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Y Drindod Dewi Sant

University of Wales

Trinity Saint David

Student name: Harriet Anyanwu

Student ID: 1916050

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Lecturer name: Racheal Adebayo

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Introduction

According to Rollin 2011, person-centred care is a clinical approach that deploys Maslow's hierarchy of needs to prioritise patients' physical tasks over social care. In short, Rollin takes PCC to mean treating the patient as a person first before treating the patient for who it is.

What is obvious, however, is that PCC is a series of processes and decisions made by a caregiver in understanding care users as individuals. These understanding warrants involving care users' friends and families in clinical decision-making.

The term PCC itself originated from Carl Rogers in 1951. Rogers used the term in Humanistic Psychotherapy to refer to the development of the person based on some key childhood interactions, which he called unconditional positive regard.

The concept prompts caregivers to be humanistic enough to have respect for patients as persons, and attempt to understand their individual rights to self-determination, mutual respect, and understanding (McCormack et al, 2011).

Underlying Concept of Person-centred Care

Person-centred care is individualised care, and this is due to its very nature that allows all focus and attention to be shifted to the patient in need of the care rather than the patient's medical needs (Fix et al., 2018). By shifting the attention to the person instead of what the person needs, it becomes easy to rescind the preferences, needs, values, and beliefs of that person towards better clinical decision making.

The need for person-centred healthcare is necessitated by outcomes in health and wellbeing that can be made more resonating through personalised and customised clinical decisions (Fix et al., 2018). These decisions are, however, carried out by social care nurses who cannot rely on their individual skills only but would need to be competent as well with other skills such as teamwork and organisational skills.

The whole concept of person-centred care and skills can be summarised in four bulleted points:

When planning care and treatment for patients, deploying person-centred care gives patients a say in decisions and, therefore, causes the whole process to be democratic.

The concept of person-centred care is never practised if patient's preferences, diversity, and backgrounds are not respected and embraced.

The rights and needs of patients must be recognised when implementing patient-centred care. For instance, patients have the right to medical confidentiality, and this is within the jurisprudence of the social care nurse to uphold.

Finally, there is no person-centred care without patient-centred care. In social care, the ultimate decision and centre of attention is the person who also doubles as the patient.

Varying Perspectives on Person-centred Care:

There are several variations to the concept of person-centred care in healthcare. When prompted on what the concept means, some carers would likely take it to mean providing chores and executing the mundane for their patients (Godfrey et al., 2018). Others might consider it to mean respecting the privacy of their patients and ensuring they have a say in decision-making.

None of these variations, however, undermine what person-centred care means. Person-centred care is about the person and due to qualities, that separate a patient from another patient, the definition of the person might mean different things to each carer (Godfrey et al., 2018). If patients are not sure whether they have been receiving person-centred care from their carers, they could ask themselves the following questions:

What level and manner of communication has the carer communicated with me? Has it been friendly or negligent? Has it been encouraging or discouraging? Has it spoken to my core, or it has only made me feel empty?

What decision-making process have I been admitted to? What was the process like? Did the process make room for my own contributions to the decisions? Have I been asked for inputs to the conversation that concerns my health?

During consultations that do not go in line with my person or that forbids my understanding, have I been asked for an interpreter or a supporting relative who can explain things better to me than the carer?

Regardless of my background, gender, colour, religion, and values, how has the carer inclusively communicated with me? Has the carer respected my decisions? Has the carer considered my values, ethics, and religions?

How was the feedback on my health? Did the carer allow for feedback? Did the carer communicate my feedback to me in clear and concise terms? How has the carer followed up on the feedback system?

Theoretical Underpinning of Person-centred Care:

In social and health care, three theories boldly capture the essence and underpinning of person-centred care. These theories suggest what could be going on in a patient's mind as well as the factors responsible for such mental dispositions. The three theories include social learning theory, systems theory, and psychosocial development theory.

Social Learning Theory of Person-centred Care

The social learning theory opined that learning can only be modelled or imitated. This means learning occurs by looking at how other people behave. Therefore, a patient does not just hold beliefs and convictions unless the patient must have been influenced by some major players.

