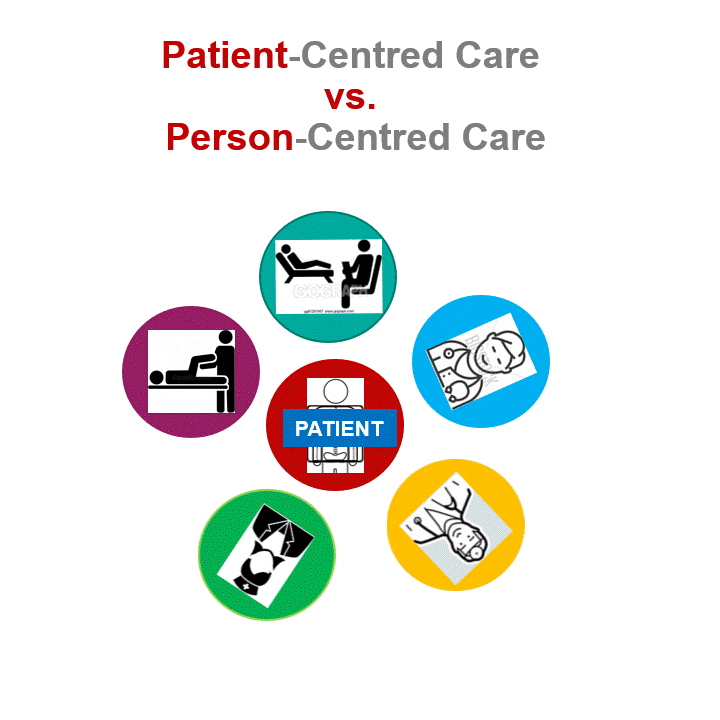
Person-Centred Care (PCC) means a step forward from well-established approach called Patient-Centred Care. The Picker Institute, identified eight characteristics of care as the most important indicators of Patient-Centred Care[1]:

1. respect for the patient’s values, preferences, and expressed needs;
2. coordinated and integrated care;
3. clear, high-quality information and education for the patient and family;
4. physical comfort, including pain management;
5. emotional support and alleviation of fear and anxiety;
6. involvement of family members and friends, as appropriate;
7. continuity, including through care-site transitions;
8. and access to care.

The most important omission in the list is partnership between a patient, their family and healthcare professionals. Thus, Person-Centred Care is shift from a model of care based on diagnoses and one side physician judgement to an approach based on a contractual agreement between a patient, their family and medical professionals. PCC involves the patient as an active partner in care and the decision-making process. Patients and health care professionals jointly develop a health plan based on the patient´s illness history which identifies personal resources and opportunities in the home and social network as well as potential barriers. Identified resources together with medical examinations and bio-markers form the foundation for elaborating the jointly agreed care plan [2].

In Patient-Centred Care a patient is in the centre of the care process but is not an equal partner in their own care and treatment.



In Person-Centred Care in the centre are “patient’s goals, capabilities and expectations” and the patient is an equal partner together health care professionals in the decision-making process concerning their care. This idea does not imply that patients and professionals take on the same roles and responsibilities as in a negotiation between equals. The fundamental equality and asymmetry between patient and professional implies that their relationship cannot be a matter of a one-way exercise of power, but neither a symmetrical exchange of information. Establishing a partnership requires an active involvement from both parties, but from different starting points and with different prerequisites. The professional is an expert in medicine, rehabilitation, care etc. and the patient is an expert on their own life, fillings and desires. Person-centred care (PCC) addresses the importance of knowing the person behind the patient.

There are many centres in Europe and the US where PCC is developed. One of the most prominent is the University of Gothenburg Centre for Person-Centred Care (GPCC) (<https://gpcc.gu.se/english>). The GPCC model consists of three essential ‘routines’ to initiate, integrate and safeguard person-centred care in daily clinical practice [3]:

1. **Patient narrative.** The first routine serves to initiate a partnership by eliciting the patient narrative - a sick person’s account of their illness, symptoms and their impact on their life. It captures the person’s suffering in the context of their everyday life, as an equal addition to medical narratives that reflect the process of diagnosing and treating the disease.
2. **Partnership.** The second routine serves to work the partnership by means of shared decision making, so that professionals, patients and very often their relatives all work together to achieve commonly agreed goals.
3. **Documentation.** The third routine serves to safeguard the partnership by documenting the narrative in the form of patient preferences and values, as well as involvement in care and treatment decision making.

These routines lead to jointly agreed care plan which have to embrace [3]:

* clinical tasks to be undertaken by the professionals and
* everyday goals undertaken by the patient/relatives.

**Questions identifying a person-centred care**

when most of the answers to the following questions are positive than one can consider that delivered care is consistent with person-centred care approach [2] [3] [4] [5]:

1. Do professionals and therapeutic teams plan care and treatment together with patients and their relatives and make key decisions together?
2. Do professionals ask about patient preferences (both treatment preferences and the goals of treatment)?
3. Do professionals listen to the patient's narrative about their life and environment, often in the presence of their family, and on this basis identify their psychophysical state, hierarchy of values, ideas and thoughts regarding the improvement of their life and document it?
4. Do professionals understand the patient as a person in a socio-cultural context and identify their individual (and their social network) opportunities and limitations.
5. Are the identified opportunities and limitations used to better transform the resources provided by health care to strengthen the functionalities desired by the person?
6. Do professionals and patients (together with relatives) work as partners in the process of care and/or treatment and/or rehabilitation?
7. Does cooperation with professionals allow patients a sense of control over their care and/or treatment and/or rehabilitation?
8. Are people with low levels of activation, self-efficacy or faith in self-management of their care and/or treatment and/or rehabilitation supported in order to develop knowledge, skills and self-confidence to manage their health and well-being?
9. By listening to the patient's narrative, does the professional identify the needs and abilities in self-care and preventive care, focusing on the patient's available strengths to promote healthy behaviours?
10. Is the professional always seeking agreement on a care and treatment plan based on ethics?
11. Is the jointly prepared care and/or treatment and/or rehabilitation plan documented?
12. Is the current version of this plan always available to the patient?
13. Are the changes introduced in the patient's life discussed at the next meeting?

