PEOPLE CENTRED CARE (PCC) FRAMEWORK

2023 -2024

INTRODUCTION

*** Please note at Traverse the people we served voted several years ago to be called "clients". A more typical title in people centred care models is consumer, resident, or person. In this document client is seen to be interchangeable with person.*

**** Proviso – where the statement is with "client, families and/or caregivers" that assumes that clients have given written consent to have families and/or caregivers involved.*

The World Health Organization (WHO) defines People Centred Care (PCC) as "an approach to care that consciously adopts individuals', caregivers', families', and communities' perspectives as participants in, and beneficiaries of, trusted health systems that are organized around the comprehensive needs of people. PCC also requires that clients have the education and support they need to make decisions and participate in their own care, and that caregivers can attain maximal function within a supportive working environment. "People" Centred Care is broader than Person Centred Care, encompassing not only clinical encounters, but also including attention to the health of people in their communities and their crucial role in shaping health policy and health services."[1]

Important Notice: While the terminology has changed over the past year, the intent is that "People Centred Care (PCC) maintains the same focus as the term "Person Centred Care" or "Client and Family Centred Care" (CFCC). Definitions with WHO will evolve gradually to reflect this new terminology of people care.

Traverse Independence is committed to People Centered Care within service provision. This framework will ensure that PCC is embedded into all levels of the organization.

PCC is provided by supporting clients in collaboration with their families to provide care that is respectful, compassionate, that practices cultural humility, while being responsive to their needs, values, cultural backgrounds and beliefs and preferences.[2]

1 WHO, "Framework on integrated, people-centred health services", accessed September 7, 2017 in the People Centred Care Criteria Guide, January 2018, version 1.0

2 Adapted from the Institute for PFCC, 2008 and Saskatchewan Ministry of Health 2011.

STRATEGIES

Traverse Independence recognized that all individuals have unique needs and situations. We prioritize clients in the center of all decisions to the best of our abilities unless the client safety is of serious concern.

Engagement, clarity, and open/honest communication play a large role in the PCC approach to care planning. This starts with recognizing the experience and expertise of the person (client), their family or caregiver in collaboration with the professionals. The client is considered an equal partner in the process. The client, family and caregivers are acknowledged as distinct and necessary components to improving the service delivery mechanism.

The means of engaging are defined as:

Partnership: The team collaborates directly with each individual client and their family/caregiver (if applicable) to deliver services. Clients are involved always, and families/caregivers if the client approved of their involvement. This is based upon their right to confidentiality and privacy.

With Input**:** Clients and families provide input collectively through advisory committees, groups, formal surveys or focus groups, or informal day-to-day feedback. Input can be obtained in many ways and at various times. This feedback is utilized across the organization.

SYSTEM

There are many ways to operationalize meaningful engagement with clients and families - from client and family councils to surveys and town hall meetings. Traverse Independence has utilized several of them, which are highlighted in the Key Stakeholder Engagement Report 2018[3]

To ensure continuous quality services to clients, Traverse Independence uses a collaborative approach to provide person-centred, holistic services, and provides information to our clients and family members about other community services that are relevant to the client or family member. Principles of the independent living model, including self-directed care, the right care in the right place at the right time, dignity of risk, and supported independence, are all reinforced by the mission, vision and values of Traverse Independence.

PCC puts the person at the forefront of their care planning, ensures they retain control over their own choices, helps the person to make informed decisions, and supports a partnership

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3 Traverse Independence Key Stakeholder Engagement Report, 2018

between individuals, families, and the service provider. The guiding principles are intrinsic to a PCC model.

Dignity and Respect

This principle speaks to the need for active listening to clients and caregivers and to honouring their choices and decisions. This is done through incorporating the client and caregiver's values, beliefs, and cultural norms into care plans and care delivery.

Information Sharing

Communication that is timely, accurate, and complete about decisions to be made and validation on what has been heard and understood, is the basis of this principle. This leads to supporting an informed decision.

