Nursing Administrators' Role in Patient-Centered Care: A Case Study

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ABSTRACT

This qualitative single-case study explored the role of nursing administrators in promoting and implementing patient-centered care in one public tertiary hospital serving diverse communities in Lanao del Sur. It focused on how administrators understood their responsibilities, the strategies and organizational conditions involved, the barriers they faced, how they responded, and how they assessed patient-centered-care initiatives. Ten nursing administrators, including the chief nurse, assistant chief nurse, supervisors, assistant supervisors, and head nurses, were purposively selected based on their administrative experience and direct involvement in nursing leadership. Data were gathered through individual semi-structured interviews guided by six open-ended questions. Because interviews were not audio-recorded, responses were documented through researcher notes and presented as paraphrased accounts. The responses were reviewed in relation to each guiding question and organized into themes that reflected participants shared and differing perspectives. Participants described their role as combining patient advocacy with leadership of the conditions that shape daily care. They reported using respectful communication, staff guidance, teamwork, coordination, and routine safety and quality practices to keep patients' needs visible in nursing work. Staffing, workload, resources, workplace culture, and the demands of specific clinical situations influenced what administrators could do. Patient and family feedback, safety information, and quality indicators were used to identify concerns and inform local adjustments. The findings portray patient-centered care as a shared practice shaped by leadership actions and organizational capacity. This study offers a context-specific account of one hospital case. Its reported practices and perceptions do not establish causal effects or represent all healthcare institutions.

Keywords: Nursing Administrators, Patient-Centered Care, Nursing Leadership, Qualitative Case Study, Tertiary Hospital

INTRODUCTION

Patient-centered care is reflected in the way patients are listened to, informed, and included in decisions about their care. Nurses bring these principles to the bedside, while nursing administrators help shape the conditions that support or limit them. In a recent qualitative study, nurse managers described patient-centered care as recognizing each patient's individuality and cultural values and building respectful relationships (Abugre & Bhengu, 2024). A review of nursing leadership research also connected leadership with organizational, staff, and patient outcomes (Hult et al., 2023).

In addition, these responsibilities are carried out within the realities of each hospital. Staffing, available resources, communication, teamwork, and everyday routines can affect how consistently patients' needs are addressed. In a culturally diverse public tertiary hospital in Lanao del Sur, understanding how nursing administrators interpret patient-centered care and respond to daily challenges can show how these commitments are put into practice in that setting.

This study uses a qualitative single-case study design to examine nursing administrators' roles in promoting and implementing patient-centered care in the hospital. A case study is suitable when an issue needs to be understood alongside the setting in which it occurs and the case is clearly defined (Jones-Hooker & Tyndall, 2023; Miller et al., 2023). This chapter describes the design, setting, participants, interview guide, data-gathering procedures, ethical safeguards, and analysis. The study draws on the accounts of ten nursing administrators.

Conceptual Framework

The framework summarizes relationships described by participants in one hospital case. It organizes their accounts; it does not claim that the practices caused specific patient outcomes or represent all hospitals.

Hospital Conditions Staffing and workload Resources and culture Clinical demands and patient needs	→	**Administrator Actions** Patient advocacy and respectful communication Staff guidance and teamwork Safety and quality practices	→	**Patient-Centered Care** Patients heard and respected Patient/family involvement Responsive and safe care

↑ Feedback guides adjustments to administrators' actions

Feedback and Monitoring Patient and family feedback • Safety and quality information

Figure 1. *Simple case-derived conceptual framework for nursing administrators' role in patient-centered care.*

Statement of the Problem

This study will explore the nursing administrators' role in patient centered care. Specifically, it will answer the following questions

1. How do nursing administrators define their role in relation to patient-centered care?
2. What are the leadership strategies used to institutionalize patient-centered care?
3. Which are the organizational factors that affect the implementation of patient-centered care?
4. What are the barriers and challenges nursing administrators encountered in the implementation of patient-centered care?
5. How do nursing administrators address these barriers and challenges?
6. How do administrators assess the effectiveness of patient-centered care initiatives?

RESEARCH METHODOLOGY

Design

This study used a qualitative single-case study design to understand how nursing administrators promoted and implemented patient-centered care in a public tertiary hospital in Lanao del Sur. The case was bounded by one institution and focused on the administrators' leadership responsibilities and practices within that setting. A case study was appropriate because the study examined a contemporary organizational practice in the context where it occurred, allowing the accounts of participants to be considered alongside the conditions that shaped their work (Yin, 2018; Stake, 1995). Recent methodological guidance also supports defining the case and its boundaries clearly before gathering and interpreting evidence (Jones-Hooker & Tyndall, 2023; Miller et al., 2023).

