Literature Review

Person-centredness in the community care of older people:

A literature-based concept synthesis

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Abstract

'Person-centredness' is a ubiquitous term, employed in modern care services to signify policies and practices that attend to the uniqueness of each individual user. Despite being highly regarded in older adult community care services, there is much ambiguity over its precise meaning. Existing reviews of person-centredness and its attributes have tended to focus on the medico-nursing literature, neglecting other interpretations, such as those relevant to community social care. A new literature-based concept synthesis reported here identified 12 common attributes within the broad themes of 'understanding the person', 'engagement in decision-making', and 'promoting the care relationship'. The review also contrasts how these attributes are applied across different interpretations of person-centredness. The article argues that not all attributes of person-centredness necessarily pull in the same direction, and that older adults may require them to be delivered in different ways than they are to younger people. Thus, a 'one-size-fits-all' approach should be discouraged in community care.

Key Practitioner Message

- 'Person-centredness' is open to multiple interpretations, causing difficulties for services trying to gauge performance and quality;

- Three themes are central to person-centred services: 'understanding the person', 'engagement in decision-making', and 'promoting the care relationship'

- A 'one-size-fits-all' approach to applying person-centredness is to be discouraged.

'Person-centredness' is a well-established term with a long history, yet its modern usage is as a neologism – a linguistic device signifying high quality health care that is flexible and responsive to the needs of the user. Literature on 'centredness' uses varied nomenclature (commonly prefixed 'person', 'patient', 'client', 'consumer' etc.) but shares a common 'humanist' philosophy in recognising the uniqueness and agency of individuals, prioritising

subjective experiences of needs and taking a holistic view of the person (McCormack & McCance, 2006). Proponents argue that it runs counter to positivist and depersonalised bureaucratic models of long-term care that were 'too uniform; too analytical; too theoretical; too negative; and too directive' (Leplege et al., 2007, p. 1559). It further challenges the assumption that disease, disability and frailty are simply coterminous with 'illness', highlighting an unpredictable relationship between levels of functional and cognitive impairment with life satisfaction (Albrecht & Devlieger, 1999).

Person-centredness has attracted widespread support as a framework for modern care services, reflected in the policies of international governments, agencies and professional organisations (Institute of Medicine, 2001; World Health Organization [WHO], 2007). WHO has recently proposed a global strategy for a 'fundamental paradigm shift' in healthcare service design, according to person-centred principles (WHO, 2015, p.7). Its influence in policy, practice and quality assessment is evident across the care systems of the USA, Canada, Australia, New Zealand and throughout Western Europe and Scandinavia (Australian Commission on Healthcare Safety and Quality, 2011; Department of Health, 2013; Institute of Medicine, 2001). Such an elevated status has not been achieved by chance. Person-centredness is reportedly associated with improved satisfaction with care experiences and appears broadly linked with positive health and wellbeing outcomes (Chenoweth et al., 2009; Robinson, Callister, Berry, & Dearing, 2008; Stewart et al., 2000). Yet its importance is perhaps most noticed when services fail in this regard and the human costs become apparent. A landmark inquiry into the neglectful care of older adults at one hospital in England concluded that problems commonly stemmed 'from a failure to see things from the patient's perspective and to understand the effects of actions – or inaction – on them' (Francis, 2013, p. 1367).

However, there is a good deal of imprecision surrounding person-centredness and what it actually means (Epstein, Fiscella, Lesser, & Stange, 2010; Hobbs, 2009; Mead & Bower, 2000; Morgan & Yoder, 2012). It is often described by forming a contrast against what it is *not* (Whalley-Hammell, 2013). Indeed, the more often its virtues are espoused, the less clear its meaning has become, with suggestion that person-centred care is being advanced on the basis of evangelical zeal rather than a firm theoretical and empirical foundation (Nolan et al., 2004). It could be that the term is used as a rhetorical heuristic, as a way of appearing to be clear and precise when in fact hard thinking about real complexity is being ignored (Kahneman, 2011). The spread of interpretation is wide. Some relate it only to psychological care, or with 'just giving people what they ask for' (Epstein et al., 2010). Others have broadened its scope where it acts as a synonym for 'good practice' (Nolan et al., 2004). This conceptual plasticity poses problems. Whilst many interventions are described as achieving person-centredness in different care environments, without a set of agreed service attributes it proves difficult to demonstrate fidelity to any core model. Conceptual ambiguity is thus weakening its scientific value (Robinson et al., 2008), with a recent Cochrane review recommending further research efforts to identify 'active elements' of person-centred approaches (Dwamena et al., 2012).

