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Introduction

In this chapter, we discuss two key concepts involved in the care of patients with dementia: person-centred care and relationship-centred care. In addition to explaining the meaning and origins of person-centred care as a term, key emphasis is placed on principles and achievement of person-centred care. We also discuss the specifics of those with dementia that need consideration and the benefits of providing person-centred care in dementia patients. Relationship-centred care is explained in the context of interplay between collaboration,
communication and relationships, and key interactions involved in dementia patients are also highlighted. We discuss relationships between various stakeholders involved in care of patients with dementia from the perspective of the agency theory. The chapter concludes with a consideration of interprofessional practice (IPP) in the provision of patient-centred care in dementia and the interprofessional team work is illustrated in a case study.

**Person-centred care**

Health care focused on the patient is increasingly becoming important for health policy makers around the world. The National Safety and Quality Framework, proposed by the Australian Commission on Safety and Quality in Health Care (ACSQHC), placed 'patient-focused care' as the first of three areas needed to be addressed in order to achieve a safe and high quality health system in Australia (ACSQHC, 2009). Alzheimer's Australia, in their Position Paper 2 on quality of dementia care, indicated that high quality dementia care is achieved through person-centred care (Alzheimer's Australia, 2003).

The support for a health care system that focuses on the patient is strong in Australia with many providers embedding patient-focused principles into practice. A person-centred care focus is also popular internationally, especially in countries such as the US, UK and Canada.

Person-centred care is gaining more ground in dementia care and has evolved to become a synonym for good dementia care practice. The UK's National Institute for Health and Care Excellence (NICE) clinical guidelines highlight that person-centred care reflects good practice in dementia care, with many principles of person-centred care reflected in its guidelines (NICE, 2006). The term 'person-centred' care, although used in other health areas before, in dementia is relatively new. The term has its roots in the work of Carl Rogers and his 'client-centred' psychotherapy. According to Rogers, the aim is to create a setting so that the client can come up with their own resolution of their problems, rather than the therapist providing advice (Rogers, 1961; Lane, 2000). The term 'person-centred counselling' in fact replaced the 'client-centred' term, with the view of recognising that the person who seeks counselling is an expert on themselves, whereas the actual therapist is the facilitator who seeks the patient's self-actualisation (Brooker, 2004). However, it was not until
the work of Kitwood that the 'person-centred' term found its way into dementia care (Kitwood, 1988; Kitwood, 1997). He supported the idea of shifting from the traditional approach of dementia care, which focused on the deficits of the person, to a model of care that values the personhood of the dementia patient. Kitwood emphasised that the term 'person-centred' care should be used with the view of highlighting communication and relationships during the process of dementia care (Kitwood, 1997). Dementia care mapping has been developed to assess the quality of care in dementia and is largely based on the person-centred care hence promoting patients' personhood and a holistic approach to their care.

Carers of dementia patients, who follow a person-centred care approach, bring out the best in the people living with dementia. This also applies to those care homes that often have their mission statement based around this approach and therefore aim to provide good dementia care. In this regard, it is worth emphasising that there are three key principles of good dementia care (Cheston, 1998; Kitwood, 1997):

- regular and structured activity;
- activity at interpersonal, recreational and therapeutic level;
- reinforcing patients' sense of worth and value.

Brooker suggested that the term 'person-centred' care tends to mean different things to different people in various situations (Brooker, 2004). Therefore, articulating 'person-centred' care in a straightforward way is complex. To some, the term may imply individualised care; to others it is a value base. This is also obvious from various approaches that regard 'person-centred' care as a set of techniques of working with a patient with dementia in comparison to other approaches in which 'person-centred' care is based on communication with the patient (Brooker, 2004). It should also be recognised that, in practice, the person-centred care term is used interchangeably with terms such as 'personalised care', 'patient-centredness' and 'relationship-centred care'. Overall, the term describes the relevance of relationships and collaboration between health care workers and patients and recognises their needs and reciprocity in relationships (ACSQHC, 2010). As a concept, person-centred care puts the patient first. This essentially means putting patients' needs, feelings, preferences, experiences and well-being ahead of the disease, in this case dementia. Therefore, person-centred care is entirely and always focused on the individual person.
There are a number of definitions of person-centred care but none is currently globally accepted. One of the definitions provided by the Victorian Government Department of Human Services (2003) defines person-centred care as 'treatment and care provided by health services which place the person at the centre of their own care and considers the needs of the older person's carers'. This definition also considers the carers (i.e. service providers) and emphasises the importance of the collaborative and respectful partnership that should be in place between carers and patients (i.e. service providers and users). According to the Institute for Patient- and Family-Centred Care (n.d.), person-centred care:

is an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. Patient- and family-centred care applies to patients of all ages, and it may be practised in any health care setting.

