



CHAPTER 7

Person-centred care

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FRAMEWORK

Person-centred care (PCC) is the ideal approach to practice informing this book. It has its roots in the work of Carl Rogers and his client-centred counselling. Understanding how this approach differs from task- or disease-focused care we believe is essential for contemporary health professionals. Although applicable to all care contexts, PCC (or the lack of it) is perhaps best illuminated in care of people with dementia (PWD). Such examples are used in this chapter. The authors discuss the importance of culture and the environment in developing a person-centred model and the need for education and value challenges for health professionals. Discussion of the Lund trial in Sweden illustrates the importance of interactions and relationships between the person and their carer. It is often not what is being done but rather how it is being done that counts. The chapter also illustrates the need for a whole organisational approach that is later discussed in Chapter 20. Whilst this approach to care is philosophically sound the actual delivery of the model depends on a variety of factors, one of which is sustaining change through budget-driven systems that do not necessarily consider the long-term outcomes that will alter the way in which the organisation operates. [RN, SG]

Introduction

Health care has a long tradition of medicalising illness (Illich 1975). Parsons (1951) wrote extensively on the 'sick role', which essentially placed the health professional as the expert in a position of power over the patient. The patient¹ was expected to hand over their body to the experts and unquestioningly be compliant

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¹ The term 'patient' is used here in line with Parson's sick role, however elsewhere in the chapter rather than move between patient (in hospital), client (community), and resident (nursing home), the term 'client' will be used for ease of expression.

with ‘orders’ given in order to regain health. Non-compliance was frowned upon and any patient so behaving was labelled as difficult. The doctor determined health care goals for the patient and they were related to curing disease. Care decisions were based on tradition and experience.

☞ **Historically the health professional was the expert in a position of power over the patient.**

Nurses and other health professionals were also required to follow doctors’ orders. There was a distinct hierarchy with doctors at the pinnacle and the client at the bottom, and very clear boundaries determined who did what, who gave orders and who took them. The organisation of hospital and nursing home care reflected staff need and convenience — often to the extent that clients were dehumanised and deliberately stripped of identity (Goffman 1968). It was thought that objectified clients, and detached staff, facilitated good care in what could be otherwise distressing and embarrassing circumstances. Clients in hospital were typically referred to according to their disease and/or bed number (e.g., ‘the stroke in bed 20’) or the tasks health professionals did for them (e.g., ‘she’s a feed’, ‘he’s a shower’). The emphasis was on the client’s deficits and problems.

In these circumstances, older people were relegated to the back wards and side verandas where they might come to long for a visit from the old person’s friend: pneumonia. This was preferable to the production line of shivering, semi-naked bodies lined up awaiting a shower, the constant drug induced state of confusion, or the abject horror of being manacled.

Some may argue the health care system has not changed much; others will not believe it was ever this bad. Nevertheless, expectations, policies, and rhetoric now demand a very different approach to health care, and this chapter aims to outline current thinking on how health professionals should practice in partnerships with clients.

☞ **Expectations, policies, and rhetoric now demand a very different approach to health care.**

VIGNETTE: Professional reflections on a personal experience

I was in agony and could barely walk when the ambulance arrived. The first thing that struck me was how they allowed me to move at my own pace and find my own, least painful way onto their trolley. On the way to hospital they chatted with me as you would a friend or colleague. I didn’t feel like a ‘patient’ — that was good. On arrival at the emergency department of a large hospital, I was not ‘handed over’ but felt very much part of the transfer from ambulance staff to hospital staff. Although the emergency department was clearly very busy, the staff seemed aware of when I needed assistance or pain relief, and when they did assist me I felt like they were giving me their full, skilled, and compassionate attention. The terror began to subside!

My experience in x-ray and in the ward was similar. I was struck by the sense of a shared philosophy that all staff understood and embedded in their practice. The environment, despite being hectic, was calm and friendly. At no time did I feel hurried or ignored or that my views were not important. The staff, equipment, and environment supported me to be increasingly independent. Similarly, my partner and friends were welcomed, respected, and valued; a great cafe, chapel, and other shops and services were tangible acknowledgments that visitors were valued. The room design assumed the client would



need space for flowers, cards, and other items that reflected the care and support of friends and family.