Person-centredness and policy

One cause of ambiguity is that a policy narrative has emerged across Western governments that adopts a selective interpretation of person-centredness. For instance, Nolan et al. (2004) described a dominant account that seeks to endow patients with greater autonomy and independence over care, with governments and international bodies seeking to promote health literacy and information sharing, encourage a wider choice of providers and services, and extend capacity for self-care (e.g. WHO, 2007). To the extent this gives greater 'choice and

voice' in a (quasi-) market system for services, analogies have been drawn between this interpretation of person-centredness and aspects of consumerism and new public management (Newman & Vidler, 2006).

Those advancing alternative interpretations (e.g. Cardol, De Jong, & Ward, 2002; McCormack, 2003; Nolan et al, 2004) criticise the implied individualism in the above, and prefer to emphasise person-centredness as reflecting the interpersonal and interconnectedness of care work, fostering a positive environment and caring atmosphere. At face value, this appears intuitively well-suited for older adults receiving longer-term community care. Older adults have traditionally expressed lukewarm attitudes to autonomy over services (Levinson et al., 2005), whilst giving more weight to their relationship with practitioners, (Bastiaens et al., 2007; Bowers, Fibich & Jacobson, 2001; Bridges, Flatley, & Meyer, 2010; Francis & Netten, 2004), not only for their direct care needs, but also to reinforce obscured personhood and achieve a validation of personal experiences (Bowers et al., 2001; Byrne, Frazee, Sims-Gould, & Martin-Matthews, 2010).

Importantly, it is feasible that these different interpretations of person-centredness pull in different directions, especially in relation to long-term community services. For example, cash-for-care schemes, advanced in many Western countries as a means of delivering person-centredness, promote autonomy by delegating purchasing controls to the end-user to recruit their own care workers (Wilberforce et al., 2011). However, this may hinder the formation of care relationships and interfere with interpersonal exchanges by turning care into an economic and contractual transaction (Beatty et al., 1998).

From values to attributes: the need for synthesis

Much that has been written about person-centredness is expressed in normative terms, with insufficient attention to describing attributes that can be used for designing interventions,

training or other 'actionable' practices. However, of reviews that have sought to articulate attributes (e.g. Hobbs, 2009; Mead & Bower, 2000; Morgan & Yoder, 2012; Pelzang, 2010), there is a narrow focus on medico-nursing literature. For example, Kitson and colleagues' (2013) carefully constructed review excluded references relating to aged care in residential settings, and therefore omitted a body of literature of particular relevance to older adults with dementia. Of the few literature reviews with wider scope (e.g. Hughes, Bamford, & May, 2008), the focus is still restricted to health services and residential care. Crucially, this neglects community social care perspectives. For example, the distinct critique of biomedical models by disability theorists and activists (e.g. see Oliver, 1986) may give rise to alternative interpretations of person-centredness. It is notable that social workers have been found to describe different attributes of person-centredness to nurses and doctors, even in a health setting and despite agreeing on its overall principles (Gachoud et al., 2012). Given that the majority share of long-term community care resources is directed at older adults, this perspective is significant.

This new study aims to identify and synthesise the key service attributes that are considered person-centred. Attention has been restricted to those attributes relevant to the community care of older adults and those which are common to different interpretations. The research further has sought to identify any heterogeneity in how these attributes are described across the literature.

Methods

A 'concept synthesis' of relevant literature-based sources was undertaken, informed by the methods outlined in Walker & Avant (1995). The approach seeks to add new knowledge by forming definitions and structures of attributes from descriptions of ambiguous phenomena. This approach is particularly helpful when confronting an idea which is in widespread use but

where the meaning is clearly variable. A concept analysis is well-suited to synthesis across multiple interpretations. It recognises that whilst language and its use may differ, concepts can be 'evaluated in reference to their resemblance, rather than strict correspondence' (Rodgers, 1989, p. 332). A concept is considered an 'image' of a broad idea; a mentally-formed construct which is articulated, imprecisely, through descriptions of its main features (Walker & Avant, 1995). For our purposes, person-centredness is considered multi-dimensional, with no single attribute describing the concept in its entirety.

