PEOPLE CENTRED CARE (PCC) FRAMEWORK

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INTRODUCTION

The World Health Organization (WHO) defines People Centred Care (PCC) as "an approach to care that consciously adopts individuals', caregivers', families', and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people. PCC also requires that clients have the education and support they need to make decisions and participate in their own care, and that caregivers can attain maximal function within a supportive working environment. "People" Centred Care is broader than Person Centred Care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services."[1]

Important Notice: While the terminology has changed over the past year, the intent is that "People Centred Care (PCC) maintains the same focus as the term "Person Centred Care" or "Client and Family Centred Care" (CFCC). Definitions with WHO will evolve gradually to reflect this new terminology of people care.

When it comes to PCC or CFCC, strategies used by Traverse must be multi-pronged and adapted to needs of the clients and their families. This framework will embed PCC in all levels of the organization in new and innovative ways.

Providing PCC means working collaboratively with clients and their families to provide care that is respectful, compassionate, culturally safe and competent, while being responsive to their needs, values, cultural backgrounds and beliefs and preferences.[2]

STRATEGIES

Engagement and other activities play a large role in the PCC approach to care planning. This starts with recognizing the experience and expertise of the person or client in collaboration with the professionals. The person is considered an equal partner in the process. The person, family and caregivers are acknowledged as distinct and necessary components to improving the service delivery mechanism.

[1] WHO, "Framework on integrated, people-centred health services", accessed September 7, 2017 in the People Centred Care Criteria Guide, January 2018, version 1.0
[2] Adapted from the Institute for PFCC, 2008 and Saskatchewan Ministry of Health 2011.

The means of engaging are defined as:

In partnership with the client and family: The team collaborates directly with each individual client and their family to deliver services. Clients and families are as involved as they wish to be in the care planning and delivery.

With input from clients and families: Clients and families provide input collectively through advisory committees, groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in many ways and at various times. This feedback is utilized across the organization.

SYSTEM

There are many ways to operationalize meaningful engagement with clients and families - from client and family councils to surveys and town hall meetings. Traverse Independence has utilized several them, which are highlighted in the Key Stakeholder Engagement Report 2018[3]

In order to ensure continuous quality services to our clients, Traverse Independence uses a collaborative approach to provide person-centred, holistic services, and provides information to our clients and family members about other community services that are relevant to the client or family member. Principles of the independent living model, including self-directed care, the right care in the right place at the right time, dignity of risk, and supported independence, are all reinforced by the mission, vision and values of Traverse Independence.

PCC puts the person at the forefront of their care planning, ensures they retain control over their own choices, helps them make informed decisions, and supports a partnership between individuals, families, and the service provider. The guiding principles are intrinsic to a PCC model.

Dignity and Respect

This principle speaks to the need for active listening to clients and caregivers and to honouring their choices and decisions. This is done through incorporating the client and caregiver's values, beliefs, and cultural norms into care plans and care delivery.

Information Sharing

Communication that is timely, accurate, and complete about decisions to be made and validation on what has been heard and understood, is the basis of this principle. This leads to supporting an informed decision.