The World Health Organization (WHO) used the term 'responsiveness' over 'person-centred care' with the view of best describing how health care systems meet expectations in a number of domains, namely respect for people and their preferences, communication between healthcare workers and patients, as well as waiting times (WHO, 2000). WHO also supports carer and patient involvement in partnership initiatives with the aim of improving safety and quality of care (WHO, 2010).

In recognising, therefore, that 'person-centred' care is a composite term, Brooker (2007) proposed that in dementia care it should encapsulate four major components referred to as VIPS:

- valuing people with dementia and those who care for them (V);
- treating people as individuals (I);
- looking at the world from the perspective of the person with dementia (P);
- providing a positive social environment in which the person living with dementia can experience relative well-being (S).

According to the UK's Royal College of Nursing (n.d.), there are some key considerations that assist individual carers in the achievement of person-centred care. These considerations are based on concepts that need to ensure:

- respect and holism;
- power and empowerment;
choice and autonomy;
empathy and compassion.

In general, there are a number of approaches reported internationally that assist in achieving person-centred care. These include a variety of strategies generally aimed at improving patients' knowledge (e.g. through training of health professionals about medicines and longer consultation times for patients); improving patients' experience (e.g. getting patient feedback through surveys that support quality improvements, person-centred communication and longer consultation times); improving service use and decreasing cost (e.g. public reporting of performance, adequate dissemination of information in formats easily understood by patients) and improving health behaviour and health status (e.g. through development of communication skills for clinicians) (ACSQHC, 2010; Coulter & Ellins, 2006).

Engagement of carers and patients is a cornerstone in achieving person-centred care. The relevance of carers and/or family should be highly valued given their knowledge of the patient (e.g. history and routines) and their ability to reassure the patient in various situations of uncertainty, anxiety or even vulnerability. Carer involvement in patients' care can be supported by designing strategies aimed at readjusting patient visiting times according to their needs, creating family response teams that alert health care staff on changes in patients' status and creating partnerships with carers and/or families aimed at addressing patients' needs (ACSQHC, 2010). Such strategies can contribute to the overall care of the patient and improve their overall experience as suggested by Frampton et al., (2008) who reported a 65% decrease in anxiety and improved overall patient experience as a result of patient-directed visiting hours.

Access to information and education by carers and patients is also a person-centred strategy that promotes empowerment. In this regard, patient personalised information, provision of printed and electronic information, as well as educational programs, improve knowledge and understanding of their condition and hence benefit patients' care (Frampton et al., 2008; ACSQHC, 2010).

Approaches aimed at improving the design of the physical care environment for patients by creating a user-centred design have also been reported to be successful in improving patients' experience of care. Service re-design has also been implemented in this context in the UK. This approach focuses on technical issues of the patient's journey and it maps steps in order to identify potential problems in the patient's care and hence generates solutions (Ben-Tovim et al., 2008).
Appointing carers and patients to advisory committees at governance level, in order to have a say in decision-making processes, is also important in ensuring person-centred care. This strategy can assist by having carers and patients providing information to policy makers on their needs and concerns, being involved in planning of patient care and innovative programs, having their say on changes affecting patients and carers, and helping to strengthen communication between various stakeholders in the patient care chain (i.e. family, carers, health care staff, administrative staff and patients). Appointment of carers and patients at governance level also encourages them to speak up and get involved in the care process (ACSQHC, 2010; Frampton et al., 2008).

Important considerations in achieving person-centred care also include ensuring that care providers offer an environment that supports person-centred care. In addition to creating an atmosphere that supports patient-centredness, providers should consider staff satisfaction and accountability strategies, as well as valuing training and ensuring that employees' behaviour in fact reflects the organisation's values (Shaller, 2007; Frampton et al., 2008).