Search, analysis and synthesis

The review began with a broad search relating to the construct of interest: in this instance, descriptions of person-centredness and its attributes. Initially, authoritative texts familiar to the authors were reviewed and key references snowballed from these. This assisted in achieving a preliminary map of the likely field. Subsequently, searches for 'person-centredness' and 'older people' (and appropriate surrogates) were undertaken in CINAHL, Medline, Web of Science, PsycINFO, ASSIA, and Social Science Abstracts in January/February 2014. Generic search engines were additionally used to identify policy- and practice-related sources. References were also pursued on the recommendations of other academics and practitioners in the course of discussions. Sources were reviewed if their titles, abstracts, contents pages, forewords or indexes indicated that they focused, in whole or in part, on descriptions of attributes. References were *not* considered if they related to contexts unlikely to be influential in the long-term community care of older people.

The search was an iterative process in combination with data extraction and preliminary analysis. Initially, references were read by a single researcher, and brief descriptions of (a) context/setting, (b) conceptual roots (where available) and (c) service attributes were recorded in Excel. Attributes were either 'self-identified' within the source,

such as in a list format or through use of subheadings, or otherwise were embedded as part of longer narratives requiring the researcher to judge where boundaries between attributes lay. The template used to extract information, and an application to one reference, are presented as Supplementary File 1. As shown, the template sought modest summary descriptions rather than 'thick' narratives, suitable for synthesis of broad descriptions but not able to provide a forensic depth of explanation.

Descriptions of attributes themselves were thematically organised and compared against new attributes as the search progressed, challenging or validating the existing categorisation. A hierarchical structure was formed by the authors grouping specific attributes under broader headings. Preliminary results were discussed amongst authors, leading to more directed searches for potential omissions. Searching ended upon reaching a stable platform, whereby new sources did little to alter the attribute or thematic headings.

Narrative descriptions for each attribute were then formed using the data collected in Excel, and then expanded upon using knowledge accrued during the review. This included following bibliographies to additional references cited in the original text, and by additional searches for texts explicating the attribute in further detail, and/or providing examples of attributes in practice.

Findings

Overview of the literature

The literature comprised a wide spread of theoretical and literature-based conceptual developments, policy narratives and syntheses, critiques, commentary and opinion, new practice developments and their empirical study, including therapeutic approaches based on person-centredness, and quality, audit and measurement literature relevant to attribute identification. Information on attributes was recorded from 51 sources, with a further 79

contributing to a further elaboration of these attributes in practice, and/or providing further information on different interpretations of person-centredness. The sources are listed in Supplementary File 2. The diversity of the literature reflects the breadth of health and social care disciplines in which person-centredness is now influential. However, the literature was bound by a shared use of 'centredness' as a term to describe care oriented to the needs and preferences of the user, rather than practitioner, and by agreement on the negative consequences of a purely medicalised perspective of illness and disability.

Using data on context and conceptual origins, five interpretations of person-centredness were identified (see Box 1) sharing common roots. For example, its psychoanalytical origins were widely acknowledged. Michael and Enid Balint are regarded as early architects in supporting general practitioners in paying closer regard to the 'whole person' (Balint, 1957) and forming 'Balint Groups' still in operation today. Carl Rogers' client-centred therapy sought to advance practitioner understanding by assuming clients' 'internal frame of reference … to perceive the world as the client sees it, to perceive the client himself as he is seen by himself' (Rogers, 1949, p. 86). Literature also commonly identifies Engel's (1977) bio-psycho-social model as marking a step-change in extending biomedical models towards psychological and social dimensions of illness. Nursing and medical literature shared much in common although origins and context often differed. For example, person-centredness in nursing initially developed in response to greater preceduralisation at the bedside, as perceptions grew that nursing was becoming task-oriented as new technologies, diagnostic techniques and specialist work was devolved to individual wards (Hobbs, 2009; van Servellen, 1988).

