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Person-Centred Approach and Service User Involvement in Health and Social Care

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ABSTRACT: Health and social care services is becoming increasingly demanding. There are three major stakeholders in the social care sector whose activities are invaluable in the success or otherwise of the well-being of service users, these are the service provider, the service user and the family of the service user. The paper contextualised the invaluable importance of service users as core stakeholder in health and social care service within the grounded theory of protecting personhood and stressed the need to mainstream their informed consent, pinion and experience into the whole process of health and social care, in order to achieve and sustain the goals of social care delivery.

KEYWORDS: Health and social care, service user, personhood, care delivey, user involvement.

INTRODUCTION

There is an increase in health and social care situations and cost globally. This can be linked to a number of reasons. People are living long, change in lifestyle, environmental factors, climate change, natural disasters, pandemics, breakdown of familism and abandonment of parents and old people. All these results in different forms of long -term ailments. Old age comes with ailments like dementia, senility, depression, stroke etc. change in lifestyle occasions diet induced illness like diabetes, hypertension, ulcer, cancer and so on. Environmental factors like pollution lead to respiratory diseases, diarrhea, skin cancer, heat waves, flu. Climate change brings about forced migration, conflicts, disruption of livelihoods, famine, drought, and some forms of disaster. Pandemics like covid 19 have propensity to alter human interactions and existence and may overwhelm the health care system. Familism which is the social security of old people and parents especially in Africa is breaking down as a result of dynamism in the society and children abandoning their parents all over the world. These situations and factors combine together to necessitate response of health and social care for the myriad of victims arising therein. It can be observed that the health care system treats some of the ailment in the short run but the long term care needs of some of the situations goes beyond short time medical treatment, but requires long time intimate continuous care where a regular care giver is readily available to attend to the needs of the service users.

This long-time service calls for personalizing the care process by putting the service user at the beginning and the end of the process. Thus, their participation, experiences, knowledge, and perspectives guide the care process. In most cases the client/service user who is being cared for may have become sort of helpless but not useless. Even in their sorry state, they are still aware that they are human beings who can still direct their life to an extent, because they still have the ability, needs and feelings. It is when these are integrated into the are system that positive outcomes are achieved. Hence, the term person-centered care. (Berntsen Chetty Ako-EgbeL, Yaron, Phan, Thanh , Castro , Curran , et al.2022, Björkman,, Feldthusen, , Forsgren, 2022. Fridberg, H., Wallin, L. and Tistad, 2022. Ekman, Swedberg, Taft, et al. 2011)

NEED FOR SERVICE INVOLVEMENT

Person-centered care is a current discourse within the health and social sector. It borders on a form of care that emphasizes service provider/service user relationship. It emphasizes that the service provider/service user, should be at the centre of are delivery. Person-centered care advocacy and campaigns grew globally and became heightened when international authorities like World Health Organization, recommended that patients should be empowered to have a say in their health are. The World Health Organisation having come up with a report on people centered and integrated health services, people-centered was adopted as acceptable model of care by stakeholders in the health sector. It is hinge on a care model that puts the individual (service user/ service provider) at the heart and centre of health and social care, it involves eliciting informed information and opinion from clients probably in the presence of their relatives and providing care along the direction of the client. There are three major stakeholders in the social care sector whose activities are invaluable in the success or otherwise of the well-being of service users. These are the service provider, the service user and the family of the service user.

Person-Centred Approach and Service User Involvement in Health and Social Care

There have been calls for personalizing the care process by putting the service user at the beginning and the end of the process, therefore patience experience is currently gaining widespread accord as an important factor in the provision of robust healthcare (Gilburt, Rose, Slade 2008). Service user involvement is at the centre of person-centre care (Yaron, Phan, Thanh , Castro , Curran , et al. 2022. Fridberg, Wallin, and Tistad, 2022) Any attempt to judge the quality of health services would be incomplete without considering the experiences of people who use them (Lee, 2023). By finding out what service users think, valuable information can be obtained about problems with the way that services are delivered and used to assess the impact of efforts to improve the quality of healthcare provided (National Collaborating Centre for Mental Health (UK) 2012).

