analyses concerning the differences in perceptions on the ICS.

Nurses (mean 4.24) scored significantly higher ($p < 0.001$) than patients (mean 3.66) on how individuality is supported through nursing activities (ICSB). Concerning the perceptions of individuality in the care received and provided (ICSA), nurses (mean 4.16) scored also significantly

higher ($p < 0.001$) than patients (mean 3.91). When comparing both parts of the ICS, differences between patients' and nurses' scores were higher on the ICSA than on the ICSB. Concerning the subscales of the ICSA, the highest mean difference (0.743) was found on the personal situation (PersA) subscale, and the lowest mean difference (0.445) was found on the clinical situation (ClinA) subscale. Among the ICSB subscales, the highest mean difference (0.396) was found on the clinical situation (ClinB) subscale, and the lowest mean difference (0.051) was found on the decisional control over care (DecB) subscale.

In Table 4, differences between nurses and patients concerning individualised care on ward level are shown.

For all the different wards, nurses scored significantly higher than patients and mean differences were higher on the ICSA than on the ICSB. For the DecB subscale, no differences in scores were found, except for medical rehabilitation wards. Concerning the subscales of the ICSA, the highest mean differences were found for the maternity and internal wards on the personal situation (PersA) subscale and for the medical rehabilitation and mixed surgical/ internals wards on all subscales. When looking at the subscales of the ICSB, the highest mean differences were found for the medical rehabilitation and mixed surgical/ internals wards on the clinical situation (ClinB) subscale.

TABLE 3 Differences between nurses and patients concerning individualised care

				95% CI	
	Mean ^a	MD	<i>p</i>	Lower bound	Upper bound
ICSA					
Nurse	4.238	0.581	<0.001 [*]	4.140	4.336
Patient	3.658			3.563	3.752
ClinA					
Nurse	4.349	0.445	<0.001 [*]	4.247	4.450
Patient	3.904			3.807	4.001
PersA					
Nurse	3.974	0.743	<0.001 [*]	3.873	4.075
Patient	3.231			3.138	3.324
DecA					
Nurse	4.283	0.634	<0.001 [*]	4.171	4.395
Patient	3.649			3.541	3.757
ICSB					
Nurse	4.158	0.251	<0.001 [*]	4.067	4.249
Patient	3.907			3.820	3.995
ClinB					
Nurse	4.361	0.396	<0.001 [*]	4.267	4.455
Patient	3.965			3.875	4.055
PersB					
Nurse	3.921	0.303	<0.001 [*]	3.837	4.004
Patient	3.617			3.539	3.695
DecB					
Nurse	4.078	0.051	0.205	3.968	4.187
Patient	4.027			3.920	4.134

Abbreviations: CI, confidence interval; Clin, clinical situation: patients their feelings, needs, abilities, health condition, meaning of illness; ICSA, Individualised Care Scale – Scale A: patients' and nurses' views on how individuality was supported through nursing activities; ICSB, Individualised Care Scale – Scale B: how patients perceive their care as individual to them and how nurses perceive the maintenance of individuality in care provision; MD, mean difference; Pers, personal life situation: previous experiences of hospitalisation, habits, family; Dec, decisional control over care: knowledge preferences, patients' wishes, opportunities for decision-making and expressing opinions.

^aRange: 1–5.

* p -value <0.05

TABLE 4 Differences between nurses and patients concerning individualised care on ward level

