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BSc (Hons) HEALTH and SOCIAL CARE
PRINCIPLES OF HEALTH AND SOCIAL CARE

ASSESSMENT 2

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PERSON-CENTRED CARE

INTRODUCTION

This is an essay looking at concepts that form the basis of person-centred care. There would be discussion of theories that underpin the person-centred care. The good and bad decisions that need to be taken when delivering person-centred care would also be considered. Advantages and disadvantages, if any, when person-centred care is applied within people with dementia would be evaluated. People now live longer than before. This has brought challenges to the health and social care services. Person-centred care is now seen around the world as an important ingredient for high quality care for people who need it. There is also the notion that person-centred care can help reduce cost of care. It would be highly welcomed because the health and social care services are facing financial challenges. Practical recommendations would be considered in the care service among people with dementia to help improve the person-centred care.

ORIGIN AND MEANING

Carl Rogers suggested that, children develop a view of themselves depending on what they get from others. If loved, valued and respected they grow with them. This Rogers called unconditional positive regard. It becomes conditional when valued only after behaving in a certain manner. The child grows in the conditional positive regard and loses 'congruence'. It is in the congruence where the child will see his ideal self in the role model. If the conditional positive regard, was due to insecurity, we grow to become unhappy and mentally ill. A client or service user, has to trust the therapist or the care giver in person-centred care. There should be a trusting relationship which calls for the therapist to be truthful, and empathetic to the client or the service user. The service user is listened to without judging. Service user's confidence and self-esteem then grow up making them open to new experiences and feelings. Here the ideal self meets the self in the therapist or the carer-(congruence). From now, the service user is happy to continue life as a process rather than a goal and (Rogers, 1951).

Many literatures point to the fact that simple definition of person-centred care is hard to come by. The basic reason for this lack is that person-centred care will depend on the needs of people receiving the care. It will also depend on their circumstances and their preferences. Different people have different needs. Also, a person's needs may change. When care is rendered on principles such as promoting dignity, compassion, and respect; ensuring personalised care, support or treatment; offering coordinated care, support or treatment; and supporting service users to develop own strengths to be able to live independent and fulfilling life then we can confidently talk about person-centred care. When in the course of rendering care-(person-centred) within people with dementia we offer more compassion, dignity and respect. In this manner, it makes no difference whether they are conscious or not, lack capacity or not. Promoting respect, dignity and compassion, there would be good communication, and no rushing with the care service. This would make the service user open up to you, being happy when they you and in no time begin to participate happily in their care. 'People-centred' is now more preferred to 'patient-centred.' The service user identifies himself in the world around him. With the term 'people' all

other needs are looked at for total wellbeing. Emotional, social as well as clinical needs are all taken care of. With the term 'patient-centred' the service user sees himself in the consulting room with the symptoms of his disease. Only the clinical needs seem to be considered.

CURRENT PRACTICE

There is the awareness all around the world of the importance of person-centred care. Care systems and organizations are having the thought to shift to this needed person-centred care. There seems to be some resistance in the way of practising fully person-centredness. Growth-mindset is required in the idea of practising person-centred care at all levels. Courage to face failure is needed to totally move from this biomedical model of care. In this model service users are passive recipients of instructions of care from health professionals and care givers (Nottingham and Larsson, 2019). For people with complex care needs there is the need move now as never before. In this direction we should have adaptive leadership. A characteristics of adaptive leaders is those who would put at points apart technical solutions from adaptive solutions. This means the leader would stop applying existing knowledge and techniques to problems and follow shifts in how people work together not just what they do (Kuluski et al., 2020).

PEOPLE WITH DEMENTIA UNDER THE NHS

National Institute for health and Clinical Excellence (NICE) gave directives to the National Health Service (NHS) Trusts to provide person-centred care to the people with dementia who use acute hospital facilities for any reason. This means all services were to be provided under the four principles: care offered with dignity, compassion and respect; offered personalised care, support or treatment, offered coordinated care support or treatment and supported to develop their own strengths to be able to live independent life (Shuster, 2006). This was reinforced in the National Dementia Strategy (Shuster, 2009). Observations later showed that for the long term settings, person-centred care was followed as directed but little person-centred care was practised at the acute hospitals. The observation might have highlighted an unnoticed reason why person-centred care was not followed at the acute hospital. Rapid diagnoses are the priorities and the time for treatment very short. Another observation brought out core problem and core process. When an adult with dementia entered there happens a confusion or disruption of normal activities-core problem. Core process is when the staff, carers and co-patients try to put the disruption under control.

UNDERLYING CONCEPTS

Kitwood did marvellous work on person-centred care. He made it clear that when working on the people with dementia, you are not dealing with only the disease process. The dementia problem has to do with also with the stage of neurological impairment, their personal health and fitness level their life history their personality

and coping style and the social psychology of the area they live in. The dementia person is not treated with person-centred care when there results in negative interplay between neurological and sociopsychological factors. The dementia person is denied with sense of personhood. This occurs when carers do not offer care with respect, compassion and dignity. The goal of person-centred approaches to care is to respect personhood despite cognitive impairment (Skaalvik and Skaalvik, 2010). The person-with -dementia is respected and valued when his personhood is recognized and valued. The people-with-dementia experience a sense of attachment, inclusion, identity, occupation and comfort when their personhood is recognised. From Kitwood's definition of person centredness another person bestows our status of being on us. It is argued out by Kitwood that we, as persons, do not live in isolation. The field of dementia care is held so much strong by the definition of Kitwood's personhood which is informed by the works of the likes of Carl Rogers (1961) and others.

ETHICAL PRINCIPLES:

Non -maleficence

This is a principle saying: 'do no harm'. A health and social care professional should not act or react to the service user so as to cause harm. It is a principle which puts the carer's situation in a very difficult situation. This is because even defending yourself or protecting yourself from impending harm could be interpreted as trying to do harm.

Beneficence

Every action taken must be to the good of the service user.

Health maximisation

If a carer happens to meet someone out there in difficulty, health wise, and we have the necessary training we can go to the scene to help in the interim before the arrival of the paramedics.

Efficiency,

Respect for autonomy,

Justice

Proportionality.

6Cs Application

Applying the 6 Cs: care, compassion, courage, commitment, competence, and communication. There is a 102year-old gentleman that I go to everyday that I'm rostered. This young man would not shower without me assisting. It is now normal telling any other carer "I am waiting for Samuel". All this is happening because I devote time for this man whenever I go to him.

Recommendation

A recommendation to build an electronic- platform to be used for health information exchange across providers and patients with the capacity to link all health care

electronic data across the spectrum. Such structures include Electronic Medical Records (EMR). These have proven to support access, coordination and safety in care delivery through enhancing health-care processes (information access, patient-health-care processes, communication, patient and family involvement, etc). E-health technology should provide secure and private platforms and its integration involves both building and updating existing health-care facilities, and effectively connecting patients and care-givers with practitioners throughout the spectrum (Schröder-Bäck et al., 2014).

CONCLUSION

New theories from names like Kitwood and Macormack about person-centred care within people-with-dementia found interesting. The seven principles of ethics opened my eyes about the care we are giving to the vulnerable adults.

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