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Introduction

Concept of person-centred care

Person-centred care literally means treating patients as individuals and as equal partners in the business of healing. The Person-centered care, also referred to as patient-centered care, is defined by the World Health Organization as "empowering people to take charge of their own health rather than being passive recipients of services (World Health Organization, 2015)." This care strategy is based on the belief that patient's views, input, and experiences can help improve overall health outcomes. One of the key ways to involve patients in their own health is by improving interactions between patients and healthcare providers, making care feel empathetic and compassionate, not merely transactional. To accomplish this, physicians, nurses, and other staff must be trained to listen to, inform, and consult patients throughout the healthcare continuum, as well as to consider individual preferences, needs, and values when making clinical decisions.

In person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care (Coulter et.al., 2015). It is coordinated and tailored to the needs of the individual. And, crucially, it ensures that people are always treated with dignity, compassion and respect. Person-centred care requires treating patients as individuals and as equal partners in the business of healing; it is personalised, coordinated and enabling. It is not a medical model and should be regarded as multidisciplinary, recognising that a person may need more than one

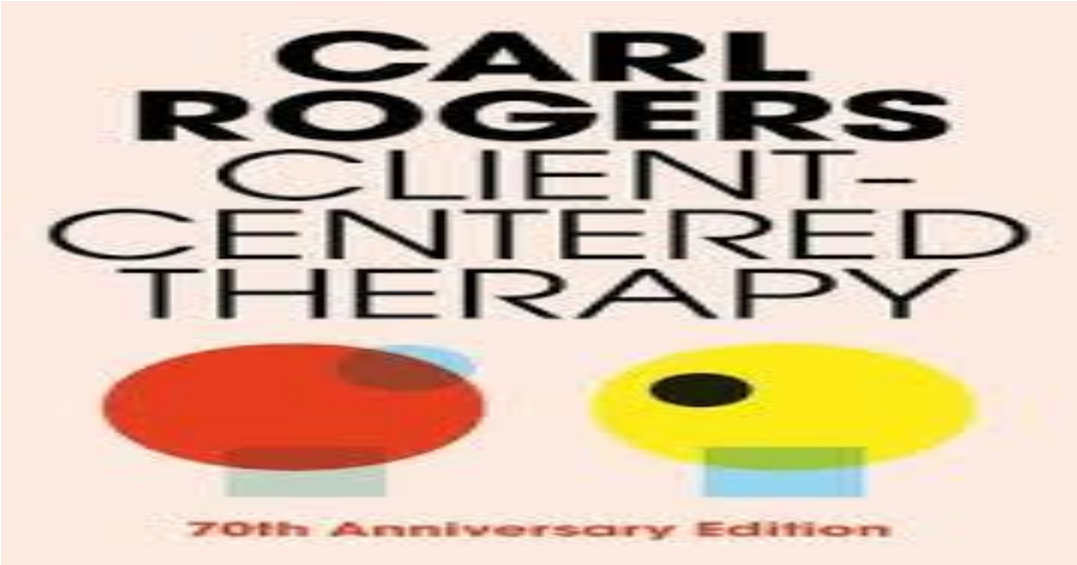
professional to support them. Working in this way means recognising people's capabilities and potential to manage and improve their own health, not seeing them simply as victims of disease or passive recipients of care. Most people want to help themselves, so the health system should be geared to ensuring they acquire the knowledge, skills and confidence to do so.

Unfortunately, the way care is delivered sometimes has the opposite effect. Overly directive or paternalistic approaches create dependency and undermine people's confidence to protect their health, prevent illness and manage their own care (Batalden, Batalden, Margolis, et al., 2016). Paternalistic practice styles risk providing inappropriate care that patients would not have wanted if they had been well-informed. Professionals often underestimate the extent to which patients are able to take responsibility for their health. Many patients would be willing and indeed eager to do so if their capabilities were recognised, supported and strengthened, instead of being ignored and undermined. For those people with limited or no mental capacity to assume greater responsibility for their care, we should ensure relatives, carers and trained advocates are fully involved in the care planning process (De Grood, Raissi, Kwon and Santana, 2016).

The main goal of a patient-centered care model is to improve individual outcomes, when patients are more involved in their own care, they often recover more quickly and are more satisfied with the care they receive. Stacey et al., (2016) found that patient-centered practice resulted in better recovery from discomfort and concern, better emotional health in the future, and fewer diagnostic tests and referrals. Additionally, studies have found that a strong patient-provider relationship is an important motivator for preventive care. When patients feel respected and experience compassion and empathy from their providers, they are more likely to return for annual physicals, immunizations, and so on. However, those are not the only benefits of a person-centered medical approach, it also lead to improved patient satisfaction scores, better morale and productivity among staff, improved resource allocation, and in the long run, even reduced expenses (NHS, 2016).