	Maternity			Internal medicine			Surgery			Medical rehabilitation			Mixed surgery/internal medicine		
	Mean ^a	MD	p	Mean	MD	p	Mean	MD	p	Mean	MD	p	Mean	MD	p
ICSA															
Nurse	4.429	0.492	<0.001 [*]	4.194	0.604	<0.001 [*]	4.215	0.471	<0.001 [*]	4.278	0.771	<0.001 [*]	4.202	0.862	<0.001 [*]
Patient	3.936			3.590			3.744			3.507			3.341		
ClinA															
Nurse	4.562	0.251	<0.001 [*]	4.290	0.460	<0.001 [*]	4.350	0.340	<0.001 [*]	4.386	0.704	<0.001 [*]	4.366	0.839	0.001 [*]
Patient	4.311			3.829			4.011			3.681			3.527		
PersA															
Nurse	3.938	0.741	<0.001 [*]	3.989	0.859	<0.001 [*]	3.932	0.663	<0.001 [*]	3.993	0.726	<0.001 [*]	3.930	0.844	0.003 [*]
Patient	3.197			3.130			3.269			3.267			3.086		
DecA															
Nurse	4.601	0.609	<0.001 [*]	4.227	0.610	<0.001 [*]	4.246	0.495	<0.001 [*]	4.337	0.855	<0.001 [*]	4.193	0.900	<0.001 [*]
Patient	3.992			3.617			3.751			3.452			3.293		
ICSB															
Nurse	4.477	0.271	<0.001 [*]	4.110	0.246	0.005 [*]	4.142	0.154	0.018 [*]	4.171	0.398	<0.001 [*]	4.193	0.407	0.042 [*]
Patient	4.206			3.864			3.988			3.773			3.732		
ClinB															
Nurse	4.648	0.339	<0.001 [*]	4.305	0.410	<0.001 [*]	4.311	0.280	<0.001 [*]	4.427	0.599	<0.001 [*]	4.406	0.573	0.009 [*]
Patient	4.309			3.895			4.032			3.828			3.833		
PersB															
Nurse	4.072	0.410	<0.001 [*]	3.867	0.342	<0.001 [*]	3.910	0.238	0.001 [*]	3.915	0.271	0.014 [*]	3.790	0.419	0.082
Patient	3.662			3.526			3.672			3.644			3.371		
DecB															
Nurse	4.546	0.099	0.187	4.048	0.006	0.945	4.097	0.048	0.483	4.040	0.253	0.018 [*]	4.060	0.204	0.313
Patient	4.447			4.054			4.144			3.787			3.856		

No data for geriatric patients available.

Abbreviations: Clin, clinical situation; ICSA, Individualised Care Scale – Scale A; ICSB, Individualised Care Scale – Scale B; MD, Mean difference; Pers, personal life situation; Dec, decisional control over care.

^aRange: 1–5.^{*}p-value <0.05.

Variables associated with patients' perceptions of individualised care

Multilevel results for the Dutch and Flemish patients

The multilevel analysis showed significant associations between patients' perceptions of individualised care and days of hospital admission (ICSA, ClinA), level of education (ICSB, PersA, PersB) and region (ICSA, DecA, DecB). Patients admitted to Dutch hospitals, patients with a degree lower than bachelor, and those with a longer hospital stay scored significantly higher on some of the ICS subscales/subsections. In Table 5, an overview of the results is provided.

Multilevel results for the Flemish patients

The multilevel analysis showed that a higher empowerment score and higher health literacy were significantly associated with higher scores on the ICS subscales/subsections (except for health literacy on ClinA). Patients who were employed and had a longer hospital stay scored significantly higher on ClinA. Patients with a degree lower than bachelor scored significantly higher on ICSB and PersB. In Table 6, an overview of the results is provided.

Variables associated with nurses' perceptions of individualised care

The multilevel analysis showed significant associations between nurses' perceptions of individualised care and age (PersA), years of work experience (DecB), type of ward (ICSB, DecA, DecB), type of hospital (PersA) and region (ICSB, PersA, DecA, DecB). More experienced and older nurses and nurses working in Dutch hospitals, regional hospitals and maternity wards scored significantly higher on some of the ICS subscales/subsections. In Table 7, an overview of the results is provided.

DISCUSSION

Comparing patients' and nurses' perceptions of individualised care

The primary aim of this study was to compare Dutch-speaking nurses' and patients' perceptions of individualised care, taking into account the perceptions of nurses and patients of different hospital wards. Multilevel analysis showed that nurses (mean 4.16) scored significantly higher on how individuality was supported through nursing activities (ICSA) compared

with patients (mean 3.91). Nurses' (mean 4.24) and patients' (mean 3.66) views of how individuality was perceived in the care provided and received (ICSB) also differed significantly. These results were seen across all hospital wards. Patients and nurses of maternity wards gave the highest assessments on both the ICSA and ICSB. Overall, it should be noticed that patients had a relatively good perception of how individuality was supported through nursing activities (ICSA; e.g. supporting patient participation, addressing patients' needs and taking into account previous experiences of hospitalisation through nursing activities) and perceived their care as relatively individual to them (ICSB; e.g. how patients' needs, previous hospital experiences and knowledge preferences were taken into account in the patient care). Yet, according to Berg et al. [31] a high quality of individualised nursing care requires a mean score >4.5.