**Person-centred care in dementia**

Patients with dementia have unique characteristics owing to their disease. Dementia imposes various levels of functional decline (both physical and cognitive). Its progressive nature in relation to cognition, behaviour, as well as function tends to make patients with dementia more dependent on other people, especially in the performance of activities of daily living (Chenoweth et al., 2009). This translates into unmet complex needs of patients with dementia leading to behaviours that are need-driven (Chenoweth et al., 2009; Kitwood, 1997). Behavioural and psychological symptoms of dementia (BPSD), also referred to as neuropsychiatric symptoms, are a diverse group of non-cognitive symptoms and behaviours that occur in patients with dementia (Cerejeira, Lagarto & Mukaeova-Ladinska, 2012). These symptoms correlate with the degree of functional and cognitive impairment. Delivery of care in dementia patients is therefore often complicated by the presence of BPSD, which includes agitation, aberrant motor behaviour, anxiety, elation, irritability, depression, apathy, disinhibition, delusions, hallucinations, and sleep or appetite changes (Cerejeira, Lagarto & Mukaeova-Ladinska, 2012).
These issues place carers in difficult and stressful positions, and also lead to distress and institutionalisation of patients with dementia. Therefore, there are specific issues that should be considered when providing, or aiming to provide, person-centred care. The degree of care provision is dependent upon the individual with dementia. This process is driven by the carers' ability to observe the person's expression of well-being and, based on that, ability to evaluate the degree of person-centred care to be offered. This detailed observation and evaluation of a person's well-being by carers assists during the process of planning, implementation and assessment of person-centred care (Chenoweth et al., 2009).

In achieving person-centred care, there are several considerations to follow in dementia care (Alzheimer's Society, (n.d.); Alzheimer's Australia, 2003; NICE, 2006). These include:

- viewing the person as an individual – this means shifting the focus from their disease as well as lost abilities as a result of their disease;
- viewing the person as a whole – this means considering the individual person's preferences, interests, needs, qualities and abilities instead of focusing solely on managing their symptoms;
- making the person an equal partner in health care – this involves empowering the patient in the decision-making processes around their health;
- getting to know the person – this means knowing about the person's life, history, family and values;
- treating the person with dementia with dignity and respect – this involves recognising and encouraging the person's unique strengths during their management and treating them with courtesy at all times;
- taking into account the person's cultural and religious beliefs.

In addition to the above individual considerations that assist dementia carers in achieving person-centred care, the Health Foundation (n.d.) outlines that person-centred care can only be achieved when:

- Staff possess adequate knowledge and skills to provide person-centred care.
- There are systems and processes designed to facilitate staff to act in a person-centred manner, and respond to service users' needs and preferences.
- People who use and those who provide the service, co-design and co-produce it, enable support for person-centred care.
In 2010, the Victorian Department of Health issued keys to delivering person-centred care for persons with dementia in their publication regarding good practice for dementia care. These are summarised in Table 8.1.

<table>
<thead>
<tr>
<th>PERSON WITH DEMENTIA</th>
<th>CAREERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care should understand the person’s behaviour in relation to their unmet needs</td>
<td>Carer-person relationship is the key</td>
</tr>
<tr>
<td>Care should not be physical focused only and it should involve the whole person, including their social, cultural and individual identity</td>
<td>Carer has good information about the person during their care and shares this information with the management in order to develop appropriate strategies</td>
</tr>
<tr>
<td>Care should acknowledge person’s unique interests and life stories</td>
<td>Carers are in touch with their own concerns and feelings</td>
</tr>
<tr>
<td>Care should acknowledge person’s abilities, interests, preferences, values and spirituality</td>
<td>All staff are able to become experts in dementia care</td>
</tr>
</tbody>
</table>

A person-centred care approach reduces behavioural and psychological symptoms of dementia patients, and it also facilitates maintenance of patients’ personhood (Edvardsson, Winblad & Sandman, 2008). Person-centred care not only enables the person to become a partner of the interprofessional health care team, but also a key driver enabling the achievement of the best health outcomes for the person. In general, person-centred care provides benefits in terms of care experience as well as operational benefits. Engagement of various stakeholders (e.g. health care providers, patients, families) in care based on partnerships results in better quality and safety of health services provided, decreased cost and increased satisfaction of patients and other stakeholders involved (ACSQHC, 2010). Decreased length of hospital stay, decreased staff vacancy rates and an increased rate of hospital discharges have also been reported as a result of the person-centred approach (Stone, 2008).

Literature has also reported that person-centred care results in decreased infection rates and medication errors (DiGioia, n.d.), and improved clinical care (Jha et al., 2008) and functional status (Flach et al., 2004). Improved chronic disease management has also been reported (Stewart et al., 2000; Bauman, Fardy & Harris, 2003).

