To change perspective

– a study circle about person-centered care

NEUROcare - Sri Lanka

Capacity building in Higher Education

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Together we shape the care of the future

Many patients feel that they are not listened to, that their care is missing continuity, and that it does not hold together. Many of us who work in healthcare feel that we do not have sufficient opportunities to do our job according to our professional ethics and our inner compass.

So, what is wrong? Is it just a lack of resources, or does it have something to do with our working methods, our work organization and the relationships between healthcare staff and those we meet who need care?

The most successful way to meet the health challenges that exist in the population, is to have person-centered care with equal health as the overriding goal. A person-centered working method gives us a better care environment. When trust increases, care outcomes improve, resources are used more efficiently, and both patients and staff will be happier. But changing to person-centered care requires effort and courage because in many ways it provokes the way that healthcare and its affiliated organizations, hierarchies, and control systems work.

We must dare to challenge ourselves – our professional identity, our self-image, our vision on the patient and our relationships with other professional groups. Together we can build up more knowledge and experience around person-centered care and contribute to the comprehensive care that is needed.

If you are reading this, you have already come some way towards developing new knowledge of person-centered care. We hope that you, along with your colleagues who participate in the study circle, will gain a deeper understanding and new thoughts to develop yourself and the care given.

We have great opportunities to influence the caregiving of the future. Now we can change the perspective!

This material is based on a Swedish Study Circle Material produced by the Association for Care (Vårdförbundet) in Sweden. We are grateful that we as members of nEUROcare have received their permission to translate and adapt the content to suit the purposes of Sri Lanka. Our hope is that the Study Circle Material will be useful and contribute to a changed perspective and increased focus on Person-centered Care.

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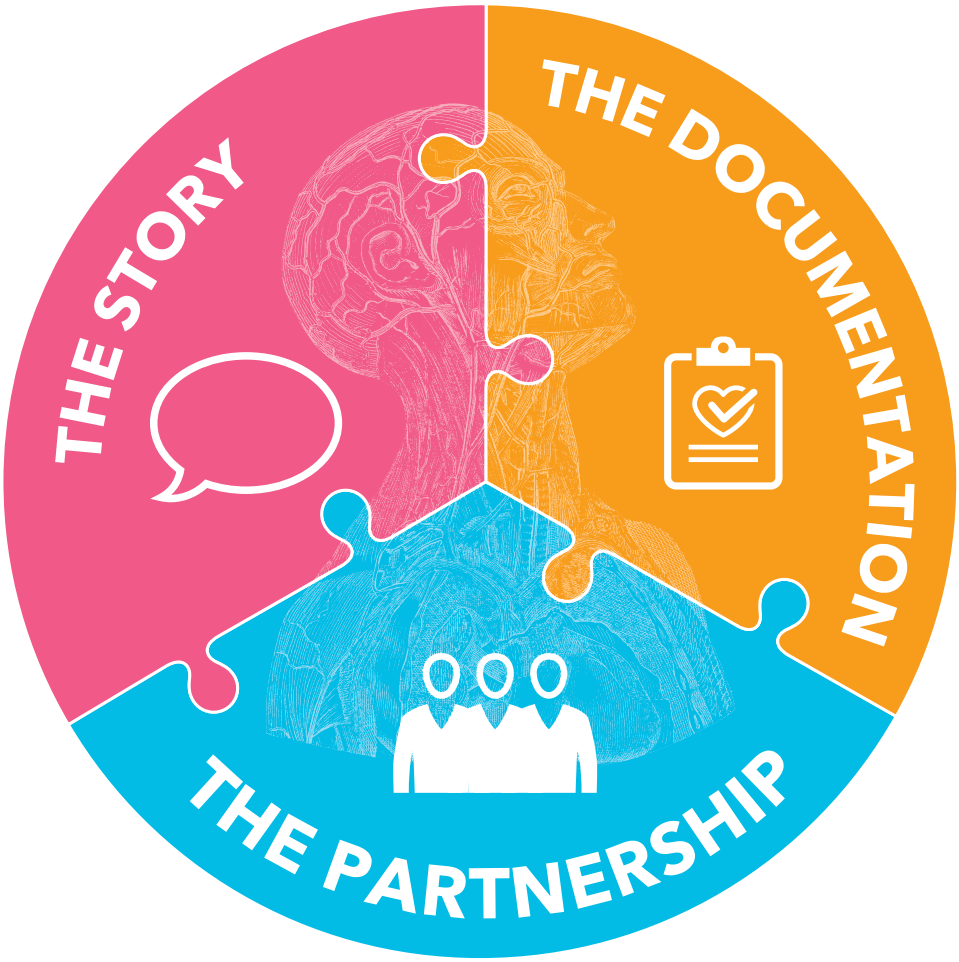


The structure of the study circle

We will meet each other a few times to familiarize ourselves with what person-centered care is. We will get to know the ethical and philosophical foundations and we must reflect on the changes the person-centered care implies and requires.

The fact that we meet in a study circle means that we learn from and together with each other. Everyone has experiences, thoughts, and ideas to contribute with. The theory must constantly be reflected in the practice we find ourselves in and in conversations that take part with other participants. The study material contains texts and suggestions for exercises and conversation questions to inspire good conversations where everyone is involved.

The study circle needs a leader to hold it all together. The circle leader is a member of the group. The role of the leader is not to be a teacher and lecturer. The task of the circle leader is to lead the learning process forward. The circle leader is also responsible for ensuring that everyone who wants to will be allowed to speak and that the group sticks to the topic. The last pages in the study material turns to the circle leader and gives tips on study circle methodology.

At the first meeting, we start by getting to know each other and the material, setting up individual and common goals and agree on how the study circle should work.

Together we can achieve something in practice!

Section 1. Health and wholeness, professional identity and professional ethics

All people have the right to live in a society that promotes health, with access to a good, safe and well-functioning care. In today's care, the focus is usually on "disease and diagnosis" instead of health and wholeness". We begin this study circle by devoting time to thinking about how care works today, how we ourselves see on our professional identity, our work environment, and our professional ethics.

Health and wholeness – the basis of care

The traditional approach in healthcare is that healthcare professionals should "treat patients" or "do something for them", rather than "meet people" and "do something together with them". Since the entire system often is structured based on those starting points, it becomes difficult to include the patients in the decisions. And the goal for patients is often seen solely in terms of individual clinical outcomes, instead of the aim of improving health. It is also what is measured in healthcare today. But what do those results really say about who the patient is and how their health is?

