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ORIGINAL

Implementation of Good Practice Guidelines for Person- and Family-Centered Care in Primary Health Care in Chile

Implementación de Guías de Buenas Prácticas para los cuidados centrados en la persona y familia en Atención Primaria de Salud en Chile

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ABSTRACT

Introduction: person- and family-centered care has become a fundamental pillar of Primary Health Care (PHC), promoting active participation, effective communication, and respect for autonomy. In this context, an implementation experience with the Registered Nurses' Association of Ontario (RNAO) Good Clinical Practice Guidelines (GCPG) was developed in a health center in Chile.
Objective: to analyze the experience with the implementation of the GCPG "Person- and Family-Centered Care" at the Dr. Fernando Monckeberg Family Health Center (CESFAM).
Method: a single-case study design was used. Data were collected through documentary analysis. The process was carried out in three phases, ensuring ethical feasibility and a thorough understanding of the phenomenon.
Results: three key GCPG recommendations were prioritized. Multi-format educational resources, a "Comprehensive Care Card," and a user satisfaction survey were developed. Eighty-two percent of staff were trained, and the survey was administered in 46 % of ECICEP check-ups. Ninety-six percent of respondents positively evaluated the care, with scores of 6 or 7 on a scale of 1 to 7.
Discussion: experience shows that it is possible to implement person-centered strategies in PHC, using evidence-based guidelines adapted to the local context. Challenges were identified, particularly with the coverage of user assessments.
Conclusions: the intervention allowed for the integration of person-centered practices in a concrete and measurable way, generating valuable learning for future implementations in similar contexts.

Keywords: Primary Health Care; Patient-Centered Care; Evidence-Based Nursing; Patient Satisfaction; Patient Participation.

RESUMEN

Introducción: los cuidados centrados en la persona y la familia se han posesionado como un pilar fundamental en la Atención Primaria de Salud (APS), promoviendo la participación activa, la comunicación efectiva, el respeto por la autonomía. En este contexto, se desarrolló una experiencia de implementación de la Guía de Buenas Prácticas Clínicas (GBPC) de la Registered Nurses´Association of Ontario (RNAO) en un centro de salud en Chile.
Objetivo: analizar la experiencia de implementación de la GBPC "Cuidados centrados en la persona y la

familia" en el Centro de Salud Familiar (CESFAM) Dr. Fernando Monckeberg.
Método: se utilizó un diseño de estudio de caso único. Se recopilaron datos a través de análisis documental. El proceso se llevó a cabo en tres fases, asegurando la viabilidad ética y la comprensión profunda del fenómeno.
Resultados: se priorizaron tres recomendaciones clave de la GBPC. Se desarrollaron recursos educativos multiformato, un "Carnet de Atención Integral" y una encuesta de satisfacción usuaria. El 82 % del personal fue capacitado, y la encuesta se aplicó en el 46 % de los controles ECICEP. El 96 % de las personas encuestadas evaluó positivamente la atención, con puntuaciones de 6 o 7 en una escala de 1 a 7.
Discusión: la experiencia muestra que es posible implementar estrategias centradas en la persona en APS, utilizando guías basadas en evidencia y adaptadas al contexto local. Se identificaron desafíos especialmente con la cobertura de la evaluación usuaria.
Conclusiones: la intervención permitió integrar prácticas centradas en la persona de manera concreta y medible, generando aprendizajes valiosos para futuras implementaciones en contextos similares.

Palabras clave: Atención Primaria de Salud; Cuidado Centrado en el Paciente; Enfermería Basada en la Evidencia; Satisfacción del Paciente; Participación del Paciente.