Awareness is growing on the importance of this development in health care. However, there is scanty research evidence to take a look at the level of equivalence of Person-centred care between those delivering and those experiencing (patient) care (Ekman, Swedberg, Taft, et al. 2011, Hyde and Hardy 2021). Viewing the services health and social care offer, through the eyes of service users provides one of the invaluable things that is being put in practice and often avails stakeholders previously unknown understanding to help them understand what is working well, what adds value and brings about improvement and what doesn't (NHS Education for Scotland 2024). Understanding service user experience provides a right direction towards person-centred services. Considering the various aspects of experience enhance a knowledge of the extent to which people receive services that are provided in response to what service users really need and want, what their preferences are, and what they value, as well as the things that matter most to them (NHS Education for Scotland 2024). The best way of measuring patient-centeredness is to seek an assessment of it from patients themselves……. yet the extent to which patients are systematically consulted on their care needs and experiences, the results analysed and assimilated and executive action taken in consequence, is limited at best (Miles and Asbridge, 2018). Engaging and involving service users in the design and delivery of care and services demonstrates a commitment to person-centred practices. It ensures care is appropriate to an individual's needs and is respectful of their preferences. Engagement builds a culture of listening to and learning from the experiences of service users and their families (Framework for Improving Quality in our Health Service 2016). Engaging and involving patients in the design, planning and delivery of all care demonstrates a commitment to person-centred care. It ensures that care is appropriate to patients' needs and is respectful of their preferences (Björkman, Feldthusen, Forsgren, 2022). Engagement builds a culture of listening to and learning from the care experiences of patients and their families. Focusing and delivering on the outcomes that matter to patients can only be achieved through meaningful engagement and partnership with patients, carers and their families. (The Health Foundation, 2014).

A report published in the United Kingdom, by National Voices, entitled 'Person-centered care in 2017. Evidence from service users' National Voices. (2017), attempted a Person-centered care assessment from patient and carer perspectives and found out that:- 1. Person-centered care is inadequately measured and that it is not current possible to adequately measure or assess person-centered care across services. 2. A mixed picture is evident: people's experiences can be highly variable. From the patchy data available it appears some aspects of person-centred care are being consistently achieved, but people's experiences can be highly variable. 3. Some aspects of person-centred care have improved. For example, 76% of inpatients who had an operation or procedure said that what would happen was 'completely' explained and 87% of general practice patients said their GP was good at listening to them. 4. There has been progress towards involvement in decisions and being in control. Here, 78% of cancer patients were definitely as involved as much as they wanted to be in decisions about their treatment and 33% of people using adult social care said they had as much control over their daily lives as they wanted; another 44% had 'adequate' control. 5. The steady progress in person-centeredness of care is now deteriorating, both for general practice and inpatient care. 6. There is little evidence of personalised care and support planning. Only 3% of people with a long-term condition said they had a written care plan. 7. The coordination of care is not measured. A 64% rise in delayed transfers out of hospital in the last five years was noted, with 46% of inpatients saying that they did not get enough further support to recover or manage their condition after leaving hospital. 8. Family involvement is not central and most carers need better support. Some 68% of carers said that their GP knew they were a carer, but did not do anything differently as a result. Additionally, 23% of carers said they had received a social care assessment. 9. There are some indicators of inequality between racial groups. What are we to make of these observations and what are we to do in response?. Wolf, Moore, Lydahl, et al. (2017) conducted an interview study with patients concerning their perception of person-centred care and found that many patients acknowledged being listened to and several expressed being known personally, for who they were and recognition of their individual needs. They observed changes in professionals' receptiveness. However, other patients did not pay much attention to this change in professionals' receptiveness because they perceived their hospitalisation as brief and only require straightforward treatment. Some patients admitted to being involved in developing a health plan, but not in setting goals, and when discussed, the discussion were being described in medicalised registers or centered around home circumstances for discharge. Personal information was obtained and illustrated but not necessarily aligned towards 'lifeworld' goals. Patients contribution was elicited in discussing choices with professionals, helping themselves, and using their initiatives. Patients expressed being informed about their condition, issues bordering on discharge and future care needs, they were satisfied with being listened to and some noted that they participated in their care plan. Apart from the opportunity of receiving written information and writing down their thoughts, questions and contributing to their care, many patients did not remember those written information in any

