Transcript

Lynn Chenoweth: Providing person-centred care (long version)

Residential care facility managers and executive can really help their middle managers, their clinical lead managers and their staff to actually focus on the person by nurturing personhood. That is the fundamental basis of the person-centred care approach and the way that they can do that is refer to the VIPS model which was developed by Brooker.

Now the VIPS model stands for 'V' which is valuing. So what it means is asserting the absolute value of the individual human being and their unique identity and that means that they can actually make use of the person's history, their life story, all of those idiosyncrasies of the person that make them unique and actually help to focus the care and processes towards their needs.

The next process is the individual approach. So 'I' stands for individual and it means that what we try to do is to focus on the individual. So looking at everything from the point of view of that person but also making sure that their care planning and the care approaches focus on the individual and particular needs of each person.

'P' stands for perspectives, focusing on the persons own perspectives in all the interventions and interactions occurring, and the way that staff can do that is to see the persons world from their perspective, treat the persons behaviour as a form of communication and respond empathetically to the persons feelings and not their behaviour in the care that is provided.

'S' stands for social psychology which is all about promoting the persons wellbeing. So in this respect, what we need staff to do is to focus on making the person feel confident in their social and emotional world, to actually create and strengthen their positive attributes and their abilities and to provide the person with warm and empathetic accepting human contact in all of the care that is provided.

There are a number of system wide obstacles that are in place that might actually prevent staff from being person-centred in their approach to care for the person. So these things would include the organisational culture, the system operations that exists for management structures, the education and training programs for staff. Things like the care planning and the lifestyle orientation, these are a number of things that really stop the services from being person-centred. If we have a work culture which prioritise system operations and

efficiencies and productivity over the needs of the individuals being cared for, then we have a system which is not able to provide a person-centred approach.

What happens in that situation is we have staff focusing on the structures and the operations and usually a task driven type approach to care rather than trying to look at the individual needs and in that situation, we have staff feeling disempowered, feeling stressed and feeling anxious and it can lead to staff burnout and turnover.

So if we had a system where the managers feel disempowered and they don't have the skills for their job, what we have is inadequate investment in education and training and leadership for our middle managers, and our clinical team leaders. When that happens, we have very poor supervision of the staff providing the care. So the remedies for that will be to provide training and mentorship for organisational leadership rather than everything being driven from the top down, let's work with the staff and the families and the residents from the ground up.

One of the next things that creates problems with a person-centred model being put into practice is that the quality assurance systems that are driven pretty much by the accreditation system and not geared particularly to the individual needs of the residents. So when we have this occurring, we have inadequate attempts for the quality systems to focus on the unique profiles of the resident when they're assessing outcomes for that person and the outcomes of that are that you have physical assessment processes being reviewed. So for example the safety systems and the quality improvement systems that are focused on things like safety in the systems but it's not really focusing on whether that system is safe in terms of psychologically socially safe and comfortable for the person in care. So in that case, what we need to do is to plan and monitor the operation systems with reference to whether they support personhood and wellbeing of a person. That is the fundamental process that we need to be focusing on.

And if we have person-centred care training occurring occasionally or not at all, then the staff focus on things like knowing how to transfer people, how to prevent them falling, things like that which are very important but they're not really the essence of a person-centred care model. We need to have staff focusing on how to communicate empathetically with the person in everything that occurs. We need to teach staff how to form personal relationships with the individual and their family.

The next major area of care is to improve person-centred care planning. What happens generally, if I have a look at the care planning processes, I find that the staff have very general approaches to care planning. So for example if a person has a particular issue where they reacted too such as getting agitated or screaming or getting very very disruptive, we don't have particular care plans which describe to the staff exactly what is going on for that person, what might be the triggers for that and what they need to do in particular ways to try and prevent that from occurring. So when we have very generalised care planning, that's not really helping the individual. So the remedy there, is to really focus the care planning on very specific issues and for the staff to work with the families, work with each other and the resident to prevent these behaviours, to improve wellbeing and to really focus on what is important to the person in supporting their personhood.

Another aspect of the system approach that we can use to provide a person-centred model is to think about practice guidelines. Now a lot of the practice guidelines that staff refer to are things like falls prevention, knowing how to feed somebody and knowing how to transfer people. These things are all terribly important but what we need to do in a person-centred model is to have practice guidelines for very specific areas of care that are difficult and one of these is behavioural management. So if somebody has an agitated behaviour, we don't have very good guidelines on how to identify the reasons for those behaviours, what are some of the triggers occurring in the environment, what can we do to make sure the environment is person-centred, what can we do to actually think about the care processes, what sort of care is being provided that's triggering the agitated response and so staff need this particular guideline on how to provide a particular approach to care for particular behaviours.

That's just an example of a person-centred approach but there are many other areas as well. For example, if the person has lost communication skills, what are the particular techniques that you use to communicate effectively with somebody who has no vocal skills remaining or vocabulary which is not understandable, so how to use body language, how do you use particular forms of communication which are non-verbal to work with that person in a more effective way. These are just a few examples of some of the clinical practice guidelines that need to be developed for particular cases and for particular needs.

Some other approaches that have been used to overcome some of the system constraints to a person-centred model would be to look at care monitoring and care staff support models and one of the examples there is the dementia care mapping process which is developed at the Bradford University in the UK. Many people are using that across this country and in many other countries to actually observe what is happening in care, what are the things that trigger wellbeing and ill-being in a person and what can you do as a system to actually prevent some of those triggers for distress and what are the things you can do as a system to actually improve the wellbeing.

Other programs of support that have been very effective would be an enriched activity program. So building in activities into the lifestyle programs which really enrich the environment, enrich the activities, help people to maintain their strengths and abilities, help the person to feel as if they are part of the organisation that they are included, that their needs are being met and that they feel as if their personhood needs have been respected.

So there are a number of things that can be done in a very practical way across the whole system to support a person-centred approach.

This is a transcript of Lynn Chenoworth: Providing person-centred care (long) video. To view the video visit www.caresearch.com.au/DementiaCare