Person-centered care is based on a holistic approach, which considers the whole person – not just one narrow focus on its disease or symptoms (patient), but also the person's abilities, will, health, well-being, and their social and cultural context (the whole person).

Introducing person-centered care therefore requires fundamental changes both in how work is done, how care is organized, and the traditional roles. This applies to both the roles of the health-care staff, the roles of the managers, and the patients' roles. New relationship patterns are required between patients, healthcare staff, managers, and healthcare teams. It also requires new ways of looking at the governance of care.

Person-centered care in brief

There is no uniformly established definition of the term "person-centered care".

However, there are some starting points that are common to person-centered care:

- That care is based on the unique person and their right to health.
- That the care demands the person's abilities and is activating.
- That the care is coherent.
- That the care always meets each person with dignity, compassion, and respect.
- That the care is based on a fundamental ethical approach.

From what to who – when the patient becomes a person

The person-centered care is coherent and based on each person's abilities, wishes, and needs. Person-centered care is planned based on the person's entire life context.

To begin with, what does the term mean? The following example is a definition of the terms patient and person from Wikipedia and Wiktionary:

Patient: *A patient is an individual who is in contact with the healthcare system to receive a diagnosis for their problems or treatment for any disease. The word comes from the Latin pati, which means "to suffer" or "endure".*

Person: *In personalistic philosophy, "person" is a holistic view of the human being with both physical and spiritual aspects included. The word person comes from the Latin persona, "man", "character", "personality", "role", originally "face mask".*

To be able to approach the question of personal identity and capture what is specific to a person you must cross the threshold between describing what you are, to telling who you are. Today, care is often based on the question "what?" - Disease, diagnosis, treatment. Person-centered care is instead based on the question "who?" - The whole person and their life situation.

> *"Patient" is a role that I have in particular contexts. When I step out through the door to the health center, I also step out of the role of patient.*
>
> *I am always a person. I have an identity. I am unique and irreplaceable.*
>
> *I am not something, I am someone. Even so in my meetings with healthcare. A person is not a passive recipient, a person is a capable and co-creative human being.*

Reflect and discuss

- Do you have your own experience of being treated as "what" when you expected to be treated as "who"? How did it feel? Think for a moment. Then discuss in pairs. If necessary, then share briefly in a "round" with the group.
- Can you tell us about an experience when a patient suddenly became a person for you? Discuss in pairs. If necessary, then briefly share in a "round" with the group.

Your professional ethics and professional identity

Person-centered care is based on ethics and requires ethical competence. Courses and books on ethics can give us a foundation with theories, concepts, and models. But ethical competence within healthcare is also closely linked to daily operations – what you do, how you manage the care situation or the organic material, how you treat patients, relatives, colleagues, and other professions.

What is professional ethics?

Our codes of professional ethics state, among other things, that you as a professional:

- Shall respect and protect the patient's/person's integrity and dignity.
- Have responsibility for developing your skills and knowledge.
- Shall respect the knowledge of other professionals and follow laws and regulations if these do not conflict with professional ethics.
- It is also included that you must work to improve and develop public health in society, nationally and globally.

Professional identity

Professional identity can be described as a profession's shared identity that is created within its own knowledge area in combination with common norms and values – for example professional ethics. When we are talking about professional identity, it can be perceived as something static and unchanging: it looks as it did as when you acquired it. But if we instead see professional identity as something that is continuously shaped through action and reflection, we get a picture of something that is in constant development and change.

Identity can be seen as a process rather than an attribute. In this way, we can explain why a group's identity can change over time and why a group's identity is not always perceived as the same by two people.

What is a profession?

Approved by the community (credentials and exams)
Common theoretical basis
Has a developed professional ethics – action ethics
The profession gathers in its own associations – organizations

Reflect and discuss

- What do professional ethics mean to you in your everyday life?
- What is professional identity for you?
- How does your professional identity affect teamwork?
- What in your professional identity are you particularly proud of?
- Can you give examples of how your professional identity has developed? What was behind the change?

First think privately for a while. Feel free to make a note for yourself. Then talk in pairs about one question at a time. In the large group, bring up what you found most interesting in the conversations and share with the whole group.

Health care environment – your work environment

Our work environment and the environment the patients encounter in care are dependent on the conditions we must perform our work in. For example: arrangement of working hours, opportunities for rest and recovery, salary, holidays, and continuing education. But the care environment is also highly influenced by our attitudes, our working methods, and our organizational culture. Those who have changed to working person-centered state that their job satisfaction has increased and that the care environment has improved.

To see how healthy your workplace is, you need to examine which approaches and which prevailing culture exists. The culture of the workplace manifests itself in, among other things, through the staff's approach to patients and relatives, but also in the staff's attitude towards each other. For person-centered care to be able to become a reality, all relationships need to be based on a person-centered approach – even the relationship between manager and employee and the relationships between employees.

What mindsets, thought systems, ideas, and reasonings are dominant in a workplace and which controls how you work? What do you see as true, right, reasonable, and desirable? Which arguments count or which, in any case, comes first?

Sometimes there are conflicts that are based on different points of view that may have to do with, for example, different educations, professional roles, and management philosophies.

Reflect and discuss

- In what way does your work environment affect the patient?
- What "unspoken rules and attitudes" govern your workplace and how does it affect the care environment?

Until next time

Read through the text in section 2.

Section 2. The essence of person-centered care – the philosophy

During this meeting we dedicate ourselves to going in depth and examining the importance of philosophy for person-centered care.

What is philosophy and why is it important for person-centered care?

Philosophy is the study of pure thinking and questions of right and wrong, true or false. Using philosophy makes it easier for us to navigate life. Philosophy can also be difficult to absorb because it can challenge beliefs and attitudes that we have acquired throughout life.

The word philosophy comes from the Greek words *philos* and *sofia* which together means "love of wisdom". Philosophy is to the highest degree a science.

Thus, philosophy is an important core of person-centered care. It is not just "a new model" that is possible to apply to the current business, it is an ethical approach.

"An ethical approach" can be described as people's way of being and acting – an effect of knowledge and skills. It is a balance between common sense, ethical principles, intuition, conscience, and the actual actions and their consequences. An ethical approach requires reflection and thought.

