Implementation of person-centred care

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The implementation program, three stages

Stage 1
Aims to support a strategic management commitment and decision to govern the change process.

Stage 2
Aims to prototyping and engaging parts of the organization to pioneer and move ahead to gain organizational learning regarding person centred care.

Stage 3
Aims to support a broad implementation of person centred care through out the organization.
The aim of the survey is to map the current situation in the organization. The survey has also the function of warming up the organization and promote reflection among employees.

The survey has, the following four questions;

1. Describe in a few sentences, what is person-centered care for you?

2. To what extent are you working person-centered today?  
   (1 = Not at all, 2, 3, 4, 5 to 6 = Completely)

3. From your perspective, what are the opportunities and benefits of a person-centered approach on your ward unit?

4. From your perspective, what are the obstacles and risks of a person-centered approach on your ward unit?
A. Select a patient.

B. Listen to the patient narrative (initiating the partnership) and set up a health plan together with him/her (working the partnership). Have the professional and patient to sign it (safeguarding the partnership). Follow the health plan during the admission and discharge the patients together. Perform the task based on how you understand person-centred care. This task need to be finished before next gathering X.

C. Submit one of your health plans to X.X@X.se by X. Describe how you worked to develop the health plan. What considerations did you do? What issues have been raised during the work?

D. Follow up the health plan with the patient after a month.

E. Summarize and document your conclusions for task 1.
A. Reflect upon the results of the pre-survey.

B. All participants selects three colleagues (from another professions, not included in the implementation program) and invite them for lunch in order to discuss the results of the survey and deepen the questions (initiating and working the partnership).

C. In your study group: Gather your reflections from your meeting with your “lunch colleagues” and formulate a change assignment to implement. The assignment will drive the development of person-centered care onto your care unit and be completed by the follow-up day: X (safeguarding the partnership).

D. Present a proposal to change assignment and get feedback from the rest of the program group: X th.

E. Perform the assignments.

F. Write and present a short report.
Our implementation program in action
1st Gathering

Goals:
- Introduce the objectives, approaches and methodologies.
- Create openness and good climate in the group of participants.
- Start and shape start study groups.
- Provide a comprehensive introduction to Person-Centered care.
- Plan the work ahead.

Agenda:
- Introduction to the program, objectives and agendas.
- Why we should implement person-centered care in our clinic?
- When did you start to work in psychiatric care?
- What questions do you have about person-centered care and integrated psychiatry?
- Introduction to Person-centered care
- Subdivision of study groups
- To what extent are you working with person-centered today?
- Introduction to "Appreciative Inquiry"
- Present the results of the survey

Participants (n=41)
- Nurse (n=12)
- Assistance nurses (n=13)
- Head of the ward unit (n=2)
- Head of the medical treatment team (n=4)
- Physician (n=4)
- Social worker (n=2)
- Secretary (n=3)
- Occupation therapist (n=1)
What questions do you have about person-centered care?

Why the concept partnership? Why not collaboration or alliance?

How do we find the balance between curing disease (psychosis) and finding the person behind the disease?

Is PCC an approach? and will it mean more paperwork?

What is the first step with each patient?

What is person-centered care?

Is PCC time consuming?

Is PCC anything new?

Don’t we already work PC…or?

Person-centred care, patient autonomy and compulsory treatment: a challenge!
2nd and 3rd gathering

Goals:
- Deepen the partnership, narrative, documentation and the concept of person-centered care.
- Follow up with study groups to formulate/articulate improvements.
- Introduction to the basic theory of change.
- Plan the work ahead.

Agenda
- Get to know each other as a person.
- Acknowledge the current state of the person-centered care research.
- Integrated psychiatric care.
- Introduction to the theory of change resistance.
- Vision Work.
- Follow-up, task 1, exercising partnership.
- Follow-up, task 2 a, lunch.
- Plan for task 2 b, formulate a change assignment to test and refine.
Issues raised during the work with the assignment

How to keep a thread and focus on the health plan in the conversation with a patient who is psychotic? How do we know that the patient felt that he/she was in focus?

What are the different responsibilities and collaborations between the professionals in inpatient and outpatient care?

When does the health plan from inpatient care stop being valid and when does the health plan from outpatients care start to function?

How does person-centered care work when patients are under compulsory treatment?
Figure 1: Example of Person-centred care plan

Person – centred Care plan

Goal setting (return to desired activity): To lower stress level, to calm down and do one thing at a time. To pursue more of own personal interests.

What and how should I do this? When? To learn to say ‘no’. To dare ask for help. To not always try and do things on one’s own.

My own resources and capabilities (How can I use these to achieve my goal?) Artistic and creative. Paints a lot and feels great doing that. Purposeful and decisive. Knows about her risk factors. Has good friends for support.

My need for support: Need to be in touch with a professional person (psychologist) to help with managing stress and finding tools to deal with internal stress.