Our results are in line with those from the study of Suhonen et al. [5] in which differences in assessments of individualised nursing care were found in nurses and patients of five European countries. In each participating region, nurses scored significantly higher than patients [5]. In the study of Papastavrou et al. [4] also conducted in five European countries, it was shown that there were disparities between nurses' and patients' perceptions of decisional control over care (DecB subscale). Our study showed significant differences for patients' and nurses' views of how decisional control over care (the power of patients to participate in their care; knowledge preferences, patients' wishes, and opportunities for decision-making and expressing opinions) was supported through nursing activities (DecA subscale). This can be explained by nurses wanting to maintain control over provision of care. Previous studies have shown that nurses' controlling behaviours appeared a major hindrance for supporting patient participation, an essential antecedent of individualised care [8, 32, 33]. For example, in the study of Theys et al. [33] it was found that nurses and midwives were hesitant towards the implementation of a hospital communication tool for patient participation. Tobiano et al. [32] found that nurses controlling approach, influenced by organisational issues and pressure to complete tasks, was in conflict with an individualised approach to care.

It is remarkable that there is an overall incongruence between nurses' and patients' perceptions of the support and provision of individualised care. This might indicate that there is a discrepancy between what nurses think they do and the care they actually provide and thus the care provided being less responsive to individual patient preferences and needs than nurses think [34]. Besides nurses wanting to maintain control over care, it also seems plausible that nurses find it difficult taking into consideration the patient's perspective. Qualitative research by Vandecasteele et al. [35] focussing on transgressive behaviour in care relationships found that nurses generally perceive the relationship

TABLE 5 Multilevel results for the Dutch and Flemish patients

				95% CI	
	Estimate	Mean ^a	<i>p</i> [*]	Lower bound	Upper bound
ICSA					
Days of hospital admission	0.004		0.032	0.0004	0.008
Region					
The Netherlands		3.968	0.039	3.626	4.310
Flanders		3.569		3.410	3.728
ICSB					
Level of education					
<Bachelor		3.945	0.029	3.813	4.077
Bachelor		3.798		3.636	3.959
ClinA					
Days of hospital admission	0.028		0.046	0.0004	0.055
PersA					
Level of education					
<Bachelor		3.299	0.014	3.166	3.431
Bachelor		3.063		2.875	3.251
DecA					
Region					
The Netherlands		4.083	0.009	3.730	4.437
Flanders		3.548		3.384	3.711
PersB					
Level of education					
<Bachelor [†]		3.723	<0.001	3.596	3.851
Bachelor		3.381		3.209	3.552
Master		3.301		3.065	3.537
DecB					
Region					
The Netherlands		4.389	0.019	4.064	4.714
Flanders		3.953		3.802	4.103

No significant associations were found for the ClinB subscale.

Abbreviations: CI, confidence interval; Clin, clinical situation; ICSA, Individualised Care Scale – Scale A; ICSB, Individualised Care Scale – Scale B; Pers, personal life situation; Dec, decisional control over care.

^aRange: 1–5.

[†]= reference category.

^{*}p-value <0.05.

with the patient from their own point of view, and do not necessarily insert the individual patient perspective in their interaction with patients. Difficulties experienced by the nurses for incorporating an individualised approach during care were also observed in a multi-site ethnography study by van Belle et al. [36] The study demonstrated that although some nurses achieve to do so, providing individualised care in hospitals remains difficult, as most nurses are not able to incorporate the physical, relational and physical elements of care [36].

The study results provide insight into the gap between nurses and patients of their perceptions of the support and provision of individualised care. They can be feededback towards the different wards to stimulate awareness among nurses regarding the support and provision of individualised care.