INTRODUCTION

The person- and family-centered care model has become the standard for quality care in contemporary health systems by promoting autonomy, dignity, and active participation of individuals.[1,2,3,4] In Chile, this approach has been implemented through the Primary Health Care (PHC) strategy and, more recently, through the Comprehensive Person-Centered Care Strategy (ECICEP), which seeks to translate these principles into concrete actions at the national level.[5,6,7,8]

It should be noted that, to guide this transition from model to practice, health teams use evidence-based tools, such as the Good Clinical Practice Guidelines (GBPC) developed by the Registered Nurses' Association of Ontario (RNAO), whose international prestige lies in their rigor and applicability.[9,10]

Despite the consensus on the importance of this approach and the existence of international guidelines, a crucial challenge emerges: the gap between theory and practical implementation. There is a scarcity of literature documenting the processes of adaptation and application of international guidelines, such as those of the RNAO, in local primary care contexts in Latin America. The specific barriers and facilitators that arise when integrating these tools into health systems with their own sociocultural and organizational realities are mainly unknown. This knowledge gap limits the ability of other centers to learn from previous experiences and optimize their own implementation processes.[11,12]

It is important to note that this article directly addresses this gap by documenting and analyzing the experience of implementing PCGB "Person- and Family-Centered Care" at the Dr. Fernando Monckeberg Family Health Center (CESFAM) in Peñaflor, Chile. The choice of this center as a case study is deliberate, as it represents an ideal setting for this research: it serves a diverse population, comprising both urban and rural areas, functions as a clinical field for the training of future health professionals, and has demonstrated a proactive commitment to improving its models of care. Its experience, therefore, offers transferable and highly relevant lessons for the Chilean PHC network.

In this context, the role of nursing is fundamental. As leaders in care management and the implementation of evidence-based practices, nursing professionals are key agents in operationalizing the RNAO guideline recommendations and ECICEP principles in daily care.[13,14] Therefore, the purpose of this article is to analyze the process of implementing GBPC in the CESFAM above, identifying successful strategies, challenges encountered, and the catalytic role of nursing, to provide practical evidence to guide future implementations in similar contexts.

METHOD

This study is qualitative in nature and falls within the post-positivist paradigm, which recognizes the existence of an objective reality that can be attained, but acknowledges the possibility that the researcher may not fully understand it.[15]

The research question posed was: How is the Good Practice Guide "Person- and Family-Centered Care" implemented in an urban family health center in Chile? The overall objective of this study was to analyze the implementation process of the Good Practice Guide "Person- and Family-Centered Care" in an urban family health center.

The theoretical and methodological approach employed was a single instrumental case study design, which is defined as empirical research that examines a phenomenon in depth within its real-world context. From this theoretical perspective, the purpose of the case study is to understand a specific process and critically reflect

on the experience from an interpretive logic. According to Yin[16], case studies can use different information gathering techniques, but the dominant logic of the research, in this comprehensive case, gives it a qualitative character.

The case under study corresponds to the process of implementing the Good Clinical Practice Guide (GBPC) 'Person- and family-centered care' in a rural-urban Family Health Center (CESFAM) in Chile, between March 2023 and November 2024. This case was chosen because of its pioneering nature in the systematic adoption of evidence-based guidelines at the primary care level in Chile, in collaboration with a national university.

To ensure greater understanding, information collection techniques were included with various data sources from user survey results and institutional records that account for the implementation and its effects, allowing for a dense and contextualized understanding of the phenomenon.

Study context

The study was conducted at the CESFAM Dr. Fernando Monckeberg, located in the metropolitan region of Chile in the community of Peñaflor. This facility serves both urban and rural populations and has interdisciplinary teams that include nurses, doctors, social workers, and nursing technicians. This health center operates according to the guidelines of the Chilean Ministry of Health, which include strategies for strengthening primary health care and implementing the Comprehensive Person-Centered Care Strategy (ECICEP).

Participants

The participants were the aforementioned healthcare professionals, as well as users who attended ECICEP check-ups during the intervention period. The sampling was intentional, and the inclusion criteria were being of legal age, having the cognitive capacity to understand the nature of the study, and agreeing to participate by signing an informed consent form. In total, 33 professionals were trained, and 308 users responded to the satisfaction survey.