detail. However, patients perceived this documentation in 'simple' terms that underpins their felt taken care of and are open to receiption of sufficient information (Wolf, Moore, Lydahl, et al. 2017).

Informal elements in the study by Wolf, Moore, Lydahl, et al. (2017) engender emotionally supportive relationships that enhance patients participation, by the time the scene is set and given the right circumstances. They found that patients were comfortable being able to ask questions and receive information. Their perception of participation is agreement and informed discussion, postponing professional knowledge and expertise and reducing opportunities for empowerment and activation. Patients mentioned participating in decision for discharge but did not relate notions of enablement or control. Patients expressed satisfaction with personal approach and sustained partnership with professionals who maintain communication empathetically and effectively with professionals who play the role of educators (Wolf, Moore, Lydahl, et al. 2017), as well as with building mutual and collaborative partnerships Roter, 2000).

Gilburt, Rose, Slade (2008) studied the service users' experiences of life from the user perspectives. An important finding of the study was that participants described their experiences in the hospital, from the context of the people that they had interactions during their admission. Out of the eight themes, five have bearing with relationships, these included safety, communication, trust, coercion, and culture and race. One of the themes, "treatment", focused on the role of admission to hospital. The other two 'environment and freedom' are structural. They provide knowledge about the environment of hospital.

Communication was identified by service users, they understood communication as comprising the activities of talking, listening and understanding of the three variables of communication, service users rated listening high. They described listening as a characteristic of being human, as service users that had enjoyed being listened to, expressed a feeling of being respected. In the study service users expressed a negative rating of a whole service because a service provider did not listen to him. According to the study, open, non-judgmental, and not patronizing were valued.

The importance of talking was identified as therapeutic if service users were open to being listened to and understood. Such service users valued relevant advice and information (Gilburt, Rose, Slade 2008).

Person-centered care stands on a tripod of three key concepts which according to the university of Gothemburg Centre for Person Centered Care, are partnership, narrative, and documentation. All these underpin service user's discourse in person-centered health and social care. Partnership: 1. Person-centered care involves partnership between the three major stakeholders in the care process. It pays due regards to and recognizes the knowledge and expertise of one another and the needs to combine this knowledge and expertise to achieve the objectives of the social care system. This knowledge and expertise are: the means by which patients and members of their family, cope with the conditions. The service providers professional's knowledge and expertise of treating and rehabilitating the conditions. Person-centered care affords service user exercising right and responsibilities over their personal care such that they are treated as partners who are cared for along their needs, and opinions which is subjects to change as the situations demands and not as customers who take delivery of care strictly on specifications. Partnership from the legal sense of it, entails a contract in which parties to issues agree on some right obligation and responsibilities that are binding on them. Thus, applied to person-centered are, the health plan which contains the care process and acknowledges that care is given as planned and agreed meeting the service user day to day is the basis of partnership formation in the care environment partnership (McCance, McCormack and Dewing(2011). Partnership holds the service user as an equal partner in the care process. This is borne at of the fact that the service user is seen as an expert on their challenge and hence person-centered care affords each service user of being a partner in how they want their care to be provided. 2. Patient narratives: One of the major attributes that dignifies human beings, is the privilege of being listened to. This attribute helps human beings to solve a lot of problems. In person-centered care, conversations of service providers, with service users in presence of members of their family engenders identifications of the client's resources and needs by carefully listening to the client's narrative. The client's resources comprise personal and interpersonal attributes like own will, joy, motivations and social networks. All these can be deployed for achieving different goals. Motivation can make a service user to try to do things which they could not or have not been doing before. For example, the ability to eat by oneself, or trying to walk unaided. The service user narrative goes a long way to deduce and understand better the client's needs, feelings and experiences which will be deployed in the care service. 3. Documentation: Documentation is essential in all human activities; it is not less important in person-centered care (Taylor 2023).. Without it care process is incomplete and delicate and as such the services provided to the client must be accurately recorded and must be subject to regular revision, must be made accessible to the client all the time. Personal health where all these information are recorded is jointly created by both the service provider and the client. The importance of this record is sparing the client from repeating a particular issue or story repeatedly (university of Gothemburg Centre for Person Centered Care n.d.).

