



ORGANISING AND IMPROVING PATIENT-CENTRED NURSING CARE DURING REHABILITATION

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Abstract

This article analyses the theoretical and practical aspects of organising patient-centred nursing care during rehabilitation. Based on a targeted literature review, a six-stage model is proposed, consisting of functional needs assessment, agreeing goals with the patient, individual planning, implementation of care, monitoring, and coordination of continuing care. The article addresses education that is understandable to patients and caregivers, interprofessional collaboration, and safety. The outputs comprise a structured account of organisational factors, a ten-item audit checklist, and criteria for separately assessing care processes, functional status, and patient experience. The article presents a scientific and methodological proposal rather than a report of a primary clinical experiment. The effectiveness of the model and the measurement properties of the audit tool need to be examined in future using real clinical data.

Keywords: rehabilitation, nursing care, patient-centred approach, functional independence, shared decision-making, individual care plan, continuity of care.

Abstract

This article examines the theoretical and practical aspects of organising patient-centred nursing care during rehabilitation. A targeted literature review



provides the basis for a six-stage model: assessment of functional needs, agreeing goals with the patient, individual planning, implementation of care, monitoring, and coordination of subsequent care. The article addresses understandable education for the patient and caregiver, interprofessional collaboration, and safety. The outputs include a structured account of organisational factors, the development of a ten-item audit checklist, and criteria for separately assessing processes, functional status, and patient experience. The article presents a scientific and methodological proposal rather than a report of a primary clinical experiment. The effectiveness of the model and the measurement properties of the audit tool need to be evaluated in future using real clinical data.

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Abstract

This article examines theoretical and practical aspects of organising patient-centred nursing care during rehabilitation. A targeted literature review informs a six-stage model comprising functional needs assessment, goal agreement with the patient, individual care planning, implementation, monitoring, and coordination of continuing care. Accessible education for patients and caregivers, interprofessional collaboration, and safety are addressed. The outputs include a structured account of organisational factors, a ten-item audit checklist, and criteria for separately assessing care processes, functional status, and patient experience. The article presents a methodological proposal rather than a report of a primary clinical experiment. The effectiveness of the model and the measurement properties of the audit tool require subsequent evaluation using real clinical data.

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Introduction

Rehabilitation aims to improve the everyday functioning of people with limitations associated with a health condition and to support them in living as independently as possible. The World Health Organization describes this process in terms of optimising functioning and providing care that reflects a person's needs, goals, and preferences [1]. Rehabilitation should therefore be viewed not merely as a set of physical exercises or treatments, but as care directed towards the patient's everyday functioning.

The International Classification of Functioning, Disability and Health (ICF) makes it possible to describe health without separating it from the environment in which a person lives [2]. When this approach is applied to nursing care, the disease diagnosis is considered alongside what the patient can do, the activities for which assistance is needed, and the barriers present in the environment. For example, it is proposed that independence in eating be assessed together with hand movement, the ability to sit, appropriate equipment, and the availability of assistance.

Coordination of care across different stages and services is central to WHO's framework for integrated people-centred services [3]. This article considers nursing care as a practical component of that continuity: it proposes bringing together the patient's daily needs, agreed tasks, and observations in a single plan. The challenge is not only to perform a care intervention, but also to establish its significance for the patient, its safety, and how it will be continued at the next stage.

The aim of this article is to systematise the factors involved in organising patient-centred nursing care during rehabilitation and to propose a practical model and criteria for its evaluation. The principal question is: how can a goal agreed with the patient be linked to an individual plan, everyday care, and reassessment of the outcome? The scientific and methodological contribution of this work lies in



expressing that relationship through observable actions and documentation criteria; no claim is made that new clinical effectiveness has been demonstrated.

Theoretical Foundations of Patient-Centred Nursing Care

In a patient-centred approach, the person's views are not simply information requested at the beginning of a conversation, but a criterion to be considered when setting the goal of care. NICE guidance on shared decision-making supports the exchange of information about available options between healthcare professionals and patients, and their collaboration in decisions about care [4]. This article translates that principle into practice by discussing the goal in terms the patient can understand, documenting the patient's priorities, and reaching agreement again when the plan changes.

In the proposed model, individualisation and patient participation are treated as related but distinct concepts. A nurse may develop a plan appropriate to the clinical condition; however, if the patient's wishes are not reflected in it, participation has not been documented. Conversely, a patient's expressed wish is not acted upon without first reconciling it with safety requirements and current clinical guidance. The goal within the model is therefore described through three components: an activity that is meaningful to the patient, the assistance needed to perform it, and the time frame for reassessment.