[Box 1 about here]

Beyond context and setting, distinct theoretical positions and epistemologies were also evident. Person-centredness in dementia care draws upon social constructionist perspectives

of ageing (Bond 1992; Estes & Binney, 1989), and of identity, personhood and agency (Sabat & Harre, 1992) in the context of cognitive decline. The seminal works of Tom Kitwood (1997) are seen as defining person-centred dementia care, which seeks to address how perceptions of dementia can detrimentally affect a person's standing in relation to those around him or her. Gerontological nursing has since produced a healthy stock of related conceptual advances, particularly in developing enabling care relationships (Dewing, 2004). By contrast, a separate literature of influence in social care is rooted in *Normalisation* and *Social Role Valorisation* theories advanced by Wolfensberger (1972), which provided a framework for analysing how social positions become (de)valued. The theory attained traction in long-term support for disabled people, where it dovetailed with critiques of institutional forms of care, the advance of the independent living movement and social model of disability (Oliver, 1986). This literature is commonly identified as 'person-centred planning', and was adopted in practice, initially in North America, by John O'Brien (O'Brien, 1980) and collaborators. Despite origins in the context of disabled younger adults, applications to services for frail older adults were evident as its influence spread.

Finally, a smaller body of literature is related to client-centred rehabilitation with roots in Canadian occupational therapy practice (Townsend et al., 1990). Though sharing similarities with medical and nursing literature, it contains a greater exposition of the importance of participation and occupational (not just social) roles in maintaining identity and wellbeing.

Attribute synthesis

The concept synthesis generated a framework of person-centredness comprising 12 attributes, summarised in Table 1. The findings are organised under three thematic headings: 'understanding the person', 'engagement in decision-making', and 'promoting the care

relationship'. Each section provides a summary description of each attribute (identified in square brackets), followed by an account of variation across the different interpretations of person-centredness outlined above.

[Table 1 about here]

Understanding the person. Person-centredness emphasises the uniqueness of individuals: that each is an experiencing and sentient being, with differing needs and aspirations. Consequently, person-centred approaches demand a heterogeneous response set even to apparently homogenous disorders and disabilities.

At its simplest, this attribute relates to the personal interpretation and meaning of illness or disability, and how this creates perceptions of health and care needs [*Understands the personal experience of illness/disability*]. In the context of medical care, it has been described as separating disease (pathological processes) from 'dis-ease' (the phenomenon of feeling unwell) (Stewart et al., 1995). In considering both, the practitioner seeks to enter the person's world, 'to see the illness through the patient's eyes' (Gerteis et al., 1993). Each account will be influenced by the person's own life circumstances, which will span personality traits, cultural and ethnic roots, religious and spiritual beliefs, education and occupational backgrounds, values and preferences, and support networks (Levenstein et al., 1986; Morgan & Yoder, 2012; Stewart et al., 1995). This is clearly observed in personal accounts of dementia, suggesting that lived experiences are profoundly individual. The erosion of cognitive capacity and abilities in activities of daily living is commonplace in dementia, and some narratives describe a deeper reflection on vulnerability, aging and mortality (Bond & Corner, 2001). However, other accounts also highlight resilience and adaptation, of new experiences and friendships, and of opportunities for enrichment (Steeman et al., 2007).

Further, person-centredness highlights the inter-relationship between the biological, psychological and social context which combine to form uniquely-framed disorders (Engel, 1977). This process has been described as achieving a 'breadth' of understanding regarding a person's situation, in contrast to a 'depth' of understanding described above (Stewart et al., 1995; p.4) [*Knows the different dimensions of life requiring support*]. In general, the literature makes reference to 'whole person' care and holistic approaches. This often focuses on identifying unmet needs, or interconnections between the immediate care needs and the person's wider context (Barry & Edgman-Levitan, 2012; Epstein et al., 2010; Mead & Bower, 2000). Further, it seeks an understanding of how preferences for different treatment and care options may be formulated according to their values [*Understands the person's values and preferences in care*], which may include the identification of personal insights into their own strengths and weaknesses (Morgan & Yoder, 2011; Radwin, 1995).

Many sources associated person-centredness with a broader understanding of a person's history and personal narrative. One goal, especially (but not uniquely) in the context of cognitive decline or intellectual disability, is to provide care in a way that establishes care goals that are congruous with an individual's values and identity [*Know what is important to the person's identity and wellbeing*]. For example, the person-centred planning literature describes the importance of 'mapping' key aspects of an individual's life, including a personal history, relationships, usual routines, dislikes and other information (Dowling, Manthorpe, & Cowley, 2006; Holburn et al., 2000; O'Brien, O'Brien, & Mount, 1997). This is achieved through the perspectives of the individual and of others who know him or her, including families, friends and carers. The form of the mapping is often pictorial, maximising opportunities for those with limited reading skills to participate, and to present a positive and colourful representation (Dowling et al., 2006). This information then acts as a foundation for establishing life goals and the necessary 'supports' needed for success (van Dam et al., 2008).