Moreover, the inquiry focused on how administrators understood their role, the strategies they used to support patient-centered care, and the organizational conditions and challenges they encountered. The purpose was not to measure the effect of a particular intervention or to represent every hospital. Instead, the case study approach was used to develop a detailed, context-specific account of leadership practice in this hospital.

Setting

The study was conducted in a public tertiary hospital in Lanao del Sur that served patients from Marawi City, other parts of the province, and neighboring communities. The hospital cared for a population with varied cultural, religious, linguistic, and socioeconomic backgrounds, including members of the Maranao community and other ethnolinguistic groups. The institution was selected because its public tertiary-care context and diverse patient population provided a relevant setting for examining how nursing administrators supported patient-centered care in everyday hospital practice.

In addition, within this setting, the study considered how administrators worked to recognize patients' beliefs, religious practices, preferences, and care needs while coordinating nursing services. The hospital constituted the bounded case; the study's focus remained on nursing administrators' roles and experiences rather than on comparing the institution with other hospitals. Describing the setting helps readers understand the organizational and cultural context in which participants' accounts were formed (Yin, 2018).

Participants

Ten nursing administrators from the participating hospital took part in the study. They represented different levels of nursing leadership: The Chief Nurse, Assistant Chief Nurse, Nurse Supervisors, and Assistant Nurse Supervisors or Head Nurses. Purposive sampling was used because the study required participants with direct knowledge of nursing administration and patient-care management in the case being examined.

To be included, a participant had to be a licensed nurse, have at least three years of experience in a nursing administrative role, and be directly involved in institutional policymaking or leadership functions. These criteria were intended to ensure that participants could speak from relevant professional experience about leadership practices, organizational conditions, and efforts to promote patient-centered care. Recruitment and participation followed the approved institutional and ethics procedures, and each participant was identified in the research records by a code rather than by name.

Instrument

The primary data collection instrument was a researcher-developed semi-structured interview guide. The research adviser reviewed the guide for clarity, relevance, appropriateness, and alignment with the study questions. It contained six open-ended questions addressing administrators' understanding of their role in patient-centered care; leadership strategies; organizational influences; barriers and challenges; responses to those challenges; and ways of assessing patient-centered care initiatives.

The guide also allowed the researcher to use follow-up prompts when a response needed clarification or when a participant wished to describe an experience in greater detail. The same core questions were used across interviews to maintain focus, while the semi-structured format allowed participants to explain their perspectives in their own terms. No audio recorder was used; the researcher documented responses and relevant observations in field notes during the interviews which served as the primary qualitative records.

Data Gathering Procedure

Data gathering began after the researcher obtained ethical clearance from the Misamis University Research Ethics Committee and permission from the hospital administration. Eligible nursing administrators were identified through purposive sampling. Before each interview, the researcher explained the study's purpose, what participation involved, how information would be handled, and the participants' rights. Written informed consent was obtained before an interview proceeded.

Moreover, individual semi-structured interviews were scheduled at a mutually convenient time outside participants' duty hours and held in a private, comfortable location. The researcher followed the interview guide and used neutral follow-up questions to clarify or invite fuller descriptions. With participants' consent, responses and relevant contextual observations were documented through field notes. Because interviews were not audio-recorded, the field notes served as the primary record; they were reviewed and organized after each session to

clarify the notes while the discussion remained fresh. The study therefore did not treat these notes as verbatim transcripts, and any direct quotation in a later report would be used only when the participant's exact wording had been captured accurately.

Finally, the researcher used participant codes in the records and kept the materials organized for subsequent analysis. Access to the research records was restricted to authorized individuals, and the materials were stored securely in keeping with the approved research protocol and applicable privacy requirements.

Ethical Considerations

The study was conducted with attention to participants' autonomy, dignity, privacy, and well-being. Ethical clearance was obtained from the Misamis University Research Ethics Committee, and permission was secured from the participating hospital before recruitment and interviews. These safeguards are consistent with the ethical principles for research involving human participants set out in the World Medical Association's Declaration of Helsinki (World Medical Association, 2024).

In this context, participation was voluntary. Before giving written consent, each participant received an explanation of the study's purpose and procedures, foreseeable discomforts, and the right to decline a question or withdraw without penalty or adverse consequences. Interviews were arranged outside duty hours and in a private setting to reduce disruption and workplace pressure. Participants could request a pause or stop the interview if they felt uncomfortable, particularly when discussing leadership or workplace challenges.