Four ethical principles

Person-centered care is based on a view of humanity based on four ethical principles:

1. **Autonomy** – Each person's right to choose their own path in life.
2. **Dignity** – Self-esteem. An expression of respect for other people with the same rights and obligations like myself.
3. **Integrity** – Not to hurt, harm, destroy or change other people's lives, but to respect and protect the person's wholeness and unity, the person's life context and life history.
4. **Vulnerability** – Vulnerability makes us human. It is not a defect but an important part of the human condition.

These principles are mutually related to each other. They are inspired by the French philosopher Paul Ricoeur's thoughts about the relationship between healthcare professional and patient as a "professional friendship", a mutual trust between patient and professional, where the vulnerability of the capable person is affirmed: the human being is simultaneously strong and weak, simultaneously acting and suffering.

Marja Schuster, Finnish nurse who researches professionalism, gives in her doctoral thesis (Profession and existence, Daidalos, 2006) an example: "Being professional is about leaving the private space to enter the professional room, with the door open to the personal room".

Reflect, mingle and discuss

- What do the four ethical principles mean to you in your professional practice?
- Imagine that each of the four corners of the room is a conversation place for one of the principles (agree on which principle is dealt with in which corner).
- Go to the meeting place/corner where the principle you are most interested in is being discussed. Feel free to move between the corners to also talk about the other principles.

Reflect and discuss two and two

How do you understand Marja Schuster's example with the different rooms connected to the four ethical principles?

The framework for the person-centered approach

Ricoeur summarizes the meaning of ethics as: "a pursuit of the good life with and for others in justice institutions. It can also be said to be the framework for the person-centered approach."

A pursuit for the good life. What the good life is for the individual person. Sometimes the patient is so sick and helpless that the healthcare staff must strive for what the good life may be, but most patients can take an active part in pursuing what feels like the good life.

With and for others. In person-centered care, the starting point is that all people have a will, abilities, and needs. Health care professionals can pay attention to and strengthen a person's abilities, just like we can neglect and thereby diminish a person's abilities. In the person-centered approach the partnership between the patient and the healthcare staff is emphasized. In this relationship, we are creator and co-creator alike of meaning itself. In our professional role, we can contribute to the person's insight into their own abilities. In the relationship with the patient, we can strengthen the person's self-esteem and self-understanding.

Within justice institutions. All people should be equal before the law and must have the opportunity to exercise influence and demand responsibility over decision-making. A well-functioning state administration with responsible institutions, transparency, and the principles of the rule of law all have a fundamental intrinsic value.

The goal of health care is good health and care on equal terms for the whole population. Care must be given with respect for the equal value of all people and the dignity of the individual. Those who have the greatest need for health care must be given priority for care.

These parts of Ricoeur's ethics do not feel alien to us who are professionals in healthcare, but they require reflection and constant conversations to keep the ethics ever relevant in everyday life.

Reflect and discuss

"The pursuit of the good life, with and for others, within just institutions." - Can you give an example of a difficult or challenging situation where these ethics guided you (without you phrasing yourself this way)?

Until next time

Read through section 3. Capture and listen to stories in everyday life and let the storyteller be the focus. Talk with some colleagues about person-centered care. Practice listening. Bring your reflections to the next time you meet – please write them down.

Some key people and ideas

The roots of the person-centered approach are found in hermeneutic philosophy.

- *Hans-Georg Gadamer (1900-2002) described how medicine's amazing progress also had a price, when the specialization on body parts or diseases made it medical science, the patient as a person with a whole world of life got lost beyond sight.*
- *Paul Ricoeur (1913 - 2005) described "the capable man" and wanted with his ethics "working with and for others in fair institutions".*
- *Martin Buber (1878 -1965), presented the I-Thou relationship, where both parties in a relationship are fully present and the relationship takes place in the whole human being.*
- *The Rogerian person-centered psychotherapy has also been important for the development of person-centered care. In it, it is essential that the therapist shows warmth and empathy and is genuine. The person and the therapist build up an equal relationship.*
- *Ideas from care theorists such as Hildegard Peplau are also highlighted as significant with her description of the relationship between patient and nurse.*

PHOTO: EMMA EDBERG MATEI.

Gathering friends in a book can mean receiving greetings and visits from the other side of the world when you least expect it. Mr. A Anaramana has friends all over the world.

PHOTO: EMMA EDBERG MATEI.

The story gives a picture of the whole life situation and captures the person´s own driving forces, resources and abilities as well as emotional, social, and practical needs.

Section 3. Who are you and what is important to you?

Person-centered care is based on three basic parts: the story, the partnership, and the documentation. At this meeting, we will immerse ourselves in the story. It is only when a person tells a story that they fully emerge as a person with their own resources and needs.

The story – Time for the meeting

The prerequisite for person-centered care is the person's own story. Often, close relatives can contribute to the story. The story gives a picture of the whole life situation and captures the person's own driving forces, resources, and abilities as well as emotional, social, and practical needs. The story becomes the basis for how the care is planned and implemented.

Listening to the patient and their relatives is also important in short meetings. It increases security and makes it easier to take advantage of the person's own capacity. The healthcare staff listens actively and responsively to sometimes short fragments, and sometimes to longer and more coherent descriptions.

Today, time is seen as a negative cost in healthcare. Therefore, the time available for the meeting is often very limited. Today, it is also us – the healthcare staff – who set the agenda for what the patient must tell. Person-centered care means that we must change our perspective.

The meeting with the person needs to be systematized and given time. In the story, there is the person and not just the patient. In the story, the person has the opportunity to describe their life situation and living conditions and not just their illness and diagnosis. "Who are you and what is important to you?" We could, by these questions, receive important information for the care process.

Create meaning and context

Person-centered care is not talk therapy. At the same time, one must not neglect the effect it has when a person gets an opportunity to tell their story and, in that way, gain more knowledge about their own situation. In the conversation, we give the person support to see and reflect on their life situation. If we ask the right questions, we can contribute further to the person becoming aware of their own abilities and resources.

The narrative does not only have the function of handing over information. The story is part of the care where the person receives support in creating meaning and context. These are important components of the road to recovery. If recovery is not possible, the need to create meaning and context may be even greater.

The challenge with the story is to give the person time to express themselves, while limiting the conversation to the current care situation.