Communication is adapted to the patient's ability to receive information. In the teach-back method recommended by AHRQ, the patient explains the relevant information in their own words; a return demonstration of a practical action helps establish whether the skill has been understood [8]. This is not a test of the patient, but a check on the clarity of the explanation. The model envisages that the involvement of a family member or caregiver will be consistent with the patient's wishes, consent, and the representation arrangements appropriate to the circumstances, and will not unjustifiably replace the patient's own views.



Factors Affecting the Quality of Care

In interviews conducted by Fernandes and colleagues with 12 professionals in rehabilitation facilities in Portugal, limited organisational support, staffing shortages, workload, and resistance to change were identified as barriers. Education, leadership, and shared decision-making were described as facilitating factors [5]. These findings relate to a small sample from another country and do not directly measure the situation in institutions in Uzbekistan. The following table organises these factors for examination in a local audit.

Table 1. Factors Affecting Patient-Centred Care

Factor category	Issue to clarify during assessment	Proposed organisational solution
Functional needs	Alignment between the assistance the patient needs in everyday activities and the patient's goal.	Record the activity, level of assistance, and the patient's priority in a single plan.
Communication and understanding	Needs related to language, hearing, vision, or understanding information.	Use brief explanations and an appropriate communication aid, and recheck understanding.
Safety	Mobility limitations, skin condition, and the need for assistive equipment.	An individual safety plan; assistance within the relevant scope of practice and reassessment.
Patient participation	Whether personal goals, concerns, and reasons for refusal have been documented.	Discuss the reasons and agree an alternative plan rather than using coercion.



Factor category	Issue to clarify during assessment	Proposed organisational solution
Work organisation	The responsible staff member, workload, and information exchange within the team.	Allocate tasks and include the principal goal in the shift handover.
Continuing care	Home conditions, caregiver capacity, and connection with the next service.	Agree the discharge plan in advance and pass information to the next team.

Note: the table is an original synthesis by the authors based on WHO and AHRQ materials, research on organisational barriers, and recommendations on pressure ulcer prevention [2, 3, 5, 8, 9].

In patients with limited mobility, monitoring skin condition, identifying the need for pressure-redistributing equipment, and informing caregivers are practical aspects of pressure ulcer prevention [9]. Rather than restricting these safety tasks to a separate list, the model proposes integrating them into the patient's everyday activity goals. The frequency and method of interventions are not set uniformly for all patients; they are determined on the basis of the relevant clinical protocol and individual assessment.

Materials and Methods

This work was developed as a targeted narrative literature review and an exercise in organisational and methodological modelling. Sources were selected from publicly available WHO, NICE, and AHRQ materials, primary studies indexed in PubMed, and their publishers' pages. Electronic sources were reviewed as of 29 September 2026. Searches focused on the terms “person-centred rehabilitation”, “patient-centred nursing care”, “shared decision making”, “rehabilitation nursing”,



and “teach-back”. No claim is made that a full systematic review or meta-analysis was conducted.

Source selection prioritised relevance to rehabilitation and coverage of patient participation, nursing activities, or evaluation criteria. Official recommendations were used to identify organisational principles, while primary studies were used to explain the specific conditions under which particular approaches had been evaluated. The type of participants, intervention content, assessed outcome, and limits to generalisation were extracted from each study. Different diseases and outcome measures were not treated as equivalent, and no pooled effect size was calculated.

The model is intended to coordinate nursing care in settings that provide planned rehabilitation services for adults. It does not replace an emergency care algorithm, the treating physician's instructions, or a specialised rehabilitation programme. No clinical trial, allocation of patients to groups, questionnaire survey, or primary measurements were undertaken. Consequently, no sample size, observed clinical improvement, p-value, or ethics committee approval is presented as though it existed.

A ten-item audit checklist was proposed to examine organisational practice. Each item is scored as follows: 0 points — confirmed not to have been performed; 1 point — partially performed; 2 points — the specified requirements have been met in full. When information is insufficient, the item is marked “not assessed”; this is not equated with an action not having been performed. When all items are assessed, the maximum total score is 20 points. This tool is not a validated clinical scale or a criterion for certifying nurses' qualifications.

Table 2. Proposed Nursing Care Audit Checklist



Action examined in the audit	Score	Source of evidence
The patient's personal priority and communication needs have been documented.	0–2	Interview and record
Everyday activities and the required level of assistance have been assessed.	0–2	Initial assessment
Safety limitations and the appropriate assistance arrangements have been identified.	0–2	Safety plan
The goal has been discussed with the patient and the agreement documented.	0–2	Goal record
The individual plan specifies an intervention, the person responsible, and a time frame for reassessment.	0–2	Care plan
Everyday care has been delivered in accordance with the agreed activity goal.	0–2	Direct observation
The understanding of the patient or relevant caregiver has been checked.	0–2	Education record
The outcome has been reassessed and any necessary adjustment documented.	0–2	Ongoing monitoring
The necessary information has been handed over between shifts or teams.	0–2	Handover record
The continuing care plan has been communicated in a form the patient can understand.	0–2	Discharge plan

Before introducing the audit, it is proposed that the content of the items be reviewed with clinical specialists and patient representatives, assessors be trained to



apply the same criteria, and a small pilot assessment be conducted. Initially, findings are analysed item by item; no threshold for “good-quality” or “poor-quality” care is assigned to an unvalidated total score. A safety violation cannot be offset by high scores on other items. Documentation audits are supplemented by direct observation of whether care was actually delivered or by obtaining the patient's views.