Moving forward, confidentiality was protected by assigning participant codes and removing identifying details from working records and reports. Because the participants held identifiable leadership positions within one hospital, the researcher took care when presenting role descriptions and accounts to reduce the risk that a person could be recognized. Electronic files were password-protected and made available only to the researcher and authorized research personnel. The handling of personal information followed the Data Privacy Act of 2012 (Republic Act No. 10173, 2012) and the conditions approved for the study.

RESULTS AND DISCUSSION

This section presents the accounts of ten nursing administrators from one public tertiary hospital in Lanao del Sur. The discussion follows the study's six guiding questions and draws together participants' responses to explain how patient-centered care was understood and practiced in this hospital. Because the interviews were not audio-recorded, participant accounts are paraphrased; participant codes identify examples without suggesting that every participant expressed the same view. The clinical areas mentioned below are contexts within the same hospital case, not separate cases or a basis for comparing institutions.

Research Question 1. How do nursing administrators define their role in relation to patient-centered care?

Theme 1. Patient advocacy and respect keep the patient at the center

The participants described their role as making sure that patients are treated with dignity, listened to, kept safe, and involved in care as appropriate. They saw themselves as leaders who support staff while protecting patients' interests. P1 emphasized setting expectations and supporting nurses; P2 linked the role to safe, respectful care throughout the surgical experience; P7 described mentoring and advocacy; P9 spoke of placing the patient at the center of decisions; and P10 described connecting policy, the team, and the patient and family. Across these accounts, the role had both a direct and an organizational dimension. In addition, administrators described listening to concerns and respecting preferences, while also guiding staff, coordinating services, reinforcing standards, and addressing barriers that could affect care. The particular examples varied with the participant's work area, such as the operating room or pediatric intensive care, but they remained accounts of practice within the same hospital.

In this case, nursing administration was understood as translating patient-centered values into the conditions and routines of nursing care. The emphasis on participation, respect, and leadership is consistent with literature describing how nursing leadership can support patient participation in fundamental care (Bahlman-van Ooijen

et al., 2023) and how patient-centered care develops within acute hospital contexts (Janerka et al., 2023). These sources provide context for reading the participants' accounts; they do not establish that the same pattern applies to all hospitals. Their responses answer the first guiding question by showing that they understood their role as patient advocates and leaders of the nursing environment. Within this case, advocacy was not limited to speaking for an individual patient; it also involved supporting staff and coordinating practice so that patients could be heard and treated respectfully.

Research Question 2. What leadership strategies do nursing administrators use to institutionalize patient-centered care?

Theme 2. Supportive leadership brings patient-centered care into daily practice

Participants described role modeling, coaching, staff empowerment, communication, teamwork, continuing education, and monitoring as strategies for sustaining patient-centered care. P1 discussed leading by example and inviting staff to raise concerns; P2 described teamwork, coaching, and reinforcement of operating-room safety standards; P3 described supporting nurses' critical thinking; P6 emphasized education and regular monitoring; and P7 and P8 highlighted mentoring, advocacy, and teamwork. The accounts point to two connected approaches.

Moreover, administrators sought to influence how staff interacted with patients through example, guidance, and feedback. They also embedded expectations in routine practices, including patient identification, consent checks, infection prevention, endorsements, patient education, and safety monitoring. These actions were described as part of everyday work rather than as a separate patient-centered-care campaign.

Furthermore, the participants' accounts suggest that institutionalization occurred through repeated leadership behaviors and routine clinical processes. This reading is compatible with reviews associating nursing leadership with care quality and with qualitative work on leadership that enables patient participation (Alanazi et al., 2023; Bahlman-van Ooijen et al., 2023). The present case describes what administrators reported doing; it does not independently verify policy compliance or measure the impact of each strategy. The answer to the second question is that participants used a combination of relational leadership and standard-setting. This matters in the case because patient-centered care was presented as a shared practice maintained through staff support, coordination, and consistent attention to safety and patient preferences.

Research Question 3. Which organizational factors affect the implementation of patient-centered care?

Theme 3. Staffing, teamwork, and workplace culture shape how care is delivered

Participants identified leadership support, clear policies, teamwork, open communication, staff competence, adequate staffing, time, supplies, and resource allocation as factors that shaped patient-centered care. P1 pointed to a climate where staff can raise concerns without fear. P2 emphasized coordination and communication among operating-room personnel. P3 and P6 referred to staff competence and continuing education. P4 and P8 described supportive leadership, teamwork, and clear standards, while P6 and P7 raised staffing and workload conditions. The accounts show that organizational factors worked together.