> *"Two truths approach each other. One comes from within, one comes from without and where they meet, you have a chance to see yourself."*
> **TOMAS TRANSTRÖMER, FROM "PRELUDIER II", 1970**
>
> *"In storytelling, we invent and discover ourselves – at the same time."*
> **BENGT KRISTENSSON UGGLA, 2012**

Reflect and discuss

- What do you think about the two quotes above? Do you yourself have experience of seeing yourself through your shared story?
- How can you give space for the story, for example in connection with telephone counseling, at the emergency department, during examination, when planning care?

The importance of getting to know the person's resources, driving forces and abilities

An ability can be a physical, mental, or social strength that supports or drives the person's health.

It can be the desire to achieve a level of physical activity, for example, to be able to run, to be able to fetch wood or water for the cabin, or being able to stand up in order to facilitate personal care.

An ability can also be more abstract or "soft". The love for one's grandchildren can be a driving force. Being able to pick up the grandchildren from preschool can be a very concrete goal in the health plan that can be created using the story.

We are not always aware of our own abilities. It is in the conversations – the story – that the healthcare staff should be curious and ask questions to find out what could be this person's driving force and this particular person's resources and abilities.

The capable man – Homo Capax

A person has abilities: will, dignity, confidence in one's own abilities and vulnerability, and in the relationships with others.

BENGT KRISTENSSON UGGLA, 2011

Reflect, practice and discuss

- What questions could you ask in a care situation, if you want the person's strengths, will, resources, abilities, and driving forces to be included in the story?

Think for a moment. Make notes for yourself. Then ask your questions to another course participant. Switch roles.

If you are a larger group, it can be advantageous to do this exercise in a "mingling". This is when you walk around the room and ask questions to those you meet. Ask questions that allow you to see their resources, abilities, and motivations.

- How did it feel to get the questions and answer them? (Each and everyone in the group tell how they felt).

To listen to the story

The story has a dual purpose. When the person is allowed to speak freely, we confirm that their perspective, experience, feelings, and judgment are important and significant.

You who listen to the patient get, in addition to relevant information for planning care, an idea of the person who seek care. An image that you need to be able to support the person in the resources and abilities that would be able to promote health.

The conversations begin with open questions:

- Tell me what happened?
- Tell me why you are coming here today?
- Tell us how it started?
- Tell me what you think is the reason?

Then, important questions can be:

- How does it affect your everyday life?
- What are your wishes and views regarding your care and care?

When you are unsure whether you have understood correctly, you follow up with questions such as:

- When you say ..., how/what do you mean?
- Do you want to put more words on...?
- Can you develop...?

Body language supports active listening; nods, eye contact, signaling openness, and interest.

Practice listening

Do an exercise in pairs in four dialogues where one talks about a problem and the other listens.

- First, the listener shows a clear disinterest.
- Then the listener shows a clear interest and listens in an active and supportive way.

Switch roles so that the one who told the story now becomes the one who listens and vice versa.

Talk afterwards:

- How did it feel when the listener showed disinterest? What happened in me then?
- How did it feel when I was listened to in a responsive way? What happened in me then?

To be enough

As healthcare professionals, we want to do our very best for the people we meet. We want the person to receive good and safe care and feel safe and respected based on their situation and their needs, regardless of background, health status, and care needs. Therefore, we begin by listening to the story which gives us the conditions to work person-centered.

Sometimes, we feel that time is not enough. Sometimes, there are other shortcomings that give us poor conditions to do a good job. This can give us a feeling of inadequacy.

This feeling of inadequacy can lead to stress of conscience. Stress of conscience is the stress that we can experience when we cannot do what we feel we should do.

We know today that those who have converted to a person-centered working method describe that the stress of conscience has decreased, and that job satisfaction increased. We are now also beginning to see the results of research studies that confirm this.

Working person-centered frees up resources that can be used to create a healthier care environment. How can we organize work so that we can listen to the story? What resources are needed to do the transition? There is no clear answer to this. But you can test how it feels to you as a professional to listen to the story and how it affects your experience of stress of conscience.

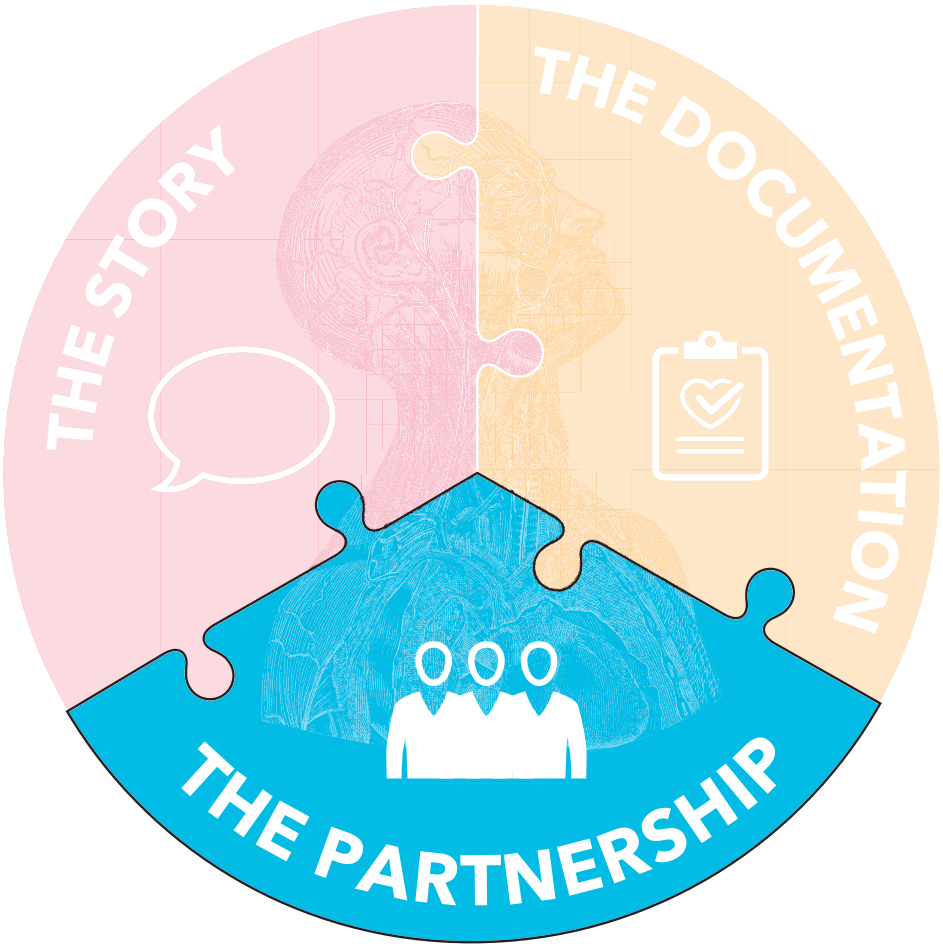
Reflect and discuss two and two

- What gives you stress of conscience?
- What does the stress of conscience mean to you in your everyday life?
- How do you think that person-centered care can be able to reduce situations of stress of conscience?