Specific clinical benefits of a person-centred care approach in patients with dementia have also been reported. These benefits can be non-pharmacological
and pharmacological in nature (e.g. reduced agitation and anxiety as well as reduced use of antipsychotic medications). The Caring for Aged Dementia Care Resident Study (CADRES), which was a cluster randomised clinical trial of 324 people with dementia, reported that as an intervention, person-centred care significantly improved agitation compared to usual care (Chenoweth et al., 2009). A reduction in agitation of nursing home residents was also reported by Cohen-Mansfield, Libin and Marx (2007) through the introduction of a personalised care technique based on individual residents’ needs (Cohen-Mansfield, Libin and Marx, 2007). In addition to agitation, anxiety can also be reduced through staff training on person-centred care in relation to specific individualised bathing practices for patients with dementia.

Similarly, a reduction in use of antipsychotic medications for the management of behavioural and psychological symptoms of residents with dementia has also been reported in a cluster randomised study by Fossey et al. (2006). The use of antipsychotic medication in patients with dementia is still a debatable and complex issue as their benefits are modest at best for these patients and their use is justified only in limited situations. Approximately 80% of people with dementia receive antipsychotic medication for behavioural and psychological symptoms (Hosia-Ranell & Pitkälä, 2005). Antipsychotics use in people with dementia has a number of adverse effects leading to deterioration of health and, furthermore, is associated with an increased mortality in this patient group. A recent Alzheimer’s Australia report titled The Use of Restraints and Psychotropic Medications in People with Dementia has highlighted the negative consequences of using antipsychotics in patients with dementia, including the fact that these drugs are not always appropriately prescribed with evidence suggesting their misuse in patients with dementia (Peisah & Skladzien, 2014). Therefore, as also highlighted in Figure 8.1, a person-centred care approach may reduce dementia patients’ mortality through reduction of behavioural and psychological symptoms, such as agitation and anxiety, and reduction of antipsychotic medication use.

Relationship-centred care

The importance of relationships and interactions to persons with dementia is clearly articulated in NICE guidelines (2006) reflecting good practice care in dementia. It is an imperative in dementia care to recognise the needs of carers, and to also consider ways of supporting and enhancing their input to the
person with dementia (NICE, 2006). Beach and colleagues argue that there are a number of functions that take place within the context of relationships and these include information exchange, diagnosing, prescribing (i.e. choosing treatment), resource allocation and assessment of care outcomes (NICE, 2006). In the general context, these authors propose that relationship-centred care is built upon four major principles:

1. Relationships in health care ought to include dimensions of personhood as well as roles. This principle acknowledges the fact that health care providers and patients have their own experiences, emotions and values, which should be recognised.

2. Affect and emotion are important components of relationships in health care. This principle acknowledges the need for health care providers being encouraged to empathise with the patient. Affect and emotion are, in fact, central to developing, maintaining and terminating relationships.

3. All health care relationships occur in the context of reciprocal influence. This principle acknowledges the interactional exchange between health care providers and patients. This principle points out that the relationship
should not be one between unequals, where health care providers are the 'experts', but rather reciprocal and based on attainment of virtue.

4 Relationship-centred care has a moral foundation.

The value of relationships in the context of person-centred care in dementia has been emphasised and initially articulated by Kitwood (1997), who used the term by emphasising communication and relationships during the process of dementia care. It can be argued that person-centred care is a by-product of nurtured and reciprocal relationships, close collaborations and effective communications between health care workers and carers involved in the care process, including the person (Figure 8.2).

Patients with dementia are key stakeholders in health care delivery and their effective collaboration with health care providers is established on their strong relationship and ultimately mutual trust. Of great importance is also the relationship between various health care providers with diverse expertise, as well as the relationship between these health care providers and dementia carers, including family. These relationships are nurtured by effective collaboration for the patient with dementia. In fact, the relationship is also dependent on collaboration outcomes.
Collaboration and, therefore, relationships between health care providers are of high importance in IPP. Previous studies have reported that relationships between health care teams have direct benefits on patient outcomes (mortality ratios) (Knaus et al., 1986; Zillich et al., 2004). Theoretical frameworks have been developed to evaluate the doctor–pharmacist relationship. Models, such as the Collaborative Working Relationship and the Pharmacist–Physician Collaborative Index, were developed to evaluate the extent of collaborative relationships of health professionals (McDonough & Doucette, 2001; Snyder et al., 2010). While these models assist in assessing the relationship, the agency theory can assist in understanding the relationship between the patient with dementia (i.e. principal), as well as health care providers and carers (agents), who in fact perform actions (as agents) on behalf of the patient (the principal). The agency theory was used in the context of drug selection by Mott, Schommer, Doucette and Kreling (1998) and then in the area of prescribing by Hoti, Hughes and Sunderland (2011) and Hoti, Forman and Hughes, 2014. Its principles can be applied in dementia care given that the theory predicts that information asymmetry is reduced when agents have more information about their principal. This is relevant in person-centred care since one of the reported strategies to person-centred care relies on the information that carers and health care providers have about the patient with dementia that assists in care planning (e.g. history, routine) (ACSQHC, 2010).