It is strange to be a professional critically reflecting and analysing *in* the experience. No doubt anyone who has had a professional as a client will recognise this conflict from the opposing side. I want to focus especially on the interactions/relationship with the specialist doctor. There is a presence that speaks of connection and acknowledgment of you as a person — he was skilful and knowledgeable, but I expected that of a specialist. What made the experience ‘therapeutic’ was the way he applied his skills and knowledge. He didn’t stand at the foot of the bed like a powerful expert in a hurry — I know he was in a hurry, but he sat lower than my bed and during what time he had, he gave me his full attention. I was at all times ‘the boss’ of my care decisions; he was working in partnership with me and all others involved in my care to ensure I was informed as he talked about my choices and the evidence-based consequences thereof. He was able to move with me from a point where I just wanted the pain to stop and I didn’t care what was done to me, through questioning and challenging. The drugs and technical aspects of care were crucial — I would have stayed at home if they were not — BUT the personal valuing of me was what created a healing ambience and what transformed a wickedly painful experience into a brilliant lived experience of person-centred, interdisciplinary, strengths-based care. I had often talked and taught about it as an ideal — here I experienced it.

So what is person-centered care (PCC)?

There are many definitions of PCC and different terminology is used to describe what appears to be directed towards a similar outcome: such examples include demand-driven care; client-managed care; and relationship-centred care. Carl Rogers is probably ‘the father’ of PCC. He coined the term and developed the notion of client-centred counselling — and drew attention to the need for a rebalancing of the expert–client relationship to privilege the client and acknowledge their capacity for self-actualisation. Tom Kitwood adapted these ideas to the dementia care setting. The idea of consumer-directed care now has broad appeal. Essential to the definition of PCC we subscribe to is the need for a recognition of and connection with the *person*, a focus on the person’s strengths and goals, an interdisciplinary approach, and recognition of the centrality of relationships. One definition in a recent review was ‘treatment and care provided by Health Services [... and residential facilities ...] that places the person at the centre of their own care, and considers the needs of the older person’s carers ...’ (Victorian Department of Human Services 2003).

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Edvardsson and colleagues (2008) performed a recent review of the literature on PCC of people with dementia. They described the defining characteristics of the concept of PCC as being:

- acknowledging the individual as an experiencing person despite the disease
- offering and respecting client choices

- using the person's history and biography in care
- focusing on abilities rather than disabilities
- supporting individual rights, values, and beliefs
- providing unconditional positive regard
- interpreting all behaviour as meaningful
- maximising potential and providing shared decision making.

It was also noted that much of the literature on PCC reports clinical experiences, personal opinions, and anecdotal evidence and that there were few theoretically and empirically rigorous studies. Thus, the review concluded that few valid, reliable, and clinically useful tools had been developed for the measurement of PCC. As a consequence, associations between PCC and health outcomes have been relatively unexplored and strategies for clinical delivery and implementation of PCC are still in development. Nevertheless, it does seem that the physical and social environments play important roles in supporting or undermining PCC.

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Person-centred care: culture and environment

Care environments in which people live for a period of time are often spoken about in terms of 'home', even if these environments often feel, smell, sound, taste, and look like anything but a home. Recent articles describe that when entering into different care settings, people get a feel for the climate, the atmosphere, or 'what's in the walls' of the place. This feeling is often accompanied by a judgment about the comfort of the place — whether or not this is a place where wellbeing can be experienced. This embodied experience emanates from sensory data such as smells, sights, sounds, taste and feel, and forms the influential first impression of new places, impressions that are of importance for whether or not the environment will be experienced as welcoming, hospitable, and person-centred. Environment, person, health and nursing (although the latter can be interpreted to apply to any health professional or care staff) are the four concepts making up the meta-paradigm of nursing, but the environment is possibly the least explored and understood (Fawcett 2005). However, attributes of the space and place have received increasing research attention, and Florence Nightingale is generally regarded as the first environmental theorist within nursing. She described that the locus of healing was within the person and the art of nursing was to provide an environment in which clients were in the best position for nature to act upon them (Nightingale 1969); that is, safe, calm and clean environments.

There is convincing evidence showing that enriching the environment with symbols that are homelike and familiar, and creating calm and safe places where interaction is supported, promote a safe climate and client wellbeing (Edvardsson et al 2005; McAllister & Silverman 1999; Moore 1999; Morgan & Stewart 1999; Rasmussen & Edvardsson 2007; Zingmark et al 2002). There are also studies indicating that creating a homelike environment can positively affect interaction and behaviour, and that enriching the environment with nature scenes, sounds and smells, and chairs, tables and pictures has been associated with positive effects on the behaviour and mood of clients (Day et al 2000; Edvardsson et al 2006).