Understanding this social learning behaviour is important to social and healthcare workers. Carers can easily come up with positive modelling or reinforcement interventions or just deploy other strategies if they notice that the behaviours of a patient are the direct result of society or a major player in their lives.

Systems Theory of Person-centred Care

The systems theory examines how patients are influenced by the environment, not excluding both the political and economic systems.

Under systems theory, it is important to consider the ways and behaviours of patients in respect of their friends, families, social settings, religious structure, racial background, and even their economic status.

Patients are suggested to be the consequence of the environment in which they exist. In such a scenario, carers must tailor patients' needs in recognition of the systems.

Psychosocial Development Theory of Person-centred Care

Psychosocial considers patients to undergo a series of changes. These changes could be the examination and workings of patients under trust and mistrust, initiative and guilt, identity and confusion, integrity and despair, and several other personality factors.

How patients have performed under these factors would warrant how they should be considered about those factors. As a carer, it would be more personal if patients who undergo a certain stage of the psychosocial stages are cared for according to their experience under those stages.

Ethical underpinning of person-centred care

There are moral and ethical obligations social and health carers must fulfil. These obligations might be theoretical, but they are, regardless, moral, and ethical to the field of nursing. Social carers must pay attention to the rational ethical or relational-ethical approaches of person-centred care. The ethical practices are six and they include:

Respecting the uniqueness of the patient as an individual

Nurses and midwives are mandated to respect the person not only as a patient but also as an individual with unique abilities and qualities. They must ensure that due respect and honour are accorded to their patients without any reservations. Here are some ways respect can be given:

Carers must knock before entering a patient's room as the case may be.

Carers must address patients by their preferred name as the case may be.

Carers must be professional with the introduction and purpose of support and treatment.

Treating the uniqueness of the patient with dignity

Patients are individuals and this makes them unique in several ways. Their beliefs might be different from the beliefs of social and health carers. They might hold varying principles, values, and ethics. Each of these factors makes the patient a unique entity and should be treated as such. Here are some ways of treating patients with uniqueness and dignity:

Carers must be ready to defend the dignity of patients regardless of background and status.

Carers must ensure dignity follows due professional ethics.

Carers must put in place behaviours that allow for trust and embrace diversity.

Maintaining confidential details of the patient

Patients cannot understand the full range of social and clinical assessments. However, it is in the place of social and health care workers to provide only what they need to know and be transparent with their care and support. Here are possible ways to be transparent:

Not keeping patients in the dark whenever it matters, ensuring lines of communication are open to patients, informing them of changes in health status, indulging them in the decision-making process.

Understanding what the patient needs and would need

Patients might not always communicate what they need but they have needs regardless. These needs might be called rights. And the fundamental part of these rights is the right to live. Other rights include:

Right to be considered and respected, right to be treated with the utmost dignity, right to know what is going on, right to be treated with no distractions, right to be kept safe and indulged, right to be seen and recognised and be informed.

Ensuring adequate care, support, and treatment

Social and healthcare services hinge on the skills and competence levels of the carer. Carers must have been admitted to the necessary skills that ensure the seamlessness of person-centred care. Some of these skills include:

- Versatile with both spoken and oral communication
- Empathetic about patient's situations.
- Knowing when and how to collaborate.
- Familiar with technological tools.
- Being diligent, positive, and time conscious.
- Understanding the role of commitment.
- Knowing the purpose of person-centred care.

Main Benefits and Limitation of Person-centred Care

There are several benefits to person-centred care as well as limitations to it. The benefits associated with it allow both carers and patients to achieve an optimum sense of healthcare satisfaction. Some of the benefits include (Summer et al., 2020):

Improved Patient Satisfaction: Since the person is first recognised in the scheme of things, personal health goals and desires of the patient as a person are put into consideration, thereby leading to improved and optimal patient satisfaction.

Improved Outcomes: Aside from improved satisfaction, person-centred care also leads to improved health outcomes. When the values and preferences of patients are recognised, patients tend to respond to treatment more keenly.