Until next time

Read section four about the partnership.

Pay attention to, listen to and ask about the person's abilities, resources, and motivations when you talk with patients, colleagues, relatives, partners, children, and friends.



Section 4. Real teamwork

Working in teams is nothing new in healthcare. But what happens when the patient becomes part of the team for real? And how do the relationships between the professionals change when we work in partnership in a team that is put together and can be changed based on the person's needs and abilities? We must devote ourselves to thinking about that at this meeting.

The collective knowledge of the team – a partnership

The partnership is the second of the three fundamental elements of person-centered care. The partnership is founded initially in the story and listening to it. Based on the person's story and the common picture of needs, resources, and abilities the team is put together.

The patient is the starting point for the composition of the team and is of course a big part in the team. Relatives can also be part of the team. The healthcare staff in the team can come from different units and different healthcare providers. Together in the team, an agreement is made on how care should be planned and carried out. It is documented in a personal plan.

In person-centered care, the patient is given both rights and responsibilities regarding their own care. This means that the person is seen as an active partner. The role of the healthcare staff is to contribute with their professional knowledge to the partnership and to engage the patient in a dialogue.

The partnership is about respect for each other's knowledge; on the one hand, the person's knowledge of themselves, their health problems, or what it's like to live with the disease, on the other hand the healthcare staff's knowledge of the disease, diagnostics, care, treatment, and rehabilitation.

Asymmetric encounters – patient authority and disadvantage

The patient is an authority based on knowledge of themselves. The patient's own story and active participation are basic prerequisites for care and treatment. So, for a consensus and an interaction to become a reality in the care meeting, the patient's authority must be self-evident. Person-centered care is based on a partnership between the various healthcare professions and the patient as a person.

To become aware of what the conditions look like for a partnership between the health care staff and the person, we may need reminding that such a relationship cannot be completely equal in the context of care.

The relationship between patient and healthcare staff is asymmetrical – uneven. The professional knowledge means a knowledge superiority, more power and thus more responsibility.

The patient's disadvantage can be described from three perspectives:

- **Institutional disadvantage:** The person is in a healthcare organization that is strongly hierarchical. The person is suddenly either at the bottom or almost at the bottom of the hierarchy.
- **Existential disadvantage:** The existential disadvantage is based on the vulnerability that is associated with being a patient, due to the sense of failing health, exposure, and vulnerability.
- **Cognitive disadvantage:** In the role of patient, one finds themselves in an unavoidable state of disadvantage of knowledge in regards to the healthcare staff. They have a professional knowledge that I, as a patient, do not have.

The asymmetry is part of the conditions for the relationships between all people in care. It is further reinforced by the strong hierarchy that exists in the care team between different professional groups.

In person-centered care, the asymmetrical disadvantage is constantly balanced against each person's right to autonomy and dignity, with respect for the person's integrity and vulnerability.

Reflect and discuss

- What can the asymmetrical disadvantage mean for you in the meeting with the patient?
- How can you balance the asymmetry?

Challenges in the partnership

In the partnership, the professional must not deviate from his professional responsibility. To enter a partnership can be a challenge. Entering a partnership with the patient requires surrendering power and control. Entering partnerships with other professions requires understanding, respect, and flexibility. A partnership must be open and respectful of what both parties can bring to the relationship.

Reflect and discuss

- How does it feel as a professional to be a partner with the patient?
- How does it feel to give up power and responsibility to the patient?
- In which situations do you already share power and responsibility? How does it feel?

What can we do to make the partnership not work? (A reverse exercise)

- How do we prevent the partnership from working with the patient?
- How do we ensure that the partnership does not work between the different professions in healthcare?

Characteristics of Partnership:

Partners must cooperate and join in sharing responsibilities, risks, power, and valuation. Partners must be open and respectful towards each other as both parties add to the relationship. **GALLANT, ET AL 2002**

Seamless care

Traditional care takes its starting point in different medical disciplines, the different professions of care, different houses, and organizational boundaries. When care is person-centered, it must be planned so that it is held together for every person.

The care should be experienced as seamless even though the person needs interventions from different parts of the care; from inpatient care, outpatient care, or care at home. The personal plan agreed upon in the team can support the transitions between the different parts of care.

Reflect and discuss

- How do the transitions in care work today?
- How could they work better? How can you and your colleagues contribute to it?