Practical Content of the Nursing Care Model

Stage One — Needs Assessment. The nurse clarifies the activities that matter to the patient and relates them to the team's assessment. The proposed record distinguishes existing abilities, required assistance, environmental barriers, and the patient's priority goal. It is intended to document preserved abilities rather than merely list limitations. This format is the authors' proposed way of adapting the ICF's attention to context to the everyday care plan [2].

Stage Two — Agreeing the Goal. The patient, nurse, and relevant specialist discuss a measurable activity goal. As a methodological example, the following formulation may be proposed: “to transfer safely from bed to chair by the reassessment date, using the assistance and equipment specified by the team”. This is not a universal clinical instruction: the activity itself, the amount of assistance, and the time frame are determined individually. If the patient regards another activity as a priority, that view is included in the discussion of the plan [4].

Stage Three — Individual Planning. The plan records, together, the nursing action that supports the goal, the person responsible for carrying it out, the necessary conditions, and the criterion for reassessment. Mobility or self-care exercises are coordinated with the recommendations of the relevant specialist. Actions that the nurse performs independently, actions performed jointly with another specialist, and problems requiring referral are distinguished. This division is proposed to make responsibilities explicit.



Stage Four — Implementation of Care. Patients are supported in participating in activities they can perform safely, while necessary assistance is not reduced without justification. Explanations are given in short sections, and the patient is asked to restate the information in their own words or demonstrate the action [8]. Instead of the general phrase “explained”, it is proposed that the education record specify which task was discussed and which step was explained again.

Stage Five — Monitoring and Reassessment. Records cover the planned task, the patient's actual participation, the level of assistance, and any circumstances that prevented completion. If the outcome does not match the goal, the reasons are discussed again with the patient. If the clinical condition deteriorates or a safety limitation is identified, the intervention being performed is reviewed and the local procedure for requesting assistance is followed. The audit checklist does not replace clinical judgement in such circumstances.

Stage Six — Coordination of Continuing Care. Before discharge, the plan clarifies where and with whom the patient will live, the need for assistive devices, caregiver preparedness, and arrangements for follow-up. The agreed tasks, limitations, and ways to seek assistance are communicated to the patient and the relevant caregiver in an understandable form. It is proposed that information be handed over to the next service and that the responsible party be identified. This stage adapts the continuity between services emphasised by WHO to practical documentation [3].

Results and Evaluation Criteria

The synthesis of the literature produced three practical outputs: a table of factors affecting care, a six-stage organisational model, and a ten-item audit checklist. These are conceptual and methodological results. The central relationship in the model is the progression from the patient's priority need to an agreed goal, and



from that goal to everyday actions and reassessment. Identifying a source of evidence for each stage makes the model amenable to future evaluation.

Evidence concerning individual clinical approaches must not be confused with outcomes of the overall model proposed here. The ProBalance trial by Gouveia and colleagues involved 52 people aged 65–85 years with impaired balance. Following a nurse-led programme, the mean change on the balance scale was +5.15 points in the intervention group and –1.45 points in the control group [6]. These findings relate specifically to that programme and sample; they do not imply that the same improvement should be expected in all rehabilitation patients.

A randomised study published by Arslan and Özkan in 2025, involving 102 patients undergoing gynaecological oncology surgery, reported that preoperative teach-back-based education positively affected mobilisation, recovery, and satisfaction with nursing care [7]. This evidence supports the patient education component. It cannot be directly extrapolated to other diseases, all stages of care, or the overall effectiveness of the model presented in this article.

Table 3. Recommended Indicators for Future Evaluation of the Model

Evaluation domain	Indicator and method of recording	Limits to interpretation
Patient participation	Proportion of patients whose priority goal has been discussed and documented.	Verify the record against actual agreement.
Plan completeness	Proportion of plans specifying a goal, an intervention, the person responsible, and a time frame for reassessment.	Documentation quality is not clinical recovery.



Evaluation domain	Indicator and method of recording	Limits to interpretation
Functional status	An appropriate standardised tool and changes in the level of assistance with everyday activities.	Account for disease, baseline status, and follow-up duration.
Patient experience	Views on participation in goal-setting, clarity of explanations, and respectful treatment.	Satisfaction does not replace functional outcomes.
Safety	Separate recording of falls, new pressure ulcers, and other relevant events.	Event definitions and the extent of observation must be consistent.
Continuity of care	An understandable continuing care plan and handover of information to the next service.	The existence of a plan does not mean that the service was received.