Improved Reputation and Job Satisfaction: This benefit is particular to caregivers and the foundations they work for. Whatever way and manner the care is rendered will reflect either positively or negatively on the caregivers as well as the organisation.

Factors that inhibit the performance of person-centred care range from finance to variations in skills and human understanding. Here are some of the limitations (Summer et al., 2020):

Increased Personal and Financial Costs: Training staff to deliver PCC can prove cost ineffective. Not forgetting that, there are several sacrifices involved in the delivery of PCC, such as the subduing of personal beliefs and values.

Exclusion of Certain Groups: PCC might be overtly generalised and not exactly focused on certain groups of people. This might make the whole concept advantageous to some while disadvantageous to others.

Compassion Fatigue and Unfair Empathy: The concept of PCC could lead to caregivers burdening themselves with care duties and responsibilities. Aside from that, it makes caregivers unduly empathetic.

Application of Person-centred Care into Practice

Caring for people with dementia requires the use and sustenance of person-centred care (PCC). This is especially useful in reaching treatment targets, dietary recommendations, and medication regimens.

Since dementia has been noted to be a form of cognitive dysfunctionality that calls for increased individualised care, focusing on the person as a patient and attending to their needs can improve medication compliance and even clinical results.

Presenting the baseline health status of Patient T as a case study. The status was analysed through an assumed series of questions, helped by a questionnaire. Here is how Patient T's dementia status can be helped with the use of PCC.

Presentation

Patient T identifies as an elderly above 85 years. He finds it difficult to concentrate and is susceptible to mood changes. Patient T cannot handle money or numbers and so has been diagnosed with Alzheimer Disease, which is a type of dementia.

Patient T constantly loses balance and has problems with movement and word association. He is losing interest in everyday life and takes longer to complete normal everyday tasks. He hallucinates and repeats questions sometimes. Patient T is experiencing signs of moderate Alzheimer's disease which can be classified as an indicator of dementia.

Patient T is 5.2 feet tall, weighs below 18.5 BMI, and only seldom eats and rests. Aside from word difficulty, Patient T also often forgets the names of family members.

Questions to consider for Patient A

- What is the drug and non-drug treatment open to Patient T?
- What PCC and support options are available to him?
- What should be considered in determining medications for Patient T?

Developing a Treatment and Support Plan

The support options available to Patient T includes medical professionals, care givers, and family and friends. Being at a moderate stage of dementia, PCC requires that Patient T be prescribed drugs that reflect the moderation. He will get drugs such as donepezil and memantine.

It's also deduced that Patient T might be suffering from depression and possible diabetes based on his responses to life and living. Drugs that ease his blood pressure, anxiety, and depression should be recommended. Also, sleeping pills should be provided to make him rest.

Patient T may need therapy and should be recommended to attend sessions to keep fit. Family and caregivers also should ensure Patient T is open to social interaction and mild fun exercises

with friends. Patient T should also be urged to engage in conscious diets. All of these factors work favourably towards his PCC.

Recommendation for Improving Person-centred Care in your Chosen Settings

Given the importance of PCC in dementia, it has been revealed by several studies that as much as caregivers have a role to play towards patient's health status, patients themselves should engage in better self-management behaviours (Tay et al., 2017).

Other than that, caregivers should be provided with the necessary tools and clinical resources to identify potential barriers and obstacles in patients that could mitigate the effectiveness of PCC in patients. This is especially useful for patients with specific risk profiles.

Furthermore, there is a positive relationship between PCC and self-care behaviours, which can only be complemented with increased patient education and understanding of the nature of dementia (Tay et al., 2017). Support from care providers as well as families of patients would foster the improvement of PCC in health and social care.

Conclusion

Person-centred care is individualized care and places priorities on the person rather than the patient. In order to improve patient satisfaction and clinical outcomes, PCC is required. But this requirement comes with some limitations if PCC at all must be well practiced. These limitations must especially be curtailed towards effective person-centred care in patients suffering from dementia.

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