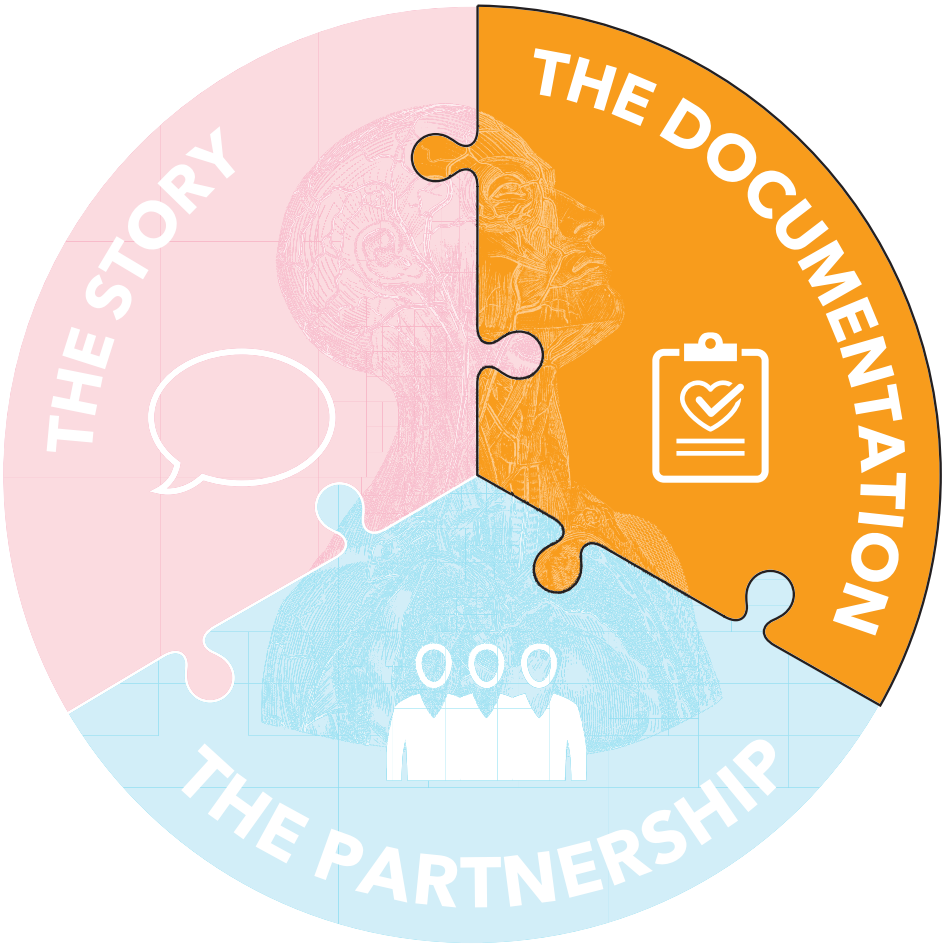
Until next time

Keep listening to stories. Think about how it feels to be part of a team/partnership.
Think about where in your professional everyday life, the patient could be included more in the team/partnership regarding their own health.

Read section 5. Review the documentation that you and others do at your workplace – based on one person-centered approach. Read about some practical examples – how have others done when they implemented person centered care?

PHOTO: EMMA EDBERG MATEI.

What better way to tell your story than to write your own biography? Mr. A. Anaramana has a precious treasure with perhaps the most beautiful and important events in his life gathered in the same place.



Section 5. Personal plan for context

It is important that there is a unified documentation that is fully accessible across care provider boundaries. But what role does documentation play in achieving person-centered care? Why is an agreement and a personal plan needed? That is the theme of today's meeting.

A consolidated documentation

The third part in person-centered care is the documented agreement. A personal plan that is based on the person's story and is accessible across caregiver boundaries is an important basis for a good, safe, and seamless care. In a person-centered care, it becomes obvious that the patient should have access to all their information and documentation. The documentation must include all record keeping, the person's own notes and self-registration of one's health status, as well as a personal plan.

The agreement

In person-centered care, it is important that the planning of the care is done together in the team where goals, strategies, and follow-up for care is determined. The agreement is documented and becomes a jointly decided personal plan. The agreement makes clear the responsibilities of each member of the team. Also, the patient's own role and responsibility are made clear. It ensures that care, treatment, and rehabilitation are carried out as planned and that the care becomes coherent.

Why is a personal plan needed?

The plan involves shared responsibility in the partnership for the entire team. The value of the plan is that everyone in the team has a common documentation with a common goal and common decisions to discuss and follow up.

Some ideas on how to create a personal plan

The agreed upon plan must be based on the story and contain the planning for care, treatment, and rehabilitation.

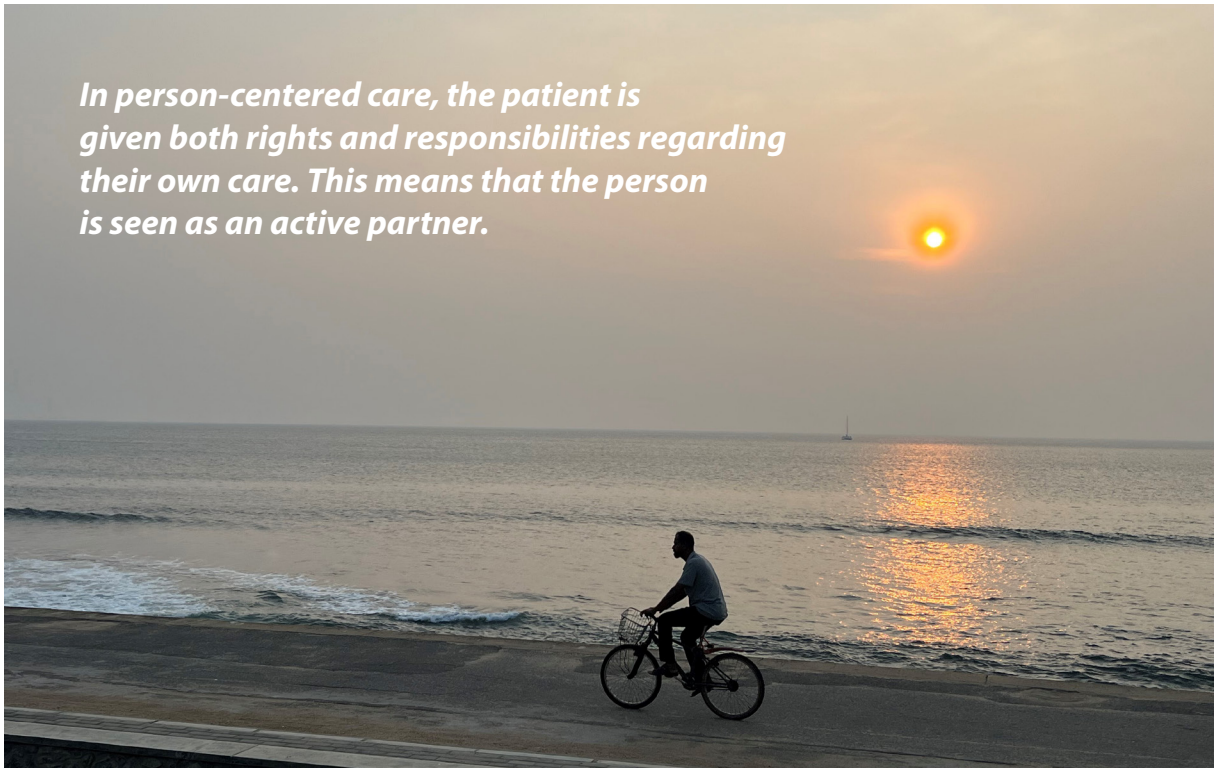
The plan is made jointly in the team and should contain three parts:

- The story – prerequisites for a partnership.
- The agreement – the partnership becomes concrete and leads to a personal plan.
- The documentation of the agreement found in the patient's medical record.