THEORETICAL FRAMEWORK

Didier et. al. (2023) viewed service user involvement in health are in the context of grounded theory of protecting personhood. The Theory of Protecting Personhood is embedded conditions, assumptions and some contextual levels. This theory postulates that (a) those that do not frequently or have never experience health issues do not patronise and do not attend hospitals as a natural or a

familiar environment and (b) the functioning of hospitals' structure is not known to people that are not faced with health challenge and therefore do not access the healthcare system. Being hospitalised can be a chronic disruptive life experience. Situations of assuming the status of healthcare patient and beginning to interact with healthcare professionals seem adaptive and occasionally a challenging processes. Once somebody gets admitted to hospitals, they begin to face a dynamic process and need to adopt strategies, attitudes, and behaviors to adequately access the care they need to receive. The theory enunciates how patients start up processes to protect and maximize their incarceration to receive optimal health care. The grounded theory of protecting personhood thus describes the process that patients individuals pass through to obtain balance in their sense of self, waving between personhood and patienthood in hospital environments that are unfamiliar. The process comprises four stages: introspection (when patients become conscious of their self as a person and as a patient); preservation (when patients maintain a balance between the feeling of person-hood and patient-hood and person-hood is protected); rupture (patients experience imbalance between the feelings of person-hood and patient-hood, wrecked person-hood); and reconciliation (patient's person-hood is restored). (Didier et. al. 2023)

The theory posits that patients in addition to seeking good care and feeling safe and protected they are also concerned with relating and interacting smoothly with healthcare professionals, this include the manner those interactions manifest, and how to bring about change when needed. Protection of personhood was remains the main issue because it presents the most explanatory power in the theory and provides explanation on how participants can continually resolved their main issues.

The first stage of the theory is introspection. This stage entails the process the patients pass through while they discern a change in their condition, they observe movement from the person they are to the status of a patient. The persons realise this change is as a result of the diagnosis and/or future hospitalisation. Consciousness of this change engenders the process of introspection, which invariably leads to the concept of self-perception. It presents a form of transition in the mind, such that any time the patients think about going to the hospital environment, they commence a phase of introspection on their conditions.

The second stage of protecting personhood is preservation. This relates to the process patients pass through in an environment that is not familiar. Such circumstances do not allow the patients to know much about the environment, the healthcare professionals or the types of interactions patients will be exposed to. The patients try to put in their best, or use signs, to indicate to healthcare professionals ways they will want to be helped to preserve their sense of personhood, in the potentially weary environment. This stage can easily waver going by patients' experiences and expectations of care, their relationships and interactions with healthcare professionals, as well as the atmosphere and context of the care environment. In the process of protecting personhood, the aim of the patient is to maintain connection to their personhood and continually feel their being a person, the circumstances of care, interactions, relationships, notwithstanding. Patients by this time aim to reduce discomfort and uncertainty owing to the environment and/or relationships they may be subjected to during care. Providing personhood protection engenders positive mentality that need be echoed by the relationship and behavior of healthcare professionals. It behooves both healthcare professionals and patients to make efforts geared towards protecting personhood. Moments of care are experienced as protecting personhood when individuals curry and tacitly elicit sense of consideration, experience respect in their dignity and autonomy, and appears to be heard and understood. They deserve to think that they are in safe hands and be availed with required information when they request for it. The extent to which healthcare professionals exhibit positive and inspiring attitudes and behaviours as well as their interactions and relationships with patients have the propensity to radiate feelings and atmospheres of respect, consideration, safety and dignity.