Moreover, supportive culture and communication helped staff coordinate care, while staffing, time, training, and supplies affected their capacity to respond to individual patients. Participants also referred to policies and patient-safety practices as structures that guide care. These are enabling conditions when present and constraints when inadequate.

Furthermore, within this hospital case, patient-centered care depended on both the values promoted by leaders and the practical capacity of the nursing service. This reading is consistent with research describing managers' support for staff and the working conditions that enable it (Gadolin et al., 2022), as well as reviews linking nursing leadership with organizational and patient-related outcomes (Hult et al., 2023). The participant accounts establish perceived influences in this case, not causal effects. The third question is answered by a set of interrelated organizational conditions rather than one isolated factor. The accounts suggest that efforts to

strengthen patient-centered care in this hospital need to consider staffing and resources alongside communication, teamwork, staff development, and leadership support.

Research Question 4. What barriers and challenges do nursing administrators encounter in implementing patient-centered care?

Theme 4. Workload and communication difficulties make individualized care harder

Participants reported high patient volume, staffing limitations, time pressure, limited resources, communication difficulties, competing clinical demands, and differences in patient or family expectations. P1 and P6 described the pressure created by heavy workload and insufficient staffing. P2 described delays and coordination demands in the operating room. P3 identified language differences. P7 referred to refusal of treatment during emergencies, while P8 described balancing urgent care for a critically ill child with parents' need for explanation and reassurance. P9 and P10 also described competing demands and time or routine-related constraints. The barriers were not described only as shortages of supplies or staff. They also involved situations in which administrators had to balance urgency, communication, patient preferences, family concerns, and established routines. The examples from the operating room, emergency care, and pediatric intensive care illustrate different pressures within the hospital, while pointing to a shared difficulty: maintaining individualized attention when work is time-sensitive or resources are stretched.

The case shows how operational demands can make patient-centered care harder to deliver consistently, even when administrators value it. The emphasis on context is important: a delay in surgery, language difference, or treatment refusal presents a different challenge, so the response cannot be reduced to a single general solution. The discussion aligns with literature examining patient-centered care in acute hospital settings and the role of communication in care transitions (Janerka et al., 2023; Chien et al., 2024). The fourth question is answered by identifying both structural and interactional barriers. Within this case, staffing and workload pressures intersected with communication and clinical complexity, affecting the time and attention available for patients and families. These are administrators' reported experiences, not a measurement of how often each barrier occurred.

Research Question 5. How do nursing administrators address these barriers and challenges?

Theme 5. Communication, coordination, and staff support help administrators respond

Participants described assessing the problem, prioritizing immediate patient safety, delegating or redistributing work, coordinating with colleagues, communicating with patients and families, and supporting staff through coaching or education. P1 described identifying the source of a barrier and prioritizing safety. P2 emphasized obtaining updates and explaining operating-room delays. P3 described using a language the patient or family could understand. P4 discussed listening and coordinating practical solutions; P7 mentioned being present with staff and attending to workload; and P8 described clear communication and teamwork in the PICU. The responses suggest a practical sequence: identify the concern, consider its effect on the patient, act on immediate safety needs, coordinate available staff or resources, and explain what is happening. Administrators also described longer-term support through mentoring, feedback, training, and workload management. Participants recognized that some limitations, particularly persistent staffing and resource shortages, could not be resolved by an individual administrator alone.

In this case, responding to barriers involved adaptive judgment within organizational limits. Communication helped address uncertainty, while delegation and teamwork helped manage immediate demands. Coaching and staff support addressed difficulties in applying patient-centered principles. This account is consistent with research emphasizing supportive leadership and communication in nursing practice (Alanazi et al., 2023; Chien et al., 2024), while remaining grounded in the participants' reports. The fifth question is answered by showing that administrators used both immediate responses and staff-development approaches. These responses helped them manage barriers in daily practice, although the accounts do not show that local leadership actions eliminated broader structural constraints.

Research Question 6. How do nursing administrators assess the effectiveness of patient-centered-care initiatives?

Theme 6. Patient feedback and quality monitoring help identify areas for improvement

Participants described using patient and family satisfaction, feedback, complaints, compliments, safety incidents, quality indicators, staff observations, and compliance with nursing standards to review patient-centered care. P1 and P6 referred to surveys and patient comments; P2 described checking surgical safety procedures, patient identification, delays, and postoperative feedback; P4 and P9 mentioned quality and safety indicators; P8 included observation of whether patients and families were informed and involved; and P10 described tracking complaints and sharing satisfaction results quarterly. The accounts included both patient-experience information and operational measures. Participants said they used these sources to identify gaps, discuss concerns, guide staff coaching, adjust processes, and monitor practice. P7's response emphasized rapport, listening, and close monitoring, while other participants described more formal feedback and quality-monitoring processes.