Despite identifying common attributes, the review identifies heterogeneity in how they are described and manifest in practice. In general medical literature, 'understanding the person' could enable a clinician to intervene more effectively, such as by promoting healthier lifestyles and health education for prevention, modify help-seeking behaviours, and identify and address 'hidden agendas' where a patient may not be forthright in expressing needs (Epstein et al, 2010; Mead & Bower, 2000). In dementia care, there is also practical value in these attributes, such as by enabling practitioners to initiate conversations, develop meaningful activities, promote helpful routines and to enhance communication (Byrne et al., 2010; Rosvik et al., 2011). Yet the intent of such biographical knowledge goes further in dementia care, and can become part of therapeutic intervention, include reminiscence-based approaches, incorporating music, photographs and scrapbooking, each appealing to the 'inner world of the individual' (Kontos, 2005). Moreover, a deep understanding of the person ensures that practitioners do not compound cognitive decline by failing to recognise the person that still is (Brooker, 2003; Kitwood, 1997). By responding to personality traits and valuing a person's competencies and skills, life experiences and expertise, a person's sense of self is protected (Sabat & Harre, 1992).

Engagement in decision-making. The inclusion of people in decision-making [*Person is involved in decision-making processes*] has been described as the 'pinnacle' of person-centredness (Barry & Edgman-Levitan, 2012). Together, the literature demonstrates different levels at which decision-making may involve service users. At the *macro*-level, person-centredness is reflected in engaging the public in establishing priorities and systems for the commissioning and delivery of services (Needham, 2009), linked to models of co-production in public service management first developed in the 1970s. At the *meso*-level, person-centredness reflects the degree to which service users/carers are engaged in the processes of

care planning, through which support needs, care goals, preferences and available services are assessed and organised [*Person's wishes shape decisions and care plans*]. At the *micro*-level, person-centredness is evidenced in direct care delivery, in the interpersonal exchange between care worker and service user in completing caring tasks [*Flexible care services tailored to individual preferences*]. For any individual, decision-making in the context of long-term support will be fluid depending on his or her position in a care pathway.

How information is exchanged is commonly identified in the literature [*Information and options are shared in a clear format*] (Institute of Medicine, 2001). In dialogue, questions are typically more open-ended than in practitioner-led discussions. Language is tailored to vocabulary familiar to the service user and avoids jargon (O'Brien & O'Brien, 1999). Information is often available in multiple formats to suit the individual, and some sources link the information with formal decision-making tools (Sanderson & Lewis, 2012). Supporting decision-making may require that complexity is minimised and that choices be restricted to a manageable number, using knowledge of the person and his or her long-standing preferences.

The heterogeneity in the literature appears linked to the *degree* to which these four attributes of 'engagement in decision-making' are realised, often considered along a continuum, from 'practitioner-led' to 'user-led', with various gradations between. These distinctions echo case management literature, differentiating by analogy the roles of 'travel agent', 'travel companion' and 'travel guide' in the role of the professional reflecting the passage through the continuum (Deitchman, 1980; Kanter, 1989).

For individual care decisions, this is presented in Table 2, within an illustrative three-stage decision-making process (after Charles, Gafni, & Whelan, 1997). At one end, the care practitioner leads the process, acting as the guardian of the service user's best interests. Practitioners take decisions by choosing what (they perceive) the patient would have picked, had s/he been sufficiently skilled to do so; a 'professional-as-agent' approach (Charles et al.,

1997). This requires the knowledge of the person underpinned by the first theme discussed above, yet still leaves decision-taking in the hands of the clinician. Similarly, practitioner-led rehabilitation will 'prescribe' enabling activities, rather than reaching these in partnership with the client (Bright et al., 2012; Whalley-Hammell, 2013). Although person-centred dementia encourages active participation in daily decisions, (Brooker, 2003; Rosvik et al., 2011) in advanced dementia practitioners may make choices in close accordance with what is known about the person and his or her 'critical interests' (Koppelman, 2002).