A shared understanding towards the support and provision of individualised care and being sensitive towards the patient perspective could generate more effective nursing care that takes into account the individuality of the patient [37, 38]. If

TABLE 6 Multilevel results for the Flemish patients

				95% CI	
	Estimate	Mean ^a	p [*]	Lower bound	Upper bound
ICSA					
Empowerment	0.015		<0.001	0.007	0.019
Health literacy	−0.117		0.007	−0.201	−0.032
ICSB					
Empowerment	0.013		<0.001	0.010	0.020
Health literacy	−0.133		0.001	−0.213	−0.054
Level of education					
<Bachelor		3.898	0.017	3.553	3.894
Bachelor		3.724		3.498	3.957
ClinA					
Empowerment	0.017		<0.001	0.110	0.022
Days of hospital admission	0.005		0.020	0.0008	0.009
Employment status					
Employed		3.989	0.003	3.520	4.074
Retirement		3.705		3.521	3.889
PersA					
Empowerment	0.098		0.009	0.002	0.017
Health literacy	−0.111		0.046	−0.220	−0.002
DecA					
Empowerment	0.012		<0.001	0.006	0.018
Health literacy	−0.157		0.001	−0.251	−0.063
ClinB					
Empowerment	0.016		<0.001	0.010	0.021
Health literacy	−0.111		0.011	−0.196	−0.026
PersB					
Empowerment	0.015		<0.001	0.008	0.021
Health literacy	−0.129			−0.228	−0.030
Level of education					
<Bachelor ^b	3.684		0.011	3.534	3.835
Bachelor	3.305		<0.001	3.122	3.488
Master	3.217		<0.001	2.952	3.482
DecB					
Empowerment	0.015		<0.001	0.009	0.019
Health literacy	−0.129		0.001	−0.208	−0.050

Abbreviations: CI, confidence interval; Clin, clinical situation; ICSA, Individualised Care Scale – Scale A; ICSB, Individualised Care Scale – Scale B; Pers, personal life situation; Dec, decisional control over care.

^aRange: 1–5.

^{*}*p*-value <0.05

[‡]= reference category.

nurses think that the care is individualised per se or if they are a priori convinced that the care they provide already incorporates individual patient preferences, needs and values, changing existing interactions between patients and nurses will be challenging. Reflecting on one's own perceptions of individualised care, how these perceptions emerge or where

they emanate from could be a starting point and essential in creating awareness among nurses to provide care that is more individualised and incorporates the patients' perspective [3, 35]. Self-awareness will contribute to professional growth of nurses and will aid in becoming more understanding towards patients, establishing an effective nurse–patient relationship,

TABLE 7 Multilevel results for nurses

				95% CI	
	Estimate	Mean ^a	p [*]	Lower bound	Upper bound
ICSB					
Region					
The Netherlands		4.414	0.025	4.212	4.616
Flanders		4.168	0.019	4.073	4.263
Type of ward					
Maternity ^a		4.600		4.258	4.942
Surgical		4.200	0.030	4.074	4.325
Internal medicine		4.170		4.020	4.320
PersA					
Age	0.006		0.011	0.0013	0.0106
Region					
The Netherlands		4.197	0.003	4.031	4.363
Flanders		3.864		3.781	3.947
Hospital					
Regional		4.150	0.003	4.038	4.262
University		3.917		3.802	4.032
DecA					
Region					
The Netherlands		4.542	0.013	4.349	4.735
Flanders		4.290		4.200	4.380
Type of ward					
Maternity ^a		4.727		4.390	5.006
Surgical		4.299	0.023	4.178	4.421
Internal medicine		4.326	0.031	4.182	4.470
DecB					
Years of work experience					
>20 years		4.204	0.017	4.074	4.335
1 to 5 years		4.369		4.234	4.504
Region					
The Netherlands		4.390	0.002	4.203	4.578
Flanders		4.076		3.986	4.166
Type of ward					
Maternity [†]		4.700		4.379	5.021
Surgical		4.140	0.007	4.016	4.264
Internal medicine		4.118	0.006	3.977	4.258
Geriatric		4.075	0.004	3.888	4.263
Mixed surgical/internal		4.205	0.030	3.871	4.538
Medical rehabilitation		4.161	0.008	3.996	4.327

No significant associations were found for the ICSA subsection and the ClinA, ClinB and PersB subscales.

Abbreviations: CI, confidence interval; ICSB, Individualised Care Scale – Scale B; Pers, personal life situation; Dec, decisional control over care.

^aRange: 1–5.

[†]= Reference category.

^{*}p-value <0.05.

and taking a more critical stance towards the care provided [39–41].