Intervention

The intervention was structured in three phases, following the RNAO clinical practice guidelines implementation model 10:

- Phase 1: Preparation: In this phase, key CPG recommendations were reviewed and selected collaboratively, considering their relevance, applicability, and local feasibility.
- Phase 2: Implementation. Clinical strategies were designed and implemented, including multi-format educational materials, the creation of the "Comprehensive Care Card," and the application of a digital user satisfaction survey.
- Phase 3: Sustainability: In this phase, follow-up was carried out using structural, process, and outcome indicators defined and adapted from the CPGBOC.

Information collection techniques

Three complementary techniques were used to collect information.

First, a document analysis was carried out during the implementation process, including plans, protocols, minutes, and other documents. This was followed by a review of institutional records, which consisted of training reports, ECICEP controls, and various clinical documentation. A user satisfaction survey was also conducted, with 12 Likert-type items rated from 1 to 7, administered via a digital form with a QR code.

Data analysis

Content analysis was performed using the method described by Bengtsson[17], which consists of seven stages. It begins with the formulation of the research question, which must be clear and open-ended. Next, the material is selected, defining the relevant texts or data. The third stage involves the construction of the category system, which can be developed inductively or deductively. Next, the material is segmented into meaningful units, followed by coding, where the categories are applied to each segment. Subsequently, the reliability of the process is evaluated to ensure consistency in coding. Finally, the analysis and interpretation are carried out, linking the findings to the initial question and the theoretical framework.

The survey data were subjected to descriptive statistical analysis using Microsoft Excel®, by calculating absolute frequencies, percentages, means, and standard deviations, to characterize user perceptions in a manner complementary to the qualitative narrative.

Ethical considerations

The study was approved by the Ethics Committee of the Faculty of Medicine of the University of Chile, under code No. 2023/APS/018. The confidentiality of the data, the anonymity of the participants, and the right to withdraw from the study at any time without repercussions were guaranteed. All participants signed informed

consent forms.

RESULTS

1. Structure indicators

The achievements in relation to the structure indicators proposed by the guide are detailed below.

- Availability of standardized measures to monitor the care experience: structured surveys and feedback tools were implemented to systematically evaluate people's satisfaction with the care they received. This strategy ensured alignment with the principles of person-centered care, providing valuable information to adjust and improve clinical practice.
- Availability of educational resources: multiple informational materials were developed in different formats, such as posters, brochures, social media posts (Instagram), explanatory videos, and verbal education sessions. These resources facilitated health literacy, supported informed decision-making, and promoted an active role for individuals in their care process.
- Availability of documentation tools: The "ECICEP Card" was introduced, a tool designed to record each person's needs, goals, and preferences, as well as the commitments agreed upon with the healthcare team. Its use contributed to improving the continuity, personalization, and effective monitoring of care plans.

2. Process indicators

To evaluate the implementation of the guide, the two indicators mentioned above were applied. The results are presented in table 1.

Table 1. Process indicators

Indicator	Target	Result obtained
Total surveys conducted / Total admissions and ECICEP checks × 100	50	(308/675) × 100 = 46 %
Total number of managers trained / Total number of managers × 100	80	(27/33)×100 = 82 %

3. Outcome indicators

Finally, the satisfaction levels of 308 people were assessed using a survey designed for this purpose. The results are presented in table 2.

Table 2. Outcome indicators

Indicator	Target	Result obtained
No. of surveys with satisfaction level 6 or 7 / Total number of surveys conducted × 100	80	(295/308) × 100 = 96 %

Regarding the application of the survey, the data show that 220 (71 %) respondents identified as female, with an average age of 34. In relation to the care dimension, 280 (91 %) people indicated that the professional introduced themselves by name, and a similar number, 279 (91 %), showed that both the objective and the time allocated for care were explained to them. A total of 259 (84 %) people indicated that they were asked what name they preferred to be addressed by, and 294 (95 %) reported that they were able to express their fears and be reassured during the consultation.