The reported approach was a feedback-and-improvement cycle, but the interviews describe how administrators assess care, not whether a specific initiative caused measurable improvement. In this case study, the accounts describe local evaluation practices and participants' perceptions; they do not establish effectiveness without outcome data or a systematic comparison over time. Nursing leadership research also treats organizational, staff, and patient outcomes as related but distinct areas of inquiry (Hult et al., 2023). The sixth question is answered by showing that participants relied on patient and family feedback together with safety, quality, and practice indicators. These sources informed local improvement efforts, but the interviews do not demonstrate a measured increase in patient-centered-care outcomes.

Case-Level Synthesis

Considered together, the six guiding questions show patient-centered care in this hospital as a leadership responsibility carried out within organizational and clinical conditions. Administrators reported supporting it through advocacy, respectful communication, staff guidance, teamwork, and routine safety practices. Staffing, workload, resources, and communication demands shaped what could be done in particular situations. Participants also described using feedback and quality information to identify areas for improvement. The accounts therefore point to a context-specific relationship: leadership practices and organizational capacity interacted in the participating hospital, and neither the participants' accounts nor this single case support a claim that the same conditions or outcomes would apply elsewhere.

Emergent Case Proposition

Within this single hospital case, nursing administrators supported patient-centered care by combining patient advocacy and respectful communication with staff guidance, coordination, and routine quality and safety practices. Their ability to sustain these practices was shaped by staffing, resources, workload, workplace culture, and the demands of particular clinical situations. Patient and family feedback, together with quality and safety monitoring, was reported as a way to identify concerns and guide improvement. This is an interpretive proposition developed from the participants' accounts; it is not a causal mode

REFERENCES

1. Abugre, D., & Bhengu, B. R. (2024). Nurse managers' perceptions of patient-centered care and its influence on quality nursing care and nurse job satisfaction: Empirical research qualitative. Nursing Open, 11(1), Article e2071. https://doi.org/10.1002/nop2.2071
2. Alanazi, N. H., Alshamlani, Y., & Baker, O. G. (2023). The association between nurse managers' transformational leadership and quality of patient care: A systematic review. International Nursing Review, 70(2), 175–184. https://doi.org/10.1111/inr.12819
3. Bahlman-van Ooijen, W., van Belle, E., Bank, A., de Man-Van Ginkel, J., Huisman-de Waal, G., & Heinen, M. (2023). Nursing leadership to facilitate patient participation in fundamental care: An ethnographic qualitative study. Journal of Advanced Nursing, 79(3), 1044–1055. https://doi.org/10.1111/jan.15329

4. Chien, L. J., Slade, D., Goncharov, L., Taylor, J., Dahm, M. R., Brady, B., McMahon, J., Raine, S. E., & Thornton, A. (2024). Implementing a ward-level intervention to improve nursing handover communication with a focus on bedside handover—A qualitative study. Journal of Clinical Nursing, 33(7), 2688–2706. https://doi.org/10.1111/jocn.17107
5. Gadolin, C., Larsman, P., Skyvell Nilsson, M., Pousette, A., & Törner, M. (2022). How do healthcare unit managers promote nurses' perceived organizational support, and which working conditions enable them to do so? A mixed methods approach. Scandinavian Journal of Psychology, 63(6), 648–657. https://doi.org/10.1111/sjop.12851
6. Hult, M., Terkamo-Moisio, A., Kaakinen, P., Karki, S., Nurmeksela, A., Palonen, M., Peltonen, L.-M., & Häggman-Laitila, A. (2023). Relationships between nursing leadership and organizational, staff and patient outcomes: A systematic review of reviews. Nursing Open, 10(9), 5920–5936. https://doi.org/10.1002/nop2.1876
7. Janerka, C., Leslie, G. D., & Gill, F. J. (2023). Development of patient-centred care in acute hospital settings: A meta-narrative review. International Journal of Nursing Studies, 140, Article 104465. https://doi.org/10.1016/j.ijnurstu.2023.104465
8. Jones-Hooker, C., & Tyndall, D. E. (2023). Application of case study research and ethnography methods: Lessons learned. Applied Nursing Research, 73, Article 151713. https://doi.org/10.1016/j.apnr.2023.151713
9. Miller, M., & Hemberg, J. (2023). Nurse leaders' perceptions of workload and task distribution in public healthcare: A qualitative explorative study. Journal of Clinical Nursing, 32(13–14), 3557–3567. https://doi.org/10.1111/jocn.16428