Variables associated with perceptions of individualised care

Variables for nurses

Compared with nurses in Flanders, those of the Netherlands scored significantly higher on the maintenance of individuality in care provision (ICSB), on how nursing interventions have supported decisional control over care (DecA), on how individuality in decisional control was actually delivered by nurses (DecB), and on how nursing interventions have supported the personal life situation of the patient (PersA). Between-country differences have been previously found in the studies of Idvall et al. [42] Papastavrou et al. [4] and Suhonen et al. [5] As mentioned by Idvall et al. [42] it is possible that the individual foci of nursing practice are perceived differently by nurses within different cultures. Type of hospital and type of ward were also significantly associated with nurses' perceptions of individualised care. Nurses working in regional hospitals and maternity wards scored significantly higher on the maintenance of individuality in care provision (ICSB), on how nursing interventions supported decisional control over care (DecA), on how individuality in decisional control was actually delivered by nurses (DecB), and on how nursing interventions have supported the personal life situation of the patient (PersA). The unique features of the patient population on maternity wards, predominantly young and healthy women, may have influenced nurses' perceptions of individualised care. Younger and female patients and patients with less severe conditions generally take on a more active role in their care [43]. In line with earlier studies, our study also found that age (PersA) and years of work experience (DecB) had a positive association with nurses' perceptions of individualised care [42, 44]. In literature, it has been reported that expertise and life experience (age) can have a positive impact on nurses' ability to deliver individualised patient care [42, 44].

Variables for patients

Compared with patients in Flanders, those of the Netherlands scored significantly higher on how individuality was supported through nursing activities (ICSA), on how nursing interventions have supported decisional control over care (DecA), and on how individuality in decisional control over care was actually delivered by nurses (DecB). Further, patients with a degree lower than bachelor had higher perceptions of individuality as regards their own care (ICSB). These

results are similar to other research results [45, 46] and could be explained by a more critical stance [47] and higher expectations [48] towards care of patients with a higher educational attainment. In addition, the longer the length of stay in the hospital the more patients regarded that their individuality was supported through nursing interventions (ICSA). Land and Suhonen [45] reported similar results but Suhonen et al. [46] Suhonen et al. [49] and Ceylan and Eser [50] found no significant association with the duration of hospital stay. Although literature provides no clear explanation, the significant association with duration of hospital stay in our study could be explained by: (1) patients becoming acquainted with the nurses and other healthcare professionals caring for them and (2) nurses and other healthcare professionals having more time for providing individualised care. Yet, further research is needed into the relationship between length of hospital stay and the provision of individualised care. One could argue that having more time for providing individualised care will not automatically result in more individualised care when such care is undervalued by nurses and the environment in which they work [51]. Recent research indicates that caring behaviours are still devaluated by healthcare professionals and are seen as a non-complex activity of care that requires little skill, not worthy of taking up the nurses' time [51, 52].

Strengths and limitations

This is the first study to compare both nurses' and patients' perceptions of individualised care, taking into account the perceptions of nurses and patients of different types of hospital wards. Data were collected using the Dutch version of the ICS, which showed adequate psychometric performance [21]. A large group of Dutch-speaking patients ($n = 845$) and nurses ($n = 569$) on different hospitals wards and in different regional and university hospitals were involved in the study, providing a representative view of the perceptions of individualised care of both groups. Multilevel analysis was used to overcome the difficulties for the multilevel data clustering and inferences from multilevel analysis are more reasonable [29].

However, there are some limitations to this study. First, due to the cross-sectional nature of the study, it was not possible to study causal associations between nurses' and patients' demographics and individualised care as would be possible in a longitudinal design. Second, the use of a self-reporting questionnaire makes it unclear if perceptions of individualised care of the respondents present a clear representation of reality [53]. Third, no subgroup analyses for patients and nurses of geriatric wards could be performed because no data for geriatric patients were available. Fourth, although it is stated in the aims that the perceptions of nurses' and patients' were compared, there were also 22 nurse assistants included

in the sample. However, results did not differ without the inclusion of nurse assistants. Last, inherent to the nature of the secondary analysis of existing data, the available data were not collected to address the particular research question. Therefore, it is likely that nurses' and patients' perceptions may depend on other important variables besides those presented in this study. Examples are type of nursing system [44] and health status of the patient [46]. Also, three variables, patient empowerment, employment status and health literacy were not available for the Dutch sample. Another problem is that data collection procedures were not entirely the same for the different samples (Flanders and The Netherlands) and the different improvement projects (Tell-us card and Bedside shift reporting). During the data collection of the improvement project on the Tell-us card in Flanders, a member of the research team was involved; therefore, patients may have answered questions more positively than the reality of their situation [53].