Regarding the quality of the information, 297 (96 %) people said that it was completely clear, and 289 (95 %) said that their questions were fully answered. In relation to the care provided, 260 (84 %) rated the professional with a score of 7 (the highest score), equivalent to "very cordial, courteous, and kind". Additionally, 305 (99 %) respondents indicated that the commitments made during care were established by mutual agreement. Finally, 295 (96 %) people rated the care received with a score of 6 or 7 on the overall satisfaction scale.

These results suggest that although the dimension relating to dignified treatment in care has been strengthened, there are still opportunities for improvement in the effective communication of clinical information and in promoting active participation in decision-making.

DISCUSSION

The implementation of person- and family-centered PCG in the PHC of the CESFAM in Peñaflor demonstrates that a structured, evidence-based model, such as that of the RNAO, allows for the successful operationalization

of comprehensive care in a context of limited resources. This project, focused on PCGP "Person- and Family-Centered Care," not only documents the applicability of the recommendations to a local context but also offers a concrete model for transforming clinical practice toward a more participatory, humane, and practical approach.

It is worth mentioning that the success of this implementation is reflected in high levels of user satisfaction, which exceed the findings of comparable studies in Brazil and Spain.[18,19] This result is attributed to two critical factors: the robustness of the implementation model and the integration of local tools. A crucial finding is that high user satisfaction is directly linked to the relational dimension of care, in aspects such as the professional's presentation, the clarity of information, and the establishment of mutual care commitments. A notable example of the success of this approach is the high rate of use of the preferred name, reaching 84 %, which reinforces the effectiveness of the strategies implemented for personalizing treatment. These strengths do not contradict the existence of areas for improvement in the consolidation of genuinely person-centered care, but they establish a solid starting point.

Compared to international experiences, the implementation at the CESFAM in Peñaflor is distinguished by the use of personalized tools such as the Comprehensive Care Card, which promotes a continuous and documented link between the patient and the team. The development of multi-format materials and the systematic incorporation of verbal and nonverbal communication strategies have also proven to be key factors that facilitate user understanding and empowerment, elements that have been little explored in the reviewed literature but are aligned with evidence on the importance of accessible language for equity in care.[20]

In terms of methodology, a significant challenge was the sustained application of satisfaction surveys. This difficulty, reflecting the high workload in PHC, highlights an inherent limitation of the study, as the continuous evaluation of the user experience could not be fully sustained. This finding coincides with reports from studies in Uruguay and Colombia, where the overload of health personnel was identified as a significant barrier to systematic evaluation.[21,22] Future efforts to evaluate the user experience should consider the implementation of sustainable institutional strategies, such as the digitization of instruments or the designation of protected times, to ensure the continuity of feedback.

Despite these limitations, the implementation demonstrates that the leadership of the nursing team and the staff's ownership of the strategies, evidenced by the high training coverage (80 %), were critical to success. The project not only achieved its initial objectives but also permeated other CPGBM guidelines, such as the principle of self-determination and the valuation of the user experience, demonstrating that a relational and contextualized approach can generate a broader impact than expected.

CONCLUSION

This experience allowed us to analyze the implementation of the RNAO's "Person- and Family-Centered Care" PCGP at the CESFAM Dr. Fernando Monckeberg, in the context of PHC in Chile. Through the prioritization of key recommendations, the design of contextualized clinical strategies, and the measurement of structural, process, and outcome indicators, it was possible to integrate principles of person-centered care into everyday healthcare practice in a concrete manner.

The results show significant progress in the availability of support tools, staff training, and people's positive perception of the care they receive.

The leadership of the nursing team was decisive in articulating evidence-based knowledge with the realities of the territory, facilitating the adoption of person-centered practices from an interdisciplinary perspective. The systematization of this experience may be helpful for other teams seeking to strengthen evidence-based, person-centered clinical practices adapted to the reality of PHC.

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CONFLICT OF INTEREST

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