The climate has been conceptualised as constituted by two interacting and interwoven dimensions: the physical environment, and people's doing and being in the environment. The physical environment contains symbols conveying messages of caring and uncaring. It also influences interaction and experiences of involvement and privacy, welcoming, and the possibilities to create and maintain social contacts. Furthermore, the physical environment can facilitate a shift of focus from oneself to the environment — being able to escape the world of illness and to think of something outside oneself for a while. All these aspects need consideration when reflecting upon the impact of the climate on wellbeing. People's doing and being in the environment is the other dimension of the climate, and the approach of staff and others in the environment will to a large extent influence whether or not experiences can emerge of welcoming, seeing and being seen, and of being safe and in a calm place.


8— The physical environment contains symbols conveying messages of caring and uncaring.

Arguably, the care of people with dementia consists of two parts: the 'doing' and the 'being' needed to satisfy basic human needs. 'Doing' consists of care tasks that need to be performed, for example, showering, toileting and feeding, and 'being' consists of the relationship (or lack thereof) that is formed between the staff member and the person with dementia. The 'being' dimension of care can be understood as the quality marker of the tasks performed; that is, the way the care tasks are carried out. As an example, a staff member can provide a shower to a frail older lady in a careful and loving way, making her feel like a queen, or in a stressful and neglecting style, making her feel like an object. In the first example, the lady's experience of the situation is in focus, and in the latter example the focus is merely on completing the task. These examples are given to illuminate that the subtle qualities of the approach to staff 'being' when carrying out the care tasks are of utmost importance for whether care is experienced as person-centred or task-oriented. The physical environment and the doing and being of people therein interact and form together the climate of a care setting — a climate that can support or obstruct experiences of *being* a person even if one is frail, confused, and dependent upon others (Edvardsson 2005; Rasmussen & Edvardsson 2007; Sandman et al 2006).

Practicalities of 'getting PCC into practice'

We have a strong sense then that PCC involves how we 'are' and the climate we create. Believing this and enacting it in the real world are very different! This section reports outcomes and learning from two intervention trials (Berg et al 1994; Bird et al 2006; Edberg et al 1996, 1999). One of the trials was an influential pilot trial in Lund, Sweden, and the other a larger Australian replication with two comparable conditions². Both the Swedish and Australian trials attempted to directly address factors that prevent staff in residential dementia facilities from providing PCC and, simultaneously, create an environment where they are assisted to do so. They illustrate the complex dynamic that leads to task-oriented care, and the consequent need for sophisticated and systematic interventions to move towards PCC. The Australian trial also illustrates the difficulties of providing PCC given the real constraints of stretched resources.

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 2 The Australian trial was funded by the Federal Government (unpublished report), and at the time of writing was being prepared for journal publication.

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Swedish trial

The Swedish study grew from observational research on screaming in nursing homes. It showed that contacts by staff with clients who screamed were extremely brief and tended to be at best terse, at worst abusive. The absence of empathic human interaction exacerbated the problem without necessarily being its cause (Berg et al 1998; Hallberg 1990; Hallberg & Norberg 1995). Further investigation, however, showed not callousness by staff but a complex dynamic between the emotional state and behaviour of clients, and the feelings, attitudes, skills and behaviour of carers. The care staff–client relationship is critical to PCC because (Berg et al 1998):

Nurses and clients with severe dementia share each other's daily life existentially by being together, as well as practically by doing together.

That is, much of the clinical expertise is not held by outside consultants such as general practitioners, medical specialists, or behaviour consultants, but rather it is held (or has to be developed) and maintained in those who carry out the care.

A key finding was communication difficulties with clients who could no longer make their physical and emotional needs known by normal means, and a consequent sense of powerlessness amongst staff. This led to withdrawal by many into a task-oriented approach. They focused on physical care, often delivered in a coercive way rather than cooperatively with the client, with an attendant absence of emotional engagement (Hallberg et al 1995; Holst et al 1999). Consequences included increased client dependence and withdrawal or, conversely, resistance and outbursts of disruptive behaviour (Hallberg 1990; Hallberg et al 1995). Consequences for staff included more judgmental attitudes towards clients, decreased job satisfaction, and increased strain and burnout (Hallberg & Norberg 1995; Hansson et al 1995).