The third stage, which is rupture is a corollary of failure to preserve personhood. It includes the situation of feeling reified and avoiding. At its early stage, patients attempt to seek protection of their personhood while relating and interacting with healthcare professionals. Rupture comes about when healthcare professionals fail to protect personhood in the healthcare process. The achievement attained through oscillation and sustained in the preservation stage is counterbalanced because the service or the behavior of healthcare professionals is at variance with the patients' expectations (Moore, Britten and Lydahl *et al*.2017). The patients (service users) thus deserve to be availed consistent information, and provided with safe and protective care. In a situation where the service users (patients) are made to feel disconnected from their personhood, the individuals do not perceive themselves as respected and considered as persons in the care process.

The fourth stage is reconciliation. Here the aim is to reconnect with personhood. This is predicated upon reinvigorating the efforts of protecting personhood during care process. Patients, even when they have experienced rupture, still hope to device ways and means of adapting and remaining connected to their personhood. They struggle to sustain their sense of personhood and try to remove the low concept of being seen as patient object. The rupture and reconciliation stages are closely knit. Patients do not wait for rupture to take its full course before reconciliation process is activated. As rupture appears, the process of personhood protected is triggered, with the sole aim of reconciling promptly with their personhood, to prevent switching to avoidance. When the protection of personhood is compromised, patients tend to repair the situation by reactivating optimal care and thus invoke the process of protecting personhood. By this, patients attempt to resuscitate (Didier et. al. 2023).

PRINCIPLES OF PERSON-CENTRED CARE

Principles of persons-centered care are germane when implementing the approach in order to achieve holistic and sustainable outcomes.

- Right to respect, dignity, and compassion. The situations and challenges of some service users might have eroded their independence, this doesn't mean that their needs, thoughts and feelings are lost. Taking this into consideration makes it incumbent on service provider to regards their needs, feelings, and opinions so that they can be empowered to feel being in control of their care. It is trite to provide care service with appropriate respect and dignity.
- Personalized care, support and treatment. The challenges and needs of each service user is peculiar to their personal situation. One-size-fits-all approach could be counterproductive in achieving the objectives of social care. Service should be personal to each individual in line with their peculiar personal situation and needs so that their autonomy is maintained and control over their health and existence and consequently recovery and empowerment are enhanced.
- Enhanced coordinated support, are and treatment effective social are services is dependent on coordinated connections and arrangement among are givers, the care services and service users. This comes through ensuring effective communications, deliberate and coordinated are as well as prioritizing service user needs.
- Ensuring skills and strength for a fulfilling and independent life. Empowering service users' involvement in decision making helps them to exercise ownership over their well-being and provide them with knowledge to be independent in supporting themselves (Lee, E. 2023).

PERSON-CENTERED VALUES

- Individualities: It presupposes every person have their peculiar characteristics values, identity, needs as well as choices. Therefore, service providers should avoid one-size fits-all approach in care services
- choice: Service users should be provided with the opportunity to make informed choices concerning their care and support. They need to be empowered to be knowledgeable to make those choices.
- Independence: Individual service users should be encouraged to be as independent as possible. They must be helped to do whatever they can do on their own, but support should be offered whenever it is compulsory.
- Right: Every human being has their fundamental human rights. Service users too have their rights including right that safeguards their peculiar situations and challenges. Service providers are obliged to safeguard these.
- Privacy: Individual service users are entitled to their privacy, which must be observed by the are provider. This is more pronounced when personal hygiene and intimate responsibilities are being carried out.
- Dignity: Human nature requires dignified treatment; hence service users must be treated with dignity in line with their ethical and moral beliefs. Personal care should not be provided in manners that can negatively impact their dignity.
- Respect: Service users value as individual should be upheld in the social care process. Their feelings, opinions, needs must be recognized.
- Partnership: Service users and members of their families are mutual collaborators in the care process. They should all be involved in the decision making in the care process (Lee, E. 2023).