While recognising that relationships between health care providers are important, in relationship-centred care the relationship between the patient and health care providers is central (Beach, Inui & the Relationship-Centered Care Research Network, 2006). In dementia care, relationship is closely affiliated with interaction between the patient and carers, and clearly in person-centred care there is a special focus on the interaction, and hence relationship, between the person and people involved in their care. In this regard, Kitwood (1997) identified 10 types of interactions specifically related to dementia care:

1. Recognition involves acknowledging the person with dementia such as greeting by name.
2. Negotiation involves acknowledging and consulting dementia patients’ preferences.
3. Collaboration involves carers and patients with dementia working together.
4. Play involves allowing patients with dementia to express themselves and be spontaneous.
5 Simulation is an interaction in which senses are the key focus. In this context it means sensuous or sensual interaction, which includes aromatherapy and massage.

6 Celebration is an interaction that involves experiencing the joy of carers and patients with dementia.

7 Relaxation is an interaction that involves provision of an environment enabling relaxation.

8 Validation involves recognising feelings and emotions of patients with dementia, and responding at an appropriate level.

9 Holding involves providing a safe psychological space enabling expression of dementia patients' feelings such as grief, anger or fear.

10 Facilitation involves interaction that enables the patient with dementia to do things that they are not otherwise able to do as a result of their functional or cognitive decline.

Interprofessional consideration of person-centred care in dementia

As highlighted above, care of patients with dementia is complex, with its own characteristics due to the progressive nature of the disease and the array of symptoms, functional and cognitive disabilities displayed. Care needs to address a range of daily living activities, including mobility, toileting, oral health, grooming and safety. There is also a range of discomforts, including pain, incontinence, malnutrition and drug misadventures, such as adverse effects and drug interactions (Edvardsson, Winblad & Sandman, 2008; Nair, 2006). Patients with dementia also have a spectrum of psychological basic human needs, including feeling of safety, sense of belonging and acceptance, socialisation, need to be respected and sense of contribution. (Edvardsson, Winblad & Sandman, 2008)

The above specifics of dementia care highlight the need for involvement of multiple health care teams with diverse expertise in the cycle of dementia care. In this regard, an IPP approach is crucial given that it improves effectiveness and safety of care (Chapter 2 of Greiner & Knebel, 2003). IPP is a partnership that involves care delivery by a range of diverse health care workers working collaboratively, with a focus on the patient, while sharing the decisions and overall care of the patient (Canadian Interprofessional Health Collaborative, 2010). Uniprofessional health care delivery is becoming increasingly less viable, given the rise in prevalence of chronic conditions (Dunston et al., 2009). Dementia too is projected
to increase in prevalence, with numbers in Australia estimated to increase by one third in less than 10 years to 400,000 cases and with World Alzheimer's Report 2010 estimating a rise from the current 36 million global cases to 115 million by 2050 (Alzheimer's Australia, 2003; Wimo & Prince, 2010). Australian health providers are increasingly recognising and employing IPP as a way of delivering person-centred care (Steketee et al., 2014). Tertiary education providers are also placing an emphasis on interprofessional education (IPE) for health students. Successful integration of students in IPE teams and positive student experiences with an attitudinal shift towards IPE and IPP have also been reported (Hoti, Forman & Hughes, 2014).

Person-centred care interventions, resulting in both pharmacological and non-pharmacological benefits, are important from the IPE and practice point of view as they allow integration of an increased number of health practitioners with varying expertise within interprofessional teams, including nurses, psychologists, doctors, occupational therapists, speech pathologists, physiotherapists and pharmacists. A more detailed discussion of the integration of these health practitioners in interprofessional teams is given in the following case study.