CONCLUSION

This study addressed the need to further explore how patients and nurses perceive individualised care, taking into account the perceptions of nurses and patients working and staying on different types of hospital wards. The results in this study showed that there is a gap between nurses' and patients' perceptions of individualised care and this across the different hospital wards. Nurses perceived that they supported patients' individuality and provided individualised care more compared with patients. This could be a major barrier when implementing interventions aiming to improve individualised care. Creating a shared understanding towards the support and provision of individualised care should be a priority as this could generate more effective nursing care that takes into account the individuality of the patient.

Relevance for clinical practice

Reflecting on one's own perceptions of individualised care; how these perceptions emerge or where they emanate from, could be a starting point and essential in creating awareness among nurses to provide care that is more individualised and incorporates the patients' perspective. Self-awareness may contribute to professional growth of nurses and aiding in becoming more understanding towards patients, establishing an effective nurse–patient relationship, and taking a more critical stance towards the care provided. Future research that focusses on in-depth qualitative interviews with patients, (head) nurses, nurse managers and research experts in the field of individualised care (multi-stakeholder perspective) could also be vital for identifying the root cause problem of

the differences in perceptions and could shed further light on what is needed to counter the discrepancy between nurses' and patients' perceptions of individualised care. Further, lower health literacy and lower scores of patient empowerment were significantly associated with lower perceptions of individualised care. Therefore, nurses are likely to need training and support in order to tailor the provision of care to vulnerable patient groups, enabling them to be more involved in their care.

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CONFLICTS OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

All authors have contributed to the conception, design, analysis and interpretation of data for the work. All authors have contributed in drafting and revising the article for important intellectual content.

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REFERENCES

1. WHO. Global Strategy on people-centred and integrated health services, Interim Report [Internet]. Geneva: World Health Organisation; 2015.
2. Håkansson JE, Holmström IK, Kumlin T, Kaminsky E, Skoglund K, Högländer J, et al. Same same or different?" A review of reviews of person-centered and patient-centered care. *Patient Educ Couns*. 2019;102(1):3–11.
3. de Silva D. Helping measure person-centred care: a review of evidence about commonly used approaches and tools used to help measure person-centred care. London: The Health Foundation; 2014.
4. Papastavrou E, Efstathiou G, Tsangari H, Karlou C, Patiraki E, Jarosova D, et al. Patients' decisional control over care: a cross-national comparison from both the patients' and nurses' points of view. *Scand J Caring Sci* 2016;30(1):26–36.
5. Suhonen R, Efstathiou G, Tsangari H, Jarosova D, Leino-Kilpi H, Patiraki E, et al. Patients' and nurses' perceptions of individualised care: an international comparative study. *J Clin Nurs*. 2012;21(7–8):1155–67.
6. Suhonen R, Leino-Kilpi H, Välimäki M. Development and psychometric properties of the Individualised Care Scale. *J Eval Clin Pract*. 2005;11(1):7–20.