Participation

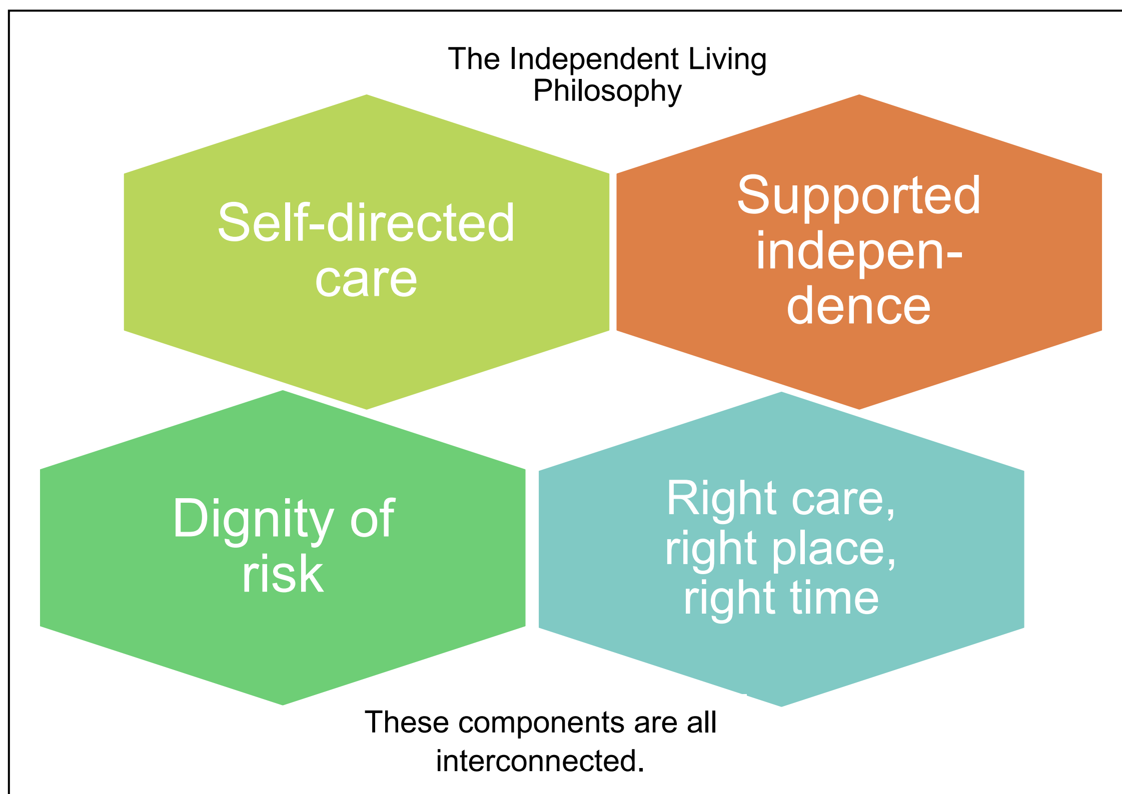
Clients and caregivers are encouraged and supported to participate in their care planning and informed decision making at the level where they feel comfortable.

Collaboration

Clients and caregivers are provided meaningful opportunities to engage with service providers and leaders in the continuum of quality improvement, policy and program development, implementation, and evaluation. This includes the potential for engagement in facility design, service redesign, professional education, and the delivery of care.

To ensure continuous quality services to our clients, Traverse Independence uses a collaborative approach to provide person centred, holistic services, and will provide information to our clients and family members about other community services that will be relevant to the client or family member.

Historically, the principles of the independent living philosophy included self-directed care, the dignity of risk, and the right care in the right place at the right time and supported independence are all supported by the mission, vision, and values of Traverse Independence. This historical philosophy meshes so simply with the newer PCC model of service.



