The complexities of enacting person-centred practice in stroke rehabilitation

Felicity Bright, PhD & David Anstiss, PhD
Centre for Person Centred Research, Auckland University of Technology, Auckland, New Zealand.
Email: felicity.bright@aut.ac.nz | Twitter: @flissbright

THE PROBLEM

Clinicians and managers of a newly-established community stroke rehabilitation service, which had a philosophy of person-centred care, reported it was challenging to embed person-centredness into routine everyday practice, despite the efforts of clinicians and support of the organisation.

THE RESEARCH APPROACH

We examined practice through interviews with five clinicians and managers. Viewing practice as occurring within complex systems, we analysed data using a complexity approach, looking at the interactions and relationships within and between individuals, teams, and systems.

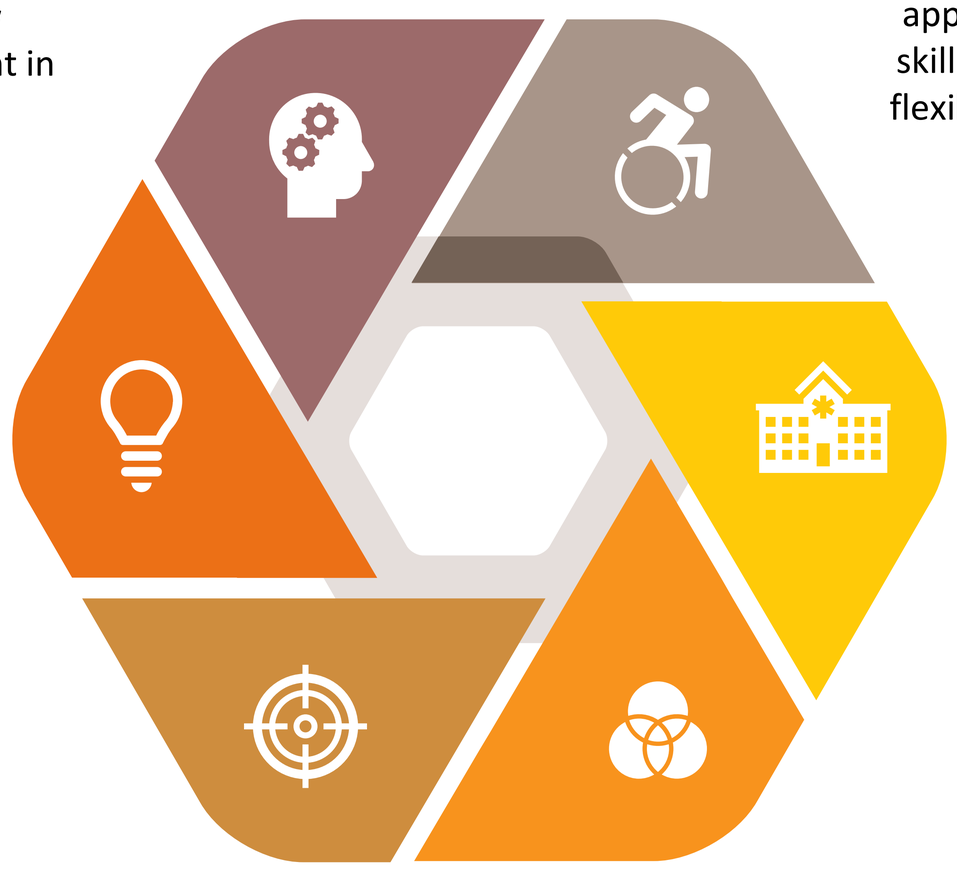
WHAT MAKES PERSON-CENTRED PRACTICE COMPLEX?

CLINICIAN IDENTITY AS PERSON-CENTRED

Clinicians saw themselves as person-centred. This was a strong part of their identity and part of why they were recruited to the service. This could sometimes limit their self-reflection on how person-centredness was, or was not, evident in their practice.

PATIENTS' EXPERIENCES AND EXPECTATIONS

Patients' care in acute services influenced their expectations of rehabilitation. Some questioned the actions of clinicians (e.g. goal-setting approaches). Clinicians need the knowledge, skill and confidence to embed the model in a flexible way that responded to the needs and priorities of the patient.



INDIVIDUAL UNDERSTANDINGS OF PERSON-CENTRED PRACTICE

Each clinician understood 'person-centred care' differently. This was informed by their own professional 'lineage' – their university training, clinical and personal experiences. These understandings were often tacit, not clearly articulated, and were not always congruent with the how the service conceptualised it.

BIOMEDICAL HEALTH SYSTEMS

Health systems (including IT and documentation) were based on a biomedical model. These did not support a person-centred approach or team communication and collaboration New goal-setting processes introduced to support person-centred practice were not well-supported by infrastructure.

ASSOCIATIONS WITH A DISCRETE SET OF ACTIONS

Person-centred practice became associated with particular activities (e.g. using the patient's own words) which the service implemented to try and help embed the philosophy of practice. However, when clinicians strictly adhered to indicators of person-centred practice, the philosophy could be lost in the midst of doing different tasks, resulting in practice that was not tailored to the needs of the patient.

THE INTERPLAY OF DIFFERENT SYSTEMS

Person-centred practice occurs at the intersection of different 'agents' and systems – the patient, the clinician, the team, the organisation. Clinicians found it easier to identify how patients and services could make person-centred practice challenging; it was more difficult to identify how their own practices could be problematic.

PERSON-CENTRED PRACTICE REQUIRES SIGNIFICANT REFLEXIVITY AND FLEXIBILITY

HOW MIGHT WE 'MANAGE' THE COMPLEXITIES OF PERSON-CENTRED PRACTICE?

Acknowledge that it is complex as a result of multiple factors.

Explore the tensions for patients and clinicians, identify and address the factors that pull people toward clinician-centred practice.

Provide opportunities for critical reflexivity, attending to individuals' professional lineage, their understandings of practice and the factors that influence practice.

Aim to create person-centred systems, not just person-centred clinicians.

Acknowledgements: Data collection by Anna Harris and Lucas Burt, funded by Waitematā DHB.