The patient's symptoms and resources are found in the story. The agreement contains all common information such as resources, barriers, risks, and the medical and nursing assessment. This is specified in the personal plan.

Reflect and discuss

- How can an agreement in a personal plan give the patient a strengthened position?
- How can a personal plan facilitate planning, implementation, and follow-up?
- What challenges regarding documentation do we see in our workplace? Discuss.
- Which of these challenges can we do something about immediately? What do we do then?
- The challenges we cannot directly influence - How do we contribute to the development being driven in the right direction?
- How can new technology contribute to the change towards person-centered care?



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Now we change perspective!

It is time to end the study circle on person-centered care. Reflect on what the circle work gave you and the extent to which the goals have been achieved.

1. Have you achieved the common goals? Check off against the goals you set at the first meeting.

2. Think individually: Have I achieved my individual goals?

3. Then talk to each other, in pairs, based on the questions below, one question at a time. Give each other time to reflect for a little while on the question before you start talking.

4. After the conversation about each question: write down the most important points of what you came up with until you move on to the next question.

Questions

1. What, of what I learned in the study circle, has made the biggest impression on me?

2. What can I do immediately to make my work more person-centered?

3. What could I do at my workplace to make care there more person-centered?

4. How can person-centered care contribute to a healthy work environment?

5. In what way has the study circle strengthened my professional identity?

Share with each other

Do a closing round where everyone, with one sentence, states what in the study circle was most rewarding to them.

To the circle leader
A study circle tutorial

The following section is a tutorial for those of you who are circle leaders in the study circle about person-centered care. Read through the tutorial before starting the circle and come back to it when you need tips on method.

Questions to discuss and exercises are usually integrated in the respective sections. The first and last gathering is special. Therefore, you will find special suggestions concerning them below under the heading "*First meeting*" respectively "*The last meeting*". You probably won't have time for all the interview questions. Then select the questions that are most interesting for you and the group. Maybe you know the group so well that you know where the energy and commitment lies? Ask another participant.

The study material and the study circle

The study material is intended for five meetings, as one section is covered per meeting. Expect that you will need at least two hours per meeting (and don't miss the tea break!). If you want to dispense the material in another way, it is of course possible.

Each participant must have a copy of the study material.

About the circle leader role

It is an advantage if you, the circle leader, are part of the group and participate in the conversations and exercises. The leader's role is not to be a teacher and lecturer. You do not need to know more than the other participants to act as a circle leader. However, you need to be one step ahead of the other participants.

You initiate conversations and exercises. You are sensitive to when the participants have finished talking and it is time to move on after you have "rounded off" the question. You have the main responsibility for the planning and the process, and make sure that everyone in the group is involved. It is your responsibility to make sure that everyone who wants to is heard, and that no one dominates at the expense of others participance. Your task is also to ensure that the group sticks to the topic. Your approach should be responsive, open, and non-judgmental.

Proposal for the structure of the study circle

As a rule, circular work works best if you follow the same structure on each occasion.
Here is a suggestion:

1. Check-in with a short rear-view mirror.
Start with a rear-view mirror (except at the first meeting when you instead start with a presentation of the circle and of each other, as well as setting goals and rules for the circle.)

A rearview mirror can be used so that the leader asks the participants what was discussed last time. We need to remind ourselves to move forward.
Also ask if any questions or thoughts about the theme have occurred since the last time.

2. The homework
The homework can be part of the rearview mirror if the task is about the theme of the previous meeting. If the homework concerns the day's theme, a simple report can be the starting point for today's circle work.

3. Today's theme
Each of the material's five sections contains several texts and in connection with these questions to reflect on and talk about. It is of course an advantage if everyone has prepared by reading the text in advance.

If the participants have not read the section in advance, you as the circle leader need to introduce them carefully, either by reading to them aloud or telling them more freely. If you speak freely you need to think about taking one thing at a time, so that it does not become too much for the participants to process.

You can also ask one of the participants to read the text aloud while those who want can follow the text in their study materials. Sometimes it is perhaps best for the participants to read the text silently to themselves. Ask your group what they prefer.

Hopefully, everyone has read through the section and only a summary of the points in the text is necessary to talk about.

4. Rounding off the meeting
Feel free to end each meeting with a round where each participant answers the question: "What do you take with you from today's meeting? Tell this in no more than three sentences."

Another question (actually two) to round off is: "Say in one word, or at most a couple of sentences, something that you felt at this meeting and also something that you thought at this meeting." (As a rule, you should avoid bringing up two questions in the same round. Here it works well.)

Give room for a little thought before you give your answers. Anyone who wants to refrain from answering can say "pass" and then the word goes on to the next person.

Give a reminder about when you will meet next and about any homework.

The first meeting

Introduce yourselves to each other
Even if the participants in the study circle are well acquainted with each other, it can be good to start the circle work with a presentation exercise. A presentation exercise can make the participants see new sides of each other and that can contribute to a more relaxed atmosphere. Here are a couple of suggestions:

Presentation using a piece of imagery or a thing.
A presentation exercise like the one above, that doesn't require any preparation, is to allow each to present themselves with an imagery or a thing that they find without looking too long. It can be in the pocket, in the bag, or in the room. When everyone has found their item, the participants tell each other why the item was chosen.

Set goals
At the beginning of the circle work, it is time to set common goals. Each of the participants has probably both hopes and expectations for the study circle, and one or more goals with their participation. They have an idea of what they want to learn or could talk about. They may have hopes of change. We can all have individual goals. At the same time, it is important for the "steering speed" in the study circle that we set common goals.

- Give each participant several post-it notes and ask them to write down their goals for participating in the circle, one goal per note.

- Then put the notes on the wall and sort them according to similarities. Feel free to ask the participants for help to do it!
- What does it look like now? Are there many goals that overlap? Are the goals reasonable? Can you, in a few points, summarize the common goals of your study circle?
- Write down the common goals and keep them in mind while working in the study circle. At the last meeting, when it´s time to evaluate the study circle, the question is: Did we achieve the goals?