[Table 2 about here]

Most papers examined promote *shared* decision-making by acknowledging the expertise service users bring to decision-making and by supporting them in interpreting information and reaching mutually-agreed choices (Sanderson & Lewis, 2012; Tutton, 2005). As such, decision-making is not considered a zero-sum game between its participants, and greater mutuality improves decisions than do individual efforts alone (Kapp, 1991). Shared decision-making is characterised by exchange and agreement at each stage, the search for 'common ground' (Stewart et al., 1995). Decisions are reached through information sharing and evaluated against service user preferences, information on the likely efficacy of care options and the availability of services (Sumison & Law, 2006). Responsibility for the final decision is also shared, by consensus or compromise.

At the other end of the continuum, the service user is seen as leading the process, and the practitioner acts as an adviser with expert knowledge and technical skills, assisting the service user in interpreting information and assessing options. The person-centred planning literature particularly stresses a user-led process, with a view that only by transferring power from the practitioner to the service user can support ever 'truly' be person-centred (O'Brien & O'Brien, 1999; Taylor & Taylor, 2013). An underpinning principle suggests that individuals have full autonomy over determining their care aims by specifying what they wish to achieve

in life (Dowling et al., 2006), and then plan the supports required. Practitioners may be required to advocate for the service user at an organisational level, to challenge prevailing rigidity of formal care services (Dowling et al., 2006; Mansell & Beadle-Brown, 2004). Sources also allude to the importance of individualised funding arrangements, whereby the service user directly purchases care. Returning to the decision-making process outlined in Table 2, individualised funding potentially extends control beyond the final 'decision' stage, to 'implementation' and then to 'management' and 'review'.

The literature also reveals heterogeneity in the *purpose* of choice and control in decision-making, with some asserting it to be more than just a means-to-an end – that of reaching the 'optimal' decision. In descriptions of person-centred planning, this autonomy serves a much broader purpose, and is paramount to achieving personal freedom and the right to full citizenship and self-determination (Duffy, 2012). Similarly, in rehabilitation literature, person-centredness attends to occupation and a means to self-expression (Townsend & Wilcock, 2004). The removal of choice also forms part of the 'malignant social psychology' in dementia care, and thus, choice and control of care are viewed as integral to personal continuity and have implications for identity to the extent that a person's 'authentic self' can be reinforced by the choices we make (Koppelman, 2002). This may be most important with regard to 'tacit decisions' – the habitual ways of interacting and engaging in daily life which gives 'expression to the operative sense of self' (Agich, 1995, cited in Eales, Keating, & Damsma A, 2001, p. 281).

Promoting the care relationship. The different narratives of person-centredness share a common recognition of the importance of the interpersonal relationship. Medical and rehabilitation perspectives have typically explored the patient/practitioner dyad, and often in relation to decision-making (thus overlapping with the above). A common theme is the

establishment of a 'working alliance' a relationship characterised by mutual respect and

appreciation of the unique insights brought by each to discussions; each treating the other

with high regard, despite asymmetrical roles [*Friendly, caring and respectful interactions*]

(Bright et al., 2012; Stewart et al., 2000). Successful care relationships depend on

practitioners demonstrating active listening and 'human communication' (e.g. humour, chat,

social talk), establishing rapport, with deeper respect being forged over time [*Continuity and

coordination in care relationships*] as the practitioner demonstrates a recognition of the

individual's background and expectations at subsequent meetings (Bright et al., 2012). Care

relationships can be disrupted by discontinuities, both in terms of regular turnover of staff

delivering services and failure to coordinate activities between different professionals and

agencies (Buron, 2008; Gerteis et al., 1993; Pelzang 2010).

Person-centred planning literature emphasises positivity in relationships by attending

to aspirations and capabilities rather than just needs and deficits [*Positive attitude to person's

capabilities and roles*] (Mansell & Beadle-Brown, 2004). However, it also stresses concern at

how easily practitioners come to dominate relationships (O'Brien et al., 1997) and, in some

accounts, the professional's role is to 'intrude' as little as possible (Taylor & Taylor, 2013).

