

# Person centred care essay



**ASSIGN  
BUSTER**

Briefly describe the key principles of person centred care and demonstrate how you implemented person centred care in practice, Illustrate with examples. Use academic literature and the insight that it provides to inform your understanding of the key principles of person centred care.

Person centred care can be viewed in many different aspects. The eight key principles of nursing practice found by the Royal College of Nursing (2011) include, dignity, responsibility, safety, choice, communication, skills, teamwork and being able to influence in a positive way. Although Nolan (2001) argued that concepts of successful ageing, health-related quality of life and person centred care overvalue autonomy and independence, which are values which may disadvantage the older generation in society. Also despite research by Davies et al (1999) indicating differences between patient and staff views, the aspects of person centred care identified in Corring and Cook's (1999) study are very consistent with the principles of person centred practice identified in the majority of the literature reviewed.

For the purpose of this assignment I will explore two of the key principles of nursing practice in depth whilst illustrating examples of how I have implemented person centred care whilst being on placement.

There are many definitions of person centred health care in the literature. This can be seen by The Victorian Department of Human Services (2003) as they define person centred care as ' the treatment and care provided by health services that places the person at the centre of their own care and considers the needs of the older person's carers'. Then again, Brooker (2009) also defines person centred care as treating people as an individual,

regardless of any disability or illness the person may have and also to be able to view the world from the individuals perspective, taking into account their disability or illness which they may have.

The overriding idea of person centred care should have a combined and respectful rapport between the service provider and the user. The service provider should appreciate the impact the service user can make to their own health, such as their beliefs, ambitions, past experience, and knowledge of their own health needs. Likewise, the service user should also appreciate the impact the service provider can make, including their professional expertise and their knowledge of the options available to the service user, whilst being able to voice their own beliefs and experience when appropriate. Together the service provider and service user are important in this rapport as neither is interchangeable and the experiences of one cannot be generalised to another.

Person centred care arose from a number of different theorists however, Rogers (1970), whom was a humanistic psychologist and is best known as the founder of client centred therapy agreed with the main assumptions from that of Abraham Maslow. Lane (2000 p311) suggests Rogers theory was that ‘ no one can make decisions for another, act for them or solve their problems — because these are matters of personal responsibility and choice’.

Maslow (1943) stated that ‘ people are motivated to achieve certain needs. When one need is fulfilled a person seeks to fulfil the next one, and so on’. He came up with a hierarchical pyramid which included five motivational needs for each individual to ‘ grow’. This five staged model is divided into

basic needs, safety needs, social needs, esteem needs and self-actualisation. Rogers agreed by adding that for a person to 'grow', they need an environment that provides them with genuineness, acceptance, and empathy.

From the RCN (2008) it is clear that principle A focuses on dignity, equality, diversity, and humanity. This can be seen as the initial point for any person who works within the nursing team, regardless of their grade, role or authority as it is seen to be essential to provide the patient with the basic needs. According to the RCN (2008) the issue of supporting and preserving the dignity of patients was seen as 'the most fundamental aspect of care'.

The RCN's (2008) definition of dignity is seen to be the 'foundation of excellence in nursing practice'. The definition is concerned with how nurses care about individuals by how they support patient autonomy and choice (Barker 2000).

The Equality Act 2010 is an updated law aimed at an attempt to stop discrimination and to help try encourage equality throughout society. The care environment should benefit from this improved equality act by ensuring certain groups of people within the healthcare who receive a worse service compared to the rest of the community receive equal opportunities. Under the Equality Act 2010, individuals are formally protected against the harm of discrimination on the grounds of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity status, race, religion or belief, and sex and sexual orientation.

As I was placed in an acute surgical ward in a hospital for my first semester placement, I have practiced this principle throughout my work by taking control and understanding a patient's dignity and privacy. When admitting a patient in triage, one of the questions in the documentation of the process of admission is about the skin. This involves ensuring there is no broken skin or pressure sores for example. As elderly people and people in wheelchairs are more prone to getting pressure sores or skin breaks on their bottom, it is a nurse's duty of care to inspect this. However, to maintain the patient's dignity and privacy I had to gain consent of the patient to do this by simply asking them.