[3] Traverse Independence Key Stakeholder Engagement Report, 2018

Participation

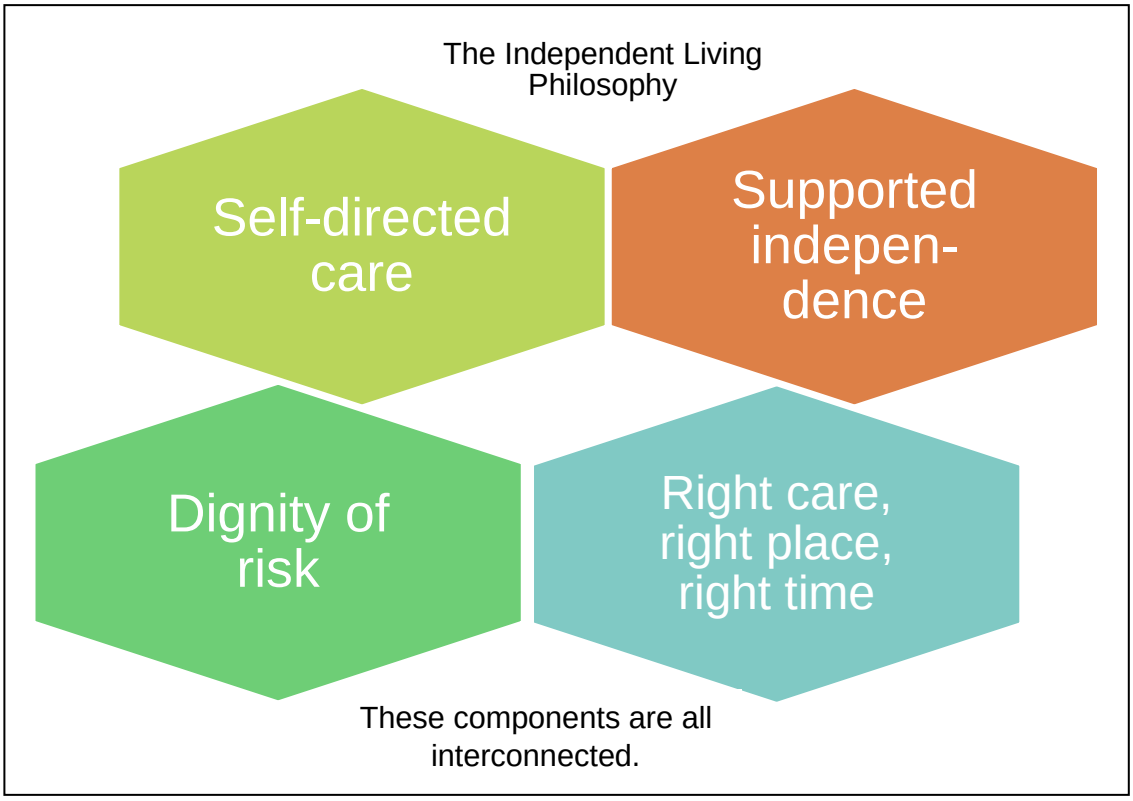
Clients and caregivers are encouraged and supported to participate in their care planning and informed decision making at the level where they feel comfortable.

Collaboration

Clients and caregivers are provided meaningful opportunities to engage with service providers and leaders in the continuum of quality improvement, policy and program development, implementation and evaluation. This includes the potential for engagement in facility design, service redesign, professional education, and the delivery of care.

In order to ensure continuous quality services to our clients, Traverse Independence uses a collaborative approach to provide person centred, holistic services, and will provide information to our clients and family members about other community services that will be relevant to the client or family member.

Historically, the principles of the independent living philosophy included self-directed care, the dignity of risk, and the right care in the right place at the right time and supported independence are all supported by the mission, vision, and values of Traverse Independence. This historical philosophy meshes so simply with the newer PCC model of service.



PEOPLE CENTRED CARE PRACTICES

Support for PCC principles should be demonstrated by an organization's leadership through both words and actions. This requires engagement at all levels of the organization. At the same time, service providers should demonstrate support for PCC principles at the client care level, pushing up in a true partnership with leadership.

Employees have a very important role in developing a culture of PCC. This requires a shift in thinking from a 'medical model' of care (providing information, guidance, and expert decision-making) to a model of care where the client is a partner in making care decisions (self-directed care). The employees must feel they have the support of the organization to engage in PCC activities with those clients who can successfully direct their own care.

In the client-provider relationship, clients are in the position of needing help and providers have the knowledge and experience needed by their clients. This creates a natural power imbalance between clients and employees that requires conscious effort to overcome. Employees should be supported to shift their values, attitudes, and behaviours to make clients true partners in the process of making care decisions[4].