Yet perhaps the most distinctive feature of a person-centred planning approach relates to those

providing support *beyond* the planning process, those who deliver the care. As noted above,

person-centred planning has been long-linked with the direct employment of care workers

(O'Brien & O'Brien, 1999), and a key role for person-centred planners is to support a close

match between service users and their personal assistants (PA) (Department of Health, 2010).

This match may include shared personality traits and common interests, in addition to seeking

skills prioritised by the service user (Sanderson & Lewis, 2012). One of the benefits includes

the potential to be supported in an atmosphere of 'companionship', where care tasks are

enveloped in a broader caring relationship free from the rigidity of care agency procedures (Ahlstrom & Waderstam, 2010).

In related fashion, recent years have witnessed the advance of 'relationship-centred' care as a challenge to individualistic interpretations of person-centredness. Developed initially in the context of broader medical care and clinical training, the approach promotes authenticity in practitioner communication [*Reciprocity in care relationships*]. It builds on Mead and Bower's (2000) analysis in which person-centredness is described as 'two-person medicine', alluding to Balint's critique of the biomedical model as being unnaturally neutral and objective, and denying the transference, counter-transference and broader emotional context brought by the clinician. The approach has arguably been most influential in the field of gerontological nursing, in particular in extending the focus to triadic relationships and, potentially, to whole communities. For example, in long-term care settings for older adults, the *Senses Framework* specifies the emotional needs that staff and residents achieve in an 'enriched' environment (Nolan et al., 2004). Interpersonal relationships are built on compassion, emotional support and empathy, developed through the knowledge of the person and inclusive approaches to decision-making (see above) (Dewar & Nolan, 2013).

The review identifies heterogeneity in the bounds of such relationship work across the different interpretations of person-centredness. Medical literature is largely focused on the practitioner / patient dyad, with some extension to the wider family and household. Yet some interpretations extend this dimension to wider communities and neighbourhoods to make best use, or to enhance, social capital. Again, person-centred planning literature stands-out as having broadest scope in promoting relationship formation at a community-level through inclusion of any number of local 'supports' such as voluntary sector agencies and community groups (Holburn et al., 2000). Potential 'circles' of neighbourhood resources are included at the point of support planning, seeking to overcome the separation of people with disabilities

from local communities (van Dam et al., 2008). Yet, although the 'language of person-centred planning is the language of reciprocity, mutual interdependence and community' (Mansell & Beadle-Brown, 2005, p. 3), in practice it has relied on a culture change that, arguably, has not moved hand-in-hand with its aspirations (Dowling et al., 2006; Mansell & Beadle-Brown, 2005).

Discussion

Person-centredness has been described as having totemic qualities. It is both emblematic of high quality services and is revered in some quarters as a morally responsible philosophy of care (Radwin & Alster, 2002). However, attempts to reach a consensus when moving from the general to the specific have proven problematic and the remaining ambiguity in clarifying its attributes has compromised its usefulness (Dwamena et al., 2012).

This difficulty is made more acute by the competing interpretations that have developed in different settings and specialisms. These differences are often ignored, with suggestion that a 'siloed' approach to person-centredness has emerged (McCormack et al, 2010). Indeed, this review highlights an irony in that person-centredness is oft-seen as adding the 'social' to the 'medical', yet existing literature reviews have focused on general health services, ignoring references in community social care. A key contribution of this review is thus an extension of scope to social care and person-centred planning literature. This body of work shares much in common with other traditions, such as a shared appreciation of early pioneers (e.g. Carl Rogers) and mutual disdain for biomedical views of disability (Dowling et al., 2006). Yet person-centred planning literature offers unique solutions from its (arguably) more radical origins in the Independent Living Movement. It has also come to enjoy significant influence in policy, especially in England where its principles have underpinned a government drive for 'self-directed' healthcare (Glasby & Littlechild, 2014).

However, for older people receiving support for long-term conditions in their own home, no single description of person-centredness can claim a monopoly on relevance. Compared with the general population, they will make substantial use of general medical services, of nursing care and rehabilitation services, of support designed specifically for people with dementia, and of social care at home and at local community venues. Hence the need to identify and describe the key service attributes that are common to each interpretation – the purpose of this article.