Theoretical underpinning of person-centred care

Several theories are applicable to social and person centred care. Among are the Carl Rogers humanistic theory, Social cognitive theory by Albert Bandura, and the Ecological system theory.



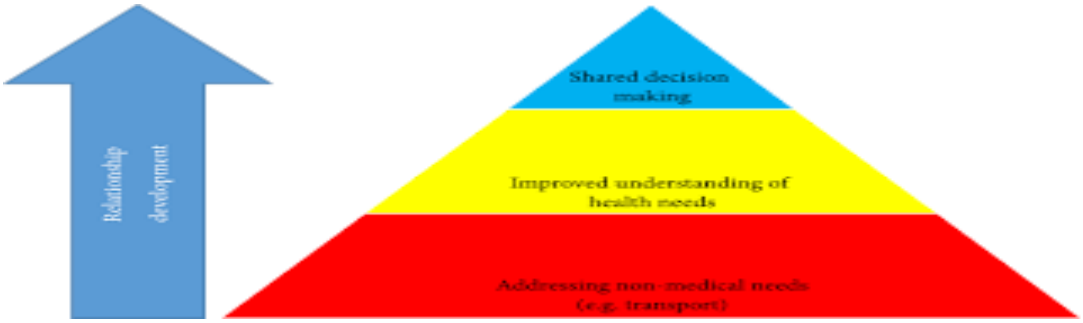
The person-centred approach was developed from the concepts of humanistic psychology. The humanistic approach "views people as capable and autonomous, with the ability to resolve their difficulties, realize their potential, and change their lives in positive ways". Carl Rogers (a major contributor of the client-centred approach) emphasized the humanistic perspective as well as ensuring therapeutic relationships with clients promote selfesteem, authenticity and actualisation in their life, and help them to use their strengths (Epstein, 2011).

The person-centred approach was originally focused on the client being in charge of the therapy which led to the client developing a greater understanding of self, self-exploration, and improved self-concepts. The focus then shifted to the client's frame of reference and the core conditions required for successful therapy such as ensuring the therapist demonstrates empathic understanding in a non-judgemental way. Currently, the person-centred approach focuses on the client being able to develop a greater understanding of self in an environment which allows the client to resolve his or her own problems without direct intervention by the therapist. The therapist should keep a questioning stance which is open to change as well as demonstrating courage to face the unknown. Rogers also emphasized the attitudes and personal characteristics of

the therapist and the quality of the client-therapist relationship as being the determinants for a successful therapeutic process (Health Innovation Network South London, 2016).

The ecological system theory posits that humans are active in the developmental process and are constantly affecting and being affected by their environment (Bronfenbrenner 1979; Bronfenbrenner and Morris, 2006). Brofenbrenner's (1979) ecological model typically involves four types of systems that interact and contain distinct but related roles, norms and rules, each nested within the next, that influence development and behaviour: microsystem, mesosystem, exosystem, and the macrosystem. The nature of the client-therapists relationship is dependent on the interaction between factors in the client's and the linicians' maturing biology, the immediate family and community environment, as well as the social landscape. In order to capture the multidimensional concepts of client's health development, client's development, Bronfenbrenner's (1979) ecological model is a helpful and commonly used framework to understand health behaviour.

Within this context, the microsystem is the individual (client) and the individuals' resources and characteristics that impact health and heling. For example, the therapist's, in addition to the client's, disposition and temperament will influence health functioning which directly affects client's healing processes. The mesosystem refers to the individual's active interaction within microsystems or the connections between contexts. The exosystem includes the link between a social setting in which the individual does not have an active role nor is it within the individual's immediate surroundings (Bronfenbrenner 1979) for example, the relationship between family experiences and school or church experiences is part of the mesosystem, while the exosystem includes support networks and influences as well as the social context to which the client has been exposed.



The mesosystem and exosystem consist of the immediate family and household, as well as the systems in which the individual and/or family are embedded. Finally, the macrosystem consists of larger cultural and societal influences with the individual being active in interactions with the social network and establishing the norms within this group Family circumstances such as socioeconomic status, lack of social support, and neighborhood factors associated with child upbringing may have a direct or indirect effect on the development of self acceptance, and these circumstances can act as risks or protective factors.