As an example of a process indicator, it is proposed that the proportion of complete plans be calculated as follows:

$$P = (\text{number of plans containing all specified components} / \text{number of plans included in the audit}) \times 100\%.$$

The audit period and inclusion criteria are specified in advance. Cases in which documentation cannot be found are recorded separately, and the indicator is not artificially increased by excluding them without disclosure. This formula describes an organisational process; it is not a patient recovery percentage or a statistical criterion demonstrating the effectiveness of care. No observed numerical value for this indicator is reported in the article.



An appropriate standardised tool should be selected to assess functional status. WHO's WHODAS 2.0 covers understanding and communication, mobility, self-care, getting along with others, life activities, and participation in society [11]. Local use requires examination of linguistic and cultural suitability, the selected version, and the assessment procedure. Clinically meaningful change is not inferred from the audit score; it is assessed using a separate outcome measure and the patient's goal.

Discussion

The principal methodological feature of the proposed model is that it examines the relationship between care interventions and the patient's goal, rather than the number of interventions. The same intervention may serve different goals for different patients. It is therefore proposed that an individual plan should be based on the meaning of the goal and observational evidence, rather than simply on ticking predefined items. Measuring patient participation, care delivery processes, and functional outcomes separately is necessary to avoid conflating these concepts when evaluating the model.

The organisational barriers described by Fernandes and colleagues show that relying solely on nurses' individual initiative is insufficient [5]. In our model, the practical implications are to simplify documentation, distinguish responsibilities, and create opportunities for team discussion. These are organisational proposals to be tested during implementation, not local findings of measured effectiveness. If the necessary time and resources are not considered, a new form may become an additional document rather than a means of delivering meaningful care.

The two randomised studies reviewed demonstrate the outcomes of specific interventions in particular samples [6, 7]. Their participants, programmes, and assessment methods differ. Consequently, evidence that education is beneficial or that balance improves does not prove that every component of nursing care is



effective. Future evaluation should specify the clinical group, the precise content of the intervention, and the primary outcome in advance.

The limitations of this work include targeted rather than fully systematic source selection, the absence of local primary data, and the lack of validation of the proposed audit. For future research, it is proposed that comprehensibility and feasibility be examined first, followed by a comparison with usual care. Sample size should be calculated on the basis of the primary outcome, taking account of baseline status, disease type, and loss to follow-up. Results should be interpreted together with uncertainty intervals and their clinical meaning, rather than relying solely on p-values.

Recommendations for Nursing Practice

It is proposed that practical implementation begin with a small-scale pilot in one ward. First, existing care documentation is examined to establish where the patient's goal, level of assistance, and reassessment records are documented. The new form should not duplicate existing records. Its comprehensibility is discussed with patients and nurses, and difficulties encountered in its use are recorded. Feedback is then provided on individual audit items, and the form is refined.

WHO's Rehabilitation Competency Framework proposes an approach to training that can be adapted to different professional groups and settings [10]. On this basis, nursing education may include practical tasks on agreeing goals with the patient, checking the effectiveness of explanations, providing safe assistance, and communicating information to the team. Scenario-based exercises and observation checklists are proposed for technical college settings. Learners' performance of a task is assessed separately from clinical effectiveness in patients.

During pilot monitoring, it is proposed that patients' views, staff time, and interventions that could not be completed be reviewed together. If an electronic form



is selected, restrictions on data access and the security of records must be ensured. Patients who cannot use digital tools should be offered an understandable paper-based or verbal alternative. Every change is coordinated with clinical scopes of practice, the institution's protocol, and the patient's consent.

Conclusion

A model consisting of needs assessment, agreeing goals, individual planning, implementation, monitoring, and coordination of continuing care has been proposed for organising patient-centred nursing care during rehabilitation. Its practical content lies in linking an activity meaningful to the patient with nursing actions and observational evidence. A table of factors, a ten-item audit, and criteria for assessing processes and clinical outcomes separately have been developed. The results of this work are scientific and methodological in nature. Demonstrating the superiority of the model requires a pilot adapted to local conditions, reliable assessment tools, and a comparative study based on real clinical observations.

Ethics and Data Transparency

No personal patient data were used in this article, and no primary clinical study involving human participants was conducted. The findings from studies conducted in other countries belong to their respective sources and are not presented as observations made by the authors of this article. Before the model is evaluated with patients, appropriate ethical review, voluntary consent, and data protection procedures must be established. The final declarations on funding, conflicts of interest, and author contributions will be confirmed by the authors when the manuscript is submitted for publication.

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