This PCC framework can be used in various ways, including:

- Admissions: perhaps inclusion of person in selecting service location or intensity of intervention
- Goal setting: identifying what is relevant to the client and focussing efforts on that are important to the client. Similarly, the discussion about transitions of care and involvement in the community
- Follow up on incidents: process improvements based on client feedback following incidents
- Information sharing: transparency of organizational practices and willingness to accept feedback
- Process improvements and organizational decision making

SERVICE DELIVERY FRAMEWORK

The services we offer are non-medical and non-clinical in nature. All decisions and referrals are done after discussion and agreement of the client, family and caregivers. Traverse does not have a regulated health care professional employed directly as we are not funded to provide clinical oversight. Clinical services require either direct or indirect regulatory oversight of the client, which can be planned in advance, or responsive to a situation or client safety incident.

[4] Ministry of Health of British Columbia Person Centred Care

However, using our intake assessment and established criteria presented to our Admissions and Transitions Committee, and in consultation with the client and their support team, Traverse refers clients to the ABI Intensive Case Coordination Services to be assessed and referred for rapid access to clinical services if required. In all cases, this would be for a client who is considered complex in nature who requires ABI specialized supports. This specialized service works closely with the client, family, and caregivers to determine the areas of support that would be most beneficial in supporting the client to maintain their goals of independence. Dependent upon the needs of the client and their wishes, services can be provided through Home and Community Support or purchased on behalf of the client from the ABI private sector through the specialized case coordination budget.

PROCESS

Traverse Independence works collaboratively with clients, families, and community partners to develop care plans specific to the client. These care plans will be holistic in nature, taking into account: elements of physical health, elements of psychosocial health (functional and emotional status, family and caregiver involvement, communication, safe care abilities, cognitive status, mental health, addictions, socio-economic status, cultural and spiritual beliefs) and trauma informed. https://braininjuryguidelines.org/. This framework is based on the Ontario Neurotrauma Foundation's clinical practice guidelines. This framework will be reviewed every 5 years to ensure that we are following best practice guidelines as well as legal regulations.

In house, and with client permission, each client is assessed with the Mayo Portland ABI Assessment Tool. This tool is exemplary as it also gathers information from not only the caregivers but also the support services staff working with the client as part of the assessment. The client is then presented at the admission and transitions committee, where the internal team reviews the client, caregiver and care team information to determine eligibility and a preliminary care plan. This is then presented to the client and their family for discussion and final approval. Complexity is one of the key factors discusses so that additional resources can be sought out for the client if necessary.

When the client starts their new service, Traverse Independence will work in collaboration with the client's family and care team to ensure we are meeting the client's ongoing needs as they gain skills and independence. At this point, dependent upon the complexity of the client and the progress made additional referrals could be discussed with the client and their family such as additional clinical support. Such supports as speech-language pathology, occupational therapy, physical therapy, social work, neuropsychology, psychology, psychiatry, nursing, physician, rehab support personnel, nutritionist, recreation therapist, and pharmacist are all possibilities along with referrals to more clinical based programs with more intensive ABI supports.

TRANSITIONS

Brain Injury Programs

As the client gains skills towards independence as validated by data collected during their stay, they and their caregivers are included in the transition plan. The goal in the ABI programs is to work towards living in an appropriate independent setting with the supports required to maintain that independence.

Adults with Physical Disabilities

Most of these clients reside in their housing unit for the duration of their life. As they age in place, their physical abilities decrease and often so does their cognitive ability. These are the typical symptoms of aging, which is exacerbated by their disability. Should the client become too frail or too medically dependent to live in supportive housing, this organization will work with the client and their families to transition to the next stage of support, which is most commonly long-term care.

CONCLUSION

The goal of PCC is clear: to embed this philosophy in all levels of the organization starting with the governors. Ultimately, the impact will be felt in all operational outcome measures, quality and safety of client care and the client and family experience.

The philosophy starts with a vision, works through engagement that is enabled through the culture, infrastructure, and processes. Our guiding principles of dignity and respect, information sharing, participation and collaboration are critical to the success of the PCC model.