Also I had to explain why I was doing this which could have helped the patients understanding and they may have been more reluctant to do so. This process is necessary for elderly people and people in wheelchairs as they may be more inclined to avoid this so they may have lied about any sores or felt embarrassed. However, it would not be appropriate to assess everyone as some people you could take their word and record it as 'patient has stated their skin is healthy with no sores'. This would be acceptable. Also, as part of maintaining a person's dignity and privacy, it is important to pull the curtains but also it is highly important to remember that the curtains only block out what others can't see but it doesn't block out what others may hear. This must be considered when asking personal questions.

Another illustration of dignity I was able to show throughout my practice was the testing of urine samples. It is important to test every patient's urine when they are admitted in hospital as it determines a pathological changes in a person's urine. Urinalysis is an extremely valuable tool for diagnosis and

screening. It is cheap and simple to perform and can indicate a variety of disorders and diseases (Wells, 1997). It is also necessary to do a pregnancy test for every woman under the age of 55. This is personal information so it is very important not to discuss with any other patient or any other staff member whom is not involved in the patients care.

I showed equality throughout my practice by not judging or showing prejudice towards the patients on the ward as there was a huge variation of ages, religious attitudes, cultures, race, sex and disabilities and even to reasons why people were admitted into hospital despite my own values and beliefs. However I understood that some people had disabilities such as eye impairments or hearing impairments, this meant that when I gave out meal cards I had to spend a bit more time with certain patients as they weren't capable in completing them on their own.

Another key principle of nursing practice is principle E which focuses on communication, handling feedback, record keeping, reporting and monitoring. According to the Essence of Care (2010) communication can be defined as ' a process that involves a meaningful exchange between at least two people to convey facts, needs, opinions, thoughts, feelings or other information through both verbal and non-verbal means, including face-to-face exchanges and the written word.' Communication should be adapted to meet the needs of patients. This may include the consideration of a patient's emotional state, hearing, vision, any other physical or cognitive abilities and developmental needs, as well as their preferred language and possible need for an interpreter and translator.

Nurses assess, record and report on treatment and care, handle information sensitively with confidentiality and are conscientious in reporting the things which may come as a risk. Without having communication, it may prevent people in relating to each other and prove difficult to make their needs and concerns known or make sense of what is happening to them. Information that is accessible, acceptable and accurate and that meets patients' needs, should be shared consistently. The importance of principle E is demonstrated when things go wrong. The National Patient Safety Agency (2007) suggested that communication difficulties as a major factor which affects patient outcomes. Many problems included unclear documentation. Nurses are required to maintain up-to-date and accurate records of assessments, risks and problems, care, arrangements for ongoing care and any information provided (Nursing and Midwifery Council (NMC) 2010a).

' Record-keeping by nurses is supposed to be an integral part of practice, not ' an optional extra to be fitted in if circumstances allow'' (NMC 2010a). By using documentation as the main method of communication at shift handover has resulted in many improvements in the quality of nursing records. To help ensure the records are accurate, nurses are encouraged to ' Do it. Document it' rather than write notes at the end of a shift (Tucker et al 2009).

Handing the care of a patient over to another clinician requires good communication and co-ordination. Incomplete or delayed information can compromise safety, quality and the patient's experience of health care (British Medical Association (BMA) 2004). This I have shown throughout my practice as when admitting a patient, the hospital I was based offered a

referral to a dietician. Sometimes it is appropriate to refer a patient to the dietician without being offered due to their health or safety. When I took a patients BMI score, I found it to be below 18. 5 which is suggested to be below average. However, not everyone would need a referral just from this information, the patient specifically said she had a problem with eating as they were never hungry and could go days without eating and I could see that they were severely thin. I then asked my mentor for advice and from there she was able to fill in the form to be sent to the dietician and also she phoned to discuss the issues and details of the patient.