Raise the issue of preparation for the meetings
To make optimal use of the shared time, it is good if each participant comes prepared to the meetings by having read through the section to be covered. Discuss and agree on how and to what degree participants must prepare. What suits your group best?

Raise the issue of agreements for our study circle
For the work in the study circle to function well, it is good to agree on some clear rules. It can involve things like how we are towards each other and being on time.

- Ask the participants to tell each other in pairs or small groups about experiences of participating in study circles, or other group activities: What has it been like when it was at its best?
- Summarize in the large group. Based on what was said in the conversations: What is important for the group to function well? Make some points that can serve as rules for your group. Write down on flipchart paper.
- Are these ground rules that everyone can agree on? Need more? Can we take a shared responsibility to follow them?

Let the rules follow the group. In case of violation of any of the rules, you are helped to refer to them. At the last meeting you can hopefully state that you have followed the rules.

Now that everyone has introduced themselves to each other, you have set goals and made up rules for your study circle, you can start with the circle's first theme.

The last meeting

Did you reach the goals?

At the last meeting, you look both backwards and forwards. Backwards by connecting back to your individual selves and common goals. Did you reach the goals? The section also contains an evaluation for reflection on what the circle meant for the individual participant where the method is that the participants interview each other and listen actively on each other - which can deepen the reflection for the person telling the story. It is important that there is time left for this important individual summation of the study circle, which you fill in at the very end.

How do you proceed?

When one has taken a step, the question always arises: how do we take the next step? Bring up the issue for discussion.
Participants can have many good ideas!
Perhaps one or a few of the participants themselves can become circle leaders for a group?

Some tips

If one of the participants dominates

If one of the participants takes up an unreasonable amount of space and has difficulty listening to the others, you can make sure that you place yourself next to him or her. You can try to limit the conversation by placing your hand on the person's arm and say: "Now let's listen to X", or: "Perhaps someone else has views?"

Good to move around

Try to find opportunities for the group to move. Get up and gather at the board, change the seating arrangement when you make beehives. Feel free to encourage the group from time to time to get up, stretch, and take a few deep breaths.

If the conversation turns negative

There are always things that we want to be different - that is also a reason why we want to transition to person-centered care - but a risk when we gather and talk about change is that we get stuck in complaining over structures or institutions that we cannot (directly) change. Of course, the obstacles must be mentioned, but we should strive to be constructive and focus on what we can change more immediately. The circle leader's task is to point further, to ask the questions that raise the eyes, if the group gets stuck in negative thoughts.

Methods that create participation in the conversations

The methods referred to in the sections are presented in more detail here.

The round

Each participant in turn, all around the group , gets to give their point of view or their answer to a question. Please start with a little moment for reflection. No one comments on what is said. The round is a method that also makes room for the more reserved participants. It is important that the leader informs before each round that whoever does not want to speak can pass. No one should feel pressured to speak out.

Some people need more time to think, and others get ideas only after hearing what others have said. Based on that, it can sometimes be good to take another round where everyone can add more points of view or answer.

Remember that the question should be clear. Raise one question at a time as several questions are included in the "question battery". Sometimes, and in certain groups, it is good to provide limits: "Each gets a maximum of two minutes", or "Tell me in one or at most three sentences".

Beehive

"The beehive" got its name from the fact that there is a buzz in the room when several people talk at the same time. Breaking up the group in smaller units, of about two or three people, is an unbeatable way to get everyone active. The hive provides all participants an opportunity to express their thoughts in words. For most people, it is easier to talk in a smaller group. Thoughts that are not fully formed can be processed for a while in the hive before possibly expressing them in a large group. The beehive is a good place for both "test thinking" and "test speaking".

When it has stopped buzzing, you can ask the groups to share something from the conversation. Sometimes it's better to let the conversation stay within the hive, the purpose of the exercise must decide this.

Brainstorm

Things must move quickly here, and the word is free. The leader asks for examples or points of view and takes notes on a flipchart or whiteboard as the answers come. What emerges should not be commented on during the brainstorm. Comments or discussion based on what has been written are taken when the ideas are exhausted. In the commenting-phase, nothing should be pointed out as wrong or stupid.

Reflection

A method that favors thoughtfulness is to take a short break for individual reflection after each question. Each one of you writes down a few bars to help you retain your thoughts, making it easier to listen with concentration to the others when they are talking. Otherwise, we often sit and struggle to remember what we must ourselves say when it's our turn.

The opposite exercise

In section four there is a reverse exercise that deals with partnership. Do this, then brainstorm and let all the ideas for how we can do the opposite of everything that person-centered care stands for emerge.

Take notes on the whiteboard.

So, what happens if we do the opposite? What is the opposite of each proposition?

PHOTO: EMMA EDBERG MATEI.

We must dare to challenge ourselves – our professional identity, our self-image, our vision of the patient, and our relationships with other professional groups. Together we can build up more knowledge and experience around person-centered care and contribute to the comprehensive care that is needed.

Many patients feel that they are not listened to, that their care is missing continuity, and that it is not coherent. Many of us who work in healthcare feel that we do not have sufficient opportunities to do our job according to our professional ethics and our inner compass.

The most successful way to meet the health challenges that exist in the population, is to have person-centered care with equal health as the overriding goal. A person-centered working method gives us a better care environment. When trust increases, care outcomes improve, resources are used more efficiently, and both patients and staff will be happier. But changing to person-centered care requires effort and courage because in many ways it provokes the way healthcare, organizations, hierarchies, and control systems work.

We must dare to challenge ourselves – our professional identity, our self-image, our vision of the patient, and our relationships with other professional groups. Together, we can build up more knowledge and experience around person-centered care and contribute to the comprehensive care that is needed.

In order to spread increased knowledge and understanding of person-centered care we need different educational approaches. Study circles are such a method where knowledge is created in interaction with others. The document you are holding in your hand is a pedagogically laid out basis to contribute to and make it easier for you to be able to conduct study circles. The material is simply and clearly structured, and also provides a manual for the person who will lead the circles. It contains short factual sections and reflection questions. There are also suggestions for how the meetings should be carried out methodically.

The material is well tested in Sweden, and is here translated and adapted for Sri Lanka within the framework of the cooperation in nEUROcare.

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