 **A sense of personal accomplishment in residential care staff is associated with more positive interactions with clients.**

Other studies illustrate similar interactions. Jenkins & Allen (1998) showed that a sense of personal accomplishment in residential care staff is associated with more positive interactions with clients. Disempowerment and demoralisation of staff in residential care is associated with low understanding of the complex needs of clients with dementia (see review by Beck et al 1999). The ways residential care facilities are run can also affect quality of care. For example, lack of adequate support for staff has negative consequences for either themselves (Cole et al 2000; Moniz-Cook et al 2000) or, more commonly, both themselves and the clients (Hallberg 1990; Jenkins & Allen 1998). Many staff in dementia care are extremely stressed by their role, but receive little support (Edberg et al 2008).

The Lund intervention attempted a holistic approach to the complex issues preventing staff from delivering PCC. The intervention consisted, firstly, of fortnightly two-hour clinical supervision sessions where all staff on duty were encouraged in a non-judgmental atmosphere to discuss their feelings about a particular client. They were then asked to consider what life must be like for that person compared with life before the onset of dementia, what his or her emotional and physical needs were, and to brainstorm how these needs could be met more effectively and humanely. In a second component, two additional registered nurses

(RN) experienced in dementia care worked for two hours a week on the unit. In what were called *nursing forums*, they assisted staff to develop and implement care plans for the individual emotional and physical needs of each client, rather than managing their behaviour. That is, they developed genuine care plans rather than management plans. Care staff were also encouraged to become advocates of particular clients, and take ownership of implementing care plans.

A particular feature of the approach in both the fortnightly clinical supervision sessions and the weekly nursing care forums was guided discovery. That is, though the facilitators would already have done some research and might have clear ideas about how the client's needs could be met, the purpose was for staff to become empowered to make these discoveries for themselves. Didactic education was not used.

✎ **The purpose was for staff to become empowered to make these discoveries for themselves.**

Multiple measures were taken at baseline in the intervention ward and in a control unit that received two days of education about clients' needs but thereafter normal clinical supervision. There was no movement in the data after six months; changes only became apparent after a year. In the intervention unit there was significant improvement in care interactions, with less resistance from clients and more cooperation between clients and staff. On the control unit care interactions decreased in quality (Edberg et al 1996). Enrolled nurses (EN) on the intervention unit showed increased creativity, job satisfaction, and less burnout. On the control unit there was no significant change (Berg et al 1994; Hallberg & Norberg 1993). For clients in the intervention unit, there were improvements in orientation and mood; clients in the control unit deteriorated on these outcomes (Edberg et al 1999).

The Australian replication

The Lund model has obvious appeal because it is consistent with the literature on sources of staff distress and burnout, task-oriented care, and disruptive behaviour. It also has appeal because it was not delivered by didactic education, which is common for residential care staff in Australia. By definition, such education provides somewhat abstract or generic information that must be brought back to the facility and adapted to the situation there, where clients may be very different and where there may be little support from management or other staff. The Lund model is an example of case-specific learning, taking place in the direct care situation.

On the other hand, the Lund study was a pilot project with small sample sizes (only seven clients with useable data in each condition, from a starting sample of 11 per unit), and undertaken under 'Rolls Royce' conditions. In addition, personal care is undertaken in Sweden mostly by ENs who have two years training, and staff ratios are somewhat better in Sweden than Australia.

The primary purpose of the Australian replication (Bird et al 2006) was to determine whether positive effects could be produced by applying a similar but less resourced and therefore more realistic intervention, with a larger sample, in the somewhat messier real-life setting of Australian residential care. Here hands-on care staff are usually less well-trained. Two hour supervision sessions attended by all staff, with external RNs on the floor for an additional two hours a week, seems an impossible luxury. A second purpose was to compare the effects of a Lund-type intervention with two days of education on PCC. There is plenty of anecdotal data about satisfaction of participants after education, though there is no data at all about its effect on delivery of care.

Two ways of developing a person-centred approach were therefore investigated: a scaled-down version of the original Lund approach to match what could feasibly be delivered in Australian conditions, and delivery of high quality intensive training in a two-day workshop. The modified Lund approach was implemented in three dementia-specific units in Canberra, each with a sample of the 12 clients staff found they needed most advice and support to care for adequately. The fortnightly discussion groups, intended to last 30–45 minutes, were led at shift handover by a nurse educator from Hammond Care, who also helped staff research the needs of the chosen client and develop individualised care plans. Management undertook to provide cover for these sessions, and registered nurses from the facility were to assist in this process. Three control sites received two-day workshops from Hammond Care on PCC. The material on the second day of the workshops was mainly presented by the same educator who delivered the intervention at the Lund model sites, and included case discussions using examples brought by participants. Both days involved interactive discussion as well as didactic teaching methods.