7. Wolfe A. Institute of Medicine Report: crossing the quality chasm: a new health care system for the 21st century. *Policy Polit Nurs Pract.* 2001;2(3):233–5.
8. Castro EM, Van Regenmortel T, Vanhaecht K, Sermeus W, Van Hecke A. Patient empowerment, patient participation and patient-centeredness in hospital care: a concept analysis based on a literature review. *Patient Educ Couns.* 2016;99(12):1923–39.
9. Suhonen R, Stolt M, Papastavrou E. Individualized care: theory, measurement, research and practice. 1st ed. Switzerland: Springer International Publishing; 2019.
10. Suhonen R, Välimäki M, Katajisto J. Individualised care in a Finnish healthcare organization. *J Clin Nurs.* 2000;9(2):218–27.
11. McMillan SS, Kendall E, Sav A, King MA, Whitty JA, Kelly F, et al. Patient-centered approaches to health care: a systematic review of randomized controlled trials. *Med Care Res Rev.* 2013;70(6):567–96.
12. Rathert C, Wyrwich M, Boren SA. Patient-centered care and outcomes: a systematic review of the literature. *Med Care Res Rev.* 2013;70(4):351–79.
13. Suhonen R, Välimäki M, Katajisto J, Leino-Kilpi H. Provision of individualised care improves hospital patient outcomes: an explanatory model using LISREL. *Int J Nurs Stud.* 2007;44(2):197–207.
14. Suhonen R, Papastavrou E, Efstathiou G, Tsangari H, Jarosova D, Leino-Kilpi H, et al. Patient satisfaction as an outcome of individualised nursing care. *Scand J Caring Sci.* 2012;26(2):372–80.
15. Cooper LA, Ghods Dinso BK, Ford DE, Roter DL, Primm AB, Larson SM, et al. Comparative effectiveness of standard versus patient-centered collaborative care interventions for depression among African americans in primary care settings: the BRIDGE study. *Health Serv Res.* 2013;48(1):150–74.
16. Van Den Pol-Grevelink A, Jukema JS, Smits CHM. Person-centred care and job satisfaction of caregivers in nursing homes: a systematic review of the impact of different forms of person-centred care on various dimensions of job satisfaction. *Int J Geriatr Psychiatry.* 2012;27(3):219–29.
17. Zhao SH, Akkadechanunt T, Xue XL. Quality nursing care as perceived by nurses and patients in a Chinese hospital. *J Clin Nurs.* 2009;18(12):1722–8.
18. Malfait S, Eeckloo K, Lust E, Van Biesen W, Van Hecke A. Feasibility, appropriateness, meaningfulness and effectiveness of patient participation at bedside shift reporting: Mixed-method research protocol. *J Adv Nurs.* 2017;73(2):482–94.
19. van Belle E, Zwakhalen SM, Caris J, Van Hecke A, Huisman-de Waal G, Heinen M. Tailoring of the Tell-us Card communication tool for nurses to increase patient participation using Intervention Mapping. *J Clin Nurs.* 2018;27(3–4):621–30.
20. Theys S, Malfait S, Eeckloo K, Verhaeghe S, Beeckman D, Van Hecke A. Patient empowerment in Flemish hospital wards: a cross-sectional study. *Acta Clin Belg.* 2020;13: 1–9.
21. Theys S, Van Hecke A, Akkermans R, Heinen M. The Dutch Individualised Care Scale for patients and nurses – a psychometric validation study. *Scand J Caring Sci.* 2021;35(1):308–18.
22. Suhonen R, Gustafsson ML, Katajisto J, Välimäki M, Leino-Kilpi H. Individualised care scale–nurse version: a Finnish validation study. *J Eval Clin Pract.* 2010;16(1):145–54.
23. Suhonen R, Stolt M, Puro M, Leino-Kilpi H. Individuality in older people's care - challenges for the development of nursing and nursing management. *J Nurs Manag.* 2011;19(7):883–96.
24. Suhonen R, Välimäki M, Leino-Kilpi H. Individualized care, quality of life and satisfaction with nursing care. *J Adv Nurs.* 2005;50(3):283–92.
25. Chew LD, Bradley KA, Boyko EJ. Brief questions to identify patients with inadequate health literacy. *Fam Med.* 2004;36(8):588–94.
26. Hibbard JH, Mahoney ER, Stockard J, Tusler M. Development and testing of a short form of the patient activation measure. *Health Serv Res.* 2005;40(6 Pt 1):1918–30.
27. Rademakers J, Nijman J, van der Hoek L, Heijmans M, Rijken M. Measuring patient activation in the Netherlands: translation and validation of the American short form patient activation measure (PAM13). *BMC Public Health.* 2012;31(12):577.
28. IBM Incorporated. IBM SPSS statistics for windows version 25.0. New York: IBM Corp, Armonk; 2017.
29. Heck RH, Thomas SL, Tabata LN. Multilevel and longitudinal modeling with IBM SPSS. 2nd ed. New York and London: Routledge; 2014.
30. Yoo W, Mayberry R, Bae S, Singh K, Peter He Q, Lillard JW Jr. A study of effects of multicollinearity in the multivariable analysis. *Int J Appl Sci Technol.* 2014;4(5):9–191.
31. Berg A, Idvall E, Katajisto J, Suhonen R. A comparison between orthopaedic nurses' and patients' perception of individualised care. *Int J Orthop Trauma Nurs.* 2012;16(3):136–46.
32. Tobiano G, Marshall A, Bucknall T, Chaboyer W. Activities patients and nurses undertake to promote patient participation. *J Nurs Scholarsh.* 2016;48(4):362–70.
33. Theys S, Lust E, Heinen M, Verhaeghe S, Beeckman D, Eeckloo K, et al. Barriers and enablers for the implementation of a hospital communication tool for patient participation: a qualitative study. *J Clin Nurs.* 2020;29(11–12):1945–56.
34. Bolster D, Manias E. Person-centred interactions between nurses and patients during medication activities in an acute hospital setting: Qualitative observation and interview study. *Int J Nurs Stud.* 2010; 47(2): 154–65.
35. Vandecasteele T, Debyser B, Van Hecke A, De Backer T, Beeckman D, Verhaeghe S. Nurses' perceptions of transgressive behaviour in care relationships: a qualitative study. *J Adv Nurs.* 2015;71(12):2786–98.
36. van Belle E, Giesen J, Conroy T, van Mierlo M, Vermeulen H, Huisman-de Waal G, et al. Exploring person-centred fundamental nursing care in hospital wards: a multi-site ethnography. *J Clin Nurs.* 2020;29(11–12):1933–44.
37. King A, Hoppe RB. "Best practice" for patient-centered communication: a narrative review. *J Grad Med Educ.* 2013;5(3): 385–93.
38. Van Humbeeck L, Malfait S, Holvoet E, Vogelaers D, De Pauw M, Van Den Noortgate N, et al. Value discrepancies between nurses and patients: a survey study. *Nurs Ethics.* 2020;27(4):1044–55.
39. Rasheed SP, Younas A, Sundus A. Self-awareness in nursing: a scoping review. *J Clin Nurs.* 2019;28(5–6):762–74.
40. Han S, Kim S. An integrative literature review on self-awareness education/training programs in the nursing area. *Perspect Nurs Sci.* 2010;13(2):59–69.
41. Rasheed SP. Self-awareness as a therapeutic tool for nurse/client relationship. *Int J Caring Sci.* 2015; 8(1): 211–6.
42. Idvall E, Berg A, Katajisto J, Acaroglu R, Luz MDAD, Efstathiou G, et al. Nurses' sociodemographic background and assessments of individualized care. *J Nurs Scholarsh.* 2012;44(3): 284–93.
43. Vahdat S, Hamzehgardeshi L, Hessam S, Hamzehgardeshi Z. Patient involvement in health care decision making: a review. *Iran Red Crescent Med J.* 2014;16(1):e12454.