PEOPLE CENTRED CARE PRACTICES

Support for PCC principles should be demonstrated by an organization's leadership through both words and actions. This requires engagement at all levels of the organization. At the same time, service providers should demonstrate support for PCC principles at the client care level, pushing up in a true partnership with leadership.

Front line employees have an especially important role in developing a culture of PCC. This requires a shift in thinking from a 'medical model' of care (providing information, guidance, and expert decision-making) to a model of care where the client is a partner in making care decisions (self-directed care). The employees must feel they have the support of the organization to engage in PCC activities with those clients who can successfully direct their own care.

In the client-provider relationship, clients are in the position of needing help and providers have the knowledge and experience needed by their clients. This creates a natural power imbalance between clients and employees that requires conscious effort to overcome. Employees should be supported to shift their values, attitudes, and behaviours to make clients true partners in the process of making care decisions[4].

4 Ministry of Health of British Columbia Person Centred Care

This PCC framework can be used in various ways, including:

- Admissions: the inclusion of person in selecting service location or intensity of intervention.
- Goal setting: identifying what is relevant to the client and focussing efforts on that are important to the client. Similarly, the discussion about transitions of care and involvement in the community.
- Follow up on incidents: process improvements based on client feedback following incidents.
- Information sharing: transparency of organizational practices and willingness to accept feedback.
- Process improvements and organizational decision making.

SERVICE DELIVERY FRAMEWORK

Our intake process is tiered on two distinct levels – our low barrier access program which requires a HELPS ABI screener to be positive and our full intake package which requires a regulated staff diagnosis of a brain injury. Our low barrier programs include ABI in the Streets geared to the homeless, precariously housed and living rough population, the ABI Day Program and our Outreach Services. To enter our housing programs, the client must have a formally diagnosed brain injury.

The services we offer are non-medical and non-clinical, but we have a regulated team that provides clinical oversight for ABI services when required. Admissions, program design, graduation are done in collaboration with client. Clients often transition from the most supportive programs to the least supportive and all attempts are made to offer consistency in staffing as they transition.

The ABI Case Coordinator has access to ABI specialized psychiatry, behavioural support, and occupational therapy to assist in supporting clients in both our adults with physical disabilities and acquired brain injury.

With the inclusion of the ABI Case Coordinator's team, Traverse Independence can provide regulated health practitioner oversight for all ABI related services ranging from the application and referral stage to the various programs offered within Traverse Independence to consultation to the community. Traverse Independence is committed to working collaboratively with the client, caregiver and their support persons, community providers and is fully embedded in the both the mental health and addictions teams.

PROCESS

Once on the program, Traverse works collaboratively with clients, families, and community partners to develop care plans specific to the client. These care plans will be holistic in

nature, considering elements of physical health, elements of psychosocial health (functional and emotional status, family and caregiver involvement, communication, safe care abilities, cognitive status, mental health, addictions, socio-economic status, cultural and spiritual beliefs) and trauma informed. https://braininjuryguidelines.org/. This framework is based on the Ontario Neurotrauma Foundation's clinical practice guidelines.

Traverse Independence will work in collaboration with the client, and their family and community team to ensure we are meeting the client's ongoing needs as they gain skills and continued independence. For some individuals, additional referrals could be discussed with the client and their family.

Adults with Physical Disabilities

It is a privilege to support individuals in the supportive housing program, as many of these clients have resided in their housing apartment for since the inception of this organization. As the client ages in place, often their physical and cognitive abilities decrease. Should the client become too frail or too medically dependent to live in supportive housing, this organization will work with the client and their families to transition to the next stage of support, which is most commonly long-term care.

CONCLUSION

The goal of PCC is clear: to embed this philosophy in all levels of the organization starting with the governors. Ultimately, the impact will be felt in all operational outcome measures, quality and safety of client care and the client and family experience.

The philosophy starts with a vision, works through engagement that is enabled through the culture, infrastructure, and processes. Our guiding principles of dignity and respect, information sharing, participation and collaboration are critical to the success of the PCC model.