BENEFITS OF PERSON-CENTRED CARE

Service User benefits include:

Person-centered care provides the opportunity for service users to decide on what and how the care direction will go and, in that case, the care service becomes flexible and therefore the service being provided is not rigid and it is not forced on the client.

In person-centered care, the service user is saddled with responsibilities, this will empower them to have a say in matters that concern them, and they will be motivated to contribute their quota in the care process.

Person-centered care empowers service Person-centered care empowers service users to be able to take control of their situation and health and thus, it gives them more awareness on their health and will easily make amend.

By being given the autonomy to make decision concerning their situation and are service users will have access to what suits their purpose and therefore, the are process will benefit them.

Because Person-centered care encourages less dependent on other people, service users may likely be motivated rely less on support and assistance from others and by so doing they may need less support.

Because of the emphasis on person centeredness in it, service users are confident about the services they receive and thus will be satisfied and be happy.

BENEFITS FOR CAREGIVERS:

Seeing their clients getting better and showing improvement over time give service providers a sort of satisfaction and psychological happiness and pride. It makes them feel a sense of pride that they are impacting life positively.

GENERAL BENEFITS

When individuality is made the watchword of person-centered care, care service will be qualitative, the reason being that the services will be focused and monitoring and evaluation will be easy to be applied.

Person-centered care by the its personalised nature affords the opportunity of people that are require health and social care to access it and not only that, they will have quality health and social care.

Person-centered care provides the service user to look after themselves, in addition to the care service being provided by the care professionals. This is important, because there is no way a second party will be able to cater for one, like the person will care for themselves.

Person-centered care is invaluable in helping to provide care opportunities to a large number of people, such that the pressure on health and social care services is reduced and consequently, effective service delivery is ensured.

Individuality is pronounced in person-centered care, service users are known and dealt with in person and thus their personal dignity and individual difference and characteristics are recognized I n the care process.

The person-centered care process treats the service user as experts on their health and care situation and therefore this is made to come to bear on the health and social care process.

Person-centered care brings about a sort of division of labour in the care process. The three major stakeholders in the care process are given responsibilities in the quest of caring for the service user. The service provider, the service use and relatives of the service user are given their responsibilities in the care process.

Person-centered care approaches health and social care holistically by mainstreaming the entire personality of the client in the care process. This also include people in the client's immediate nuclear family.

Person-centered care does not limit care process to the service user alone, members of his family are also drawn into the care process. Including this category of people will help ensure the efficacy of the care process.

Person-centered care by its nature is sort of flexible, this is evident in its holistic nature, the collaboration and partnership embedded in it make it accessible and its operation is not too cumbersome.

Person-centered care considers service environment and mainstream it in the care process, the physical environment is taken care of as well as the psychosocial and cultural environments. Thus, the care process is properly situated.

Person-centered care makes it incumbent to use professionally trained staff, to be able to execute person-centeredness. Therefore, it ensures and enhances staff training and continuous development.

Person-centered care attempts a systemic approach to health and social care. It sees the service user's personality as a whole and does not leave out of the components therein, it also looks at the environment of the service users and incorporate it in the care process, Therefore the efficacy of the approach in delivery of health and social care services cannot be overemphasized.

It is beneficial in the sense that service users are able to live up to their social, partial and emotional needs, thus enhancing high quality of life for them and ensuring their comfort and confidence in the are process. For example, service users will not suffer from loneliness, because there is no time that care professionals will not be with them.

CONCLUSION

Service users are important stakeholders in health and social care delivery, effective service thus must take into consideration the input of service users for the goals of care delivery to be achieved and sustained. The fact that patients/clients are at the core of person-centred care, their informed consent, opinion and experience must be mainstreamed into the whole process of health and social care service delivery.

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