44. Rodríguez-Martín B, Stolt M, Katajisto J, Suhonen R. Nurses' characteristics and organisational factors associated with their assessments of individualised care in care institutions for older people. *Scand J Caring Sci*. 2016;30(2):250–9.
45. Land L, Suhonen R. Orthopaedic and trauma patients' perceptions of individualized care. *Int Nurs Rev*. 2009;56(1):131–7.
46. Suhonen R, Välimäki M, Katajisto J, Leino-Kilpi H. Patient characteristics in relation to perceptions of how individualized care is delivered—research into the sensitivity of the individualized care scale. *J Prof Nurs*. 2006;22(4):253–61.
47. Heijmans M, Waverijn G, Rademakers J, van der Vaart R, Rijken M. Functional, communicative and critical health literacy of chronic disease patients and their importance for self-management. *Patient Educ Couns*. 2015;98(1):41–8.
48. Rademakers J, Delnoij D, Nijman J, De Boer D. Educational inequalities in patient-centred care: patients' preferences and experiences. *BMC Health Serv Res*. 2012;17(12):261.
49. Suhonen R, Land L, Välimäki M, Berg A, Idvall E, Kalafati M, et al. Impact of patient characteristics on orthopaedic and trauma patients' perceptions of individualised nursing care. *Int J Evid Based Healthc*. 2010;8(4):259–67.
50. Ceylan B, Eser I. Assessment of individualized nursing care in hospitalized patients in a university hospital in Turkey. *J Nurs Manag*. 2016;24(7):954–61.
51. Feo R, Kitson AL. Promoting patient-centred fundamental care in acute healthcare systems. *Int J Nurs Stud*. 2016;57:1–11.
52. Zwakhalen SM, Hamers JP, Metzelthin SF, Ettema R, Heinen M, de Man-Van GJ, et al. Basic nursing care: the most provided, the least evidence based – A discussion paper. *J Clin Nurs*. 2018;27(11–12):2496–505.
53. Polit DF, Beck CT. *Nursing research: generating and assessing evidence for nursing practice*. Philadelphia: Lippincott Williams & Wilkins; 2016.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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