Much of the material was therefore the same in both conditions and the workshops were highly practical and delivered by educators with many years experience in dementia care. The differences were the emphasis in the Lund component on emotional support of staff and sharing feelings, and the focus on case-specific learning where ideas and solutions from all staff caring for the same client could be pooled. That is, in an atmosphere of emotional support, staff were helped to develop a deeper understanding of the needs of each of their clients, and how to meet them.

There was universal take-up of the two-day education sessions. Cover was provided by facilities for these events, which were staggered and repeated so that all staff could attend regardless of the shifts they worked.

In contrast, there were major problems in implementation of the Lund approach in Australia. They were an integral part of the story of this project, and raise questions about the capacity to deliver PCC in many Australian facilities. One site had to withdraw when half their RNs left because of a change in management. At another site where many of the problems were due to the physical environment, clients and staff moved to a different part of the facility halfway through, making it impossible to determine whether effects (if any) were due to the move or the intervention. The manager who made the initial commitment at one of the other sites left, subsequent commitments could not be honoured, and many staff refused to take part. Overall throughout the project cover was often not provided, and discussion groups therefore took place amongst the clients and were often much shorter than 30 minutes. Some sessions were cancelled and at others there was low attendance, or staff had to disappear to deal with crises. At only one site was the intervention carried through as planned. The control sites were more stable, and we had to make one of these an intervention site halfway through to obtain a large enough Lund sample.

Largely because of the difficulties in implementation, and in obtaining completed research questionnaires from all facilities, there was substantial attrition of the initial sample. However, data on roughly two-thirds of staff and clients was available by follow-up. There was no convincing ‘Lund effect’ on the quantitative outcome measures. In neither the Lund nor control group was there a decline in ‘difficult’ behaviour, nor in various measures of staff distress. There was a significant reduction in use of physical restraint in the Lund group during the first half of the study, but these sites had started with higher levels of restraint.

Conversely, in the only Lund site that completed the intervention as planned, there was an apparent increase in use of PRN ('as required') psychotropic medication rather than psychosocial means to deal with behavioural incidents, though these data are of questionable reliability. Nonetheless, the main findings were robust and occurred regardless of whether staff received the Lund intervention or two days of education. Both approaches produced a large reduction in the necessity to call out medical practitioners to deal with difficult behaviour of clients and a consequent decline in frequency of antipsychotic medication changes. Secondly, in both groups there was significant reduction in pejorative attitudes towards clients; there was a decline in staff members attributing disturbed behaviour to clients being hostile or deliberately difficult.

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Qualitative measures showed a clear 'Lund effect'. These were obtained from optional comments on questionnaires during and just after the project, in addition to focus groups of staff held 8–11 months later and attended by approximately half of the study participants. Those who received the Lund sessions were very clear about the components of the intervention and how this differed from normal education, and spoke in detail about the effects on their clinical skills, their relationship with and attitude to clients, the effects on their emotional wellbeing and job satisfaction, and the effects on team cohesion. The most common comments addressed:

- the appreciation of learning to see the client as a person
- being able to admit to each other that they had difficulties (e.g., being frightened of a client)
- feeling more supported and appreciated
- the fact that the process provided a forum to learn from each other about how to care for the different needs of clients.

These additional effects, only detectable in our qualitative measures, are highly desirable both in the context of PCC and in staff support.

The only negative remarks related to difficulties in implementation of the Lund process, not on the value of the intervention itself, about which there was universal enthusiasm. A site that received both conditions was clear that the Lund approach was superior in inducing greater understanding of the individual needs of their clients, and in the provision of emotional support. Control sites provided comments on improved skills, but nothing about improvements in attitudes to and interaction with clients, and improvements in their own emotional wellbeing. Two sites bemoaned the absence in their facility of central features of the Lund approach, including regular team case-conferencing in an atmosphere of emotional and practical support.

In summary, either explicitly or implicitly, all participants from whom qualitative data were obtained were enthusiastic about something like the Lund approach, and those who had received the Lund intervention were clear that it had a significant effect on their wellbeing as carers, their attitude to clients, and the way they carried out care. Yet this effect was not reflected in quantitative outcome measures. Two days of high-quality interactive education was just as effective in improving attitude to clients, and reducing reliance on GPs.

The original Lund study illustrates the complexity of interacting factors that lead to task-oriented care and the consequent complexity of interventions required.