**Evidence about how PCC improve quality and contain costs of medical services**

**Jędrzeju, sprawdź czy tłumaczenie terminów medycznych na j. ang. jest dobre. Bo ja już nie zaglądałem do angielskich źródeł, tylko tłumaczyłem z polskiego.**

Zastosowanie Opieki Zorientowanej na Osobę (OZO) u pacjentów ze złamaniami szyjki kości udowej doprowadziło do skrócenia liczby dni opieki o 50 procent oraz zredukowało liczbę powikłań medycznych i poziom odczuwanego przez pacjentów bólu. To samo badanie pokazało, że najwyższą poprawę osiągnięto u najstarszych pacjentów. W grupie 91–97 lat liczba dni opieki zmniejszyła się z 46 dni do 12 dni, w porównaniu z grupą wiekową 65–70 lat, w której liczba dni opieki została zmniejszona z 16 do 14 dni

The use of PCC to patients with hip fractures has reduced the number of days of care by 50 percent and reduced the number of medical complications and the level of pain experienced by patients. The same study showed that the highest improvement was achieved in the oldest patients. In the 91–97 year group, the number of days of care decreased from 46 days to 12 days, compared to the age group 65–70 years in which the number of days of care was reduced from 16 to 14 days [6].

Wykorzystanie OZO w stosunku do pacjentów z reumatoidalnym zapaleniem stawów wykazało zmniejszone zmęczenie, zwiększoną siłę mięśni, większe zaufanie do własnych zdolności i lepszą samoocenę zdrowia, a także wpłynęło na redukcję kosztów leczenia

The use of PCC in relation to patients with rheumatoid arthritis has shown reduced fatigue, increased muscle strength, greater confidence in their own abilities and better self-assessment of health, as well as reduced the cost of treatment [7].

Podobnie, wprowadzenie OZO podczas leczenia nowotworów i opieki paliatywnej doprowadziło do wyższej jakości życia i większego złagodzenia objawów w porównaniu do grupy kontrolnej

Similarly, the introduction of PCC during cancer treatment and palliative care led to a higher quality of life and greater relief from symptoms compared to the control group [8] [9].

Również w opiece nad osobami starszymi z demencją i generalnie w opiece psychiatrycznej po wdrożeniu OZO odnotowano pozytywne efekty. Indywidualnie dostosowane interwencje OZO dla osób z demencją w 12 domach opieki obniżyły odsetek mieszkańców przyjmujących neuroleptyki o około 19,1 procent w porównaniu z innymi podobnymi ośrodkami

Positive effects were also seen in the care of elderly people with dementia and generally in psychiatric care after the implementation of PCC. Individually tailored PCC interventions for people with dementia in 12 nursing homes reduced the proportion of residents receiving neuroleptics by about 19.1 percent compared with other similar centers [10],

a inne badania pokazały, że atmosfera w domu opieki po zastosowaniu OZO była bardziej przyjazna niż wcześniej, a personel był mniej zestresowany

and other studies have shown that the atmosphere in the nursing home after applying PCC was more friendly than before and the staff were less stressed [5].

W opiece psychiatrycznej około 50 procent pacjentów zgłosiło podczas badania, że OZO doprowadziła do obniżenia lęku w porównaniu z 10 procentami wśród pacjentów leczonych konwencjonalnie. Podobne wyniki wykazano w przypadku depresji

In psychiatric care, about 50 percent of patients reported during the study that PCC led to a reduction in anxiety compared with 10 percent among patients treated conventionally. Similar results were shown in the case of depression [11].

Istotnym problemem współczesnej ochrony zdrowia jest również nieprzestrzeganie przez pacjentów zaleceń profesjonalistów medycznych, szczególnie w okresie po ostrym incydencie choroby. Wyrazistym przykładem może być choroba wieńcowa, w której dzięki postępowi medycyny inwazyjnej znacznie spadła śmiertelność, jednakże efekty te są niszczone poprzez brak późniejszej rehabilitacji, gdyż tylko nieznaczny odsetek pacjentów w niej uczestniczy

An important problem of modern health care is also the patients' failure to comply with the recommendations of medical professionals, especially in the period after an acute incident of illness. A clear example may be coronary artery disease, in which due to the progress of invasive medicine, mortality significantly decreased, however, these effects are destroyed by the lack of subsequent rehabilitation, because only a small percentage of patients participate in it [12].

Podobne problemy dotyczą stosowania profilaktyki związanej np. z aktywnością fizyczną, zdrowym żywieniem, paleniem oraz utrzymywaniem odpowiedniego poziomu cholesterolu. Również w tym obszarze zastosowanie OZO przynosi wymierne rezultaty

Similar problems relate to the use of prophylaxis associated with e.g. physical activity, healthy eating, smoking and maintaining adequate cholesterol levels. Also in this area, the application of PCC brings measurable results [12] [13].

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