The principal finding of this review is that 12 such care attributes can be distinguished. However, it finds significant differences in how these manifest in practice, requiring careful consideration when applying them in older adult community services. For example, the review finds a consensus in promoting greater service user involvement in care decision-making, but variation in how this is achieved in practice. Some interpretations recommend autonomy to be achieved at the 'system-level', through co-production of service design alongside agencies and providers or by seeking influence over wider community resources. Others instead focus on care planning, such as through encouraging choice of service providers and by specifying what care is to be provided. The review thus prompts a return to a decades-old question in gerontology: autonomy over what? (Collopy, 1988; Simon-Rusinowitz, & Hofland, 1993). Prior research suggests that older people may prefer less overt approaches to directing care: by involvement in decisions (decisional autonomy), rather than in implementation (executional autonomy) (Boyle, 2005); by being actively consulted, but not asked to lead decision-making (Axtell-Thompson, 2006; Bastiaens et al, 2007; Tutton, 2005); and by engaging in immediate features of care rather than in long-range planning (Collopy, 1988). A 'one-size-fits-all' approach is to be discouraged.

The review also indicates some variation in the underlying intent of person-centred care. Many references adopt a relatively 'functional' approach in which person-centredness acts a

means-to-an-end, prescribing approaches that permit the best possible decisions to improve care outcomes for the individual. Some commentators have criticised this stance, arguing it may unintentionally act to reinforce a biomedical model (citing examples of clinicians using person-centred approaches to improve 'adherence' and 'compliance' to medical treatment [Grob, 2013]). Other literature, by contrast, regards person-centredness as an end-in-itself, worthy of pursuit regardless of care outcomes (Epstein et al, 2010). Yet by appealing to ethical arguments, this standpoint may appear to absolve person-centredness from the rigour of scientific study. Such debates are not easily resolved.

The growing influence of relationship-centred care, particularly in gerontological nursing, offers new insights into the importance of interpersonal relationships promoted through person-centredness. The *Senses Framework* (Nolan et al, 2004) offers a return to relationship work, and parallels can be drawn with broader theories of social relationships (Huxley et al., 2009). New relational models of care are now being developed with testable components (Keady & Nolan, 2013), although with few applications in community care. However, it may be that a focus on relationship work in itself creates new obligations for service users, to divulge life details that they prefer to keep private, and to enter a form of inter-dependency forced upon them by virtue of their need for care services[1].

Limitations

This review was not systematic according to Cochrane criteria. Instead, the search and analysis were undertaken using an iterative process, as the primary reviewer became more familiar with potential attributes in each field. This was justified by the diverse nature of the literature, and meant that authors could seek further validation and description of emerging attributes through additional searches. Yet it also introduced subjectivity into the process.

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[1] The authors are grateful to an anonymous reviewer for this observation.

What constituted an 'emerging attribute' may have been influenced by the authors' own observations, and other reviewers may have followed different lines of enquiry. Further, whilst the initial selection of attributes was based on a systematic recording of data, the subsequent illustration of these attributes was narratively formed using the authors' knowledge obtained during the review process.

A further limitation was the requirement for references to identify themselves as 'person-centred' for inclusion. Whilst a range of surrogate terms were also used, it is possible that these were not complete. Furthermore, in providing a sketch of person-centredness spanning multiple health service and social care perspectives, what the review gained in 'breadth' of scope, it arguably lost 'depth'. For example, person-centredness in the context of cultural diversity, religious expression and in palliative medicine were not addressed.

Lastly, the framework of 12 attributes is an attempt to summarise what person-centred care 'looks like', but introduces an arbitrary simplicity to how they are inter-related. This review is not alone: Brooker's (2003) framework presents person-centredness as an additive form, $V+I+P+S$[2], a mnemonic geared to assisting its use in practice. Yet one analogy advances the idea of person-centredness as a rope, comprising multiple fibres which form a whole only when twisted together (Hughes et al., 2008). As such, the sum may be greater than its parts.

Conclusion

Person-centredness is widely regarded as being a 'good thing', but at present the mantra encouraging its spread has outpaced the search for evidence as to its components, boundaries and effectiveness. This review has identified 12 attributes common to both health and social

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[2] **V**aluing people with dementia; treating people as **i**ndividuals; looking at the world from the **p**erspective of the person with dementia; a positive **s**ocial environment.

care interpretations of person-centredness, but finds significant variation in how they are applied in practice. In application to older adults receiving community care, the study concludes that a 'one-size-fits-all' approach should be avoided.

Acknowledgements

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