Interventions need to systematically identify and target the emotional, educational, and practical staff issues that prevent a shift to PCC. Mission statements about PCC of the kind seen in many residential care foyers, or basic dementia education, are not likely to ever make a difference. The best illustration is the time it took to obtain effects in the original Lund study.

There were substantial difficulties in the implementation of the Australian replication, despite support from the facilities concerned and the fact that the intervention was free of charge and explicitly designed to assist staff. Similar difficulties are likely to occur frequently in the messy real-life setting of Australian residential care. Overall, if the underlying philosophy of this book is correct, that PCC is essential, and if a central thesis of this chapter is also correct, that sophisticated interventions are required, then a very large commitment is needed to achieve PCC. It is likely that it will remain an elusive goal for some time to come, except for well-resourced and strongly committed facilities.

A whole-of-organisation approach

Effective implementation of PCC requires a whole-of-organisation approach, from the management structures, philosophies, and systems through to bedside and ancillary care services. While an individual may be able to *be* person-centred and connected to the client, this experience can be undermined if the organisation is focused only on achieving the financial bottom line. We would argue that an organisation committed to PCC would have the following attributes:

- leadership that models PCC in all actions and decisions — PCC is not just pulled out of the drawer for accreditation or something staff at the bedside have to enact
- a PCC philosophy that is understood by all staff — not just a framed piece of paper to hang on the wall
- relationships across the organisation that demonstrate valuing of employees as ‘persons’ — if staff are to be person-centred they need to see the philosophy modelled by management
- environments that value and support clients, families, and staff and acknowledge the importance of supportive relationships to healing and wellbeing
- flexible systems and processes that enable — or indeed force — staff to move away from a task/disease orientation; for example documentation focused on the ‘doctor’s orders’ and ‘nursing plan’ and written *about* the client will invite medico-centric care whereas PCC documentation would be reflecting the client’s goals and involvement in decision making.

☞ Effective implementation of PCC requires a whole-of-organisation approach.

Practical approaches to foster PCC at a local unit level

The recent PCC literature review lists common barriers to implementation of PCC:

- perception that providing care in a person-centred manner will take more time (in the longer term PCC may actually reduce time demands on staff)
- loss of autonomy, power, or professional status by staff
- lack of clear understanding of what PCC is, and how it can be applied in the health or care setting

- perception of greater challenges working in a PCC manner with clients with communication difficulties
 - constraints of the physical, and spiritually impoverished environments in some settings.
- However, each of these perceived barriers can be worked through to achieve positive outcomes for staff or carers and clients and their families. Factors identified in this review considered to facilitate or support PCC were:
- having skilled, knowledgeable and enthusiastic staff, especially with good communication skills, and supporting development and sustainability of these features
 - providing opportunities for involvement by the client, carer, and family
 - providing the opportunity for staff to reflect on their own values and beliefs and express their concerns
 - opportunities for staff training and education, including feedback from service users
 - organisational support for this approach to practice
 - working in an environment of mutual respect and trust
 - providing physically and emotionally enriched care environments
 - treating the environment as the client's home.

Conclusion

Person-centred care is an approach to care that places the client and their carer central to all aspects of care and related decision making. We have argued that for it to be successful, there needs to be an organisation-wide approach and PCC needs to be firmly embedded in policies, systems, and relationships. Although, like any change, there are barriers to implementation, each barrier can also be addressed and some useful examples have been identified.

This is an emerging area of both practice and research, and although there is growing appreciation of the value and need for this approach in health services and residential care settings, there is a need for a concerted, sustained and management-supported approach for the necessary changes to be achieved on a wide scale.

Reflective questions

- 1 Most health professionals recognise the value of the person-centred approach to care delivery. How do they manage change and sustain a new approach in a work environment that does not support change?
- 2 Why is it that management cannot see past financial implications when in the longer term they would actually save money by having a more stable workforce, happier clients and healthier outcomes?
- 3 Research is needed to demonstrate the actual cost of the model and clearly define improved outcomes by hard data. How would you control such a study?
- 4 Most organisations have mission statements, philosophies of care, strategic plans, risk management plans and quality improvement plans, and they often state the values that most people would agree are consistent with PCC. Why is it not seen in practice very often?
- 5 Do families and the community understand what is meant by PCC?

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Other resources

Person-centred health care website (Victorian Government Department of Human Services and the National Ageing Research Institute) — www.nari.unimelb.edu.au/pchc/index.htm

Provides some useful resources and project methods and outcomes for PCC initiatives undertaken in health services