Thelma is a 79-year-old lady diagnosed with Alzheimer's disease two years ago. Over the last couple of months, her condition has deteriorated with Thelma not being able to perform most of her basic daily activities. She was admitted to Harmony Keys Nursing Home two weeks ago, after her daughter Brenda, who is also her full-time carer, found it increasingly difficult and stressful to manage her mum on her own, especially her toileting and bathing. Prior to being diagnosed, Thelma also suffered from osteoarthritis, hypertension and incontinence.

Thelma's current medications are displayed in the table below.

<table>
<thead>
<tr>
<th>Description</th>
<th>Dosage</th>
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<tbody>
<tr>
<td>Aspirin 100mg tablets</td>
<td>1 in the morning</td>
</tr>
<tr>
<td>Paracetamol 500mg tablets</td>
<td>1 in the morning (refuses to take)</td>
</tr>
<tr>
<td>Doxycycline 50mg, with Senpra 8mg tablets</td>
<td>2 in the evening</td>
</tr>
<tr>
<td>Unnaedra 5mg tablets</td>
<td>1 in the morning</td>
</tr>
</tbody>
</table>

At 2 am, Brenda was called by carers of the nursing home as Thelma became very agitated, and was suffering delusions and hallucinations. They called her to see if she remembered her mother having similar behaviours before. Today, Thelma is still agitated, although her delusional behaviour and hallucinations seem to have settled.

The Harmony Keys Nursing Home has recently adopted an IPP policy and, as a result of this practice, Thelma is today being assessed by an interprofessional team consisting of a doctor, nurse, pharmacist, physiotherapist and speech pathologist.
There are two key questions about Thelma’s care pathway that currently arise from the team:

1. What profession-specific recommendations can be made for Thelma’s current situation?
2. What would an interprofessional care plan for managing Thelma’s current situation consist of?

The interprofessional team management

Profession-specific recommendations would vary, given the diverse expertise of the doctor, nurse, pharmacist, physiotherapist and speech pathologist. From an IPP point of view, it is the prioritisation of recommendations (i.e. interventions) that becomes of crucial importance for Thelma’s care. Involving Brenda is also important as it is one of the steps needed to deliver person-centred care for Thelma. This is the first time that Thelma has experienced these symptoms; therefore, the information that Brenda, her daughter and long-time carer, provides is highly relevant. After consulting Brenda, the team finds out that Thelma has never displayed this sort of behaviour at home and that she does not like taking multiple tablets. Each professional undertakes their own assessments then presents their findings to produce an interprofessional care plan, as shown in Figure 8.3.
From Figure 8.3, we can see that Thelma's behavioural and psychological symptoms in dementia symptoms are being caused by undiagnosed or undertreated pain. Some of the profession-specific recommendations, such as increasing paracetamol dose or adding a new analgesic, although relevant, are therefore not included in the current actions in the interprofessional care plan to manage Thelma's pain.

By working collaboratively, the health care team is informed and their final recommendations influenced by each other when designing an interprofessional plan (e.g. increasing the number of paracetamol tablets to reach the optimum dose, or changing it to a higher slow release formulation, becomes less attractive as a first choice given that the speech therapist has recommended crushing medications). In a person-centred approach, which includes the patient's carer/family and also considers the person’s needs and preferences, information provided may also influence the interprofessional decision-making process (i.e. Thelma does not like taking multiple medications, which can also influence the decision as to whether to increase the paracetamol dose or add a new analgesic, in addition to other clinical reasons such as potential adverse effects).

Conclusion

This chapter has emphasised the relevance of providing person-centred care and relationship-centred care in patients with dementia. The achievement of patient care is described through revisiting key principles and interactions involved in achieving person-centred care. An interprofessional model designed and trialled in practice has been provided to illustrate the integration of various members of the health care team while ensuring that the patient remains the focus of interprofessional care.

Self-directed learning activities

1 How would you achieve person-centred care at Harmony Keys Nursing Home?
2 What key activities would you consider, both profession-specific and interprofessional, while ensuring patient-centred care is maintained at Harmony Keys Nursing Home?
3 How could you strengthen collaboration within a nursing home with a view to providing patient- and relationship-centred care?
1 Review the principles recommended in the provision of person-centred care.

2 Check out the recommended websites to further explore the relevance of person-centred care in patients with dementia.

3 Consider the interprofessional model described in this chapter, and the advantages of and barriers to applying a similar model in your residential aged care facility (RACF).

4 Review the characteristics of patients with dementia in your RACF and consider how these characteristics affect the provision of patient-centred care.

References