Ethical underpinning of person-centred care

Choice and education are central to person-centred care, which is also related to increased service user satisfaction (Mulley, Trimble and Elwyn, 2012). However, this move from a dependent, passive service user to an empowered partner in care requires a trusting relationship in which nurses do not react negatively to missed appointments or perceived 'non-compliance'. However the ethical principles are outlined below:

Respect for patient values, preferences, and needs: as mentioned previously, patient preferences should be considered during person-centered healthcare decisions, as this will foster a relationship of respect and collaboration.

Coordination and integration of care: improved coordination and integration of clinical care and support services can help reduce patient uncertainty and vulnerability.

Information and education: to make better decisions about their health, patients need information on their clinical status, progress, and prognosis. Many patients may also benefit from educational resources that are tailored to their level of health literacy.

Physical comfort: pain management and assistance with daily needs are key to improving patient experience in hospitals and acute care facilities.

Emotional support and alleviation of fear: similarly, patients should be provided with the resources needed to minimize stress and fear regarding their physical status, treatment, and prognosis, as well as worry caused by financial aspects of care.

Involvement of family and friends: support from family and friends is a key aspect of person-centered care, so providers should take the needs of caregivers, family, and friends into account. This might mean providing accommodations and support for these individuals or involving them in decision making.

Continuity and transition: to minimize patient concern about post-discharge care, medical providers should educate patients on medications, physical limitations, dietary needs, and so on.

Access to care: healthcare organizations aiming to provide person-centered care should do their best to streamline appointment scheduling, make referrals accessible, and provide information on transportation options (Health Foundation, 2014).

Benefits and limitation of person-centred care

The following are the benefits of the person centred care; it helps to:

i. negotiate a treatment plan for people with recurrent mental health problems, working with them during a well period to plan for how their treatment should look when they are less able to choose
ii. support people living with conditions such as diabetes, chronic obstructive pulmonary disease (COPD), depression and long-term pain to become more effective self-

managers through structured education, training for health care professionals and improving organisational processes

iii. support women to decide whether to have a mastectomy or breast-conserving surgery, and men with enlarged prostate to decide whether to take drugs, have surgery or make lifestyle changes

iv. enable patients to carry out as many of the steps to managing their own hospital treatment as they felt comfortable with

Limitations

Most of the existing literature sheds light on the positive sides of the person-centred care. However, alongside the benefits, there are some few limitations.

i. **The major and first limitation is the financial cost:** The "costs" generated by injuries, fractures and pain. These costs not only include suffering on the patient's part and risks to patient safety but are also felt in economic terms through increased expenses for hospital care and rehabilitation.

ii. **Exclusion of staff personhood:** Usually, the focus of PCC is on the patient/person and their rights and staff and their personhood has often been neglected. This might diminish the value of the staff as autonomous persons, which in turn might result in poor working conditions and high turnover rates.

iii. **Unfairness due to empathy:** Empathy can be described as one of the fundamental aspects of PCC and as a positive value in care. However, there is a risk when one is "too empathetic." Showing excessive empathy to certain persons can be unjust and unfair and is against the principles of ethics, even if it is unintentional.

Application of person-centred

The term 'person-centred care' is used to refer to many different principles and activities, and there is no single agreed definition of the concept. This is partly because person-centred care is still an emerging and evolving area. It is also because, if care is to be person centred, then what it looks like will depend on the needs, circumstances and preferences of the individual receiving care. What is important to one person in their health care may be unnecessary, or even undesirable, to another. It may also change over time, as the individual's needs change (Maeng, 2014).

The application is therefore predicated on the following:

a. Affording people dignity, compassion and respect.
b. Offering coordinated care, support or treatment.
c. Offering personalised care, support or treatment.
d. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

Recommendation for improving person-centred care in your chosen settings

The arrangement of health and social consideration is significant in the general public; nonetheless, medical services workers need to comprehend the principles that support the implementation of effective person-centred health care practice. In view of the above the following recommendation are highlighted for considerations:

- ✓ the concept of person-centred care needs to be embedded at all levels of the healthcare system, from government policy to delivery of care by individual clinicians.
- ✓ initiatives to promote better integration of care should start from an understanding of the patient's perspective, focusing on personalised care planning and care coordination rather than organisational integration. Patients should be invited to help redesign these systems.
- ✓ Professional training is important too; the way doctors and patients interact and negotiate treatment plans should be a core element of undergraduate and postgraduate training for all medical disciplines.
- ✓ There is need to also provide a supportive work environment that ensures adequate resources for staff to practice. Current reimbursement models are one of the main obstacles for promoting and practicing person centred care.
- ✓ The environments should integrate services to accommodate patients, such as language support and, appropriate and flexible visiting hours.
- ✓ Developing a common e-health platform for health information exchange across providers and patients with the capacity to link all health-care electronic data across the continuum of care must also be implemented (Wu et. Al., 20160.

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