Team decision (A)

To be completed by physician, nurse and patient

| PCC plan prepared prepared and agreed as per patient’s requests and wishes | Yes | No |
| Discharge planning, anticipated discharge date: | Yes | No |
| Next of kin informed about PCC plan in accordance with patient’s requests and wishes: | Yes | No |
| Are there any anticipated complications in the PCC planning? | Yes | No |

Anticipated complications If no coronary angiography: 4/12

Signature patient: E. [Name]
Date: 02.12.2015

Signature physician: H. [Name]
Date: 02.12.2015

Signature nurse: H. Castle
Date: 02.12.2015

Wellbeing (B)

Symptoms assessed by patient every 48 hours

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<tr>
<th>Date</th>
<th>Day 1</th>
<th>Day 3</th>
<th>Day 5</th>
<th>Day 7</th>
<th>Discharge day</th>
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<tr>
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<tr>
<td>Fatigue 4 (1-5)</td>
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<td>2</td>
<td></td>
<td>3</td>
<td></td>
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<td>Health 5 (0-10)</td>
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<td>6</td>
<td>4</td>
<td>5</td>
<td>4</td>
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<td>Other symptoms</td>
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</table>

4: Likert scale, 5: Visual Analogue Scale

Evaluation (C)

by patient

I was involved in my care planning | Yes | No |
I was involved in discharge planning in a satisfactory way | Yes | No |

Continued PCC plan (C)

Patient keeps PCC care plan and brings it to appointment

2 days after discharge the patient will be contacted by primary care centre

Contact at primary care centre: L. Settembri Telephone number: 022 345 678

A= Patient narrative; B= Symptom monitoring; C= Evaluation/discharge planning
Reflections gathered from "lunch colleagues"

How to involve professionals from outpatient clinics?

How do we get patients more involved?

How to get better understanding of the type of care and the treatment patient receives from outpatient clinics?

How to identify the patient's resources and abilities?
4th and 5th gathering

Goals:
• Deepen the partnership, narrative, documentation and the concept of person-centered care (lecture).
• Follow up study groups and invited guest regarding person centred care assignments
• Deepen the knowledge of person centred care and theory of change
• Supervision, task 2 b, change assignment
• Formulate first draft of action plan for the implementation

Agenda:
• Follow up - task 2 b.
  - What have we achieved?
  - What benefits have we seen so far?
• Supervision - task 2 b
• Narrative and documentation
• Formulating a first draft of an action plan for the upcoming 3 months (stage 3)
Examples of assignments

- Increase the partnerships with staff from outpatient clinics
- Plan health plan together with the patient
- Remove a couple of team conferences and put the time on patients instead
Examples of formulated core issues, challenges or nodes in the assignments

How to be person-centered to patients who are psychotic?

What is a person-centered health plan?

From a psychiatric perspective, what risks do we perceive with person-centered care?

How do we relate to the patient's will and worldview?

How to carry out PCC in combination with compulsory treatment?
Action plan for implementation (version 0.8)

What resources, partners and support do we have?

Important steps we already taken?

What should we do within a week?

What should we do until May the 27th?

What should we do until September the 30th?

What should be done until next summer?

What should we do until next summer?

What are the challenges with the steps above?
6 th gathering

Goals:
• Sum up and draw learnings from the program.
• Reconciliation of task 2 b change assignment.
• Deepen the action plan and establish it for future work.

Agenda:
• Reporting the change assignment (task 2 b)
• Follow up and continuing work on the action plan for the upcoming year (stage 3).
• Reflection and evaluation.
Action plan for coming year (version 1.0)

What should we do within a week (June 2015)?

- Review the need of staff training in PCC
- Inform the case managers about the patient’s health plans
- Create a separate board for information about PCC
- Inform the staff about the project “person-centered care”

What should we do until September 2015?

- Starts tutoring in PCC
- Asks the outpatient staff for the patient’s health plan
- Start staff training

Fully developed partnership with staff from outpatient clinics
All patients are fully involved in the writing of their personal health plans
Fully develop a partnership with patients and relatives
Reached the position in December 2016

What should we do until September 2015?
What is person-centered care for you?
1. Starting from the patient's experience and together with that person, create a health plan. Ask for the patient's expectations, concerns and perceptions and address these.
2. Together with the patient establish a plan for the hospital stay, including a provisional discharge date.

What opportunities and benefits are there to develop a more person-centered approach at your department?
1. More involved and satisfied patients. A more efficient and transparent planning during the hospital stay, reduces the "surprises" before patients discharge.
2. To structure and standardize certain elements makes the work easier.
3. Better cooperation between the different categories of staff. Involved patients shortens their hospital stays.

What are the obstacles and risks to develop a more person-centered approach at your department?
1. The other ward units in the clinic is not working as effectively as ours. Our unit will still have the biggest turnovers of patients thus have a maximum workload.
2. None. Possibly increased documentation
3. Shorter hospital stay on one, but not the other ward units at the same clinic leads to greater workload.
Patients experience questionnaire

Implementation of person-centred care in an internal medicine ward

Mean hospital stay in days

- 2011: 6.4 days
- 2012: 5.6 days
- 2013: 4.4 days
Summary

• In a person-centred approach a patient and relatives are capable partners

• A person-centred approach is feasible in all conditions

• Person-centred care make patients more satisfied with care and is cost-effective
Thank you for listening

Questions?